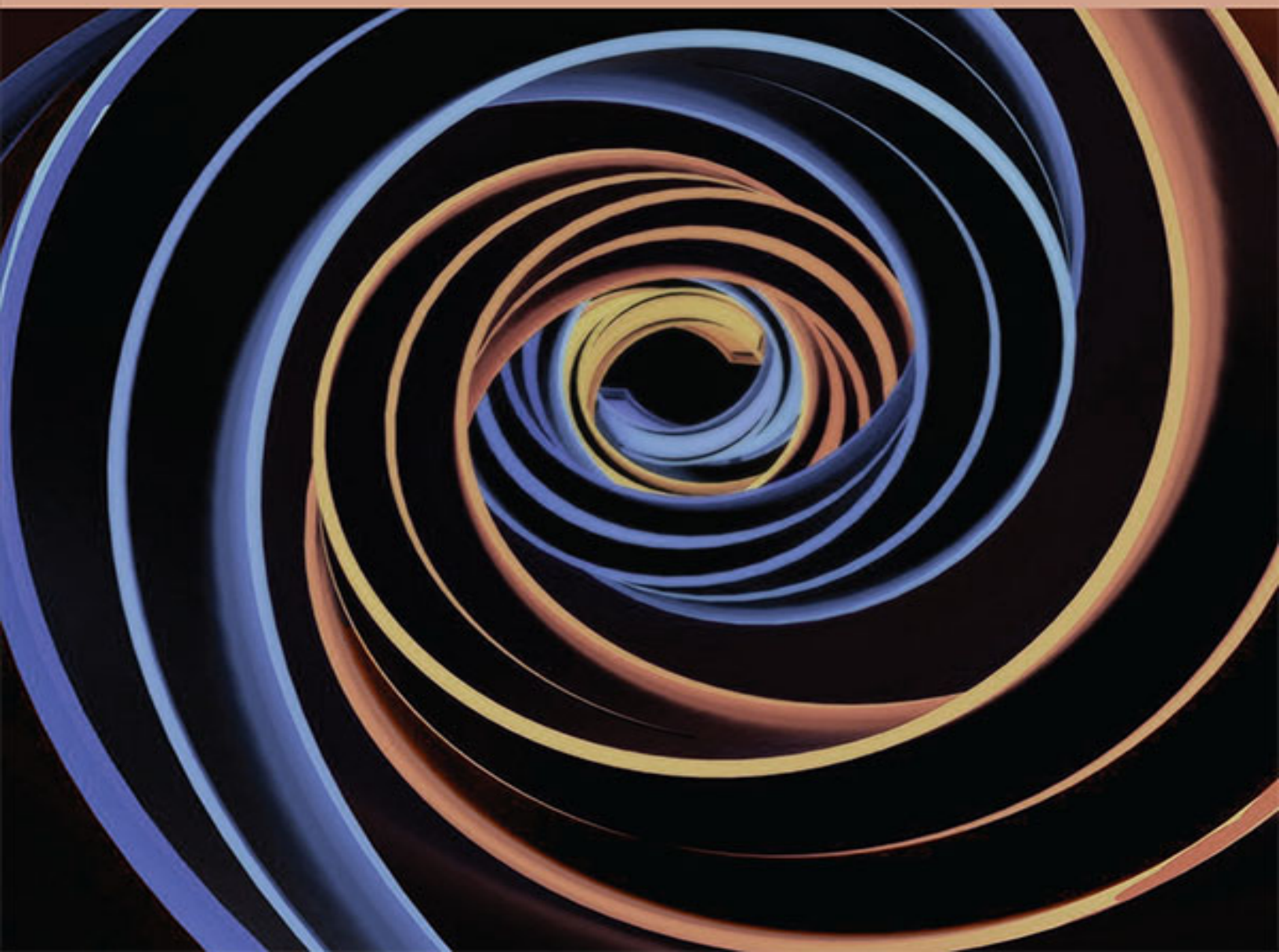
Clinical Handbook of Emotion-Focused Therapy

Edited by
Leslie S. Greenberg and Rhonda N. Goldman



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CONTENTS

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PREFACE

Emotion-focused therapy (EFT) aims to help clients enhance their emotional processing, which we define as approaching, accepting, tolerating, symbolizing, making narrative sense of, and utilizing or transforming emotions. This increases people's ability to respond adaptively to situations as they arise. EFT helps people face previously disclaimed, painful emotions; reflect on them to create meaning; use them to inform adaptive action; and transform those that are maladaptive. Developing this type of emotional competence (Greenberg, 2015) then involves the ability to (a) experience emotions and symbolize them in awareness, (b) tolerate and regulate dysregulated emotions, (c) transform maladaptive emotions, and (d) develop positive identity and relationship narratives on the basis of new emotions. Emotional competence thus is seen as the ability to use adaptive emotional responses *to guide a process of becoming, and to transform emotions that have become maladaptive, to redirect this process.* This enhances people's capacity to deal with problems in living and promotes harmony within and among people.

The therapeutic relationship is the cornerstone of EFT, serving as an essential reference point throughout the treatment and providing the stability and structure for clients to grow and change. Growing out of the

client-centered and experiential traditions that emphasize the importance of the therapeutic attitudes of acceptance, prizing, congruence, and empathy, EFT similarly stresses the importance of therapists' attitudes toward their clients. Emotion-focused psychotherapists are accepting of and empathically attuned to their clients' inner worlds to facilitate changes in clients' emotion schemes and emotional processing as well as their relationship with self and others.

This volume provides a comprehensive review of the most current research-informed work on EFT in both individual and couple therapy. We see this approach as highly comprehensive and relevant to a broad array of clinical populations. The approach is the premier therapy model for addressing emotion at a deep, experiential level that is not psychoanalytic, nor cognitive behavioral in orientation, although we believe that it can contribute to these approaches. The chapters in the book provide systematic coverage of theory, research, and practice of an emotion-focused perspective that has emerged from the work of Greenberg and collaborators emphasizing emotion as the fundamental datum of human experience.

This is a clinical handbook and as such, the focus is on clinical practice. The contributors were all asked to emphasize clinical applications of their work. Researchers and clinicians alike were asked to make their chapters research informed and as clinically relevant as possible. The EFT authors in this handbook are all both researchers and skilled clinicians, a necessary aspect of doing meaningful research on how people actually change in therapy. The chapters by these clinician researchers, therefore, are all highly clinically focused. The chapters in the book follow a trajectory from the developing theory, to current hypothesis testing, to practice.

The aim with this collection is to reach both professionals in the field who are somewhat knowledgeable about EFT as well as established therapists who are looking to learn about this approach. Advanced graduate students looking to incorporate working with emotion into their approach

will also benefit. The goal of this book is to promote the emotion revolution, which is rapidly gaining momentum.

EVOLUTION OF THE THERAPY APPROACH

Initially, Greenberg and colleagues called the individual therapy *process experiential therapy* (Greenberg, Rice, & Elliott, 1993; Rice & Greenberg, 1984), while Greenberg and Johnson (1986, 1988) called the couple's treatment *emotionally focused couple therapy*. There was a seamless transition between the name *process experiential* and *emotion-focused therapy* in the individual model. In the couples model, however, although there are a lot of similarities in an emotion-focused and an attachment-based, emotionally focused approach to couples, the approaches have taken slightly different paths. As was originally conceptualized (Greenberg & Johnson, 1988), couples functioning is seen as organized around both attachment and influence; however, over time, Johnson dropped this differentiation, focusing solely on attachment and increasingly viewing couple's functioning primarily through the lens of attachment theory (Johnson, 2004). Greenberg (2002), on the other hand, stayed with emotion as the primary focus from the original version of the emotionally focused approach to couples. All the individual and couple work was then integrated under the name *emotion-focused therapy* (Greenberg, 2002) to accord with the term *emotion-focused* used more generally in the psychology literature. Greenberg and Goldman (2008) presented an updated view of EFT for couples (EFT-C) in which they viewed affect regulation as the central force that organizes couples' dynamics. The aim was to produce an integrated volume with both approaches, but this effort did not succeed because of Johnson's desire to maintain the separate identity of emotionally focused couple therapy. EFT for couples, grounded as it is in affective

neuroscience and empirical studies of how people change in therapy, is covered in this volume.

HOW THIS BOOK IS ORGANIZED

This volume is organized into five parts. Part I offers an introduction by the volume editors, with Chapter 1 covering the history and development of EFT theory and research in further detail. It covers the development of EFT from its origins in the 1980s through the present. Chapter 2 then elaborates EFT's theory of emotion and its dialectical constructivist theory of functioning. Chapter 3 presents the theory of EFT practice and describes the four compasses that guide it.

Part II follows the theme of integrating research and practice in EFT. In Chapter 4, Timulak, Iwakabe, and Elliott present a summary of quantitative, qualitative, and case study research on EFT to illuminate the evidence base of the approach and discuss the clinical implications of the research. Chapters 5 and 6 present the relationship foundations of the approach based predominantly on empathy (Watson) and therapeutic presence (Geller). These are the cornerstones of EFT practice. The next three chapters focus on clinical applications of the process research done over the last decades. Chapter 7 by Pascual-Leone and Kramer provides an empirically based model of the sequence of emotions in therapeutic change. In Chapter 8, Pos and Choi look at research relating process to outcome with an emphasis on depth of experiencing in EFT. Herrmann and Auszra, in Chapter 9, define and give examples of productive emotional processing. In Chapter 10, Sharbanee, Goldman, and Greenberg review task analyses of emotional change, some of which are published here for the first time. In Chapter 11, Angus, Boritz, Mendes, and Gonçalves focus on the relationship between narrative change processes and treatment outcome. Part II ends with Chapter 12 in which Warwar and Ellison discuss the role and process of experiential teaching in EFT with a focus on homework.

Part III focuses on EFT with specific client populations. In Chapter 13, Salgado, Cunha, and Monteiro review EFT of depression, including their recent randomized clinical trial comparing the effects of EFT and cognitive–behavioral therapy on depression. In Chapter 14, Watson, Timulak, and Greenberg present their recently published manualized approaches to EFT for generalized anxiety disorder. Elliott and Shahar then cover in Chapter 15 EFT for social anxiety coming from both their research programs. Following in Chapter 16 by Khayyat-Abuaita and Paivio is EFT for complex interpersonal trauma. In Chapter 17, Pos and Paolone present an EFT approach to the treatment of personality disorders and emotion dysregulation. In Chapter 18, Dolhanty and Lafrance present their novel approach to emotion-focused family therapy for eating disorders. Part III ends with a focus on cultural populations rather than populations with a disorder. In Chapter 19, Levitt, Whelton, and Iwakabe discuss integrating feminist-multicultural perspectives into EFT.

In Part IV, the focus is on EFT for couples. In Chapter 20, Woldarsky Meneses and McKinnon present the updated theory and practice of emotion-focused couple therapy, whereas in Chapter 21, Edwards and Levin-Edwards present strategies for integrating individual tasks into EFT for couples. Part IV ends with Chapter 22, in which Bradley presents a detailed description of specific interventions that can be used with couples.

The editors provide in Part V a review of the themes that emerged from the chapters and offer some future perspectives.

In many of the chapters the authors provide examples from clinical cases as a way of illustrating how EFT works in practice. To protect the confidentiality of therapy clients, authors have disguised names and other details, or used composites with details drawn from multiple cases. The contributors hope readers will take away clinically useful suggestions that span setting up therapeutic relationships and facilitating productive emotional processing and will apply these to specific populations and

different disorders. The hope that this volume will help readers see the important role of emotion in therapeutic change and understand how to work effectively with clients who have too little emotion of the right kind and those who have too much emotion of the wrong kind. If you are already trained in EFT, hopefully this handbook adds a more differentiated understanding on how to work with emotion. If you are new to this approach, hopefully it will encourage you to pursue further EFT training so that you can help your clients engage in deeper emotional work.

I
INTRODUCTION TO EMOTION-FOCUSED THERAPY

1
HISTORY AND OVERVIEW OF EMOTION-FOCUSED THERAPY

RHONDA N. GOLDMAN

Fritz Perls and Carl Rogers did not likely ever sit down and have coffee together, but perhaps they should have. They might have shared a conversation after shooting the Gloria films.[1] If they did, little of that conversation was ever recorded or published. Although both pioneers' therapeutic approaches are associated with and emerge from the humanistic tradition, thus sharing a number of important common philosophical principles and assumptions, it is doubtful that they saw their therapies, gestalt and client centered, being integrated. This is in a sense what happened, however, in the creation of emotion-focused therapy (EFT).

In 1970, Leslie Greenberg, having recently immigrated to Canada from South Africa, entered graduate school to study clinical and counseling psychology at York University in Toronto. He had previously completed a master's in engineering but did not feel content to make a career of it. It was at York that he met his mentor, Laura Rice, a professor at the university and herself an immigrant from the United States, where, during the 1950s, she

had studied under Carl Rogers before making her way to Canada. As a faculty member at York, she conducted research within the client-centered approach.

EVENTS-BASED PARADIGM AND TASK ANALYSIS

Over the next 20 years, Rice and Greenberg worked together to create the events-based paradigm that in many ways revolutionized the field of psychotherapy research. The debate over the Dodo Bird Verdict (Luborsky, Singer, & Luborsky, 1975) was raging. Some researchers claimed that all therapies were essentially equivalent and that change should be attributed to common factors across psychotherapy models, whereas others claimed that specific techniques used in specific therapies for different disorders accounted for change. Many were calling for an end to the horse races. Psychotherapy research was beginning to focus not just on outcome, specific disorders, and particular client groups, but also on the relationship between what happened during therapy and outcome (Orlinsky & Howard, 1978). In this endeavor, some thought it best to study the content of therapy (e.g., how many times in a therapy session do you mention your mother; Marsden, 1971), whereas others were advocating for a new paradigm to study the process in relation to outcome (Kiesler, 1973).

Rice and Greenberg were strong advocates for the study of psychotherapy process, not only in in relation to overall outcome, but also to small outcomes, which could themselves be broken down into in-session and postsession outcomes. In 1986, Greenberg published a seminal paper that advocated for the study of *in-session change process research* that took both in-session context and the therapeutic relationship into account. This was followed by a research handbook, coedited with William Pinsof, that spelled out how to conduct process research (Greenberg & Pinsof, 1986) and further emphasized the importance of change process research. This

built on the ideas that Greenberg and Laura Rice articulated in the book *Patterns of Change* (Rice & Greenberg, 1984). The paradigm promoted more idiographic study of therapy as both a supplement and an alternative to existing outcome research approaches and integrated qualitative methods with quantitative methodologies to provide a rich picture of the therapy change process and its relationship to outcome.

Out of the events-based paradigm, task analysis emerged, a specific research methodology that Greenberg (Rice & Greenberg, 1984) in part imported from engineering and in part from cognitive science through an important academic collaboration with Juan Pascual-Leone (Greenberg, 1984). Task analysis represented a new, rational–empirical method for the intensive analysis of psychotherapy events and held the promise of providing greater understanding and specification of productive client performances and the interventions that facilitate them. It was with task analysis that EFT researchers were able to specify the many markers and therapy tasks interventions that occur in the course of EFT. This would become an important line of research for Greenberg and collaborators (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg & Pinsof, 1986; Greenberg, Rice, & Elliott, 1993), resulting in the development and refinement of a unique, integrative psychotherapy model called EFT.

EARLY THEORETICAL DEVELOPMENTS

In his tenure at the University of British Columbia (1975–1986), Greenberg built three important collaborative academic relationships that proved fruitful and productive. It was during these early years that Greenberg began to study emotion, originated the theory of EFT for couples, and developed the Working Alliance Inventory.

Emotion Theory: The Functions Emotions Serve

Building on the humanistic–existential principles inherent in the therapeutic approaches of Rogers, Perls, and Gendlin (Rogers, 1951; Perls, 1969, 1973; Gendlin, 1981, 1996), Greenberg became interested in the developing field of emotion theory (Arnold, 1960; Fridja, 1986; Izard, 1977; Tomkins, 1962). He intuitively understood and believed that emotion was a primary source of motivation and regulation in human functioning and saw this as implicit in the theories of Rogers, Perls, and other humanistic theories. He saw that emotional responses, not cognitions or beliefs, prompted primary evaluations of goal attainment success and signaled the personal significance of events for clients, and as such should be the focus of therapeutic intervention. Working with then-graduate student Jeremy Safran, Greenberg published *Emotion in Psychotherapy* (Greenberg & Safran, 1987), an initial articulation of the principles of working with emotion in therapy. A key development here was the distinction between different types of emotion. It was recognized that not all emotions serve the same function and that a differential model of emotion was needed. Thus, *primary adaptive* emotion responses were seen as direct reactions consistent with the immediate situation that help the person take appropriate action, whereas *primary maladaptive* emotions, although also direct reactions to situations, were seen as associated with negative learning experiences and no longer helping the person cope constructively with the situations that elicit them. *Secondary reactive* emotions are covers or defensive emotions that obscure or transform the original emotion and lead to actions which are, again, not entirely appropriate to the current situation. *Instrumental* emotions are emotions expressed to influence or control others.

Development of EFT for Couples

Influenced by his time spent at the Mental Research Institute in Palo Alto studying and working with couples and families, Greenberg came to

see emotion as a primary communication system in couples. At the same time, Greenberg was also impressed with the importance of cycles and the power dynamics in the relationship. His interest in studying couples had evolved mainly from his research, begun in his doctoral years on how individuals resolved intrapsychic conflict, in which he found that softening of the critic led to resolution. From his perspective, the EFT for couples process looked very much like intrapersonal conflict resolution, but now it was a critical or blaming *partner* who softened and a withdrawn partner who revealed. He received a grant from the Social Science and Humanities Research Council of Canada to study how couples resolved conflict, and it was from this that the EFT for couples therapy manual and the first outcome study were developed. It was the integration of his work on emotion with his training with Virginia Satir and his work at Palo Alto with systemic therapists that led to the innovative development of emotionally focused couples therapy that was later tested in his graduate student Susan Johnson's dissertation (Greenberg & Johnson, 1988; Johnson & Greenberg, 1985). At the heart of the theory was the revealing of underlying vulnerable primary feelings and circular interactions around closeness (attachment) and dominance (influence). Both emotion and interaction, and affiliation and influence, seemed important to help conceptualize, understand, and treat couples. As noted in the Preface, Susan Johnson later developed the therapy with a strong emphasis on the attachment piece (Johnson, 2004). Further theoretical developments in EFT for couples are outlined later in the chapter.

The Working Alliance

While participating on a panel at the Society for Psychotherapy Research, Greenberg was introduced to Bordin's (1979) model of the working alliance. He and his graduate student Adam Horvath became interested in the idea of developing a client self-report measure that could

capture the separate contribution of tasks, goals, and bonds in the development of the therapeutic relationship. They thus developed the Working Alliance Inventory (Horvath & Greenberg, 1989), a now widely used alliance measure across a broad range of treatment approaches. One important finding that emerged from this research to challenge Greenberg's core assumptions was the finding that task alliance was a stronger predictor of outcome than the bond component or empathy. Greenberg became more convinced that the client was the active change agent and that therapy must engage clients in the tasks of therapy, which in EFT was most centrally deeper experiencing and, more specifically, marker-guided tasks.

DEVELOPMENT OF EFT FOR INDIVIDUALS

Having moved back to York University, his alma mater, in 1986, Greenberg once again resumed his collaboration with Laura Rice. In earlier research, Rice emphasized client information processing, drawing on early cognitive science (Wexler & Rice, 1974). She later conducted a series of studies broadening the investigation of client processes to examine client stylistic variables, such as expressiveness and vocal quality, and published an influential paper that articulated the evocative function of the therapist (Rice, 1974) through the use of metaphor and vocal expressiveness.

Working within the events paradigm, Rice and Greenberg (1984) adapted the method of task analysis to study how clients use therapy to solve their personal, cognitive-affective problems. Rice (1974) first studied how clients reexperience events to resolve and make sense out of puzzling personal overreactions. This became the first client-centered EFT task to be mapped: evocative unfolding for a problematic reaction point (Rice & Saperia, 1984). This task was further developed and studied by Jeanne Watson, wherein the steps and stages of working through the task were clearly laid out (Watson & Rennie, 1994).

As a graduate student, Greenberg had partaken in, and studied, gestalt therapy with Harvey Freedman, a protégé of Fritz Perls. In his dissertation research in 1975, Greenberg became interested in studying the process of resolving internal conflicts using the gestalt therapy technique of two-chair dialogue, in which the client enacts the two conflicting aspects of self, usually a critic (“top dog”) and a part that was being criticized or pressured to do something (“underdog”).

In 1985, Robert Elliott was a microprocess researcher studying therapist response modes and client in-session experiences, and he was also interested in Gendlin’s (1981) experiential focusing therapy method. Elliott came to collaborate with Greenberg and Rice, and together they developed process-experiential therapy, which later became known as emotion-focused therapy. The approach was first articulated in a book entitled *Facilitating Emotional Change* (Greenberg, Rice, & Elliott, 1993).

The book outlined six guiding therapeutic principles, a macrotheory of human functioning, and six core therapeutic tasks for specific in-session problem with charts and diagrams that mapped the client and therapist process that lead toward resolution for each particular task. Emotional experience was seen as influencing modes of processing, guiding attention, and enhancing memory, and much behavior was seen as in the service of emotional regulation and attachment. The first six process-experiential (later EFT) tasks defined in the book were (a) two-chair dialogue for negative self-evaluative conflict splits; (b) two-chair dialogue for emotional interruption; (c) empty chair dialogue for unfinished business; (d) systematic evocative unfolding at the presentation of a puzzling, problematic reaction; (e) focusing for an unclear felt sense; and (f) empathic affirmation for a revelation of vulnerability. The therapy model articulated here formed the major basis of EFT for individuals today. Ultimately what was underway was the development of two innovative, research-supported psychotherapy approaches—EFT for individuals and for couples.

EARLY GUIDING PRINCIPLES FOR WORKING WITH EMOTION IN THERAPY

Throughout the 1990s, Greenberg continued to develop EFT theory, with a particular focus on the theory of functioning. Greenberg and Paivio (1997) laid out guidelines for working with emotion and set out the first version of the fundamental change process of moving from secondary through primary maladaptive to adaptive emotions. Greenberg further elaborated how to work with emotion and its general role in functioning in the 2002 volume on EFT (Greenberg, 2002). The different principles of emotional change were articulated and delineated in this book, and the concept of emotion coaching was also presented. The therapist was conceptualized as a facilitative coach whose aim is to activate and guide people through emotional processing. This represented a significant shift toward a stronger articulation of and emphasis on emotion processing that is facilitated by the working through of EFT tasks. The process of therapy was seen as coconstructive, with the therapist guiding but with a highly nonimposing stance. The new emotion processing perspective was further applied to the treatment of depression (Greenberg & Watson, 2006; Greenberg, Watson, & Goldman, 1997). Several fundamental aspects of the theory were built during this period. Emerging out of the humanistic–experiential tradition, EFT adopted and remained committed to many of the fundamental assumptions of client-centered and experiential therapies but now integrated constructivist philosophy, emotion theory, and some aspects of cognitive science. The basic principles were framed as neo-humanistic (Elliott et al., 2004).

EFT adopted an integrative, neo-humanistic view of motivation seeing that there are multiple forces guiding experience and behavior that are influenced by both biology and culture. People have the potential for creativity and agency, and they are capable of awareness and choice.

Survival and growth are key motivators as people strive for adaptive viability in the environments in which they find themselves.

Dialectical Constructivism

At the basis of the theory was dialectical constructivism, which was in part influenced by Greenberg's academic collaboration with Juan Pascual-Leone (1991) and his relationship with Guidano (1991) and Mahoney and the then-developing constructivist movement (Neimeyer & Mahoney, 1995). Dialectical constructivism came to inform the theory of self and therapy. It also represented an evolution out of a more structural view of self offered by client-centered theory. At the heart of the theory, then, is the view that people are dynamic, self-organizing systems in constant interchange with the environment, forming and being formed in mutually regulating ways.

Refining Emotion Theory: Emotions as a Compass

Emotion theory was a growing field (Ekman, 2003; Oatley, 2004; Scherer, 2005), and Greenberg (2002; Greenberg & Paivio, 1997; Greenberg & Safran, 1987) integrated aspects of the theory to help explain human functioning and dysfunction as well as the theory of emotional change in therapy. As noted previously, the key here is that emotion is thought to be fundamentally adaptive and as providing us with our basic mode of information processing, rapidly and automatically appraising situations for their relevance to our well-being and producing action tendencies to meet our needs. People respond emotionally, in an automatic fashion, to patterns or cues in their environment that signal novelty, comfort, loss, or humiliation. Thus, emotions act as a kind of compass, guiding people as to what is important and what needs are being met or not.

A key principle of EFT that emerged is that emotions provide access to needs, wishes, or goals and the action tendencies associated with these. Thus, every feeling has a need, and every emotion scheme provides a direction for action, one that will promote need satisfaction. It follows, then, that a key source of pathology relates to a lack of awareness or disavowal of needs. On the other hand, when people acknowledge feeling sad, their tacit processing involves an evaluation that they have lost something important and are in need of comfort, and it may even involve a cry for connection. This conceptualization also formed a fundamental basis of the EFT for couples therapy model. In couples interaction, although emotion provides information to the individual, change occurs through the expression of underlying adaptive emotions to the partner that are seen as crucial in changing the partner's view of the self and thereby changing negative interactions (Greenberg & Goldman, 2008; Greenberg, James, & Conry, 1988).

Emotion and how to work with it in therapy formed the basis of the theory. A corollary and very important distinction that continued to differentiate this model from other therapeutic approaches was that emotion is a brain phenomenon vastly different from thought as was the focus in cognitive behavior therapy (CBT). It has its own neurochemical and physiological basis and is a unique language in which the brain speaks.

Experiential Constructivist View of Emotion and Change

The implications of a constructivist view of self and the integration of emotion theory meant a further evolution in the view of emotions in terms of how they are formed, how they operate in therapy, and how they change. In a dialectical view, people both have emotion and live in a constant process of making sense of their emotions. We are biologically hardwired with innate affective responses, yet also build on and develop our innate affective repertoire in cultural contexts and through our lived histories.

People are seen as dynamic systems attempting to *maintain the coherence* of their organizing processes by continuous synthesis. Growth is inherently dialectical and dialogical.

The integration of constructivist thinking also meant an update in the view of how nonaware emotions are conceptualized. This is an issue that has been long debated by therapists from different theoretical perspectives. Take, for example, the statement that a client might make, such as “I have been angry, but I wasn’t aware of it.” A Freudian or psychoanalytic theorist would say that the person’s anger was repressed but now the barrier to consciousness was lifted and the person essentially remembers. Following Rogers’s (1959) incongruence theory, one could say that the person’s organismic experiencing had been one of anger, but that it had not been admissible to the self-concept. Gestalt, more guided by field theory, sees the emotion as coming into being in the moment but doesn’t explain the process. Gendlin’s (1996) perspective contributed to a change in views that denial and congruence offered, saying that the person has been blocked in a state of incipient anger, which is only now being experienced and expressed. According to Gendlin, it is not a matter of having had the anger all the time, out of awareness, but it is “completing” a feeling that was blocked from occurring in the first instance. A constructivist view does not see anger as “there” or even denied or blocked. Rather, a fully agentic constructivist view sees anger as only now being realized and only certain words will “fit” it. This view sees the anger being constructed in the moment from constituent parts that were previously there, but not yet *organized* or configured into a coherent form (Greenberg, 2010). Rather than blocked anger being realized, we have constituent elements of experience being organized.

Theory of Emotional Change

The development of the theory of functioning and dysfunction was a direct outgrowth of theoretical developments in dialectical constructivism and emotion theory. Emotion schemes were seen as at the basis of human functioning in the world and, in turn, formed the basis of pathology that develops and presents itself in therapy. Emotion schemes were conceptualized as at the base of the adult emotional response system, and their maladaptive development formed the basis of an EFT conceptualization and understanding of pathology.

From an EFT perspective, people's basic mode of processing is seen as fundamentally emotionally motivated, and this is set in motion by scheme activation that occurs out of awareness but influences conscious processing. Emotion schemes develop throughout the lifetime and represent internal emotion memory structures that synthesize affective, motivational, cognitive, and behavioral elements into internal organizations that are activated rapidly, out of awareness, by relevant cues. Core emotion schematic autobiographical memories with an internal narrative structure represented in language develop over the lifetime (Angus & Greenberg, 2011). For example, with fear, once the basic schematic mode of processing has been activated, a person begins to process more consciously for sources of danger and ultimately symbolizes in words the appraised danger and generates ways of coping with it. Emotion schematic learning makes emotion systems flexible and adaptive but also open to the possibility of becoming maladaptive. For example, people not only learn to flee from predators and get angry at violations of their territorial boundaries, but they also fear their boss's criticism and get angry at self-esteem violations.

The most obvious therapeutic implication of this framework is that it is most productive to activate emotional processing and the whole scheme in therapy to focus on all of the narrative schematic elements. Particular difficulties are seen as occurring when the person excludes all the elements from awareness, or neglects one or more types of elements, so that his or

her experiencing is not completely coherently processed. This focus on maladaptive emotional processing, then, is what forms the focus of the therapy. As the theory has developed over the years, it has further differentiated so that disorder is seen as resulting from multiple possible sources related to emotion including failures in the dyadic regulation of affect, avoidance of affect and fear of expression, traumatic learning, a lack of processing of emotion, and a crisis of existential meaning. Awareness, regulation, and transformation through accessing an alternate emotion are offered as three overarching empirically supported principles of emotional change (Greenberg, 2010). Reflecting the development toward the importance of emotion processing and regulation as a major concern especially for some more traumatized and personality disordered clients (Kennedy-Moore & Watson, 1999), Watson and Prosser (2007) developed a measure of affect regulation and studied its role in change. The shift toward studying emotion processing was a significant developmental milestone transforming process experiential into EFT.

Construction of Meaning, Narrative Shifts, and the Process of Change

Another important theoretical development that has grown with EFT is an articulation of the importance of the meaning-making process and its contribution to change. As mentioned, EFT has its roots in the humanistic–existential tradition that has long emphasized meaning creation in the context of the therapeutic process (May, 1950). This has been particularly thematic and strong in the work of Eugene Gendlin. His focusing method, which has been integrated into the EFT model (Elliott et al., 2004; Greenberg, Rice, & Elliott, 1993) as a task designed to facilitate emotional awareness and meaning making engages the exploration of the “bodily felt sense” in the creation of meaning. Clarke (1989; Elliott et al., 2004) conducted several task-analytic studies describing the EFT task of meaning creation that is very helpful for clients facing crises of meaning related to

past trauma and loss. Greenberg has identified the search for meaning as core to survival (Greenberg, 2010), and existential and meaning-making processes have come to be seen as one of the core change processes in EFT (Greenberg, 2010). Further research studies have explored and validated the importance of change in narrative themes and meaning as it relates to outcome (Goldman, Greenberg, & Pos, 2005; Missirlian, Toukmanian, Warwar, & Greenberg, 2005).

A narrative focus is now seen as important during therapy, and narrative changes are thought of as indicators of progress at the end of therapy (Angus & Greenberg, 2011). The capacity to narrate, understand, and integrate our most important life stories is key to adaptive identity development and the establishment of a differentiated, coherent view of self. Specifically, the articulation of a more coherent, emotionally differentiated account of self and others develops that facilitates heightened self-reflection, agency, and new interpersonal outcomes. Addressing discrete event stories is important when individual events are associated with trauma or interpersonal conflict, such as an assault or the discovery that a spouse has been unfaithful. It is often in the face of traumatic emotional losses and injuries that clients find themselves unable to provide an organized narrative account of what happened—and to make meaning of those painful emotional experiences—because to do so challenges deeply held cherished beliefs about the feelings, concerns, and intentions of self and others. For instance, when a middle-aged man who has been a loving husband and partner suddenly loses his wife, his entire sense of personal identity and understanding of how the world works is shaken to the core. Such events must be described, reexperienced emotionally, and restoried before the trauma or damaged relationship can heal. It is through the exploration of emotion and the emergence of new emotion and meanings that clients come to be able to coherently account for the circumstances of

what happened. Through this process clients gain a more plausible account of the roles and intentions that guided the actions of self and others.

Growth in EFT

As process-experiential therapy developed, it became increasingly clear that it was in fact an integration of the client-centered relationship with other gestalt and experiential methods and techniques. It was never in question that the core therapeutic conditions of empathy, genuineness, and unconditional positive regard (Rogers, 1957) were fundamental to building trust and safety necessary for a client to reveal vulnerability and deepen emotion so that it can be changed through therapy. The chair dialogues that are now such a hallmark of the approach, in which clients either dialogue between different aspects of self in chairs or express emotion to an image of a significant other, have clear roots in the work of Fritz Perls and the methods he used (Perls, 1969, 1973; Perls, Hefferline, & Goodman, 1951). Similarly, focusing was adapted from Gendlin's (1996) focusing-oriented psychotherapy. While Greenberg was actively involved in the psychotherapy integration movement and saw it as an important direction in the field, some within the humanistic family of client-centered and experiential therapies felt that process-experiential therapy had lost its way and was in potential violation of the person-centered principle of nondirectivity that Rogers had carefully laid down in early theory (Rogers, 1959), although he emphasized it less in later years. The challenge from some leaders within the World Association of Client-Centered and Experiential Therapy movement (Brodley, 1990; Elliott, 2012) that process-experiential therapy no longer belonged under the person-centered umbrella was jarring to Greenberg, Rice, and Elliott. Much debate and discussion with many involved in the development of process-experiential therapy, including Jeanne Watson, Rhonda Goldman, Sandra Paivio, as well as those deeply involved with the World Association movement (i.e., Germain

Lietaer, Art Bohart, Mia Leissjen), led to a reexamining of the core principles from which the therapy had emerged. The conclusion was that the therapy was directive in process (or “process guiding”) but not directive in content. This meant, for instance, that therapists maintained an empathic attitude at all times but were selectively responding on a moment-by-moment basis to core aspects of what clients were understood to be communicating. Empathy was seen as both an attitude and a technique, and empathic responding was understood as a multidimensional process (Bohart & Greenberg, 1997; Greenberg & Goldman, 1988; Rice, 1974). Different forms of empathic responding were defined (Goldman, 1991; Watson, Goldman, & Vanaerschot, 1998). In terms of training, this meant therapists could specify how and what to listen for in the client’s communication. Similarly, the therapy was understood to be marker driven. Markers were verbal and nonverbal in-session indicators that therapists could respond to with invitations to engage in different types of tasks designed to facilitate certain types of emotional processing. This initial framework and focus on specification organized much of the thinking going forward, and although debate continued within the World Association, process-experiential therapy, later known as EFT, settled and became comfortable with these theoretical developments, descriptions, and distinctions.

EMPIRICAL VALIDATION

As mentioned earlier, having been instrumental in the promotion of the events paradigm, Greenberg and Rice were at heart process researchers who had devoted much academic energy to the endeavor. In the early 1990s, however, the field of psychotherapy research was moving rapidly in the direction of empirically supported treatments. There was, at the same time, a strong appreciation that conducting randomized, controlled treatment trials using standardized treatment outcome measures had the potential to

demonstrate the power of the therapy that they were creating. The generation of data from the psychotherapy studies also promised to allow further study of key client process variables in relation to both session and final outcomes. It was in this vein that in 1992, Greenberg and Rice received a National Institute of Mental Health grant in support of a randomized, controlled trial comparing brief client-centered and brief process-experiential therapy (16–20 weeks) for depression.

When completed, results of the comparative study showed that both client-centered and process-experiential therapy were effective treatments for alleviating depression, although process-experiential therapy was more effective in alleviating interpersonal problems and increasing self-esteem (Greenberg & Watson, 1998). This finding was based on a sample size of 34 clients (17 in each group), however, and was moderately powerful according to research criteria, but perhaps not powerful enough to demonstrate differences. A replication study was done some years later. Results demonstrated that with a second sample of 38 clients (19 in each group), EFT (formerly known as process-experiential therapy) was equally effective in alleviating interpersonal problems and increasing self-esteem, but more effective in alleviating depressive symptoms. When the two samples were combined, providing sufficient power to find differences, EFT was found to be more effective on all indices of change (Goldman, Greenberg, & Angus, 2006). Significant differences among treatments were found at termination on all indices of change, and the differences were maintained at 6-month and 18-month follow-ups (Ellison, Greenberg, Goldman, & Angus, 2009).

Process-Outcome Research in the Development of EFT

The research program that began with the National Institute of Mental Health (NIMH) study continued over several more studies in the next 25 years (Goldman, Angus, & Safran, 2010) and that lead to many productive

research investigations. The main thrust of the process-outcome research program was to (a) further articulate the therapy model and (b) further understand the relationship between emotional processes and change in therapy. Research studies in this period thus focused on two strands: the therapist process and the client process. The next section will briefly review research findings from both lines of inquiry and describe how they impacted the overall development of the EFT model. Note that for a fuller description of much of the research reviewed, the reader is encouraged to read Chapters 4 through 11 in this volume.

Therapist Processes

In 1988, shortly after Rhonda Goldman became Greenberg's graduate student, Greenberg and Goldman published an article in the *Journal of Consulting and Clinical Psychology* that defined how training was conducted in process-experiential therapy. In the article, they identified that ideal training used a cross section of didactic, skills training, experiential, and personal growth work to effectively teach the approach. This training framework loosely formed a model of how courses and workshops in the therapeutic approach were organized and taught from this point forward.

Early on, EFT therapists became interested in studying what they do in therapy to make it work. Studies helped them define and communicate the approach. Elliott et al. (1982) developed a new approach to the measurement of the empathic quality of therapist behavior. They devised the Response Empathy Rating Scale, which consisted of the following eight components: intention to enter client's frame of reference, accuracy, here and now, topic centrality, choice of words, voice quality, exploratory manner, and impact. Centrality was found to be the "core" component of this scale, and factor analysis suggested two underlying factors: depth-expressiveness and empathic exploration (Elliott et al., 1982; Horton & Elliott, 1991).

Gearing up for the randomized clinical trials and heeding the general call from within the field of psychotherapy research for further specification of therapy approaches and methods, Goldman got involved with identification and specification of therapist actions and interventions that characterized the approach. Goldman and Greenberg then developed a training manual that described what the therapist does in the provision of process-experiential therapy. The manual described six therapist relational attitudes and 14 therapist actions, including four different types of empathic responding and the steps involved in three major therapeutic tasks including the empty chair for unfinished business, the two-chair for negative self-evaluative conflict splits, and evocative unfolding at a problematic reaction. The manual was later validated (Goldman, 1991). The different types of responses are the basis for the microresponses that were outlined in further publications, including the book *Learning Emotion-Focused Therapy* (Elliott et al., 2004). The therapy adherence measure that was developed helped Goldman and Greenberg better understand what they did in therapy. The adherence measure was derived from observation of EFT practice. One interesting realization was that the therapist did more than empathically reflect. Indeed, it was here that Goldman identified three different types of empathic responses and, in fact, coined the term *empathic conjecture* to describe how the therapist remains in an empathic framework but speculates, guesses, or feels what the client is experiencing, offering what he or she senses about what was not quite expressed. Empathic conjectures became an important microskill adopted in both the EFT for individuals and for couples model (Elliott et al., 2004; Johnson, 2004; Watson, Goldman, & Greenberg, 2007; see also Chapter 22, this volume). At this time Goldman also coined the term *experiential teaching*. In this case, observation allowed the researchers to see that although much of the time is spent emotionally exploring, there are moments when the therapist in fact stands back and teaches about emotions and experiencing. It was stressed from the

beginning, however, that in this process emotions must be alive or felt (aroused) to be taught about. Experiential teaching and all the different forms of it were later outlined and further articulated by Greenberg (2002) and in this volume by Warwar and Ellison (Chapter 12).

Elliott and colleagues set out to further specify therapist actions as well as measure their frequency. They found that experiential questions occurred relatively frequently, about 19% of the time (Horton & Elliott, 1991), and that therapists gave high ratings to intentions associated with reflections and questions (e.g., conveying empathy, fostering client exploration, and evoking feelings). On the other hand, Horton and Elliott (1991) reported therapists' ratings of their "out of mode" responses were also present, including "interpretation," "out of session advisement," "disagreement," and "confrontation." All this helped to clarify what therapist actions were taking place in EFT, especially in the process-directive style.

To study how therapist actions relate to outcome, Adams and Greenberg (1999) tracked moment by moment client–therapist interactions and found that therapist statements that were high in experiencing influenced client experiencing and that the depth of therapist experiential focus predicted outcome. More specifically, if the client was externally focused, and the therapist made an intervention that was targeted toward internal experience, the client was more likely to move to a deeper level of experiencing. The study highlights the importance of the therapist's role in focusing on internal narrative processes.

Another important development in the articulation of the EFT therapist process has been in the area of therapeutic presence. Specifically, developments have been made in the conceptualization and provision of therapeutic presence in EFT. This seen as a continuation of a tradition that began in client-centered (Rogers, 1980) and gestalt therapy (Perls, 1973) that was further developed within the emotion-focused relationship by Geller (Geller & Greenberg, 2012). Geller developed a measure of therapist

presence and the establishment of it as an important condition related to positive outcome (see Chapter 6, this volume). More recently, Geller developed a manual outlining how to cultivate therapeutic presence. This is outlined in Chapter 6.

Watson and her team have studied key aspects of the EFT therapy process and in comparison with CBT. Watson and McMullen (2005) examined differences between therapist and client behaviors and found that CBT therapists taught more and asked more directive questions, whereas EFT therapists offered more support. Watson and Prosser (2007) examined the complex relationship between empathy, affect regulation, and outcome, reporting that the effect of therapist empathy on outcome was mediated by changes in clients' affect regulation. These studies continue to provide additional evidence and support for the role of the clients' experience of the therapeutic relationship in promoting positive outcomes in psychotherapy.

Client Processes

Another important track followed in the ongoing research program explored emotional change across therapy, focusing on the client process as it relates to outcome. A study that investigated the relationship between theme-related depth of experiencing and outcome in experiential therapy with depressed clients found that client level of experiencing (EXP) on core themes in the last half of therapy was a significant predictor of reduced symptom distress and increased self-esteem (Goldman, Greenberg, & Pos, 2005). Experiencing on core themes accounted for outcome variance over and above that accounted for by early EXP and alliance, demonstrating that an early emotional processing skill, although likely an advantage, appears not to be as important as the ability to acquire and/or increase depth of emotional processing throughout therapy and that although the alliance is integral to change, experiencing is a separate but related process.

The importance of emotional arousal in the overall change process was then explored. Studies have shown that a combination of visible emotional arousal and experiencing was a better predictor of outcome than either index alone, supporting the hypothesis that it is not only arousal of emotion, but also reflection on aroused emotion that produces change (Missirlian, Toukmanian, Warwar, & Greenberg, 2005). Researchers then developed the concept of emotional productivity and a measure to capture it, and they found that clients with better outcomes expressed significantly more productive, highly aroused emotions than did clients with poor outcomes, suggesting that it is productivity, especially of highly aroused emotions, that is important in facilitating change (Auszra, Greenberg, & Herrmann, 2013).

As EFT continued to develop and become further refined, researchers delved more deeply into the relationship between the alliance, emotional processing, and outcome. Pos, Greenberg, and Warwar (2009) found that that the alliance, measured after Session 1, directly predicted outcome, and client therapy process at the beginning of treatment predicted reductions in interpersonal problems. Findings have suggested that although the EFT theory of change was supported, longer term EFT therapy may be necessary to sufficiently address interpersonal problems. More recently, Alberta Pos worked on applying EFT specifically for work with interpersonal processes common in personality disorders (see Chapter 17, this volume). Findings support conclusions drawn by Watson, Goldman, and Greenberg (2007) that unsuccessful EFT clients were most likely in need of longer term therapy that would allow for the support provided by the formation of stronger relationships and long-term bonds.

In a further study on emotional arousal, the relationships between the alliance, frequency of aroused emotional expression, and outcome were examined in the therapy of depression (Carryer & Greenberg, 2010). The frequency of expression data showed that a frequency of 25% of moderately to highly aroused emotional expression was found to best predict outcome,

whereas lower frequencies were associated with poor outcome, and highly aroused emotion was negatively related to good therapeutic outcome. This suggests that having the client achieve an intense and full level of emotional expression is predictive of good outcome, as long as the client does not maintain this level of emotional expression for too long a time or too often. In addition, frequency of reaching only minimal or marginal level of arousal was found to predict poor outcome. Thus, expression that is on the way to the goal of heightened expression of emotional arousal but does not attain it, or that reflects an inability to express full arousal and possibly indicates interruption of arousal, appears to be undesirable rather than a lesser but still desirable goal.

Pascual-Leone and Greenberg became interested in how clients move through emotions in therapy sessions and across therapy. They observed that positive outcome was associated with client capacities to move from "global distress," or unprocessed emotion with high arousal and low meaningfulness, through fear, shame, and aggressive anger to the articulation of needs and negative self-evaluations followed by assertive anger, self-soothing, hurt, and grief. This effective emotional processing was associated with steady improvement and increased emotional range (A. Pascual-Leone, 2009; see also Chapter 7, this volume).

Research in EFT over the last 30 years has supported the emotion-change hypothesis and the idea that the exploration of new emotion and integration of emotion and meaning making are key processes in the path toward change. In the context of emotion-focused relationships characterized by empathy, high degrees of presence, authenticity, and unconditional positive regard, a strong, collaborative alliance is forged. Therapists, through their actions as well as the implementation of various tasks, promote emotional deepening and the exploration of aroused emotion in a productive fashion. Clients move from secondary to primary

maladaptive to adaptive, and through the therapeutic process, changes in emotional meaning occur that lead to changes in the client's self-narrative.

WHAT'S IN A NAME?

By the late 1990s, the suitability of "process-experiential" as a name for the therapy was in question. Originally, Greenberg, Rice, and Elliott (1993) had thought it was the best descriptor of the therapy; it fitted within a humanistic framework and captured that it was both process oriented and experiential. However, over time and with the development of emotion research and the dominance of cognitive therapy, it became apparent that the term *emotion focused* captured the essential contribution of this approach. The transformation occurred in the book by Greenberg (2002) on EFT and was introduced in the writing of the 2004 book by Elliott, Watson, Goldman, and Greenberg titled *Learning Emotion-Focused Therapy: The Process-Experiential Approach to Change*. Eventually the process-experiential title was dropped, and from this point forward it has been known as emotion-focused therapy. The book by Elliott et al. (2004) laid out the theory, principles, and practice in clear and understandable terms replete with organizational charts and diagrams that help beginning-level therapists walk through the therapeutic practice in a straightforward fashion.

CASE FORMULATION: AN INTERTWINING OF EMOTION AND NARRATIVE

In the mid-1990s, Goldman and Greenberg (1997) were asked to contribute a chapter on case formulation to the *Handbook of Psychotherapy Case Formulation*. At first this proved a challenge. Process-experiential therapy was clearly emerging out of the humanistic tradition, and both

Greenberg and Goldman associated case formulation with assessment and diagnosis, activities that neither found particularly useful in the therapeutic process. One concern was that formulation would create an unwanted emotional distance between client and therapist. The very act of diagnosis or formulation involves standing back from the client, diverting one's attention toward analysis and categorization, and potentially not freeing the therapist to be emotionally present and available. From within the humanistic approach, diagnosis and formulation was traditionally seen as putting the therapist in a more powerful "one up" position, placing the therapist in an "expert" role and thereby creating an unwanted and inhibiting relational imbalance. Rogers (1951) had expressed this concern at an earlier point in social philosophical terms, stating that diagnosis may in the long run place the "social control of the many in the hands of the few" (p. 224).

The dilemma that presented itself in creating our theory of case formulation was somewhat solved in a number of different ways. First, it was recognized that even in practicing case formulation, the therapist maintains adherence to the core relational principles of both client-centered and gestalt therapies and their humanistic theoretical roots. Case formulation, as practiced in EFT, does not interrupt the emotional immediacy of the therapeutic relationship. It was also through practice that Goldman and Greenberg came to realize that the establishment of a focus was helpful in therapy and that in fact themes did emerge and coalesce across therapy. Therapists seemed more effective when they have a treatment focus. Furthermore, refinements, advancements, and additions to the theory have helped establish the usefulness of case formulation, particularly the idea of coconstructing an evolving narrative structure that organizes the therapeutic process and provides a focus.

It was also helpful to redefine case formulation in humanistic, emotion-focused terms. One of the key defining features of formulation is

that it is fundamentally process oriented (Goldman & Greenberg, 1997). Case formulation is not based on a priori assessments but rather evolves and emerges, particularly through the early stages of therapeutic exploration. As therapy progresses, working hypotheses are developed in conjunction with the client about the nature of underlying mechanisms related to presenting symptoms and problems.

A full descriptive and applied picture of case formulation in EFT is included in a book entitled *Case Formulation in Emotion-Focused Therapy: Co-Creating Clinical Maps for Change* (Goldman & Greenberg, 2015). It provides a guiding framework that can be adopted by the therapist from start to finish. It allows the therapist to be highly process oriented in the moment without becoming too chaotic or disorganized. This means that diagnosis is a moment-by-moment process of discovery that always takes place in consultation with the client.

Case formulation is ultimately guided by the client's emotional pain. While setting up empathic, collaborative relationships, therapists are guided by what is poignant and what is painful. EFT therapists are seen as operating with a pain compass that guides them through deepening the emotional narrative and exploring the chronic enduring pain.

Case formulation follows the two tracks of emotion and narrative/meaning making, through an ever-evolving, dynamically interactive process throughout a course of therapy. Emotion is given meaning through the identification and understanding of narrative themes, which in turn influence and organize emotions. This process of narrative theme consolidation and emotional exploration continue in an iterative fashion until emotions change and the narrative becomes more coherent. Emotion cannot be understood outside the context of the narrative, and the narrative does not have meaning without emotion. These two tracks thus run through and provide a scaffold for all three stages of case formulation.

EFT case formulation is divided into three stages. In the first stage of case formulation, through the unfolding of the narrative, therapists hear the story and learn what brought the person to therapy. They begin by attempting to understand how clients make sense of their selves and their worlds. Therapists organize information and hear those themes in relation to attachment relationships and identity formation. Therapists hear how clients have formed and now maintain attachment relationships in their lives, on the one hand, and are curious about how they view themselves, how they treat themselves (Watson & Greenberg, 2017), and how they seek validation from others. An additional goal in the first stage is to observe emotional processing style. Therapists observe and listen to facial expression, vocal styles, and other nonverbal and paralinguistic cues and empathically explore and track emotion in relation to the narrative. This helps form an understanding, for example, of how clients regulate emotion and whether emotional processing is productive. Further specific work may be indicated to engender productive emotional processing.

In the second stage of case formulation, therapists form a clearer understanding of the maladaptive emotion scheme. Out of the exploration of markers, secondary and maladaptive emotions, core needs, and how people interrupt these processes, one gets clearer on the core maladaptive emotion scheme, how it works, and how it creates the problems people bring to therapy. Therapy becomes thematically focused on the maladaptive emotion schemes.

In the third stage of case formulation, a thematic focus, driven by the core emotion scheme, has been established and is assumed. Therefore, the focus is on the formulation of emotional state and process to understand how to most productively move forward. Ongoing and emerging markers are diagnoses in the moment, and associated tasks ensue. In the last step of formulation, however, narrative themes are readdressed. By now, therapy has given new emotions and meanings a form by offering a space for self-

reflection and self-construction, and clients will now reinterpret and make meaning of experience in light of new information as they reform the narrative.

DEVELOPMENT OF SPECIFIC THERAPEUTIC TASKS

A hallmark of EFT is the use of specific therapeutic tasks that are offered at particular in-session nonverbal and verbal markers that emerge as therapy progresses. All markers and tasks are highly specified with criteria in the form of models that guide the therapist through the steps from marker through to resolution. Such models have been developed for all tasks and are summarized in more depth in a number of EFT publications, including Elliott et al. (2004), and for more recently developed tasks (see Chapter 10, this volume). Task models have been proven to be highly facilitative in the training of therapists in the approach.

The two primary tasks used in EFT are the two-chair dialogue for internal conflict splits and the empty chair for unfinished business. The two-chair dialogue helps address intrapersonal processes and ways in which people treat themselves (Watson & Greenberg, 2017; i.e., self-critical, self-interrupting, self-silencing, etc.). Unfinished business is an interpersonal task that helps address self-in-relation to other problems, such as emotional injuries and traumatic abuse and neglect suffered at the hands of caregivers and developmentally significant others. Research on the tasks has primarily been task analytic in nature and has helped to identify the steps in working through the tasks as well as the key components associated with change.

Early studies were conducted on the two-chair dialogue for conflict splits (Greenberg, 1975, 1984; Greenberg & Webster, 1982; Whelton & Greenberg, 2005). More recently, Shahar et al. (2012) examined the efficacy of the task at times of stress with nine clients who were judged to be self-critical. The intervention was associated with clients becoming

significantly more compassionate and reassuring toward themselves and led to significant reductions in self-criticism and symptoms of depression and anxiety.

The empty chair for unfinished business was studied and the steps specified early (Greenberg & Foerster, 1996; Greenberg, Rice, & Elliott, 1993). Subsequent studies have shown that full resolution requires restructuring of unmet needs, a shift toward a more positive view of self, and a more differentiated view of the other and that the attainment of this in therapy leads to positive outcome (Greenberg & Malcolm, 2002). Paivio and colleagues developed the unfinished business task for complex trauma, adapting it to suit the needs of the population. A fuller explanation of how to facilitate this task with the trauma population can be found in Paivio and Pascual-Leone (2010).

Other tasks developed have at times been referred to as subtasks to suggest that they are supplementary to the two main tasks outlined previously. Systematic evocative unfolding for problematic reactions was first developed by Rice (1974; Rice & Saperia, 1984) and later developed by Watson (Watson & Rennie, 1994). Meaning creation work was developed by Clarke (Clarke, 1989). Focusing was initially drawn from the work of Gendlin (1981, 1996) and others (Cornell, 1996) and adapted for EFT by Elliott (Horton & Elliott, 1991). Watson and Greenberg completed task analytic work that further developed the model of using the two-chair technique for self-interruption. Keating and Goldman (2002) conducted a task analysis to further develop and specify the empathic affirmation task that was originally specified in Greenberg, Rice, and Elliott (1993) when clients present with markers of vulnerability and shame. Self-soothing has become a centrally used task in EFT to help people develop internal capacities for self-compassion, and a number of studies have contributed to its specification (Fox-Zurawic & Goldman, 2012). For further elaboration of how to undertake such EFT tasks, see Chapter 10, this volume.

Subtasks can be distinguished from primary or core tasks by clarifying that they are undertaken to facilitate access to more primary therapeutic material. For example, systematic evocative unfolding might help identify and access a core maladaptive emotion scheme related to shame. Resolution of the task may provide clarity and produce a new marker for the two-chair dialogue work to work on the core shame. Self-interruptive work might be used to access core maladaptive emotions and blocked access to needs related to unfinished business with a significant other. Focusing is often used when clients are having difficulty accessing emotion. Self-soothing is used at a variety of different moments but may be used when a client is having trouble accessing compassion for the self in the context of either the two-chair work for self-criticism or unfinished business with a significant other. For more differentiated explanations of when to use tasks and subtasks, see Goldman and Greenberg's (2015) work on case formulation.

DEVELOPMENT OF EFT FOR SPECIFIC DISORDERS AND POPULATIONS

Since its inception, EFT has been developed and applied to work with various populations and clinical disorders. EFT has been most developed and empirically validated for depression; however, more recent studies have demonstrated its effectiveness with complex trauma, social anxiety, and generalized anxiety. A great deal of development has occurred in the area of EFT for eating disorders. EFT for couples has also received strong empirical support. The following section will review recent developments in this area.

EFT for Depression

Emotion-focused therapy was first conceptualized and empirically validated in relation to depression (Ellison et al., 2009; Goldman, Greenberg, & Angus, 2006; Greenberg & Watson, 1998). The theory is most thoroughly spelled out in the book *Emotion-Focused Therapy for Depression* (Greenberg & Watson, 2006) and applied to and illustrated in relation to multiple cases in *Case Studies in Emotion-Focused Treatment of Depression* (Watson, Goldman, & Greenberg, 2007). From an emotion-focused perspective, depression is seen as resulting from failures in the dyadic regulation of affect, avoidance of affect, traumatic learning, and lack of processing of emotion. Awareness, regulation, and transformation through accessing an alternate emotion are offered as three empirically supported principles of emotional change.

Watson, Gordon, Stermac, Kalogerakos, and Steckley (2003) carried out a randomized clinical trial comparing EFT and CBT in the treatment of major depression. Sixty-six clients participated in 16 sessions of weekly psychotherapy. There were no significant differences in outcome on depression between groups. Both treatments were effective in improving clients' level of depression, self-esteem, general symptom distress, and dysfunctional attitudes. However, clients in EFT therapy were significantly more self-assertive and less overly accommodating at the end of treatment than clients in the CBT treatment. At the end of treatment, clients in both groups developed significantly more emotional reflection for solving distressing problems. This represented a key development in EFT. Based on this culmination of studies, EFT for depression now meets criteria as an empirically supported treatment listed by the task force commissioned by Division 12, the Society of Clinical Psychology of the American Psychological Association.

EFT for Trauma

A number of studies have demonstrated the effectiveness of EFT for unresolved relationship issues, including emotional injuries with a significant other (Greenberg, Warwar, & Malcolm, 2008; Paivio & Greenberg, 1995). Paivio and colleagues have further adapted EFT for complex trauma (EFTT; Paivio & Pascual-Leone, 2010), characterized by repeated exposure to extremely disturbing events in childhood or abuse and/or neglect that occurs at the hand of caregivers or individuals known to the child. Studies have demonstrated the effectiveness of EFTT (Paivio, Jarry, Chagigiorgis, Hall, & Ralston, 2010). Paivio et al. (2010) found that EFT with empty chair work produced better outcomes but more dropouts than EFT without chair work. This study evaluated and compared EFTT with imaginal confrontation (IC) of perpetrators (n = 20) and EFTT with empathic exploration (EE) of trauma material (n = 25). Results indicated statistically and clinically significant improvements on eight measures at posttest, maintenance of gains at follow-up, and no statistically significant differences between conditions. There were higher rates of clinically significant change in IC and a lower attrition rate for EE (7% vs. 20%). For further developments, see Chapter 16, this volume.

EFT for Social Anxiety

Elliott (2013) tested EFT for social anxiety in comparison with client-centered therapy and found that although both therapies were helpful as evidenced by results on a variety of change indices, EFT was significantly more effective. Shahar, Bar-Kalifa, and Alon (2017) also demonstrated the effectiveness of EFT for the treatment of social anxiety. Further study has also allowed for the refinement of EFT theory in application to this specific clinical presentation (Elliott, 2013). Researchers observed that the provision of a strong interpersonal relationship was very important, as well as a moderate degree of structure and the sequencing of particular tasks. High degrees of self-observation and judgment in this population meant that the

use of the two-chair task for anxiety generation is at first a strong focus but that this eventually gives way to unfinished business that is important to resolve through the use of the empty-chair dialogue. The development of the capacity for self-soothing was also seen as integral to the change process (Elliott, 2013; Goldman & Fox-Zurawic, 2012). See also Chapter 15, this volume.

EFT for Generalized Anxiety

Watson and Greenberg (2017) proposed that anxiety and worry in generalized anxiety disorder (GAD) are attempts to protect the self from being overwhelmed by painful emotions that people are unable to soothe to meet their needs effectively and that instead their feelings and perceptions are silenced, dismissed, and invalidated. Dysfunction in GAD is seen as arising from the activation of core painful maladaptive emotion schemes of fear, sadness, and shame and the associated vulnerable self-organizations that result from the synthesis of these schemes together with the inability to symbolize and regulate the ensuing painful affect (Timulak & McElvaney, 2017; Watson & Greenberg, 2017). In EFT, when a person experiences anxiety, the self is organized as scared and vulnerable because of the activation of emotion schematic memories of harmful and painful experiences that were endured in the absence of protection, soothing, and support.

The EFT model of anxiety postulates that avoided emotions are embedded in idiosyncratic emotion schemes developed over the course of the client's personal history (Timulak & McElvaney, 2017) and that, as such, these idiosyncratic emotion schemes that center around chronic experiences of loneliness/sadness, shame, and traumatic fear must first be accessed during therapy, experienced as bearable, and eventually transformed by the activation of compassion and assertive/protective anger (Timulak & McElvaney, 2017; Watson & Greenberg, 2017).

Timulak and McElvaney (2017) conducted an open trial, assessing pre–post outcomes and 6-month follow-ups of EFT for GAD on 14 clients. The quantitative assessment was supplemented by qualitative posttherapy client accounts of helpful and unhelpful aspects of therapy and changes reported since the therapy started. The effect sizes indicated large outcomes, and the 6-month follow-up suggested that the treatment gains were largely maintained. Qualitative data captured changes in emotional functioning, anxiety, self-acceptance, self-confidence, self-understanding, and interpersonal functioning. For further developments, see Chapter 14, this volume.

EFT for Couples

After the initial development of emotionally focused couples therapy, Greenberg moved away from the promotion of EFT for couples to concentrate on research on individual therapy. He obtained an NIMH grant to study the effects and processes of the emotion-focused treatment of depression. Greenberg and his former student Susan Johnson decided that Johnson would continue to promote and develop EFT for couples while he concentrated on the individual approach. As Johnson developed the approach, she emphasized attachment theory more thoroughly (Johnson, 2004) and successfully developed and promoted it. This approach has come to be known colloquially as the “Johnson” approach to *emotionally* focused couples therapy, whereas Greenberg and Goldman adopted *emotion*-focused therapy to designate it as a branch of the broader emotion-focused approach to therapy, the one in application to couples. The approach is described in their 2008 book (Greenberg & Goldman, 2008). The Johnson approach to couples therapy became exclusively attachment focused, although the practice manual remained similar to the initial conceptualization.

Greenberg became more involved again in research on EFT for couples after he had developed a study of the process of forgiveness in both

individuals and couples. Research evaluated the effects of EFT for couples when one member had an unresolved emotional injury resulting from the partner's actions (Greenberg, Warwar, & Malcolm, 2008) and demonstrated that couples scored significantly better than wait-list controls on all indices of change. Thus began the resurgence of his effort to develop EFT for couples, and the integration of prior work on emotion in individual therapy came to further influence. *Emotion-Focused Couples Therapy: The Dynamics of Emotion, Love, and Power* by Greenberg and Goldman (2008) further delineated the approach to couples that he originally inspired. The book expands the framework of the therapy, focusing more intently on the role of emotion in marital therapy in both regulating interaction but also in self-regulation and stressed the importance of both self and system change through the promotion of both self-soothing and other-soothing. The book outlines how to work with anger, sadness, fear, and shame, as well as with positive emotions, and focuses on both the dominance dimension of couples' interactions in addition to the attachment dimension. For further elaboration, see Chapter 20, this volume.

Emotion-Focused Family Therapy and Eating Disorders

EFT has also been developed and found to be very helpful in the treatment of eating disorders (Dolhanty & Greenberg, 2009). This approach started mainly with an EFT group treatment of women with eating disorders (Wnuk, Greenberg, & Dolhanty, 2015). It was, however, found through extensive practice and treatment that an integration of family-based therapy could improve treatment and thus the model was developed in this direction (Robinson, Dolhanty, & Greenberg, 2015). The approach combines work on transformation of underlying maladaptive emotions seen as driving symptoms, with emotion coaching of parents so that they can support loved ones as well as specific "relationship repair" to facilitate the healing of old wounds and the release of child and caregiver self-blame. An overriding

process is the identification and processing of emotion experiences that block the parents such as denial, criticism, or accommodating and enabling behaviors. These behaviors are regarded as attempts to manage strong negative affect in the parent, in particular, fear and self-blame. Over time this work has developed as well into a parent coaching approach. See also Chapter 18, this volume.

CONCLUSION

Through 40 years of development, EFT has emerged from the humanistic tradition and developed into both a flourishing and powerful therapeutic approach that has increased in breadth and complexity. Working from within the events-based paradigm and making thorough use of task analytic research strategies, EFT scholars have allowed research to inform practice and practice to inform research. The continued focus on practice and scholarship in tandem has been productive and allowed for EFT to be extensively developed to treat a wide range of problems seen in psychotherapy. Initially an integration of client-centered and gestalt, EFT evolved to incorporate and synthesize a theory of emotion that describes and explains how emotion changes through sessions and ultimately through the course of therapy. Emotion change principles have been developed and a theory of case formulation has emerged that helps therapists to be focused and productive in their work. After forming empathic relationships and experientially unfolding client problems, therapists form a picture with their clients that allows them to structure the therapy in an ongoing fashion, conceptualize the core emotions to form a focus of therapy, and guide clients through the emotional change process, with the recognition of markers and the facilitation of tasks designed to promote this.

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[1]The *Gloria films* refers to the now famous recording of “Three Approaches to Psychotherapy” (1965) in which a client Gloria was seen by Carl Rogers, Fritz Perls, and Albert Ellis, who each saw her for one demonstration session. They are now considered classics and are some of the most watched films in psychotherapy history. They are often used for educational purposes as exemplars of each of the approaches.

2
THEORY OF FUNCTIONING IN EMOTION-FOCUSED THERAPY

LESLIE S. GREENBERG

In emotion-focused therapy (EFT), emotions are viewed as the basic datum of experience and as providing information, action tendencies, and motivation. Emotion is a complex multicomponent phenomenon. We start with the idea that we have basic, evolutionarily given, emotional action tendencies but see that with development, human emotions become much more complex. No longer are emotions simple separate natural kinds with independent processes with their own distinct, innate, physical correlates. Rather, lived emotional experience rapidly becomes the product of a complex synthesis of many processes, starting from some basic biologically given building blocks it incorporates, among others cognitive, memory, motivational, and behavioral processes. In the dialectical constructivist approach to emotion (Greenberg, 2010; Greenberg & Pascual-Leone, 1995, 2001), EFT practitioners see emotion as emerging when a set of sensations from the world are synthesized with a set of action tendencies and sensations from the body, and these are symbolized as, say, anger, sadness,

or fear as a situated conceptualization of what one is experiencing. For instance, in the context of looking at a photo of a lost loved one, a warmth in one's chest, a welling in the eyes, and a sense of reaching in one's arms, plus an emerging smile on one's lips, is symbolized as sadness. In this way, what we feel is constructed from basic elements of emotional experience.

There is not as yet a clear agreement on what emotion is (Barrett, 2006; Ekman & Davidson, 1994), but whatever it actually is, EFT's claim is that emotion differs from thought and beliefs, from behaviors, and from motivation. Emotions in our view are embodied connections to our most essential needs (Frijda, 1986). They rapidly alert us to situations important to our well-being, giving us information about what is good and bad for us and telling us if things are going our way. They also prepare and guide us in important situations to take action toward meeting our needs. As Frijda (2016) argued, rather than basic emotions, what is probably most basic are modes of action readiness that aim to establish, modify, maintain, or terminate a given self-object relationship. What may be universal are not emotions as feelings, but rather emotions as dispositions for various forms of action readiness. Feelings in this view then are reflections in consciousness that accompany action inclinations. Action tendencies have an *aim*. If the current situation lends itself to it, the state of readiness will activate an action or action sequence from the individual's repertoire that appears capable of achieving the aim of modifying or maintaining relationships. Actual actions appear when subthreshold activations turn into full-blown action.

Action readiness and action in a sense then are more basic than feelings, because feelings largely are the conscious reflections of states of action readiness. LeDoux (2012) suggested that what is most basic are *survival circuits* that mediate a coordinated set of adaptive brain and behavioral responses. It is these survival tendencies, such as defense against harm, that develop into basic emotions such as anger and fear that are

defined by brain circuits and adaptive functions that are conserved across mammals, rather than subjective emotional experience.

EFT thus views human emotion as a complex response system that activates a basic action tendency and a fundamental mode of processing (Greenberg, 2002, 2010), which are accompanied by a bodily felt feeling. Emotion then involves the action tendencies to approach and withdraw, to open up or close down, and to process information in accompanying ways. For example, fear prepares us for escape, sets fear processing in motion, organizing us to search for danger, and gives us, among other things, a feeling, possibly in the chest and stomach. Anger, on the other hand, prepares us for boundary setting, sets anger processing in motion, focusing us on identifying signs of violation, and gives us, among other things, possibly a feeling in our arms and legs. These felt tendencies, which can be highly idiosyncratic, then can be symbolized in language and developed into narratives that can be expanded or altered at will by the person as agent. To summarize, in our view emotions thus move us, reason guides us, whereas the meaning we give to our feelings is what we ultimately live by.

EMOTION-FOCUSED THERAPY PROCESS

EFT's approach to working with people differs from approaches that prioritize motivation, cognition, behavior, or interaction. In the context of an empathically attuned relationship, we help clients to attend to their bodily felt emotional experience, to connect cognition to emotion, and to be guided by the goal-directed action tendencies and needs inherent in emotion. In therapy we therefore guide people's emotional processing to promote three main processes: (a) reclaiming and developing underdeveloped emotional responses that were frozen in an earlier time (often from childhood situations of deprivation or intrusion or from trauma) and did not evolve or mature, (b) utilization of the innate adaptive potential

in emotion by connecting it to cognition, and (c) regulation of emotions when they overwhelm meaning creation and can no longer be connected to cognition. We thus focus on enhancing three emotion processes: emotion development, emotion utilization, and emotion regulation.

Previously disclaimed emotions, when activated in therapy, can be used to reclaim unwanted self-experience. This gives the person information about needs met or not met and provides information about one's response to situations as well as action tendencies to cope with them. Activation of new emotions in therapy additionally can help change obsolete emotional responses and transform previously disowned dreaded feelings from the past. Activation of these disowned feelings in the session makes them amenable to development by incorporating new experience to the past situation, generated in the present. This new experience helps transform peoples' persistent memory-based problematic emotional states by means of a process of memory reconsolidation (Lane, Ryan, Nadel, & Greenberg, 2015). This in turn helps people change their interactions with the environment. However, when emotions no longer can be connected to cognition, they need to be regulated.

As part of the process of providing goal-directed action tendencies, emotion evaluates if something is good or bad for us, a meaning crucial to our survival and well-being, and this must be distinguished from reason, which involves evaluations of whether something is true or false. Ultimately feelings are not facts; rather, they inform us of what is significant to us in the moment and form a disposition to act.

It is important to note that it is not just an appraisal that activates an emotion but an appraisal in relation to a concern. Appraisal in relation to a need/goal/concern that governs emotion activation is not produced by stimulus-activated associative learning. Appraisal, initially called *intuitive appraisal* by Magda Arnold (1984), mostly just emerges from one's interactions with the environment. Appraisal does not involve thought or

language. Also, one generally does not set out to appraise events. Emotional action tendencies rather result from a very rapid evaluation of the immediate survival and hedonic repercussions and consequences of a situation for the individual's concerns. And all this is done automatically without language by a complex system of future projection (goal) and feedback comparison of actual with desired states (Smith & Lane, 2016).

A DIALECTICAL CONSTRUCTIVIST VIEW: INTEGRATING BIOLOGY AND CULTURE

A core feature of EFT is that it makes a distinction between conceptual and experiential knowledge, and people are viewed as wiser than their intellects alone. Rather than "I think, therefore I am," EFT is based on the idea that "I feel, therefore I am" and that in any significant personal experience, we think only inasmuch as we feel. Emotions thus influence thought. However, both automatic thoughts and reflective evaluations also can produce emotion. Emotion, as well as being generated bottom-up, can also arise from top-down influences. We can, for example, think our way into fear and activate a defensive motive state this way. But because thought can produce emotion does not mean that all emotion is produced by thought. Rather the emotions produced by deliberative orbital frontal cortex processes are not nearly as important, in function and dysfunction, as are our more primary emotions produced by the limbic and body-based homeostatic system. It is these latter systems that are more impenetrable to reason and harder to change.

The emotion system is highly related to biologically based homeostasis, which is designed to keep the organism alive. The instinctual body is a survival system designed to live. So to have a more complete understanding of functioning, we not only have to recognize emotion and cognition in the form of conscious concept and bodily felt sense, but also

include the sensory body and homeostasis in the emotion system. The body has a will to live regulated by homeostasis, which is essential to life regulation. Emotions emerged as the body's way of evaluating what would help us survive.

Interoception, the ability to sense internal states and bodily processes and a much-neglected sense, is among the most fundamental ways we experience ourselves, right from birth. This process remains important in guiding us throughout life. We constantly sense our bodies from the inside. This emphasis on the sensory body is not an argument to supplant reason with primitive instinct and automatically felt emotion. Rather than glorifying the primitive over the reflective, I am arguing for the importance of the ability to feel the physical sensation of our bodies through awareness—to have an embodied sense of ourselves. Summarizing from Levine (2010), people have lost their relationship with their bodies, and therapists need to help them reconnect to their bodies. We need to be guided by our body-based felt inclinations and to simultaneously be able to be aware of their guidance. Conscious reflection on our bodily felt experience is what is needed. It is thus through a process of combining thought and feeling that we come to know ourselves. The EFT perspective is that much conscious personal experience and meaning derives from attending to, exploring, and making sense of implicit bodily felt self-organizations by a process of attention and reflection.

So, as well as having automatic bodily based emotional responses to situations, people also live in a constant process of making meaning of, and from, emotions. Conscious meaning is created by an integration of reason and emotion via an ongoing circular process of symbolizing bodily felt sensations in awareness and articulating them in language, thereby *making sense of experience* (Greenberg & Angus, 2004; Greenberg & Pascual-Leone, 1995; Greenberg, Rice, & Elliott, 1993). In this *dialectical constructivist view* (Greenberg, 2010; Greenberg & Pascual-Leone, 2001;

Greenberg & Watson, 2006; Guidano, 1995; J. Pascual-Leone, 1987, 1991; Watson & Greenberg, 1996), behaviors are seen as being generated by our brains for reasons that we are not consciously privy to, and we then interpret our behaviors in such a way as to create a coherent story about our current experience that makes sense in terms of our past and future (Gazzaniga, 1988).

It is helpful to distinguish between two fundamental ways in which emotion is generated. The first, a more sensory process, involves the automatic activation of basic responses following simple perceptual appraisals—like fear of heights or the dark. However, as individuals have more lived experience and develop more cognitive/linguistic capacities, these automatic processes are followed by more complex emotion processing in which sensory, memorial, and ideational information is combined to form emotion schemes. We now have more complex emotion schematic responses—like fear of disapproval or rejection. The more complex automatic system thus produces an emotion schematic–based bodily felt experience that is really felt in the body, but then how this bodily felt emotional experience is symbolized influences what the experience becomes in the next moment.

It is important to note that the ability to experience emotions is facilitated by the ability to put emotion into words. Words help form what we feel, and they construct a more complete sense of self while simultaneously creating a working distance from emotions to allow us to work with them and also to be understood by others. Putting feelings into words, or some other form of symbolic representation, thus matters enormously in therapeutic change, as it gives meaning to experience. Therapists therefore need to work with both emotion and meaning making.

There is a curious relationship between experiencing emotions that are felt by naming them versus expressing emotions in words, which leads to them being felt. It appears that often by attending to one’s bodily felt sense,

one can explore what is felt, and words then capture the waiting-to-be felt feeling, and one comes to feel the feeling. But it is also true that expressing what one feels in words brings forth the experience of emotion previously not felt. Expressing, by saying something, can activate a not currently felt experience. So expressing generates an as yet unfelt feeling, and this differs from articulating a feeling in words that is felt to be there but has not yet been articulated. Regardless by which path, awareness or expression, emotions come to be felt, therapists need to facilitate access to emotional experience and then promote further creation of the narratives that help make sense of the experienced feelings (Angus & Greenberg, 2011; Greenberg & Angus, 2004).

The elements involved in the dialectical construction of the self are depicted in Figure 2.1. In this diagram we see that two main streams feed conscious experience. One stream, which comes from within, is biologically based and affective in nature. The other, which comes from without, is linguistically based and cultural in nature. The experiential stream is constituted by the instinctual body and by bodily felt emotional experience, and these are balanced with reflective awareness.

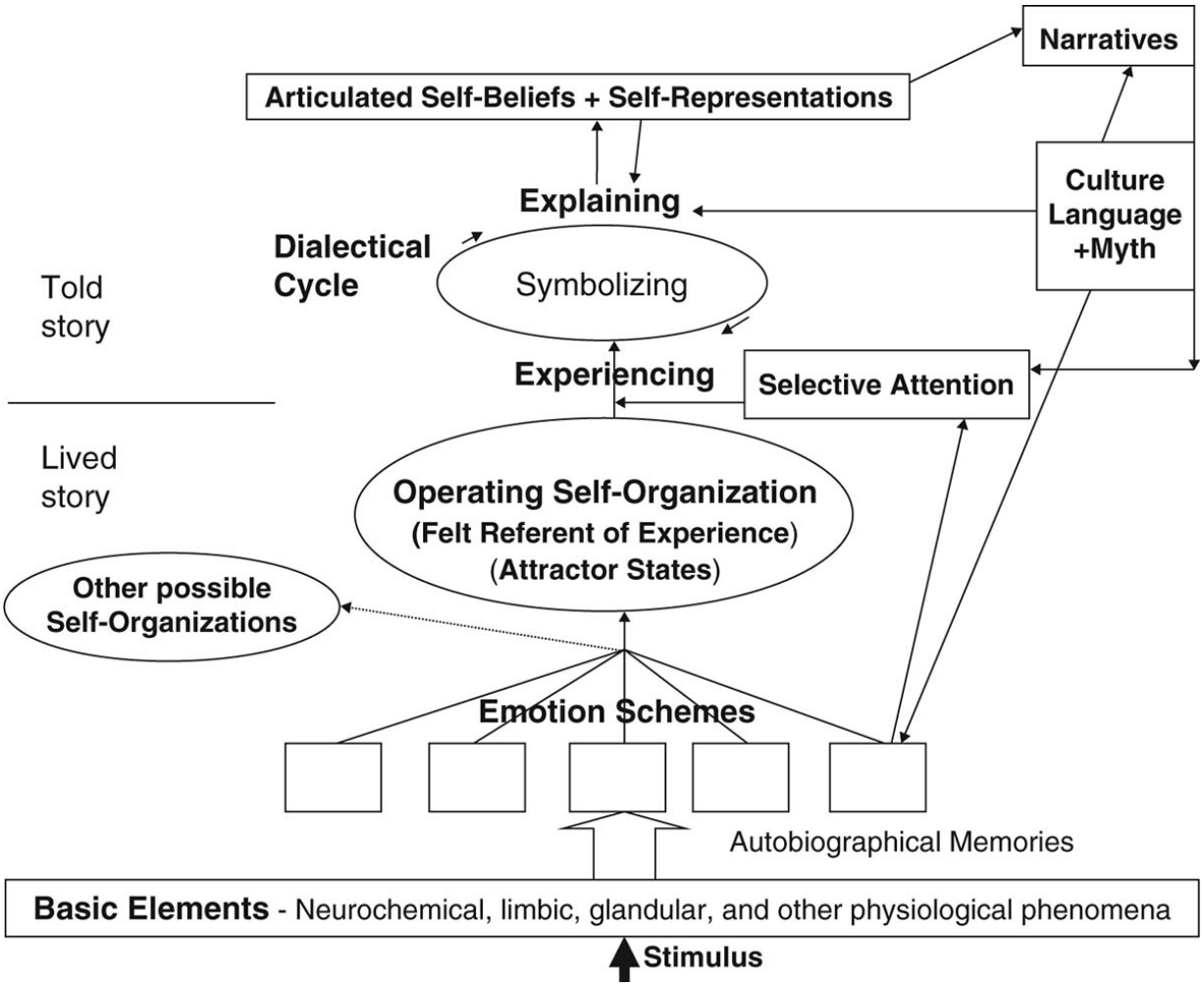

Figure 2.1. The dialectical construction of the self.

In addition, both streams themselves are in constant interaction with other people and the environment in a dialogical process of meaning construction. The internal affective stream, based mainly on in-wired action potentials of emotion and on biology and its homeostatic processes, provides the building blocks for a person's basic self-organization. Over time this level is influenced by cultural practices (e.g., culturally determined child-rearing practices) and by learning and experience and is organized into schemes based on bodily felt emotion experienced in situations. These schemes become the primary generators of experience.

It is important to note, however, that experience and performance are not generated by a single emotion scheme or by a single level of processing. Rather they are generated by a self-organization that is formed by the tacit synthesis of a number of schemes that are coactivated and coapply. It is as though there is a parliament of schemes; each scheme has a vote in the dynamic self-organizing process, and the majority of schemes voting in a similar direction will determine how the person is organized. The experiential state of the self at any one moment is referred to as the current self-organization, and this provides the bodily felt referent of experience. These schemes do not simply act alone to create a response; rather, they are synthesized to configure a response to a situation with the help of other mental operations such as attention, executive processes, and reflection, which can both boost and interrupt the application of certain schemes (Greenberg & Pascual-Leone, 1995, 2001; J. Pascual-Leone, 1987, 1991).

At any one time a person is thus organized by a tacit dialectical synthesis of a number of coactivated emotion schemes into one of many possible self-organizations, such as feeling confident, insecure, or worthless. In addition, the self-organizations that emerge from the dynamic synthesis of a variety of emotion schemes are not permanent states of affairs, so a person can change from one moment feeling worthless to the next moment feeling angry. This tacit organization provides “the feeling of what happens”—a bodily felt sense of who one is. Conscious experience results when this implicit feeling is attended to and symbolized explicitly.

Given the internal complexity generated by the synthesis of many schemes and levels of processing, experience is always multidetermined and multifaceted. Thus we are always in a process of constructing the self we are about to become in the moment by a dialectical process of symbolizing our bodily felt feeling in awareness, generally in language, and then reflecting on it and forming narratives that explain ourselves to ourselves and provide self-understanding.

Self-organizations thus are continually constructed and reconstructed (Greenberg & Pascual-Leone, 1995, 2001; Whelton & Greenberg, 2000). Stable self-structures and trait-like characteristics appear only because people regularly recreate these stable states out of the same basic component elements as they interact with their situation, with some states acting as attractors in the dynamic synthesis process. This makes self-states idiosyncratic and variable, both across people and within the same person over time, and provides an optimistic view of the possibilities of change.

Experiencing is generated by a dynamic tacit synthesis of sensory, schematic, and conceptual levels of processing that integrate by a type of summation of related or mutual elements into a gestalt with figural and background aspects. Symbolizing experiencing is not simply a process of representation, but rather a process of construction, always limited and incomplete. Not all tacit information is used in any construction. Thus we can always explore for what more there is and reconfigure it in a new way. Explicit knowledge needs to fit adequately, to make sense of, and to integrate elements into a coherent, meaningful whole.

Emotion Schemes

Emotion schemes are seen as the primary source of human emotional experience and are at the base of the adult emotional response system. A scheme is an organized internal structure or network. *Emotion schemes* refer to response-producing internal organizations that synthesize a variety of levels and types of information including sensorimotor stimuli, emotion memory, perception, motivation, action, and conceptual-level information. In contrast to a cognitive schema, the emotion scheme is a network that includes a large component of nonverbal and affective experience. Emotion schemes are not necessarily conscious; they, however, can be activated by recalling specific experiences.

Emotion schemes are dynamic affective-cognitive networks that rapidly and automatically synthesize a wide variety of information to organize one's moment-to-moment experience of oneself and the world. They develop by representing internally people's lived emotional experiences plus the activating situations. Emotion schemes then form our emotion schematic memories. Experienced emotion is produced by the activation of these emotion schemes. In contrast to cognitive schema that are language-based beliefs, emotion schemes consist largely of procedural, preverbal, and affective elements (e.g., bodily sensations, action tendencies, visual images, and even smells). They are networks containing scripts that can be understood as wordless narratives consisting of beginnings, middles, and ends; agents; objects; and intentions (Angus & Greenberg, 2011; Greenberg, 2010). They are built from lived experiences, they predict what to expect, and when activated they produce higher order organizations of experience that form the foundation of the self (Greenberg, 2002, 2010).

Synthesis of Emotion Schemes With Other Information

A number of activated emotion schemes then synthesize at a higher level into an operating self-organization that provides the person's emotional experience and reaction in a given situation. For example, a person's conscious experience of danger is fear. But it is important to notice that there is no one thing that the word *fear* refers to. Rather, a person's fear is a complex idiosyncratic experience that comes from a synthesis of a variety of emotion schemes built from the person's previous unique experience. For example, one's fear of a snake is different from the fear of rejection or the fear of public speaking or the fear of taking of a test. An emotional experience of fear is an emergent property of the synthesis of many underlying personal schematically activated processes. Our unique experience is synthesized from our activated schemes much like the flavor of a recipe emerges from its ingredients. When all the ingredients from the

various schematic components are synthesized in consciousness with information about the external stimulus and long-term memories about what that stimulus means, then the resulting feeling that emerges is some personal variant of fear with an idiosyncratic bodily sensed feeling. People, depending on the situation and their past experience, might find themselves feeling terrified, apprehensive, shaky, or anxious. Whether we feel concerned, scared, terrified, alarmed, or panicked thus depends on the particular characteristics of the schemes aroused in the brain and from information about the stimulus and its context. In the presence of these different ingredients, feelings occur automatically in consciousness. To understand emotions, we need to understand individuals' construction of their felt experience. We thus live in a dual process in which our feelings orient us to the world, and we construct personally relevant meaning from our feelings. Exploration in psychotherapy is the process of attending to and constructing in language what we feel.

Scheme Activation

Guided by Pascual-Leone's concepts (J. Pascual-Leone, 1987, 1991; J. Pascual-Leone & Johnson, 2011), we define a *scheme* formally as a functional structure constituted by the coordination of three internally consistent functional components: a *functional component* that embodies the gist (goals and overall procedures) of the scheme, a *releasing component* that contains conditions that when matched with features of the input state constitute releasing cues, and *an effecting component* that contains a set of effects of many sorts that follow from the scheme's application to the experienced reality (external or internal). In addition, all components are internally consistent. So a scheme with a theme of fear of rejection may be released by a person's facial expression, which has the effect on one of automatically glancing to the side and moving away slightly and releasing an action tendency or motive state of either wanting

to escape or alternatively to pursue to prevent the rejection, depending on one's emotional history. So a scheme is activated by releasing cues and has effectors that produce complex responses.

In addition to releasing cues, the likelihood of scheme activation can be boosted by a variety of factors including attention, prior activations, field factors that pull for a certain view, and an agent who through control processes can influence what happens (choice; J. Pascual-Leone, 1987, 1991). So a view of functioning based on emotion schemes is not a mechanistic view like a simple stimulus response, associationistic view, or a simple cognitive appraisal model, but instead offers a view of functioning as cue released but "thoughtfully" anticipatory (J. Pascual-Leone & Johnson, 1991; Piaget, 1954, 1973). Schemes, unlike associations, are not blind or dumb associations; rather they are complexly released and can anticipate the result of their application. As schemes develop, they also include *expectancies* (J. Pascual-Leone, 1987, 1991; Piaget, 1954, 1973) and produce automatic predictions. For this reason, they offer an alternate conceptualization to S-R and cognitive appraisal views of learning and development and emotion activation (Greenberg & Pascual-Leone, 1995, 2001; Greenberg & Safran, 1987; J. Pascual-Leone, 1987).

Emotions as a Meaning System

Emotions provide evaluations of whether something is good or bad for a person—fundamental meaning—and they also provide action tendencies that express the associated evaluations and desires or needs. Emotions, therefore, are our fundamental meaning system. This type of meaning making implies expectations about the future. Peoples' predictions are based on the meanings they make. These meanings exist implicitly and nonverbally. It is these meanings that are made without awareness, without words that are given to us through the emotional body that provide expectancies. Because these are implicit, they cannot be reflected on

verbally. They exist at the procedural level, and they need to be changed at a similar level by having new experiences. When this occurs, it leads to changes in self-organizations, and it is this new feeling of what happens that then brings about changes in explicit understanding.

As people develop, lived experiences of situations thus are associated with representations of the bodily states they experienced in the situations, and the situations are thereby given affective meaning. Emotional experiences are integrated with cognition, motivation, and behavior to form internal organizations (emotion schemes), which determine peoples' future experience of that emotion. In this way a somatic state, a visceral experience, becomes a marker for a specific experience and is stored in memory (Damasio, 1999, 2010). When cues evoke an emotion schematic organization formed from a past bad experience, the person will experience an unpleasant gut feeling (Damasio, 1994), and the feeling will have an implicit meaning that what is currently occurring is bad. People will then tend to make decisions to avoid this kind of unpleasant event to protect themselves from feeling bad. In this way, the body is used as a *guidance system*, and it is emotions that guide decisions, helping people anticipate future outcomes on the basis of previous experience stored in emotion schemes that activate gut feelings.

Emotion schemes are a particularly important target for change. They exhibit distinctive types, not all of which are considered adaptive. Rather, at the heart of dysfunction are the operations of secondary and primary maladaptive emotion schemes. So although all emotion states have the intrinsic potential to provide useful information (e.g., although the experience of shame may be negative, it has the potential adaptive value of preventing undesirable behavior to preserve social relationships), important distinctions are made in EFT to differentiate whether the emotion scheme *type* currently being experienced is adaptive or maladaptive. Maladaptive schemes, which are schemes at the heart of a client's vulnerability, need to

be transformed, whereas adaptive emotions have the capacity to transform maladaptive emotion.

It is also important to note that according to EFT, experience is not generated by a single emotion scheme or by a single level of processing. Experience rather is generated by a tacit synthesis of a number of schemes and a number of levels of processing that are coactivated and coapply (Greenberg & Pascual-Leone, 2001). This synthesis of multiple schemes forms the basis of our current self-organizations in any one moment—the self I find myself to be in a situation—such as feeling confident or feeling shaky. It is this self-organization in a situation that provides the bodily felt referent of experience (Greenberg, 2010) to which one needs to attend to experience oneself. These experiences are not a product of will or deliberation but rather of an automatic dynamic self-organizing process that occurs outside of awareness.

CONSCIOUS COGNITION AND INTENTION

A distinguishing characteristic of being a human being is the ability to evaluate one's own desires, feelings, and needs (Taylor, 1990). Thus, in determining the self one will become, people have the ability either to desire or not desire their first-order feelings and desires. In this second, higher order, evaluation, the worth of a desire is evaluated against some ideal or aspired-to standard. Being a self thus involves being self-evaluatively reflective and developing and acting according to higher order desires. Essentially this means developing feelings and desires about feelings and desires. For the emotion system, the evaluation is simply: "Is it good or bad for me?" whereas in the stronger, self-reflective evaluation, there is also a judgment of the value of the emotion and its accompanying desire. People evaluate whether their emotions and desires are good or bad, courageous or cowardly, useful or destructive. People thus form subjective

judgments of the worth of their own desired states and courses of action (Taylor, 1990). Thoughtful reflection on emotional promptings is thus a crucial part of emotional intelligence. This is where conscious thought plays its crucial role. Thought must be used to judge whether emotional prompting coheres with what people value as worthwhile for themselves and others.

In addition to the role of higher level thought in reflecting on emotion, emotion itself, as one can verify by attending to one's next emotion, generally is not without thought. An emotional experience is a combination of bodily feelings and thoughts. In addition to the bodily sensations, emotion in adults almost always includes mental thought. Whenever people experience an emotion, they will find themselves awash with sensations as well as inundated with related thoughts. Anger sometimes involves a burning sensation that erupts up a central shaft through a person's stomach and mushrooms out into the center of the chest. It is accompanied by thoughts of unfair treatment and protest, such as "I won't take this anymore!" or "How dare he (or she)?" At these times images of a cold, heartless other, uncaring and judgmental, may vividly cross the person's mind.

Sadness sometimes comes as a burning behind the eyes that cascades down into the body, especially into the stomach. It makes the person want to curl up into a ball and is accompanied by thinking such thoughts as "I give up" or "I feel so alone." Images of being alone and small in a vast universe sometimes accompany these thoughts. This symphony of bodily feeling, mental thought, and images is emotion. It is this symphony on which people must learn to focus, to understand their inner stirrings, and to harness its message.

SELF-FUNCTIONING

In our view the self is a temporal process unfolding in the present in interaction with the environment. Rather than a spatial metaphor that localizes the self as an entity, the self is seen as arising in contact with the environment. The self is always formed in relation, is decentralized, and unfolds in time (Perls, Hefferline, & Goodman, 1951). The self is organized moment by moment into different forms such as happy, worthless, cautious, or bold as the organism engages in ongoing transactions with the environment. The self is more like a constantly flowing river than a structure, much more constituted by the passing of time than by spatial location and a fixed form. The self is a dynamic self-organizing process, always creating the self the person is about to become. It is the forming of forms. The person is constantly putting the self together in the situation. Like touch only exists in touching, so the self only exists in experiencing something in a situation. Therefore, we are concerned with the self-organizing processes and with the flexibility of this process rather than with finding a "true self." The therapist thus needs to interact with the way the person is organized in the present situation of the session. This is why EFT's notion of problem markers is important, as a marker is a signal of the person's type of current organization that is troublesome. Responding to markers allows the therapist to meet the person how he or she is currently organized. Thus, if a person is organized self-critically now, the therapist intervenes with a two-chair dialogue.

In addition, setting up tasks for people to engage in to create new experience is a way of helping the self come into being by expression. Expression as opposed to awareness is so important because in expression the self is forming itself in the world, not simply reflecting on or making sense of experience. Rather the self forms itself in the action of expressing. Thus contacting a parent in imagination in an empty chair and expressing to the parent "I love you" or "I hate you" is a process of creating new self-

experience. It is behaving but in a virtual reality rather than in the real world.

MOTIVATION AND NEEDS

In general, *need/motivation* refers to what a person wants, wants to do, desires, or intends. Derived from the word *motivus*, motivation means “to move.” Hypothesized evolved motives range from survival, attachment, self-actualizing, belonging, mastery, power, esteem, and many others (Bowlby, 1988; Maslow, 1970; Rogers, 1951; White, 1959). EFT, although not denying the importance of these organizations, hypothesizes that emotions are the givens and that motives, needs, wishes, and desires develop from emotion and the processes of affect regulation. Emotion, which as we have seen is best understood as fundamentally an action readiness, is itself a motive state.

In EFT, in addition to the fundamental motive to survive, common across species, the basic operating processes or what can be called *major human motives* are seen as (a) affect regulation, the effort to have the feelings we want and not have the feelings we don’t want, and (b) meaning creation, the effort to make sense of ourselves and our world by narrative construction. Note these are general-purpose motivational processes, not specific content motives. The attempt to identify specific content motives such as attachment, autonomy, achievement, or power, however, is so strong in Western thinking that it is hard for people to see these content motivations as derivatives of emotion, as I propose, rather than as fundamental motivations. The notion of basic drives or motivations is so deep in our theoretical preconceptions that it takes some thought to escape the givenness of the view that life is governed by predetermined motivational systems. In my view, human psychological needs, rather than being givens like instincts or reflexes, are emergent phenomena,

constructed in a complex process of development. Psychological needs are not simply inborn and are not the same as biologically based drives like hunger or thirst or the fundamental motivation to survive and thrive. Rather, human psychological needs emerge and are created and coconstructed in relationships by the operation of affect regulation and meaning construction. Basically, we come to desire that which we have experienced and feels good to us and makes sense to us and our culture.

Thus, rather than postulate a set of basic motivations, such as attachment, mastery, power, or control, we see that needs are coconstructed from basic affective values with which the infant is born in conjunction with interactional experience. We are born with a motivation to survive and with processes to regulate affect and to create meaning. Over and above this, all other needs emerge from these basic elements plus inborn emotional preferences as well as from interactional learning. The infant is prewired through the affect system, for example, to favor warmth, familiar smell, softness, smiling faces, high-pitched voices, a certain level of stimulation, and shared gaze. These all produce pleasant affect and, once experienced, begin to be sought after. Needs derive from affective experience and memory, and people have hundreds, if not, thousands of psychological needs that are somewhat situation dependent. We come into the world with basic motives to survive and thrive, serviced by affect regulation and meaning creation. Out of this develop our other needs, such as needs for connection, validation, and achievement. These are sculpted from initial emotional biases and from experience. Many needs are situationally evoked, such as a desire for the fresh-baked bread we smell coming from the kitchen or for the touch of others when we see them.

Guided by a relatively small set of affectively based biases and preferences experienced as feelings, selective strengthening and weakening of populations of synapses as a result of experience carve out circuits that become needs (Damasio, 1999, 2010). The circuits are organized on the

basis of lived experience. No narrowly fixed universal drives exist as fundamentals; rather, they are derived from emotions. So without emotions, we wouldn't have attachment or mastery, or nurturing motives.

This view—that human beings are wired to seek the experience of emotions because how the emotions make them feel aids survival—is not a simple hedonistic view in which people seek pleasure and avoid pain. Rather people seek to attain/achieve the needs/goals/concerns embedded in their emotions: goals such as closeness and proximity, the lack of which is signaled by sadness; safety, the lack of which is signaled by fear; agency, the lack of which is signaled by shame; and effectiveness. Those who had feelings like these fared better than those who did not and survived and thrived (Ekman & Davidson, 1994).

As made apparent in therapy, and especially in couples therapy (Greenberg & Goldman, 2008), content needs, related to attachment and identity, usually appear to be of the greatest psychological concern to most people. Needs to be connected, protected, and effective and valued appear to be related to people's basic interpersonal nature. Love and power and connection and status are important in understanding human experience (Gilbert, 1992). Needs for security and interest, curiosity, and mastery also appear to be basic to human nature. Thus needs to be securely attached, belong, seek affection, and be valued by others, and to have control, mastery, and novelty, all seem of critical importance to survival (Bowlby, 1988; White, 1959). Our ancestors probably survived if they belonged to a group and if they were curious, because they learned about things ahead of time, before the necessities of survival demanded it, and this helped them master their situations. Those whose emotion systems oriented them toward attaining attachment and mastery probably survived better than those who lacked this emotional makeup.

Once emotions are accessed, they inform about what the person wants or needs. In EFT we do not work with understanding motivation as

fundamental, but rather to access emotions, as needs are inherent in them. So we are not trying to understand people's motives by analyzing the content of their lives and interactions, looking for patterns or explanations of why they do certain things. Rather we let the emotions reveal their motivations and action tendencies. We do not see dysfunction as arising from neurotic needs or their denial, nor do we see dysfunction as occurring because of interpersonal patterns based on unfulfilled wishes or on internal working models related to attachment. Rather we see problems arising from the disclaiming of emotion, the perseveration of certain past emotional responses in the present, or because of emotion dysregulation. Therapeutic work involves keeping our finger on the emotional pulse of our clients rather than figuring out their conscious or unconscious patterns or errors.

In addition, we don't see people as stimulus-driven organisms governed either by stimulus response links (S-R) or stimulus cognition response links (S-O-R) formed by association. Instead, people are seen as purposive goal-driven beings who are always comparing where they are with where they want to be. Reducing discrepancy between present and desired state rather than associative learning is a core process. Emotions and motives then involve automatic goal-directed processes that produce action tendencies where a stimulus evokes a valued state that acts as goal S: R− O^{V}. Responses (R) are determined by anticipated effects actions (V Value) will have. This means the brain is involved in forward modeling of how it essentially wants the body to feel (V) and then compares how it finds itself in relation to its valued goal and initiates a readjustment. The importance of this will be seen when we suggest in Chapter 3 that we do not see change as coming about by mere exposure, which is based on associative learning theory.

DYSFUNCTION

Psychological health is seen as the ability to creatively adjust to situations and to be able to produce novel responses, experiences, and narratives. Dysfunction is seen as lacking in these capacities and as arising through a variety of different emotional mechanisms (Greenberg, 2010) described next.

Emotional Dysfunction

In general terms, emotion is dysfunctional when it gives poor information. When responses are not adaptive or are inappropriate to the situation, and when the emotional reactions cannot be monitored and regulated and cannot be effectively communicated, they are said to be dysfunctional (Scherer, 2015). EFT posits that three emotional processes, lack of awareness, lack of regulation, and disclaiming of emotion, underlie most, if not all, psychological dysfunction. A good example of this view can be seen in looking at ruminative thinking or repetitive thought, which has been shown to be related to much dysfunction and suggested as an underlying mechanism of disorder (Nolen-Hoeksema & Watkins, 2011). EFT, however, views rumination as a symptom of protection against/avoidance of/attempts to cope with underlying painful emotions. Treatment involves helping clients to concretely describe their feelings and process their unresolved anger and sadness, rather than working cognitively through protests or complaints about why bad things happen. We do not try to retrain their attention but rather help them reexperience the concrete situation and the feelings related to their unresolved sadness of loss, fear of threat, or shame at humiliation. These core feelings, once reclaimed, accepted, and experienced, are then processed according to EFT's principles of emotional change. It is not that emotions are repressed but that they are disclaimed that is the biggest problem. Dissociation, especially in trauma, rather than repression is as work. The effectiveness of this approach to processing emotion has been borne out by our productive processing

measure and our research on the steps of emotional change (Auszra, Greenberg, & Herrmann, 2013; Herrmann, Greenberg, & Auszra, 2016; A. Pascual-Leone & Greenberg, 2007).

The four major sources of dysfunctional failures to process emotion adequately are (a) *lack of emotion awareness*, that is, the inability to symbolize bodily felt experience in awareness, often resulting from the avoidance or disclaiming of primary experience; (b) *maladaptive emotional responses*, generated by emotion schemes, formed from unprocessed or disowned emotion, often resulting from traumatic learning in interpersonal situations such as with primary caregivers; (c) *emotion dysregulation*, involving the under- or overregulation of emotion, often resulting from failures in the early dyadic regulation of affect; and (d) *problems in narrative construction and meaning creation*, stemming from people's inability to make sense of their experience and develop adaptive narrative accounts of self, other, and world (e.g., incoherent narratives, maladaptive narratives of self or other blame). In therapy we have found that people struggle with both dysfunctional self–self processes, such as conflict between two parts of the self, and dysfunctional self–other relational problems, such as unresolved feelings toward others. Either or both of these feature in most dysfunctional processes. Another source of dysfunction is current interpersonal conflict, so we see dysfunctional forms of interaction as a further source of dysfunction.

Interactional Dysfunction

Emotion-focused couples therapy from its inception evolved from a combination of intrapsychic and systemic perspectives (Greenberg & Johnson, 1986, 1988). This has involved bringing emotion to a systemic perspective by continually integrating our growing understanding of emotion from individual therapy with a systemic perspective of circular causality, context dependence, and narrative. An emotion-focused approach

views negative interactional cycles and vulnerable emotions and unmet needs as the major sources of dysfunctional interpersonal conflict. In this view, conflict is seen as resulting from underlying emotional vulnerabilities, which drive escalating interactions that rigidify into negative interactional cycles. Generally, negative interactional cycles are viewed as being driven by secondary reactive emotions, such as anger and disinterest, which obscure more rapid-acting and core underlying emotions (e.g., fear, sadness, shame) that arise from core attachment and identity needs not being met. Revealing vulnerable attachment- and identity-related emotions and needs underlying interactional positions, then, is seen as an ideal means of changing negative interactional cycles and ultimately narratives. The fundamental task of therapy is to identify negative cycles related to threats to security and identity and to engender positive interactional cycles by having partners reveal previously unexpressed primary, adaptive attachment- and identity-oriented emotions and needs and finding new ways of dealing with these. Given that relational conflict most often results from hurt feelings and unexpressed amygdala-based feelings of threat related to unmet security and identity needs, it is important to help people deal with their own and their partner's emotions and needs related to these threats.

The initial theory of emotionally focused therapy with couples proposed that it was the process of revealing underlying vulnerable feelings, based on adult unmet needs for closeness and recognition, and the partner's subsequent empathic responsiveness to these feelings that helped restructure the emotional bond (Greenberg & Johnson, 1986, 1988). In this view it is the seeing of the face of the other that is so important to evoke new experience. As Levinas (2003) highlighted, we are impacted by the ways others face us. We therefore need to encourage people to face each other and express their underlying vulnerable feelings. It is to be noted, however, that the face is an ambiguous text open to interpretation, and so how we react to others also is subject to our interpretation of the other. In

couples therapy we thus also encourage each partner to express in words what they feel in such a way that there is no doubt about what is being felt, so that it is not misinterpreted. This core hypothesis that expression of vulnerable feelings predicts outcome has been supported in a number of studies (Greenberg, Ford, Alden, & Johnson, 1993; Greenberg, James, & Conry, 1988; Greenberg, Warwar, & Malcolm, 2010; Johnson & Greenberg, 1988).

Over time we have expanded our understanding of couple functioning. We see affect regulation as a core motive in coupling, more fundamental than attachment and identity, and that partners attach to, influence, and are drawn to others, to regulate their affect. In an affect-regulation view of coupling, we suggest that we are motivated to have the emotions we want and not have the emotions we do not want and that we function in this way because it aids survival and growth. Much interaction thus is driven by the satisfaction of feelings—by the felt excitement and satisfaction when relationships are meeting our needs and by anxieties and loneliness when they are not. People thus are drawn to each other, attach, maintain their identities, and exercise their capabilities in their relationships because of how these actions make them feel. Although we are suggesting that people do seek to feel more positive emotions, “negative” emotions are highly functional and serve survival goals, and people self-regulate emotions with the aim of achieving their goals, not to simply seek pleasure. People’s goals, therefore, consist of more than feeling good; at times, and under certain circumstances, they will seek “negative” emotions, tolerate pain, or sacrifice themselves in the service of experiencing higher order feelings of virtue, achievement, or love.

CONCLUSION

The theory of functioning underlying EFT emerged bottom-up from empirical studies of the process of change, and from a theory of practice, and was grounded in contemporary psychological theories of functioning, most specifically on affective neuroscience and emotion theory and research (Auszra, Greenberg, & Herrmann, 2013; Greenberg, 2002; Greenberg, 2015; Greenberg & Safran, 1987; Herrmann, Greenberg, & Auszra, 2016; Kennedy-Moore & Watson, 1999). It is an attempt to explain functioning in terms of modern emotion theory as well as drawing on aspects of humanistic philosophy. It draws from psychotherapies such as client-centered therapy (Rogers, 1951) and gestalt therapy (Perls, Hefferline, & Goodman, 1951) and, in couples, on systemic therapies (Hoffman, 1981).

A major premise of EFT is that emotion is foundational in the construction of the self and is a key determinant of self-organization. The lives of human beings are viewed as profoundly shaped and organized by emotional experiences. At the most basic level of human functioning, emotions are an adaptive form of information processing and action readiness that orients people to their environment and promotes their well-being. Emotions influence the biological and neurochemical levels of system functioning, as well as the psychological, cognitive, behavioral, and interactional levels. In EFT, bodily felt experience is viewed as being influenced not only by evolutionarily based affect motor programs but also by cultural and social learning process. Central to EFT theory is the organizing function of emotion schemes.

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3
THEORY OF PRACTICE OF EMOTION-FOCUSED THERAPY

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In this chapter, we present the theory of practice of emotion-focused therapy (EFT) for individuals. First, we review some general issues in working with emotion, then we discuss the importance of emotion assessment. This is followed by an elaboration of principles of emotional change with the focus on individual therapy. The theory of practice in couples therapy is presented in Chapters 20, 21, and 22.

WORKING WITH EMOTION IN PSYCHOTHERAPY

EFT is designed to help clients become aware of and make productive use of their emotions. The goal is to enhance emotional processing. This is achieved by helping clients better identify, experience, accept, tolerate, regulate, explore, make sense of, transform, and flexibly manage their emotions. As a result, clients become more skilled in experiencing emotion and connecting it to cognition. They gain important information and form

new meanings about themselves and their world and become more skilled in using that information to live vitally and adaptively. Clients are encouraged to face dreaded disowned emotions so that the emotions can develop, be processed further, and be symbolized and transformed into new experiences and meanings. A major premise guiding intervention in EFT is that if you do not accept yourself as you are, you cannot make yourself available for transformation. We thus communicate to clients: “you have to arrive at a place before you can leave it” or “you have to feel your painful emotions in order to heal them.”

At the center of the approach is helping people discern when they (a) need to use adaptive emotion as a guide and be changed by its urgings, (b) need to change maladaptive emotions, and (c) need to regulate dysregulated emotion. A key tenet of EFT is that a person needs to experience emotion either to be informed and moved by it or to make it accessible to change, but with the proviso that emotion needs to be sufficiently regulated to be able to serve these purposes. People do not change their emotions simply by talking about them, by understanding their origins, or by changing beliefs. People change emotions by accepting and experiencing them, by regulating them when they overwhelm the creation of meaning, by opposing them with different emotions when they are maladaptive, and by reflecting on them to create new narrative meanings.

In EFT, awareness is directed to emotion so that people can concentrate attention on as of yet unformulated, automatically produced, emotional experience to intensify its vividness and symbolize it consciously. In therapy, it is this primary emotion that is focused on as visceral experience. It needs to be accepted, as well as worked with directly, to promote emotional awareness, emotional development, and emotional change (Greenberg, 2002, 2010). Finally, it is the articulation of newly experienced automatic emotions in new narratives that promotes new ways

of being with self and others and provides new, more adaptive stories to live by (Angus & Greenberg, 2011).

A number of studies have shown that making sense of moderately aroused emotions predicts good therapy outcome (Carryer & Greenberg, 2010; Greenberg, 2010; Missirlian, Toukmanian, Warwar, & Greenberg, 2005; see also Chapters 7, 8, and 9, this volume). Rather than a cathartic getting rid of emotion, we help people experience their emotions in the present and relate to them from a working distance. People thus experience having the emotion rather than the emotion having them. They develop the ability to rule their emotions rather than being ruled by them. Although we have shown that it is making sense of emotion and bringing cognition to previously unacknowledged emotion that leads to change, it is important to note that it is not understanding or awareness that is crucial to change, but rather new experience. It is the experience and expression of new emotions to change old emotions that brings with it the bodily change that is crucial to rewiring at an experiential level. It is the newly accessed and transformed experience that then needs to be made sense of in new narratives that consolidate the change.

THE DUALITY OF EMOTION: WHEN TO ACTIVATE AND WHEN TO REGULATE?

One of the therapeutic dilemmas in working with emotion is when to help clients regulate by distracting and down regulation and when to facilitate emotion approach and intensification. Rather than treating emotion activation as singularly good or bad or always promoting its expression, we need to recognize that at times greater awareness and experience of emotion is therapeutic, and at other times it is best to regulate emotion. The duality then is that emotions are both forms of knowing and providers of pleasure and pain.

An important issue in any treatment, then, is when emotions should be activated and when they should be regulated, as well as what emotions are to be regulated and how they are to be regulated. Underregulated emotions that require down regulation generally are either secondary emotions, such as despair and hopelessness, or primary maladaptive emotions, such as the shame of being worthless, the anxiety of basic insecurity, and panic, that currently cannot be connected to adaptive cognition because they are so overwhelming. When distress is so high that the emotion no longer informs adaptive thought and action, it needs to be regulated (Pascual-Leone & Greenberg, 2007). Maladaptive emotions of core shame and feelings of shaky vulnerability benefit from regulation to create a working distance from them rather than to become overwhelmed by them. Table 3.1 outlines some guides as to when to activate and when to regulate emotions.

TABLE 3.1
When to Activate and When to Regulate Emotions

Activate	Regulate
Good alliance, safety and agreement on deepening emotional experience	Poor alliance, relationship cannot yet support emotion
1. Avoids emotion, disclaims experience	1. Overwhelmed, emotion does not inform or promote action, or it confuses
2. Behaves maladaptively, no awareness or action tendency	2. Previous history of aggression, falling apart
3. Reprocesses trauma, assimilates emotion, creates new meaning	3. Destructive coping: drugs, bingeing, self-harm
4. Emotion inhibits action	4. Skill deficit

PRACTICE COMPASSES

There are four compasses that guide the practice of EFT. These are the things a therapist needs to be able to do to engage in emotion-focused practice. The first is emotion assessment. Without assessing emotion, one cannot intervene differentially with different emotions. Second, therapists need principles of emotional change to know what to do with emotion to produce change. Third, a case formulation is needed to guide work with this particular client. Finally, identification of markers of different emotional problem states plus knowledge of which tasks to engage in at different markers for different types of in-session resolutions is needed.

Emotion Assessment

An important feature of EFT is the distinction it makes between *primary* and *secondary emotion* on the one hand, and *adaptive* and *maladaptive emotion* on the other (Greenberg, 2002; Greenberg & Safran, 1987). Primary emotions are defined as a person's first, immediate gut response to a situation, such as sadness about loss or fear at threat. Secondary emotions, in contrast, are responses to preceding emotional reactions, often obscuring or interrupting these more primary emotional reactions (e.g., depressed hopelessness covering shame at not being good enough, rage covering shame at loss of self-esteem). They can also be secondary to more cognitive processes (e.g., anxiety in response to catastrophic thinking). Most secondary emotions are symptomatic feelings, such as phobic fear, feelings of depletion, and hopelessness in depression. Although secondary emotions are generally maladaptive, primary emotions can be either adaptive or maladaptive. Primary adaptive emotions serve a person's goals, needs, and concerns in the world and prepare the individual for adaptive action. Examples are fear at threat, preparing the individual to escape or avoid a dangerous situation, or anger at a violation, preparing the individual to reassert his or her boundaries. Primary emotions are not reducible to other feelings. They can occur either in or out of awareness.

Adaptive primary emotions provide useful information about the current situation and orient the individual experiencing it toward the appropriate action necessary to meet his or her needs. They make coherent situational and biologically adaptive sense. In this way adaptive primary emotions encourage active problem solving, such as setting boundaries in response to anger at a violation or seeking comfort and support after experiencing sadness at a loss. Secondary emotions require validation and exploration to first understand their protective function. Even more important, the primary emotions underlying these secondary reactions need to be accessed (Greenberg, 2002); these potentially adaptive emotions can lead to awareness of important unmet needs and can guide effective action.

Primary maladaptive emotions are core painful emotions that are more a reflection of past unresolved issues and unmet needs (based often on traumatic learning) than an adaptive response to current circumstances. Consequently, they do not prepare the individual for adaptive action in the world. Maladaptive primary feelings are responses that may once have served a useful purpose, but when presently activated in current situations they lead to responses that are now inappropriate (e.g., fear in response to affection from a past abuser is now activated in response to a loving other, or feeling the shame of inadequacy when one is criticized, which stems from invalidation by one's peers or parents). As such, they do not provide useful information to guide present action for the adult. Because maladaptive primary emotions do not change with changing circumstances, they often leave the individual experiencing them feeling stuck, hopeless, and helpless (i.e., depressed or anxious). Present functioning is ruled by the past, and the newness and richness of the present moment is lost (Greenberg, 2010). At the core of maladaptive emotions often are deep fears, such as fear of abandonment or fear of annihilation, sadness of loss, or shame at being unworthy or despicable. An EFT treatment target is to

transform primary maladaptive emotion schemes by accessing alternative primary adaptive emotions (Greenberg, 2010; Greenberg & Paivio, 1997).

It is of central importance to note that from an EFT perspective, it is the activation of primary emotion that is therapeutic. Primary adaptive emotions need to be accessed to extract the adaptive information they contain and to use them in problem solving. Primary maladaptive emotions need to be activated and accessed to make them amenable to transformation by bringing them into contact with more adaptive emotional responses (Greenberg, 2002, 2010). As noted previously, EFT works on the basic principle that people must first arrive at a place before they can leave it. Secondary emotional experiences including symptomatic emotions, in contrast, are best bypassed or explored to get to their underlying primary generators. EFT introduces a concept of deepening of emotion that involves not simply arousal, but also moving from secondary to primary emotion. In addition, symptomatic emotional experiences are not viewed as the primary targets of intervention; rather they are explored to gain access to the person's underlying primary emotions.

Underlying emotion scheme-based self-organizations and the subsequent meaning-making process, by which people make sense of their experience, are the primary targets of intervention and change. Clients need to arrive at their core painful emotions to make them accessible to new input and activate new adaptive experience in therapy to transform their maladaptive experience. *Core* here means the emotion has endured over time and is like a good old friend whom one knows well but is bad for one. These emotions are ones that people are stuck in and need to be reached to be developed and to grow into more mature responses.

Principles of Emotional Change

EFT theory has developed seven major principles of working with emotion to produce change in therapy. The seven principles fall into three

broad categories shown in Table 3.2. The first category is emotion utilization and includes *awareness*, *expression*, and *reflection.* The second category is emotion transformation and includes *changing emotion with emotion* and *corrective emotional experiences through relationship*. The third category is emotion regulation and includes both *deliberate* and *automatic regulation.* These are all seen as best facilitated in the context of an empathic therapeutic relationship that facilitates these processes.

TABLE 3.2
Principles of Emotional Change

A. Emotion utilization	Awareness
	Expression
	Reflection
B. Emotion transformation	Changing emotion with emotion
	Corrective emotional experience
C. Emotion regulation	Deliberate regulation
	Automatic regulation

Emotion Utilization

The utilization principles each relate to increasing the awareness of emotion to be used productively.

Awareness. Increasing awareness of emotion involves labeling what one feels to provide access to the adaptive information and the action tendency inherent in it. Putting emotion into words or symbolizing it through imagery has adaptive value because (a) it differentiates what is felt in a given moment, and this conveys information about the situation and the self's reactions to it and to possible courses of action; (b) it reconnects people to their motivation to meet the needs and goals embedded in the emotions; (c) it facilitates strivings or goal attainment, as when anger promotes assertion; (d) it provides the first step in problem solving and

problem definition; and (e) it enhances regulation because known emotions are easier to regulate. Overall, healthy emotion management in the previously mentioned ways promotes greater well-being by facilitating the pursuit of aims that would be hampered without such emotional competency.

It is important to note that emotional awareness is not thinking about feeling; rather, it involves feeling the feeling in awareness. Awareness of felt experience covers five aspects of experience: sensation, movement, memory perception, feeling, and meaning. So a client can say “I feel a tightness or a burning in my chest” or can become aware of a slumping or a drawing back, or can remember the sound of a critical father’s voice or a mother’s face, or can label a feeling of sadness or anger, or can identify meanings such as “I’m a loser” or “I’m unlovable.” Awareness of these aspects of experience helps people come into the present and often has a calming effect. Finally, the goal of awareness is acceptance of emotion. Self-acceptance and self-awareness are interconnected. What is disowned or split off cannot change. When that which is disclaimed is felt, it changes.

Expression. Expression differs from awareness. It involves saying or showing what one feels using words or actions. Expression is a manifestation that represents or embodies something else. Expressing emotion in therapy does not involve the venting of secondary emotion but rather overcoming avoidance to experience and express previously constricted primary emotions.

Reflection. In addition to recognizing emotions and symbolizing them in words or images, promoting further reflection on emotional experience helps people make narrative sense of their experience and promotes its assimilation into their ongoing self-narratives. What we make of our emotional experience makes us who we are. Reflection helps to create new meaning and develop new narratives to understand experience (Goldman,

Greenberg, & Pos, 2005; Greenberg & Angus, 2004; Greenberg & Pascual-Leone, 1997; Pennebaker, 1995).

Exploration of emotional experience and reflection on what is discovered to form coherent narratives is another important change process. Through language and narrative, individuals organize, structure, and ultimately assimilate both their emotional experiences and the events that may have provoked the emotions. Reflection promotes understanding of the way in which the self is psychologically constructed and constituted. Narrative provides a cognitive organizing process, a type of temporal gestalt in which the meaning of individual life events and actions is determined by a particular plot or theme.

Emotion Transformation

The transformation principle refers to the fundamental ways in which emotions change through the therapeutic process.

Changing Emotion With Emotion. The most novel and important principle, and indeed the core change hypothesis, is changing emotion with emotion. This applies most specifically to primary maladaptive emotions such as fear, shame, and the sadness of lonely abandonment (Greenberg, 2002, 2010). Often these withdrawal emotions are transformed by access to the adaptive, approach emotions of empowering anger that set boundaries and overcome obstacles, and a contact-seeking form of the sadness of grief that promotes compassion for the self and soothing by self and other. This principle of emotional change suggests that a maladaptive emotional state can be undone by activating another, more adaptive emotional state. This involves the client first arriving at a maladaptive emotion to make it accessible to transformation. This process of changing emotion with emotion goes beyond ideas of catharsis, completion, letting go, habituation, or detachment, in that the maladaptive emotion is not purged, nor is it simply attenuated by the person feeling it. Instead, another more adaptive

emotion is used to transform or undo it. In addition, it does not involve exposure to feared, and avoided, internal or external cues, but rather it involves transforming emotions, such as feeling worthless or insecure, that are too often felt.

Change, therefore, is produced by transformation, not by exposure. The third wave of cognitive behavior therapy has tended to construe EFT as exposing people to emotion, but in EFT transformation goes beyond exposure. Transformation is not reduction of symptomatic emotion or extinction of unwanted responses, but rather change of an underlying emotion scheme through new opposing experience. Transformation is not mere reduction of negative affect, but creation of new states. Transformation is not the development of a new counteractive learning that overrides or suppresses the unwanted response, but rather a process of synthesizing the old with the new to form a totally novel response (Greenberg, 2015). Whereas exposure is focused on reducing symptomatic emotions like traumatic fear and phobias, EFT focuses on the experience and expression of new primary adaptive emotion to undo maladaptive emotion, not on the extinction or habituation of secondary emotion. One therefore needs to distinguish between primary/secondary and adaptive/maladaptive emotion in discussing differences between exposure and transformation. EFT promotes transformation by (a) acceptance, (b) making sense of, (c) changing emotion with emotion, and (d) creating new meaning.

A key way in which emotion is transformed is through memory reconsolidation (Lane, Ryan, Nadel, & Greenberg, 2015). A traditional view of memory suggests that once memories have been consolidated, they become long-term, permanent memories. Recent neuroscience has shown, however, that every time a memory is retrieved, the underlying memory trace is labile and fragile once again and requires another consolidation period (Nader, Schafe, & LeDoux, 2000). This is called *reconsolidation*.

This reconsolidation period allows for another opportunity to disrupt the memory. As memory reconsolidation only occurs when memory is activated, it follows that emotional memories have to be activated in therapy to be malleable. Thus, emotional memory is changed through activation of the "old" emotional memory and, within a window of minutes, the experience of new emotion.

In our view, people, to be less afraid, need to experience (learn) that they both can survive fear and that they can generate an alternate response rather than merely staying in an exposure situation until fear declines. People need to experience that they do not die by facing the pain but also that they can triumph over adversity; that a new experience of, say, assertive anger transforms the previous fear; and that they can experience themselves as becoming agents of their own survival.

Corrective Interpersonal Emotional Experience. The second type of emotional transformation involves a corrective emotional experience that occurs with another person. New lived experiences with the therapist contributes to an interpersonal corrective emotional experience. For example, having one's anger accepted by the therapist rather than rejected leads to new ways of being. Having one's shame seen or fear accepted by one's partner is a new relational experience and leads to a new way of being. Overall, the genuine relationship between client(s) and the therapist, and its constancy, also is a corrective emotional experience.

Emotion Regulation

Emotion regulation is the third principle of emotion work. At times it is necessary to regulate emotion more deliberately to make good use of it, and at times regulation of emotion leads to greater healing.

Deliberate Regulation. The development of deliberate regulation involves reducing emotional arousal that has become problematic because it is no longer connected to cognition. It has the quality of free-floating

emotion that is not productive or helpful for the person. An important issue in any treatment is what emotions need to be deliberately regulated. Emotions that require down regulation are emotions that are interfering with people's coping. These generally are either symptomatic, secondary emotions, such as despair and hopelessness or anxiety, or primary maladaptive emotions, such as an overwhelming shame of feeling worthless and traumatic fear and panic. These are emotions people come into therapy saying they need to get rid of to cope better in their lives. These emotional states usually are made apparent fairly quickly at the beginning of therapy. They are the problem, and this is more prevalent in some psychological disorders involving such things as self-harm, trauma, and borderline functioning (Linehan, 1993).

In such situations, skills of down-regulation must precede or accompany utilization of emotion. The first step in regulation is to be able to represent the emotion to oneself. One has to label what one is feeling before one can regulate it. Distraction and distress tolerance skills then can be used (Linehan, 1993) and involve, for example, identifying triggers, avoiding triggers, allowing and tolerating emotions, establishing a working distance, increasing positive emotions, coping self-soothing, diaphragmatic breathing, and relaxation. Distraction helps people feel better by diverting attention away from the distressing thoughts. Distraction can be achieved by engaging in, for example, home-care leisure, getting out, being creative, self-soothing, and making contact with others. Distress tolerance skills are used to help cope and survive during a crisis and tolerate pain. Self-soothing in this context is designed to help coping and involves, for example, breathing and soothing using each of the five senses to have a pleasant experience. Tolerating distress includes a mindfulness of breath and mindful awareness of emotion. Forms of meditative practice and self-acceptance often are helpful in achieving a working distance from overwhelming core emotions. The ability to regulate breathing and to

observe one's emotions and let them come and go are all important processes to help regulate emotional distress.

Automatic Regulation. The development of automatic self-soothing involves the activation of unresolved emotional suffering—the anguish of painful emotions that in the past never received the soothing needed—to reduce the experienced threat by providing a new soothing experience in the present. Once a painful emotion schematic memory has been evoked, soothing of emotion can be provided both by individuals themselves, reflexively, by an internal agency, or by another person. Note the difference with coping self-soothing, which is a deliberate skill to be used to addresses symptomatic dysregulation that one needs to overcome. Transformational soothing is focused on bringing soothing to unresolved painful emotions from the past to resolve the past threat to ultimately develop automatic soothing.

The first step in helping develop automatic emotion regulation is the provision of a safe, calming, validating, empathic environment. This helps soothe automatically generated underregulated distress (Bohart & Greenberg, 1997; Linehan, 1993) and helps strengthen the self. Soothing comes interpersonally in the form of empathic attunement to one's affect and through acceptance and validation by another person. Being able to soothe the self develops initially by internalization of the soothing functions of the protective other (Bohart & Greenberg, 1997; Linehan, 1993; Sroufe, 1996; Stern, 1985). Over time this is internalized and helps clients develop implicit self-soothing, the ability to regulate feelings automatically without deliberate effort. Caring relationships stimulate oxytocin and activate the myelinated polyvagal nerve to produce calm and contentment. All of these act to regulate threat. Emotions from another that are friendly and caring are important to well-being and promote the regulation of emotion. Internal security develops by feeling that one exists in the mind and heart of the other, and the security of being able to soothe the self develops from this.

Infants who are unable to elicit caring signals from others that would calm their fear and threat cannot soothe themselves.

In EFT, therapists thus help clients soothe and regulate emotional experience by providing a safe and caring environment and engaging a specific self-soothing task (Bohart & Greenberg, 1997; Linehan, 1993; Sroufe, 1996; Stern, 1985), described more fully later in this chapter. Over time this is internalized and helps clients develop implicit self-soothing, the ability to regulate feelings automatically without deliberate effort. We have also found it important to help clients develop their abilities to exercise self-compassion. Promoting clients' abilities to receive and be compassionate to their emerging painful emotional experience is an important step toward tolerating emotion and self-soothing. Emotion is then down regulated at a variety of different levels of processing. Physiological soothing involves activation of the parasympathetic nervous system to regulate heart rate, breathing, and other sympathetic functions that speed up under stress. Self-soothing involves self-empathy and compassion and comforting self-talk.

Methods for Accessing New Emotions

Empathy is continuously helping clients access new feelings, but in addition to empathy, therapists help the client access new *subdominant* emotions occurring in the present by shifting attention to emotions that are currently being expressed but are only "on the periphery" of a client's awareness or, when no other emotion is present, focusing on what is needed and thereby mobilizing a new emotion. This is a key means of activating a new emotion (Bohart & Greenberg, 1997; Greenberg, 2002, 2015; Linehan, 1993; Sroufe, 1996; Stern, 1985). These new feelings were either felt in the original situation but not expressed or are felt now as an adaptive response to the old situation. For example, accessing implicit adaptive anger at violation by a perpetrator can help change maladaptive fear in a trauma victim. When the tendency to run away in fear is transformed by anger's

tendency to thrust forward, a new relational position of holding the abuser accountable for wrongdoing is formed.

Other methods of accessing new emotion involve using enactment and imagery to evoke new emotions, remembering a time an emotion was felt, and changing how the client views things, or even the therapist expressing an emotion for the client (Greenberg, 2002). Once accessed, these new emotional resources begin to undo the psycho-affective motor program previously determining the person's mode of processing. New emotional states enable people to challenge the validity of perceptions of self/other connected to maladaptive emotion, weakening its hold on them. The accessing of adaptive needs acts automatically as disconfirmation of maladaptive feelings and beliefs. In our view, enduring emotional change of maladaptive emotional responses occurs by generating a new emotional response, not through a process of insight or understanding but rather by generating new responses to old situations and incorporating these into memory. In terms of what intervention promotes access to emotion to change emotion, we have observed that often core shame is accessed in two-chair, self-critical dialogues and changed by assertive anger against the shaming voice. Fear of abandonment often is accessed in empty-chair unfinished business and changes through sadness, anger, and self-compassion. The sadness of loneliness experienced from neglect or nonattunement throughout life is often healed in the relationship with the therapist by having the corrective interpersonal experience of feelings being understood and feelings of being close and together with the therapist.

Basic Emotional Processing Steps in Transformation

In addition to the previously mentioned principles, an understanding of emotion sequences also guides therapists in how to work with emotion. On the basis of both clinical theory and practice, a core change process in EFT, which involves moving from secondary emotions through primary

maladaptive emotions to primary adaptive emotions, has been proposed and tested (Greenberg & Paivio, 1997; Herrmann, Greenberg, & Auszra, 2016; Pascual-Leone & Greenberg, 2007). These are processes that have been primarily observed and tested within the individual model, although thought to be applicable in EFT for couples as well. Transformation of distressed feelings begins with attending to the aroused bad feelings ("I feel bad") followed by exploring the cognitive-affective sequences that generate the bad feelings ("I feel hopeless, what's the use of trying?"). Eventually, this leads to the activation of some core maladaptive emotion schematic self-organizations based most often on core painful feelings of fear of abandonment, sadness, or shame ("I'm alone and can't survive on my own," or "I'm worthless"). Transformation of these core maladaptive states occurs when these states are differentiated into *adaptive needs.* Validation of the need by the therapist helps the client to feel deserving of having had the need met, and the client begins to feel adaptive assertive anger, the sadness of grief, or compassion for self.

The essence of this process is that core adaptive attachment and identity needs (to be safe, to be connected, to be validated) embedded in the maladaptive fear/sadness/shame, when mobilized and validated, act to access core needs and the generation of more adaptive emotions related to needs not being met.

Case Formulation

Case formulation (Goldman & Greenberg, 2015) provides a guiding framework that the therapist can adopt and guides intervention from start to finish. It allows the therapist to be highly process oriented in the moment without becoming too chaotic or disorganized. This means that diagnosis is a moment-by-moment process of discovery that always takes place in consultation with the client.

Therapists keep their fingers on a client's emotional pulse at all times as they formulate what is happening and listen for what painful emotions seem key to the client's suffering. Case formulation is ultimately guided by the client's emotional pain. While setting up empathic, collaborative relationships, therapists are guided by what is poignant and what is painful. EFT therapists are seen as operating with a pain compass that guides them through deepening the emotional narrative and exploring the chronic enduring pain. Process is always privileged over content.

Case formulation follows the two tracks of emotion and narrative/meaning making, through an ever-evolving, dynamically interactive process throughout a course of therapy. Emotion is given meaning through the identification and understanding of narrative themes, which in turn influence and organize emotions. This process of narrative theme consolidation and emotional exploration continue in an iterative fashion until emotions change and the narrative becomes more coherent. Emotion cannot be understood outside the context of the narrative, and the narrative does not have meaning without emotion. These two tracks thus run through and provide a scaffold for all three stages of case formulation.

EFT case formulation is divided into three stages. In the first stage of case formulation, through the unfolding of the narrative, we hear the story and learn what brought the person to therapy. We begin by attempting to understand how clients make sense of their selves and their worlds. We tend to organize information and hear those themes in relation to attachment relationships and identity formation. We hear how clients have formed and now maintain attachment relationships in their lives, on the one hand, and on the other hand, we are curious about how they view themselves, how they treat themselves (Watson & Greenberg, 2017), and how they seek validation. An additional goal in the first stage is to observe emotional processing style. We observe and listen to facial expression, vocal styles, and other nonverbal and paralinguistic cues and empathically explore and

track emotion in relation to the narrative. This helps us understand, for example, how clients regulate emotion and whether emotional processing is productive. Further specific work may be indicated to engender productive emotional processing.

In the second stage of case formulation, we form a clearer understanding of the maladaptive emotion scheme. Out of the exploration of markers, secondary and maladaptive emotions, core needs, and how people interrupt these processes, one gets clearer on the core maladaptive emotion scheme, how it works, and how it creates the problems people have brought to therapy. Therapy becomes thematically focused on the maladaptive emotion schemes.

In the third stage of case formulation, a thematic focus, driven by the core emotion scheme, has been established and is assumed. Thus, the focus is on the formulation of emotional state and process to understand how to most productively move forward. Ongoing and emerging markers are diagnosis in the moment, and associated tasks ensure. In the last step of formulation, however, narrative themes are readdressed. By now, therapy has given new emotions and meanings a form by offering a space for self-reflection and self-construction, and clients will now reinterpret and make meaning of experience in light of new information as they reform the narrative.

Intervention: Markers and Tasks

A defining feature of the EFT approach is that intervention is *marker guided*. Research has demonstrated that clients enter specific problematic emotional processing states that are identifiable by in-session statements and behaviors that mark underlying affective problems and that these afford opportunities for particular types of effective intervention (Greenberg, Rice, & Elliott, 1993; Rice & Greenberg, 1984). Client markers indicate not only the client state and the type of intervention to use, but also the client’s

current *readiness* to work on this problem. EFT therapists are trained to identify markers of different types of problematic emotional processing problems and to intervene in specific ways that best suit these problems. Each of the tasks has been studied both intensively and extensively, and the key components of a path to resolution and the specific form that resolution takes have been specified. Thus, models of the actual process of change act as maps to guide the therapist intervention. The following main empirically investigated markers, interventions, and resolution processes have been identified and studied (Greenberg et al., 1993):

1. Problematic reactions expressed through puzzlement about emotional or behavioral responses to particular situations, for example: “On the way to therapy I saw a little puppy dog with long droopy ears and I suddenly felt so sad and I don’t know why.” Problematic reactions are opportunities for a process of systematic evocative unfolding. This form of intervention involves vivid evocation of experience to promote reexperiencing the situation and the reaction to establish the connections between the situation, thoughts, and emotional reactions to finally arrive at the implicit meaning of the situation that makes sense of the reaction.
2. An unclear felt sense in which the person is on the surface of, or feeling confused and unable to get a clear sense of, his or her experience, for example: “I just have this feeling but I don’t know what it is.” An unclear felt sense calls for focusing (Gendlin, 1996), in which the therapist guides clients to approach the embodied aspects of their experience with attention and with curiosity and willingness to experience them and to put words to their bodily felt sense.
3. Conflict splits in which one aspect of the self is critical or coercive toward another aspect, for example, a woman quickly

becomes both hopeless and defeated but also angry in the face of failure in the eyes of her sisters: “I feel inferior to them. It’s like I’ve failed and I’m not as good as you.” Self-critical splits like this offer an opportunity for two-chair work. In this situation, two parts of the self are put into live contact with each other. Thoughts, feelings, and needs within each part of the self are explored and communicated in a real dialogue to achieve a softening of the critical voice and an integration between sides.

4. Self-interruptive splits that arise when one part of the self interrupts or constricts emotional experience and expression, for example, “I can feel the tears coming up but I just tighten and suck them back in, no way am I going to cry.” In the intervention, the interrupting part of the self is made explicit. Clients become aware of how they interrupt and are guided to enact the ways they do it, be it by physical act (choking or shutting down the voice), metaphorically (caging), or verbally (“shut up, don’t feel, be quiet, you can’t survive this”), so that they can experience themselves as an agent in the process of shutting down and then can react to and challenge the interruptive part of the self.
5. An unfinished business marker that involves the statement of a lingering unresolved feeling toward a significant other, such as the following, which was said in a highly involved manner: “My father, he was just never there for me. I have never forgiven him, deep down inside I think I’m grieving for what I probably didn’t have and know I never will have.” Unfinished business toward a significant other calls for an empty-chair intervention. Using an empty-chair dialogue, clients activate their internal view of a significant other and experience and explore their emotional reactions to the other and make sense of them. Shifts in views of both the other and self occur.

6. A vulnerability marker that indicates the emergence of a deep sense of fragility, depletion, weakness, self-related shame, or helplessness. This is a current state of primary depletion. Empathic affirmation, in which the therapist is fully present, accepting, and validating the experience whatever the client is experiencing, allows the client to be where he or she is. The therapist explicitly does not encourage inner exploration to differentiate experience. Rather, the therapist is attuned to the client's vulnerability, coveys understanding and acceptance, and does not try to "do" anything to guide the client but simply follows and understands. When the therapist follows and affirms the client's experience in this way, it helps the client go into the experience and hit rock bottom, before beginning spontaneously to turn upward toward hope.

Self-Soothing and Self-Compassion

The marker for self-soothing is emotional suffering or anguish. Typically the anguish occurs in the face of powerful interpersonal needs (e.g., for love or validation) that were not met by others. Intervention involves imaginally reentering the scene of deprivation or invalidation and providing some soothing where none was available before. This is done by imagining the self as an adult reentering the evoked scene and providing a reparative response, or a dialogue, in which clients are asked if they, as an adult, could soothe their wounded child. The goal is to evoke compassion for the self.

Additional Markers and Interventions

A number of additional markers and interventions such as *trauma* and narrative retelling, *alliance rupture* and repair, *confusion* and clearing a space, and more, have been added to the markers and tasks identified

previously (see Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2002; Greenberg & Watson, 2006). In addition, a set of narrative markers and interventions combining working with emotion and narrative has been specified (Angus & Greenberg, 2011).

PHASES OF TREATMENT

In addition to the four compasses that guide EFT practice, it is helpful to look at how a therapy progresses over its course. For this reason, EFT individual treatment has been broken into three major phases of intervention, each with a set of steps to describe its course over time (Greenberg & Watson, 2006). These phases map how *intervention* progresses over time as opposed to the stages of formulation where the focus is on how *understanding* the underlying determinants of a client's presenting problem evolves. The first phase of bonding and awareness is followed by the middle phase of evoking and exploring. Finally, therapy concludes with a transformation phase that involves constructing alternatives through generating new emotions and reflecting to create new narrative meaning. The first phase involves attending to, empathizing with, and validating the client's feelings and current sense of self. It often is helpful in this early phase to provide a rationale for working with emotion. In the first sessions, the therapist works to promote awareness of internal experience and, by the end of the first few sessions, is hopefully able to establish a collaborative focus on an underlying determinant of the problem or symptom that the client presented.

In the second phase, the therapist needs to establish that the client has sufficient internal and external support for deepening of emotional experience. After this has been established, it is time to evoke the painful problematic feelings. To do this, interruptions of emotion need to be

addressed, and core maladaptive schemes and primary emotions are accessed.

The final phase involves generating new emotional responses to transform core maladaptive schemes. Once this is done, the painful emotion and the new emotions are reflected on to help people make sense of their experience, and finally the therapist validates new feelings and supports the client's emerging sense of self.

In EFT, it is through the shift into primary emotion and its use as a resource that the deepest change occurs. In some cases, change occurs simply because the client accesses adaptive underlying emotions, such as empowering anger, and reorganizes to assert boundaries, or accesses adaptive sadness, grieves a loss, and organizes to withdraw and recover, or reaches out for comfort and support. In these situations, contacting the need and action tendency embedded in the emotion provides the motivation and direction for change as well as an alternative way of responding. Action replaces resignation, and motivated desire replaces hopelessness.

In many instances, however, once a core primary emotion is arrived at, it is understood to be a complex maladaptive emotion schematic experience, rather than unexpressed primary adaptive emotions such as sadness or anger. Core schemes that are maladaptive result in feelings such as a core sense of powerlessness, or feeling invisible, or a deep sense of woundedness, of shame, of insecurity, of worthlessness, or of feeling unloved or unlovable. It is these feelings that often are accessed as being below the secondary bad feelings such as despair, panic, hopelessness, or global distress. Primary maladaptive feelings of worthlessness, weakness, or insecurity have to be accessed to allow for change. It is only through experience of emotion that emotional distress can be cured. One cannot leave these feelings of worthless or insecurity until one has arrived at them. What is curative is the ability to symbolize these feelings of worthlessness or weakness and then to access alternate adaptive emotion-based self-

schemes. The generation of alternate schemes is based on accessing adaptive feelings and needs that get activated in response to the currently experienced emotional distress. It is the person's response to their own symbolized distress that is adaptive and must be accessed and used as a life-giving resource.

THE EMOTION-FOCUSED THERAPY RELATIONSHIP

After focusing on the processes of working with emotion, we again come back to the centrality of the relationship in working with emotion. EFT can be seen as involving islands of work within an ocean of empathy. The empathic relationship is seen as both a curative factor in and of itself and as providing a facilitative environment for therapeutic work.

This forms an approach in which empathic following, with high degrees of therapist presence, plus process directive guiding, in which the therapist facilitates clients to engage in different forms of emotional processing at different times, combine synergistically into a sense of flow. Therapy involves a coconstructive process in which both client and therapist influence each other in nonimposing ways to achieve emotional deepening and the creation of new meaning. EFT therapists are not experts on the content of clients' experience or the meaning of their behavior, but rather they offer expertise on how to facilitate emotional deepening and engage in productive emotional processing. They also offer methods to help clients access and become aware of their emotions and needs.

EFT is built on a genuinely valuing, affect regulating, empathic relationship in which the therapist is fully present, is highly attuned, and is sensitively responsive to the client's experience. The therapist is respectful, accepting, and congruent in his or her communication. The relationship is seen as being curative in and of itself in that the therapist's empathy and acceptance promotes breaking of the isolation, validation, strengthening of

the self, and self-acceptance. In our view the relationship with the therapist provides a powerful buffer to the client's distress by the coregulation of affect. A relationship with an attuned, responsive, mirroring therapist provides interpersonal soothing and the development of emotion regulation. This type of relationship helps clients regulate their overwhelming, disorganizing, painful emotions. When an empathic connection is made with the therapist, affect processing centers in the brain are affected, and over time interpersonal regulation of affect becomes internalized into self-soothing, and new possibilities open up for the client. This type of relationship creates an optimal therapeutic environment, which as well as contributing to affect regulation, also helps the client feel safe enough to fully engage in the process of self-exploration and new learning. Thus, the therapeutic relationship, as well as being curative, also promotes the therapeutic work of exploration and creation of new meaning.

Another important aspect of a helping relationship is establishing an *alliance* by collaborating on the goals and tasks of therapy. This promotes the experience that *the two of us are working together to overcome the problem.* Getting an agreement on goals and tasks is dependent on understanding the client, and what might be helpful to the client, and thereby it is an enactment of empathy. Goal agreement in EFT often is achieved by being able to capture the chronically enduring pain with which the client has been struggling and establishing an agreement to work on resolving this pain, rather than setting a behavioral change goal.

The task principle is based on the general assumption that human beings are agentic, purposeful organisms with an innate need for exploration and mastery of their internal and external environments. The task principles guide the therapist to work on different therapeutic tasks and facilitate different types of processes at different times, depending on client states. In this process, the different client in-session problem states that emerge are seen as markers of opportunities for differential interventions

best suited to help facilitate productive work on that problem state. Therapeutic work involves suggesting experiments, which essentially involves the therapist offering “try this” followed by “What do you experience?” Experiments in EFT are designed to promote facilitating access to experiencing by the articulation of primary emotions and needs, the acceptance and transformation of painful unresolved emotions, and the explication of implicit feelings and meanings. The work of therapy is not aimed directly at a goal of coping, changing, or fixing, but at the process of allowing, accepting, and transformation. Change comes as a dynamic self-reorganizing process facilitated first by acceptance and then by moving on rather than by direct efforts to deliberately change or achieve a specific goal.

EFT thus involves a combination of following and leading, but following is always seen as taking precedence over leading. Over time, with application of EFT to different populations, it has become clear that the degree of guiding and of structure providing needs to be varied according to the degree of client emotion dysregulation. More distressed and more avoidant clients often benefit from more process guidance and emotion coaching, including a form of emotional reparenting involving soothing and compassion, whereas clients with greater internal locus of control and more reactant styles, or more fragile clients, benefit from more responsive following and less guiding. Clients from different cultural backgrounds often have different expectations of the degree of therapist directiveness, and so this can be varied to match clients’ expectations, especially early in therapy.

Interpersonal Processes Leading to Emotional Change

To date, the writings on EFT have tended to conceptualize EFT practice into two aspects: the bonding aspect that occurs through the therapist’s presence, empathic processes, and alliance formation and

maintenance, and the “work” aspect that involves specific marker-guided tasks (Elliott et al., 2004; Greenberg et al., 1993). Psychotherapy research studies have shown that only approximately 30% of the therapy is spent in task work. This begs the question of what is occurring the other 70% of the time. Are we only engaging in empathic or evocative responses to solidify the relationship, unfold the narrative, and deepen emotion? This is clearly what we do a good portion of the time. However, it is apparent that therapists do more relationally than being empathic and creating a good alliance. We have come to recognize that we have not, until now, specified the additional elements of how a relationship and alliance are built. In this section, we describe the interpersonal processes that are seen as leading to change in EFT.

In the initial configuration of EFT (process-experiential therapy), Greenberg, Rice, and Elliott (1993) referred to processes such as self-disclosure and process observations. Goldman and Greenberg developed an adherence measure with a variety of interpersonal actions (Goldman, 1991), and Elliott et al. (2004) further spelled out specific types of therapist actions such as directing experiential process, directing expression of emotion, heightening experiencing, and experiential teaching.

Two things, however, have made us conscious of the need for further specification of therapist relational processes. First, in increased involvement in training beginning-level therapists who have not had other interpersonal skills training, we have learned that it is necessary to teach relational processes like self-disclosure, confrontation, and process observations from an EFT perspective. Second, often in EFT training programs people previously trained in relational psychodynamic and interpersonal approaches ask how we work with the relationship. They generally are thinking that core conflictual themes inevitably come up in the relationship with the therapist or that dysfunctional interpersonal patterns are enacted with the therapist (transference).

So, for example, what does an EFT therapist do with overly dependent, aggressive, or withdrawn clients? And what about dealing with transference or avoidance? Our response generally is that in short-term therapies, we do not work with interpersonal diagnosis, nor do we address what are referred to as transference and interpersonal enactments with the therapist. Then how do we deal with the patterns that characterize different personality disorders? How, for example, do we work with people who are unlikable, who are highly entitled and vulnerable to slights, and who withdraw after the most harmless comment, or with people who have a strong wish to be loved and taken care of and a great fear of being ignored, or with people with a marked submissiveness to a dominant other from whom unending guidance and nurture is desired?

First, we work with the client's interpersonal difficulties by providing a truly compassionate and empathic environment in which we enter into the internal world of the other and understand the person's core painful emotion. Rather than evoking and producing change through insight into the past or enactments in the relationship, we evoke people's core emotional experiences involved in their interpersonal problems in empty-chair dialogues with the significant others with whom they developed. This allows the core emotions to reveal themselves more rapidly, more purely, and possibly more accurately, allowing for optimal intervention to transform these emotions through new emotions.

In addition, we adopt certain guiding principles of interpersonal attitudes and skills, as well as empathy. Rogers articulated the importance of the interpersonal attitudes and skills of positive regard and congruence (Lietaer, 1993; Rogers, 1957). Greenberg and Geller (2001) went on to specify a number of specific skills that constitute congruence and later proposed presence as a core prerequisite of all the Rogerian conditions (Geller & Greenberg, 2012). Congruence involves being both aware of what one feels and transparent. Being therapeutically congruent relies on three

factors: first, on therapist attitudes; second, on certain processes such as facilitativeness, disciplined genuineness, and comprehensiveness; and third, on the interpersonal stance of the therapist.

Congruence (Rogers, 1959) means being transparent, matching the internal and external. Congruence needs to be embedded in an attitude of respect and positive regard and thereby needs to be communicated nonjudgmentally. There is such a thing as being congruently destructive, such as being honest but critical, blaming, or mean, and this is not what we are referring to. The term congruence is really qualified tacitly by the previously mentioned attitudes and by a belief in doing no harm. We thus find it important to use the word facilitative to qualify the word *congruent*. Facilitative congruent communication requires a disciplined form of genuineness. To be facilitatively congruent, therapists need first to be aware of their deepest level of experience, and this may require self-exploration, time, and reflection. Next, they need to be clear on their intention for sharing their experience. In other words, is the disclosure in the client's best interest, for the good of the therapeutic relationship, or for themselves? It is also always important for therapists to be sensitive to the timing of disclosure, sensing whether clients are open to, or too vulnerable to receive, what one has to offer. Discipline thus also involves not blurting out whatever the therapist is feeling and making sure that what is expressed is a core or primary feeling, rather than a secondary, blaming statement. Another aspect of the communication to consider is comprehensiveness. That is, congruence needs to include respectfully saying "all of it." The therapist not only expresses the central or focal aspect that is being felt, but also the meta-experience, what is felt about what is being felt and communicated. Thus, saying that one feels irritated or bored is not respectfully saying "all of it," and as such, this alone could be damaging. Therapists need to choose their words more carefully, framing their experience in a more ego-enhancing fashion for clients: "I find myself not

being able to stay attentive" or "I am finding myself reacting to what you said and would like to understand further what you mean." Therapists also need to communicate their concern about the disclosure potentially hurting their clients and express that they are communicating this out of a wish to clarify and improve a connection, not destroy it.

The set of skills involved in facilitative congruent communication can be explicated further by looking at congruent interaction in terms of the interactional stance of the therapist. Generally, interpersonal interaction is best understood as occurring on the two major dimensions of affiliation and influence (Benjamin, 1996) Consistent with interpersonal theory, complementary responses fit each other and "pull" interactionally for each other. Therefore, attack pulls for defend or recoil, and affirm pulls for disclose or reveal. The skill of disciplined, congruent responding involves not reacting in a complementary fashion to a negative interpersonal pull of the client, like recoiling when attacked, but rather to act in such a way as to pull for a more therapeutically productive response from the client. This would be achieved, for example, by an empathic understanding or a friendly disclosing response to an attack rather than a defensive one.

Congruent responses that are facilitative "antidotes" probably most often fall in the high-affiliation, low-influence domain on interpersonal interaction, what Benjamin (1996) termed the friendly differentiation quadrant of the affiliation/influence axes of interaction.

Interpersonal Skills for Dealing With Difficult Interactions

The skills of congruent responding in dealing with difficult feelings and interactions involve the following: First identifying one's own internal feeling response. This is the general skill of awareness. Next is the skill of responding. To best describe both client and therapist responses, one needs to look at the interactional context in which they occur. The context is specified by where on the interactional dimensions the person's action, to

which one is responding, falls. For example, in the context of being attacked by the client, the first step involves the therapist becoming aware of what he feels when being attacked, which often is feeling threatened. This feeling then needs to be symbolized in awareness. The next step is being facilitatively congruent in communicating feeling threatened. This is best done in a nonblaming, nonescalatory manner. Here therapist responses perceived by clients as openly disclosing and revealing are likely to facilitate friendly listening, whereas empathic understanding will facilitate clear expression from the client. It is the interpersonal stance, particularly that of disclosing, that is crucial in making transparency facilitative. For example, in the context of feeling angry, a therapist's facilitative congruent process involves first checking if her anger is her most core primary feeling; if it is, then she needs to disclose this in a nonblaming, nonescalatory fashion. If the therapist is feeling more primary hurt or diminishment, or is feeling threatened rather than angry, then congruence involves being aware of this and disclosing this in an effective manner.

There are recognizable classes of difficult experiences that are often discussed when addressing congruence in training or teaching therapists. For example, trainees often ask such questions as what do you do if you feel angry, what do you say if you feel bored, what do you say if you feel sexual, what do you say if the client doesn't leave on time or if you feel rejecting? Situations such as these represent interpersonal interactions, which can be well responded to in a facilitatively congruent manner. As we have seen, the facilitativeness or destructiveness of expression is dependent on interpersonal stance. Anger expressed as an attack from a hostile dominant stance, or feeling sexual expressed in a seductive stance without sensitivity to power and boundary violation issues, will not be facilitative. Similarly, expressions of boredom or expressions of rejection (e.g., of somebody's dependence) that occupy an interactional position of being distant or ignoring will not be facilitative. Responses of anger will pull for

recoil and rejection for walling off if expressed from hostile or dominant stances. The issue becomes one of how a therapist helpfully interacts when feeling one of these feelings or when this type of issue arises in a relationship in which the therapist is trying to be facilitative.

As we have already said, if the therapist responds from an affirming stance, this is likely to be facilitative. But what to do when the therapist is not feeling affirming but is feeling angry, critical, and rejecting and can't get past this feeling to something more core? Again, each interactional response, to be facilitatively congruent, involves first connecting with the fundamental attitudes or intentions of trying to be helpful, understanding, valuing, respecting, and nonintrusive or nondominant. This will lead to these feelings being expressed as disclosures. If the interpersonal stance of disclosing is adopted, rather than the complementary stances of attack, expressing erotic desire, or rejection, then this congruent response is more likely to be facilitative. It is not the content of the disclosure that is the central issue in being facilitative, rather it is *the interpersonal stance of disclosure in a facilitative way* that is important. What is congruent is the feeling of wanting to disclose in the service of facilitating and the action of disclosing.

The different ways of being facilitatively congruent in dealing with different classes of difficult feelings all involve adopting a position of disclosing. Expressing a feeling that could be perceived of as negative, in a stance that is disclosing, rather than expressing it in the stance that usually accompanies that feeling, will help make it facilitative. Disclosure, implicitly or explicitly, involves willingness to, or an interest in, exploring with the other what one is disclosing. For example, when attacked or feeling angry, a therapist does not attack the other but rather discloses that she is feeling angry. She does not use blaming "you" language. Instead, she takes responsibility for her feelings and uses "I" language that helps disclose what she is feeling. Above all she does not descend into a one-up,

escalatory position, but rather openly discloses feelings of fear, anger, or hurt. When the problem is one of the therapist experiencing nonaffiliative, rejecting feelings or loss of interest in the client's experience, the interactional skill involves being able to disclose this in the context of communicating congruently that the therapist does not wish to feel this or does not feel it will be conducive to healing the client. Or the therapist discloses these feelings as a problem getting in the way and that she is trying to repair the distance so that she will be able to feel more understanding and closer. The key in communicating what could be perceived as negative feelings in a congruently facilitative way, generally occupying an interactional position of disclosure, is the nondominant affiliative quadrant, which involves a warm approach.

So if a client "door knobs," always bringing up something important at the end of session and seeming to not want to leave, one empathically understands the underlying feelings rather than pointing out what one thinks the client is doing. If needed, therapists might at this point share their feeling of, perhaps, the pressure of time or anxiety because another client is waiting.

In a more complex example, a very fragile and explosive client with whom I had a long-standing good relationship and who could be described as having a terrible fear of abandonment, a wish for constant closeness, and hostility when she perceived abandonment, once told me in an intense encounter that she feared me and hated me because I was so phony and that I acted so presumptuously in assuming that I understood what she felt.[1] She said she saw me as a leech trying to suck her emotional life out of her and that although I professed empathy and good intentions I was really out to destroy her. Under the mounting, relentless attack, I told her I felt afraid of her anger, that I remembered just last week how close she had felt to me, but I understood that I had somehow hurt her by my last response to her. A genuine tear, from both my hurt and my compassion to her hurt, came to my

eyes as I told her this. This was disclosed without blame or recrimination and without an explicit power- or control-related intention to get her to stop. It was just a disclosure of what it felt like inside for me in that moment. This disclosure did have her stop and drew from her some integration of her past feelings of closeness with her present feelings of abandonment, tinged now with concern for me.

The principle being specified here for therapeutic congruent communication is that the therapist responses be embedded in helping attitudes and be affirming or disclosing responses, and that it is the interpersonal stance, not the content of the transparent response, that is important in making it therapeutic. But there is still something more suggested by an EFT framework, which we call *emotion-focused guiding*.

Emotion-Focused Guiding

This form of responding is the EFT equivalent of *giving feedback, or confronting clients*. At times, this way of interacting arises out of therapists' observations and concerns that their clients' evident interpersonal personality issues are getting in the way of their forming functional relationships. Dealing with these issues in this way is less central in EFT than, say, in interpersonal therapies, because identifying relational patterns and focusing on personality disorders and underlying motivations is not the focus in EFT. However, markers may arise of evident client distortions or problematic patterns that the client does not seem to understand or denies. In this case, some form of feedback about maladaptive interpersonal patterns is necessary. How does an emotion-focused therapist respond in these situations?

When faced with these situations, the therapist first needs to be aware of what is occurring between the client and other people, and also possibly between therapist and client. When the therapist has some sense of what seems to be involved in the client's interpersonal difficulties but of which

the client seems to have little awareness, the therapist can begin intervening. However, the therapist needs to maintain a not-knowing stance, and this creates a dilemma because how can the therapist know more than the client and give the client feedback or confront the issue, as this means taking a position of knowing that the client is not recognizing something that the therapist thinks is happening. This type of situation first is managed by being present and always speaking from a position of sharing one's own experience rather than stating objective realities. Second, the therapist remains empathic to the client's underlying experiences, rather than focusing on the client's behavioral or motivational patterns. The therapist does not focus on discrepancies between what clients are saying and what they appear to be doing. Rather the therapist's responses need to be based on the crucial EFT principle of acknowledging the secondary defensive emotion and guiding toward the underlying primary vulnerable emotion. The secondary emotion is seen as both generating the problematic behavior and protecting against an underlying painful emotion. The underlying emotion often is focused on by conjecturing about the person's underlying feelings. Rather than confronting or opposing what is said, one handles many potentially complicated interpersonal events by acknowledging the secondary feeling and segueing empathically into the underlying feelings,

In an example of this type of intervention, a 47-year-old single man who had lost a number of girlfriends tried to explain to his therapist that his behavior of blowing up in anger and being verbally attacking in his intimate relationships often led to his girlfriends leaving, but the real reason they left was because he "loved them too much." Knowing something about the client and his difficulties, an EFT therapist would find this client's narrative challenging to validate. This is a marker for a relational intervention. First the therapist would need to remain nonjudgmental. After empathizing with the client's secondary anger at rejection, the therapist would highlight the client's more primary underlying emotions, the hurt and the fear of

abandonment, and gently focus on what the client experienced and meant by loving them too much. This would then be differentiated into his unmet need for connection and his fear of abandonment. The client's anger would be validated, but with the recognition that this was his secondary reaction to feeling hurt/rejected. The therapist would conjecture that his hurt and love may come out as anger and that this is probably what scares the women in his life and what drives them away. This feedback would be phrased predominantly as the therapist's understanding, rather than as a confrontation about what is true. So it would not be best phrased as "You say you are too loving, but really you are angry" as some therapists might do, as this would be a negative confrontation of a discrepancy, highlighting that the client is not doing what he says. Nor would an EFT therapist say, "You are defending against your hurt," which would be coming from a more knowing position and likely encourage the client to shut down because of feeling blamed or having to save face. Rather, it would be phrased in exploratory or understanding terms such as "It seems like you end up getting angry because you feel you are too loving, and you fear they will leave you, as it was the case in the past, and that leaves you feeling maybe so misunderstood or hurt." This therapeutic form of relating is based on acknowledging the secondary defensive emotion but guiding to the underlying primary vulnerable emotion, in this case, of fear of abandonment. If the therapist sees the client's reaction to what he or she is saying, then the therapist might follow this up with an exploration of the client's feelings to the statements.

So a lot of what is done in the 70% nontask work in EFT is acknowledging whatever the client says or does and then guiding toward the underlying primary emotion. Rather than contradicting or opposing what is said, one handles many potentially complicated interpersonal events by segueing empathically into the underlying feelings.

CONCLUSION

Changing emotions is seen as central to the origins and treatment of human problems, but this does not mean that working with emotions is all that is focused on in EFT. Most problems have biological, emotional, cognitive, motivational, behavioral, physiological, social, and cultural sources, and many of these need attention. EFT in practice ultimately adopts an integrative focus on motivation, cognition, behavior, and interaction; it's just that in EFT, the focus is on people's emotions as the primary source of human functioning and dysfunction to change in therapy and to promote healthy coupling and living.

Key to practice is the importance of empathic attunement to affect, distinguishing between primary and secondary and adaptive and maladaptive emotions, and following the pain compass to get to the client's chronic, enduring painful emotion. Thereafter the main tasks are to facilitate productive emotional processing, promote the transformation of maladaptive emotion, and create new and more salutary narratives.

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[1]The authors verify that they have concealed client identity by disguising details of the case or by combining details from multiple cases.

II
INTEGRATING RESEARCH AND PRACTICE IN EMOTION-FOCUSED THERAPY

4
CLINICAL IMPLICATIONS OF RESEARCH ON EMOTION-FOCUSED THERAPY

LADISLAV TIMULAK, SHIGERU IWAKABE, AND ROBERT ELLIOTT

Emotion-focused therapy (EFT) has been steeped in research from its beginning. It is the product of a program of psychotherapy change process research, which first focused almost exclusively on what happened in sessions but later expanded to look at client outcomes and the relationship between in-session processes and posttherapy outcome (see earlier reviews by Elliott, Greenberg, & Lietaer, 2004; Elliott, Greenberg, Watson, Timulak, & Freire, 2013; Greenberg, Elliott, & Lietaer, 1994). For the past 20 years, however, much of the research on EFT has been on outcome, complemented by process–outcome prediction studies, qualitative research, and case studies. In this chapter, we provide a brief overview of the existing body of outcome, qualitative, and case study research on EFT and outline some of the implications of this research for the practice of EFT.

CLINICAL IMPLICATIONS OF QUANTITATIVE OUTCOME RESEARCH ON EMOTION-FOCUSED THERAPY

An essential part of the development of EFT research has been the project of assembling the available research on humanistic–experiential psychotherapies, which Greenberg et al. (1994) undertook in the early 1990s and which has been repeatedly enlarged over the ensuing years, to the point where the most recent version (Elliott et al., 2013) contains research from almost 200 studies carried out up to 2008. This overall data set shows large pre–post client gains and controlled effects, along with equivalent outcomes for humanistic–experiential therapies and other therapies, including cognitive behavior therapy (CBT).

EFT outcome research is a key component of this data set, particularly with regard to depression and interpersonal difficulties. We focus here on the 34 EFT studies in this data set, with three lines of evidence summarized in Table 4.1 (Elliott & Greenberg, 2016). First, the uncontrolled pre–post effects are large (weighted standardized mean difference = 1.16; *n* = 1,124 clients). Second, 12 studies compared EFT with no-treatment or wait-list controls for a quite large weighted controlled effect size (ES) of 1.05 (*n* = 255). Third, in 11 studies comparing EFT with some other nonhumanistic therapy, a medium weighted comparative ES of .57 (*n* = 183) was found favoring EFT. However, a limitation of the existing comparative outcome research is that it is predominated by research carried out by advocates of EFT, making it vulnerable to researcher allegiance effects.

TABLE 4.1
Summary of Overall Pre–Post Change, Controlled, and Comparative Effect Sizes for Emotion-Focused Therapy Outcome Research

Finding	*n*	*M*	*SD*
Pre–post change ES (mean *g*)			
By assessment point:			
Post	34	1.22	.59
Early follow-up (1–11 months)	15	1.50	.62
Late follow-up (12+ months)	4	1.63	.48
Overall mean ES:			
Unweighted	34	1.20	.55
Weighted (d_W)	1,124	1.16	.42
Controlled ES (vs. untreated clients)[a]			
Unweighted mean difference	12	1.29	.75
Unweighted mean difference, RCTs only	8	1.31	.72
Experiential mean pre–post ES	11	1.58	.75
Control mean pre–post ES	10	.21	.22
Weighted	255	1.05	.70
Weighted mean difference, RCTs only	116	1.31	.67
Comparative ES (vs. other treatments)[a]			
Unweighted mean difference	11	.67	.50
Unweighted mean difference, RCTs only	9	.68	.56
Experiential mean pre–post ES	10	1.40	.60
Comparative treatment mean pre–post ES	10	.74	.71
Weighted mean difference	183	.57	.46
Weighted mean difference, RCTs only	156	.57	.50

Note. ES = effect size; *M* = mean; RCT = randomized controlled trial; *SD* = standard deviation. Hedge's *g* used (corrects standardized mean difference for small sample bias). Weighted effects used inverse variance based on number of participants in experiential therapy conditions. From *Comprehensive Textbook of Psychotherapy: Theory and Practice* (2nd ed., p. 113), by A. J. Consoli, L. E. Beutler, and B. Bongar (Eds.), 2016, New York, NY: Oxford University Press. Copyright 2016 by Oxford University Press. Reprinted with permission.

[a]Mean difference in change ESs for conditions compared, except where these are unavailable; positive values indicate pro–humanistic therapy results.

A systematic review done for this chapter (January 2018) identified 31 new EFT outcome studies meeting the criteria used in the previous meta-analysis. The largest amount of emerging evidence involves EFT for couples (14 new studies) and EFT for individuals (nine new studies); however, a rapidly developing area of practice is EFT for groups (five studies; e.g., Robinson, McCague, & Whissell, 2014). Relational conflict and distress remain a major focus (12 new studies), with emerging work on EFT for eating difficulties (four studies, e.g., Wnuk, Greenberg, & Dolhanty, 2015), coping with chronic medical conditions (four studies, e.g., McLean, Walton, Rodin, Esplen, & Jones, 2013), and anxiety (e.g., Timulak et al., 2017). Clearly, a new meta-analysis incorporating this new evidence is called for.

To sum up, the existing outcome evidence on EFT most strongly supports its use with current relational distress and unresolved relational injuries. There is also strong support for its use with depression, anxiety (social and generalized), eating difficulties, and coping with chronic medical conditions. EFT individual therapists may want to consider adding couples, group, and family therapy skills to their repertoire. This expanding range of modalities and client populations bodes well for the continuing relevance and importance of EFT.

CLINICAL IMPLICATIONS OF QUALITATIVE OUTCOME RESEARCH ON EMOTION-FOCUSED THERAPY

As a humanistic psychological therapy, EFT lends itself well to qualitative and case study investigations. EFT grew out of other humanistic therapies, such as person-centered and experiential psychotherapy, and researchers from these traditions have often been at the forefront of developments in qualitative and case study research in psychotherapy (see the work of Robert Elliott, David Rennie, or John McLeod, to name just a

few). This intellectual tradition in turn means that qualitative and case study research is particularly extensive in humanistic therapies (see the reviews in Angus, Watson, Elliott, Schneider, & Timulak, 2015; Elliott et al., 2013).

Outcome research has typically been the domain of quantitative investigations and, in particular, of randomized controlled trials. However, the growth of qualitative research has led to the emergence of qualitative outcome investigations, with several of them reporting on qualitative outcomes achieved after EFT (e.g., Angus & Kagan, 2013; Elliott, 2002; Elliott et al., 1990, 2009; Goldman, Watson, & Greenberg, 2011; Klein & Elliott, 2006; MacLeod & Elliott, 2012; MacLeod, Elliott, & Rodgers, 2012; Steinmann, Gat, Nir-Gottlieb, Shahar, & Diamond, 2017; Timulak et al., 2017). In each study, outcomes were obtained from client interviews that used open-ended questions to elicit client perspectives regarding therapy-related change. Although these studies reported on a variety of positive outcomes that are not unique to EFT (e.g., mastery of symptoms, better relationships, insight), they also offer a unique perspective on outcomes that are especially relevant for EFT practitioners.

Self-Compassion, Pride, and Appreciation of Emotional Pain

In several studies, clients reported that their emotional experiencing was much smoother than before therapy (e.g., Klein & Elliott, 2006). Interestingly, in several studies clients reported a newfound capacity to be more aware of their emotional pain and to experience this emotional pain more fully, describing this as a positive outcome of therapy (e.g., Elliott, 2002); the differentiation of painful experience crystallized for them what they lost, what hurt, or what hurt most. Paradoxically, newfound awareness and deeper experiencing of pain were valued by clients over avoidance of pain. This finding is important for EFT practice, fitting as it does with the EFT practice of focusing on primary chronic painful experience as a source of information and with the EFT principle that it is important to approach

painful experience rather than to seek to manage painful experience without submerging oneself in it. In addition, however, it may be helpful for EFT practitioners to know that an ability to attend to what is painful can be appreciated by some clients as a positive outcome in and of itself, and not just as an intermediate step toward the transformation of painful chronic emotions.

Qualitative outcome studies also have reported on other theoretically compatible findings. For instance, several studies (e.g., Angus & Kagan, 2013; Goldman et al., 2011) reported on client accounts that after therapy they were more self-compassionate and more self-accepting. It is important to recognize that in addition to being present during therapy sessions (cf. Pascual-Leone & Greenberg, 2007), self-compassion and self-acceptance are reported by clients at the end of therapy as consolidated experiences that they take with them from therapy into their everyday life. Similarly, after therapy, and as a consequence of therapy, clients reported experiencing more feelings of empowerment, inner confidence, self-worth, pride, validation, and righteous or self-affirming anger (cf. Angus & Kagan, 2013; Elliott, 2002; Elliott et al., 2009; Goldman et al., 2011; Klein & Elliott, 2006). These reported changes correspond with theoretical recognition of the importance of adaptive, self-developing experiences. Again, it is interesting to see that although clients reported these experiences as emanating from therapy sessions, they also reported them as lasting beyond these sessions and as permeating into their everyday life.

Appreciation of Relational Connection

Several studies reported that clients identified a broader appreciation of their close relationships as a positive outcome of therapy (e.g., Elliott et al., 1990, 2009). This finding closely parallels comments made by many clients that they felt understood and validated by their therapist and that during therapy they felt close to and connected to their therapist. These

types of findings should encourage EFT practitioners to be courageous in offering a very open, relational presence to their clients.

All of these qualitative outcome findings suggest that it is important for therapy to go beyond focusing on symptoms (e.g., as can be the case in CBT) or understanding (e.g., as can be the case in psychodynamic therapy) to focus also on the actual experiencing of emotional pain. This is important as the process of doing so can crystallize for the client a sense of his or her unmet needs, in turn allowing for the generation of adaptive experiences such as compassion and healthy anger or pride, all of which happens in the context of a real, validating, and compassionate relationship in which the therapist is prepared to acknowledge, and respond from, the impact the client's pain and journey has on the therapist himself or herself.

CLINICAL IMPLICATIONS OF QUALITATIVE PROCESS RESEARCH ON EMOTION-FOCUSED THERAPY

Several studies have reported that clients clearly appreciate the helpfulness of a validating, empathic, respectful, and warm therapeutic relationship (e.g., Angus & Kagan, 2013; Elliott et al., 1990). In some studies, clients also appreciated the therapist's confident sense of hopefulness with regard to where therapy could lead (Elliott, 2002; MacLeod et al., 2012). Many studies have pointed to how clients appreciated the various forms of experiential work (e.g., chair work) and the therapist's skillfulness in this regard (e.g., Angus & Kagan, 2013; Klein & Elliott, 2006; MacLeod et al., 2012; Timulak & Elliott, 2003; Watson & Rennie, 1994).

These studies suggest that if the client has a sense that the therapist is not only warm and kind, but also offers both profound understanding (empathy) and skillfulness and understanding regarding emotional processing (e.g., knowledge as to how to successfully transform painful

emotional experiences), the client is enabled to go along with the flow of therapy and engage in emotional exploration and experiencing. When this is paired with the client's experiencing of the therapist as profoundly engaged on a human level with his or her life story (e.g., by the therapist's willingness to say, "I am moved by what you are saying"), there is the possibility that therapy can have a particularly powerful and healing effect on the client. In such a context, the client has an experience of the therapist not only as relationally and personally engaged in therapy, but also as capable of helping him or her access painful emotions in a new way—crucially, in a new way that allows these painful emotions to be followed by self-caring and self-empowering emotions.

CLINICAL IMPLICATIONS OF CASE STUDIES IN EMOTION-FOCUSED THERAPY

Both clinicians and researchers are increasingly interested in systematic case studies. In such studies, outcomes are measured by standard quantitative instruments, and the process of therapy is described in depth, thus tracking client change in a systematic way aimed at bridging the gap between the science and the practice of psychotherapy (McLeod, 2010). In EFT, different types of systematic case study methods have been used (e.g., Elliott, 2002; Honos-Webb, Stiles, Greenberg, & Goldman, 1998; Honos-Webb, Surko, Stiles, & Greenberg, 1999).

The importance of client readiness and motivation for therapy are well documented in the wider psychotherapy literature (Prochaska & DiClemente, 1983). Motivation for therapy, positive and realistic expectations, and clarity of and orientation to problems have all been associated with successful early processes in therapy, such as client engagement and the establishment of a working alliance. Case studies in EFT also demonstrate that many of these characteristics are important,

particularly with regard to engaging clients in productive therapeutic processes early in therapy.

On one hand, those clients who achieved successful outcomes in treatment studies for depression were clients who were able to specify issues they wanted to work on in therapy and to identify aspects of themselves that they wanted to change (Goldman et al., 2011; Watson, Goldman, & Greenberg, 2007). They also had aspirations to realize more satisfying life options, which gave them hope and a sense of direction. Later in therapy, these clients were able to make plans and carry out new behaviors as a result of their therapeutic work, thus accelerating and cementing their progress.

On the other hand, poor-outcome clients focused on external events, such as parents' behavior or other people's judgment, and were largely unaware of their own contribution to problems; therefore, they were less able to form a clear focus regarding what they needed to change about themselves (Watson et al., 2007; Watson, Goldman, & Greenberg, 2011). They felt hopeless and had a sense of resignation with regard to the possibility of improving their life situations. They tended to lack a sense of agency that they could change themselves and have an impact on their environments by actively and willfully working on issues in therapy, and this appeared to prevent them from achieving significant improvements in a short-term treatment context. Therapists need to pay attention to these aspects of client presentation in order to facilitate productive engagement early in therapy.

Emotional Processing

One of the main tasks engaged in by emotion-focused therapists is the facilitation of clients' emotional processing. It appears that good-outcome clients (cf. Watson et al., 2007) were more aware of their feelings and were more in touch with their bodily sensations from the early stages of therapy.

They had difficulty modulating their levels of arousal and expressing their feelings, wants, and needs to others in an appropriate manner. They needed to learn to reflect on their feelings so that they could allow these feelings to guide relevant actions, and they needed to learn how to access more adaptive feelings.

For example, one middle-aged male client in an EFT treatment for depression was aware of his sadness and regret at the loss of his mother when he was 13 years of age. He was also aware of negative unresolved feelings toward his father, who was physically present but emotionally absent. Through an empty chair dialogue with his father, he was able to access loving introjects of his father; consequently, he was able to see himself and his father differently. His in-session gain was then translated into action plans, which he carried out in his daily life. The full cycle of emotional processing was also achieved with regard to other problematic areas of his life, such as his workplace relationships and marriage. The sequence of emotions experienced by clients follow the EFT model of change: secondary distressing emotions to adaptive emotions via painful maladaptive emotions and unmet needs (Greenberg, 2002; McNally, Timulak, & Greenberg, 2014; Pascual-Leone, 2009).

In contrast, clients in the poor-outcome cases (cf. Watson et al., 2007) appeared to have difficulties becoming aware of their feelings and labeling feelings in conscious awareness. They expressed doubt that identifying and working with feelings would be useful for alleviating their depression. They felt deeply ashamed of themselves and their experiences; as a result, they actively avoided feeling or reported feeling numb when encouraged to access their feelings (Watson et al., 2011). It appears that for effective emotional processing to occur, some level of resilience to face difficult emotions and some capacity for distress tolerance are necessary. When clients repeatedly show difficulty gaining awareness early in therapy,

therapists may need to consider extending the therapy as these clients are likely to require more time to benefit from emotion-focused work.

Quality of Therapeutic Relationship

In EFT, a validating, empathic, and affirming therapeutic relationship is considered both an active agent of change and a precondition for the successful implementation of therapeutic tasks (Greenberg, 2002). In successful cases of treatment for depression and anxiety disorders, clients were able to trust their therapists right from the beginning of therapy (Elliott, 2002; Elliott et al., 2009; Goldman et al., 2011; MacLeod & Elliott, 2012; MacLeod, Elliott, & Rodgers, 2012; Watson et al., 2007, 2011). Entering therapy with a positive expectation about their therapist's ability to help them, clients were cooperative and open to therapist suggestions. They trusted their therapist for support and guidance. In turn, therapists were more responsive to their clients' needs, reinforcing the working alliance further and thus making even deeper work possible. Some clients reported that the therapeutic relationship was healing in and of itself (Elliott, 2002).

Poor-outcome clients (cf. Watson et al., 2007, 2011) typically did not report a poor working alliance. The detailed analysis of interaction between therapist and client, however, revealed that minor negative shifts sporadically occurred in the therapeutic relationship (Watson et al., 2007, 2011). These clients were sometimes reluctant to take in the therapist's empathy and support, and they were more likely to disagree with aspects of their therapist's formulation or with the methods suggested by the therapist for addressing the client's difficulties. One client, for example, disagreed with the therapist about the utility of focusing on emotions. Although the therapist offered a rationale for engaging in evocative tasks, the client continued to express doubt about the proposed tasks.

Clients with poor outcomes often tended to have had very limited access to social support in their childhood, and also in their current life, thus

perhaps making it difficult for them to rely on their therapists or to receive the empathy and validation that might allow them to experience emotional pain in session. In assessing the suitability of clients for short-term treatments, therapists need to pay close attention to their clients' access to social networks in addition to identifying the nature of the underlying emotional pain caused by past traumas and mistreatment. Emotion-focused therapists also need to pay attention to and address small signs of clients' discomfort and disagreement as and when they arise in order to repair minor alliance ruptures (Watson & Greenberg, 2000).

SUMMARY OF CLINICAL APPLICATIONS

The reviewed qualitative and case studies highlight a number of issues that are known to be relevant to the practice of EFT. For instance, qualitative outcome studies point to the importance of experiences such as empowerment, emotional relief, connecting vulnerability, sense of belonging and connection, and adaptive grieving. They also point to the importance of narrative elements that correspond with new awareness or insight, as well as the role played by narrative in the consolidation of new emotional experiences. What is particularly worthwhile to focus on is the fact that clients, after a course of therapy, reported not only changes in symptoms, but also a newfound appreciation and explicit valuing of experiences such as vulnerability, sense of belonging, and grieving. These are experiences that are not necessarily valued by other (e.g., cognitive–behavioral) therapeutic approaches. This suggests that EFT therapists may need to be actively emphasizing these important outcomes of psychotherapy that may not currently be sufficiently stressed by other approaches (e.g., connecting vulnerability; cf. Elliott, 2013, on connecting sadness).

With regard to other process and case studies, one visible trend that has practical implications is the reported finding that the therapeutic process is

sequential. In other words, the therapist needs to have different goals in mind at different times during the session, during different stages of the task, and at different phases of therapy. For example, several studies pointed to the fact that it is important to first build a sense of safety for the client so that he or she can overcome natural avoidance of emotional pain and allow himself or herself to become immersed in the therapeutic process (cf. Timulak, 2015; see the clinical vignette below). Furthermore, it is important to bear in mind that clients then need to be able to access and stay with painful feelings so they can learn both that they are capable of bearing the pain and that they can distill important information from those painful feelings. This information typically informs clients about what it is they miss most (i.e., what needs are unmet or unfulfilled). The identification of unmet needs then allows for the generation of adaptive emotional responses (particularly compassion and assertive anger), a process often followed by grieving for how these needs were not met in the past, as well as grieving in relation to past painful experiences.

Another important area of interest identified by qualitative and case studies concerns the potential pitfalls of emotion-focused work. It appears that for some clients, touching on painful feelings may be particularly difficult (e.g., Elliott et al., 1990; MacLeod et al., 2012). It also seems that clients who have experienced particular adversity but have not had relational experiences of a caring other may have difficulty benefiting from short-term EFT (see Watson et al., 2007). It may also be that certain profound vulnerabilities or chronic experiences cannot meaningfully be addressed within a short-term framework. Furthermore, it may be that efforts to do so are experienced as invalidating by clients (e.g., a client might view such efforts as indicative of the therapist not being truly aware of the level of adversity the client had gone through or of the degree of pain or suffering he or she continues to experience). EFT therapists thus have to be careful in their assessment and strategy for therapy, perhaps thinking in

terms of appropriate time frames or smaller, more realistic goals when working with particularly vulnerable clients.

CLINICAL VIGNETTE

To illustrate our understanding of the sequential nature of client emotional transformation in therapy, we examine the case of Lisa. Although this case has already been studied from many perspectives (e.g., Brinegar, Salvi, & Stiles, 2008; Carcione et al., 2008), Dillon, Timulak, and Greenberg (2018) provided a new perspective using an original EFT framework to track Lisa's emotional transformation.

Lisa's presenting issue was a sense of loneliness (feeling abandoned by her gambling husband) compounded by a sense that she was somewhat responsible for it. She was not sure of herself and did not have a sense that she had a right to be looked after and loved. She felt that her husband's behavior was somehow her fault, and this sense of failing was exacerbated by a painful belief that her mother thought of her as a failure from early on in her life. Her chronic sense of loneliness and abandonment had been with her for most of her life; she recalled a childhood in which she missed the love of her mother. She also missed her father, who like her husband had a gambling problem. As a parent now, she suffered when she saw how her children missed their father. She also felt that she had no right to stand up for herself, something that she felt would be viewed by her mother as another sign of how bad a daughter and mother she actually was.

In therapy, Lisa often collapsed into global distress (Pascual-Leone & Greenberg, 2007), a state characterized by hopelessness and helplessness, as well as undifferentiated sadness and hurt. This happened especially when she touched on her sense of loneliness, abandonment, and shame. She had particular difficulty standing up for herself and quickly felt bad about herself whenever she did so. She feared the sense of guilt and shame that

might ensue if she hurt her husband or parents. Although her emotional fragility stayed with her throughout the course of therapy, she nonetheless managed to articulate her past and current needs, build her capacity for assertiveness, and access self-compassion. It appeared that the building of a capacity for self-assertiveness was especially important to Lisa. Although her interactions with her husband outside of therapy did not change, as therapy ended she did feel stronger about her needs and expressed much more hope and calmness.

In therapy, Lisa gradually stood up to her imagined husband (in chair work), which was often followed by an undermining of the self through fear and a sense of guilt for not being a good wife. The therapist and Lisa had to focus not just on standing up to her husband but also on standing up to her own critic and on generating self-compassion. For instance, in Session 9, Lisa articulated some of her unmet needs and stood up to her own self-critic:[1]

Lisa: I feel I'm important and I count—um—I care a lot about myself and my feelings, and . . .

Therapist: Uh-huh. What do you want from her?

Lisa: Um, just to accept me the way I am.

Therapist: So accept me unconditionally.

Lisa: Yeah, accept me for what I feel and when I do speak my mind or—say something that I feel is right for me, I—I want you to accept me, accept me unconditionally.

Later on in the same session, after witnessing her own pain, Lisa—in the critic chair—softened and expressed compassion toward the self:

Lisa (in the critic chair, speaking to the experiencer): Um (crying), yes—I'm, I'm sorry. (crying)

Therapist: What's happening inside?

Lisa: Um, I'm sad (sniff)—yes, um, you deserve to be loved and comforted . . .

Therapist: So how would you be there for her, how could you be there?

Lisa: Um, I'd understand, yeah (crying)—understand her needs . . .

Therapist: Can you tell her what you understand?

Lisa: Um (crying)—that you're, um, that you're in pain (crying)—(sigh) . . . (sniff)—um, that you're sad and, um, you feel cheated. I understand that.

In Session 11, Lisa dialogued with her imagined mother. She expressed much hurt, as well as sadness and a sense of loneliness and abandonment. She also expressed the sense that she was made to feel worthless. In the dialogue, she immersed herself in the core pain of feeling unloved, and she expressed the need to be loved. However, although her imagined mother softened after this expression of need, Lisa continued to experience tension, and she was unable to accept fully this expression of compassion from her mother. Although she did shift toward more adaptive grieving, she also at points became overwhelmed by a chronic sense of loneliness:

Lisa: I forgive you.

Therapist: What happens when you say that?

Lisa: I—I feel sad (crying).

Therapist: Tell her why you feel sad.

Lisa: um (crying)—I, um, I feel sad that, um, I missed—missed a lot.

Therapist: Tell her what you missed out on.

Lisa: Um (crying) . . . um (sigh) . . . a good relationship between you and I.

This painful expression of loneliness and need evoked a compassionate response from the imagined mother, who then regretfully expressed the wish that she could have been different (i.e., that she could have been there for Lisa). Lisa was then capable of letting in this compassion as communicated to her by her imagined mother and in turn expressed her appreciation:

Lisa: I accept her the way she is (sniff).

Therapist: Tell her.

Lisa: Um, I love you as a person and as my mother.

With regard to her husband's behavior, Lisa struggled to be assertive, with fear that she could end up alone appearing to drive her self-interruptive and submissive stance. With the therapist's help, Lisa was able to recognize the protective function of her self-interruption; however, she was also able to see its cost. She articulated a wish to be freer and to be her own self:

> I realize I'm an individual and I have the right to vent my feelings and what I think is right or good for me, and that's been the improvement of the therapy, like, that I think to me and myself.

CONCLUSION AND FUTURE DIRECTIONS

Assessing the effectiveness of EFT for various presentations and modalities remains an ongoing task for quantitative outcome research. Qualitative process research richly informs us about clients' experiences of EFT. It is reassuring to see that although clients often find experiential work (chair work) challenging, they also often value it as the most important part of therapy. Theoretically informed qualitative studies also show that EFT theoretical conceptualizations are useful and to a great degree match the observed processes. However, these qualitative studies also show that the

process is far from simple and linear and that there many intricacies and factors that impact change processes. The review of qualitative studies suggests that there is relatively little known about hindering aspects of EFT or circumstances and presenting problems for which EFT may have a limited or unwanted impact. A research focus in this direction would certainly be welcomed. Also, given that the emotional injuries that lead to the development of core pain are typically interpersonal in nature, it would be particularly interesting to study relational events that not only help build a safe therapeutic relationship but also provide a corrective healing experience that can assist in the restructuring of problematic emotion schemes (cf. Greenberg & Elliott, 2012).

As EFT is expanding internationally throughout European and Asian countries, research on how cultural and social factors impact the practice of EFT would be of high clinical value. The nature of emotional expression within interpersonal relationships is often influenced by display rules (Ekman & Friesen, 1969). In Asian countries, for example, the therapeutic relationship tends to be characterized by the underlying hierarchical social relationship within the society where therapy is taking place. The expression of powerful emotions such as anger as well as emotions such as pride might be strongly suppressed for fear of violating unwritten yet self-evident social rules. Therefore, it is important to promote research on the practice of EFT in different cultural contexts.

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[1]The excerpts are reprinted with permission from Andrew Dillon (2012).

5
ROLE OF THE THERAPEUTIC RELATIONSHIP IN EMOTION-FOCUSED THERAPY

JEANNE WATSON

Grounding their work within the relationship conditions of acceptance, prizing, congruence, and empathy, psychotherapists who use emotion-focused therapy (EFT) offer process-guiding interventions to their clients to focus them on problematic aspects of their emotional processing, including the problematic ways in which they interact with their experience and with others, that clients view as challenging and difficult and wish to change in therapy. To facilitate clients' goals, they are encouraged to become more aware of their emotions, to find the labels for their feelings and emotional experience, to differentiate their emotional experience to understand the impact and personal significance of events, and to identify what they need to thrive and live more optimally in the present.

In the process, clients may become aware of the negative ways in which they treat their experience and regulate their emotions, including dismissing, avoiding, and silencing them, and may learn new ways to

process and express their emotions to better meet their needs and objectives. As clients learn to listen to their feelings and become more empathic and accepting of themselves and their experience, they develop and acquire new ways of being with others that are more self-enhancing and self-protective. They become more respectful of their own and others' well-being. They learn to set limits and be more nurturing of themselves. EFT therapists respect their clients' autonomy and see them as the experts on their subjective experiencing and their process during therapy, while tailoring their treatments to fit each client's problems and ways of working. They are fully present in their interactions with clients, providing warmth, empathic attunement and acceptance, while being congruent and transparent in their relationships with them. This way of being is seen as healing in and of itself, fostering clients' emotional processing capacities and self-organization. As clients internalize their therapists' attitudes, they develop the capacities for more optimal affect regulation and improve their relationship with self and others.

ACCEPTANCE AND PRIZING

To listen in an experiential way that is open and receptive to the nuances of clients' subjective experience, EFT therapists suspend judgment and adopt a prizing, accepting attitude toward their clients. They respect their clients' humanity and bear witness to the challenging and negative life experiences that may have contributed to their problems, including emotional processing and regulation and negative self-organization. Feeling accepted makes it easier for clients to own and examine aspects of their experiencing that they may have avoided or denied to awareness. Acceptance and lack of judgment provide safe and supportive conditions for clients to expose vulnerable and damaged parts of themselves in order to

heal and find new ways to process their pain and thrive in the world (Bozarth, 2001; Rogers, 1975; Warner, 1998).

To communicate acceptance, EFT therapists try to remain decentered and focused on their clients' experiences. *Decentering* requires therapists to put aside their own perspective, values, and experiences as much as possible to enter the client's world. They try to listen and reflect what their clients are saying to provide a mirror for clients' perceptions, inner subjective experiences, and ways of being in the world. Therapists engage in deep experiential listening, attuning to clients' moment-to-moment affective experience and bringing it alive in the session to make it known. To listen in this attentive manner requires that therapists be sensitive and alert to clients' emerging experience to capture their moment-to-moment felt shifts. As emerging experience becomes more conscious, it opens up new gestalts and ways of seeing and sensing that can lead to shifts in feeling, perception, and behavior.

Experiential listening is receptive, open, and accepting as opposed to judging, assessing, or advising. It is characterized by respectful curiosity about the other, motivated by a desire to understand and learn about the other's experience from the inside out (Warner, 1998). Following their clients' leads, EFT therapists are tolerant of uncertainty and ambiguity and tolerate a state of not knowing as the process unfolds. EFT therapists trust that clients' emotional processing will act as the silken thread leading in and out of the Minotaur's cave. This type of listening is demanding—it requires that therapists adopt a stance of not knowing as they follow their clients and come to inhabit and experience the world as their clients do.

CONGRUENCE AND TRANSPARENCY

To be fully present with clients requires therapists to be *congruent*—sincere and clear in terms of what they are feeling and what they are

communicating (see Chapter 3, this volume). This does not mean that emotion-focused psychotherapists always share what is happening within themselves, but they do need to be aware of their own issues and internal process so that they do not hijack or contaminate their clients' process. There are times when therapists may need to be transparent and share what they are feeling or thinking if this may have contributed to tensions or difficulties in the relationship. However, this sharing is always done with a client-centered focus to ensure it does not impact the client negatively. EFT therapists engage in such disclosure for the benefit of the client and the therapeutic process, leaving the exchange by returning the focus to the clients' experience.

At these times of greater transparency and disclosure, EFT therapists are always clear that they are responsible for their own process and that clients do not need to assume responsibility or care for them. It can be challenging, but it is important, especially for clients who may not be clear about what their feelings are or who are quick to defer to others, privileging others' experience instead of their own. It is also problematic with clients who deflect from their experience and for whom tensions in the therapeutic relationship may provide a way to avoid their own experience in the session.

EMPATHY

Emotion-focused therapists work to empathize with their clients' experiences to better understand how they see and experience the world—to see what formed them and how they want to grow and change. Apprehending the significance and impact of events and coming to see why clients act as they do and how this might be contributing to distress in the moment are key to facilitating clients' emotional change. The objective is to understand the other and to illuminate his or her experience. The process of

listening and reflecting allows clients' experience to come into view and shift as it is apprehended, seen, and understood. As experience is being articulated, it assumes new shapes—becoming clearer, more differentiated, smaller—and alternative courses of action come into view (Watson & Greenberg, 1998, 2017; Watson & Rennie, 1994).

Thus, EFT therapists try to remain responsive to their clients even as they attempt to provide structure and support to facilitate clients' emotional processing and the regulation of their inner experience. Therapists' empathy in the context of an accepting, prizing, congruent relationship enables clients to develop new ways of relating to themselves and others. Clients become more empathic, respectful, and accepting of their experience and learn more positive ways to regulate it to enhance their well-being.

Therapists offer reflections tentatively, asking clients to check within themselves, attending to their bodily reactions and sensations, to determine whether the reflection is indeed what they were trying to express and whether it is an accurate way of symbolizing and describing their experience. In this way the relationship remains balanced as therapists continually remind clients that they are the experts on their own experience and that the road to understanding and change lies within themselves—including what problems will be addressed in therapy and the tasks or ways of working that they experience as beneficial at any one time.

WORKING WITH EMOTION AND MAINTAINING AN EXPERIENTIAL FOCUS

In EFT, there is a delicate balance between leading and following. As therapists try to respect clients as the experts on their experience and support them to look inward to articulate their own perceptions, felt sense, and impact of events and situations, they are also intent on working with clients on their moment-to-moment processing in the session to facilitate

the resolution of problematic experiences and ways of being. To be fully empathic and present, therapists actively decenter from a focus on the self to a focus on the other (Watson & Greenberg, 2009). A self versus other focus may be culturally acquired either through macro cultural processes or micro ones, as in family units, for example.

The more other focused an individual is, the more likely he or she is to exhibit sensitivity to the needs and concerns of others (Cheon et al., 2013). Support for this hypothesis was provided by a comparison between participants from a culture identified as other focused and one that was more self-focused. Participants from Korean culture were more sensitive to others in interactions compared with their North American counterparts, whose dominant focus was on self, which made them more aware of their own feelings when interacting with others. This research suggests that focus of attention can be acquired and different foci cultivated, which is important to provide optimal conditions in the therapeutic relationship.

THERAPISTS' USE OF SELF

In EFT therapists, empathy is viewed as an embodied phenomenon (Bozarth, 2010; de Greck et al., 2012; Gallese, 2009). Neuroscience research demonstrates that empathy is a whole-body experience (Gallese, 2009; Gibbons, 2011; Watson & Greenberg, 2009). Gallese, Eagle, and Migone (2007) described empathy as "shared embodied simulation" that allows people to share, know, and understand the experience of others, including their feelings, sensations, emotions, and intentions. Moreover, they noted that this simulation is not a deliberate, conscious process, but rather one that is nonconscious and prereflexive. It is through the simulation of others' facial expressions and bodily reactions that the emotions of others are experienced and recognized (Schore, 2001). Mirror neuron research continues to support the biobehavioral synchrony between the empathizer

and the person with whom he or she is empathizing (Gallese, 2009; Lord, Sheng, Imel, Baer, & Atkins, 2015; Porges, 2007). Optimizing synchrony between the participants in the therapeutic relationship is important to healing as well as to honing therapists' empathy in psychotherapy.

Studies have shown that maintaining an inquiring attitude increases empathy. Therapists work harder to understand others when they remain uncertain (Chambers & Davis, 2012). Hatcher et al. (2005) found that both therapists' self-reported empathy and their performance of empathy were more highly correlated with greater perceived differences between therapists and clients. In these cases, it was less easy for therapists to rely on preformulated assumptions and understandings of situations and events. Other activities that have been found to increase therapists' empathy include actively imagining clients' stories and actively thinking about their clients' experience. Deliberately imagining events produces stronger responses in the mirror neuron circuit than observation alone (Decety & Jackson, 2004). Therapists' empathy is enhanced when they deliberately imagine and sense into clients' experience and attend to their own body and physiological sensations and reactions (Greenberg & Rushanski-Rosenberg, 2002; Watson, 2007).

THERAPISTS' FOCUS ON THE OTHER

While emotion-focused psychotherapists are listening intently to their clients' stories and narratives, simultaneously and in parallel they are acutely aware of clients' experiential processing in the session. Emotion-focused psychotherapists are focused on the experience of the other as they work with clients to give it primacy within the session. Clients and therapists keep their attention focused on clients' inner worldview and experiencing in the moment to give it form and enable clients to view it from different perspectives and judge its adequacy and fit. Clients are

encouraged to listen and observe the flow of their organismic experience and its transitions as they develop and share their narrative and to make space to attend to and symbolize it and integrate it into more conscious ways of being. This type of intense focus by therapists is sometimes referred to as *attunement* or *responsiveness* and is characterized by heightened alertness and awareness of the clients' nonverbal cues and bodily experiencing, including breathing, vocal quality, and latency of speech.

MIRRORING CLIENTS' EXPERIENCE

An important way of focusing clients' attention on their experience is through the use of empathic reflections. These are therapist responses that attempt to capture what clients have said, often using their words, to distill the essence of clients' meaning. Emotion-focused psychotherapists look for the "live edge" or emotional meaning in what their clients are saying, paying particular attention to clients' nonverbal signals to capture the flow of their emotional experience in the session. A number of different empathic responses have been identified, including validation, understanding, evocation, conjecture, exploration, doubling, and reframing. The use of reflections slows the process so that clients pay more attention to the inner flow of experience. Reflections are offered tentatively to underscore that clients are the experts on their experience and convey that therapists are actively trying to follow and understand what they are sharing. Reflecting what clients say facilitates their process of turning inward to consider their own experience, as they put it in words and differentiate it and gain access to their experience. In this way they come to know it and learn to trust their perceptions and feelings as a guide to what they need and how to behave. Clients have the opportunity to see how they relate to their own experience—for example, whether they avoid it,

suppress it, or doubt it—allowing clients to see what they might want to change in order to use their organismic experience more optimally as a guide.

Emotion-focused therapists do not reflect only the cognitive and emotional meaning in clients' narratives but attend to and mirror their clients' physiological experience. They are aware of their clients' breathing, their facial expressions, the manner in which they sit and hold their bodies, their micro movements, and their vocal tone. All of this information reveals what clients are feeling moment to moment as well as how they feel about themselves. By mirroring their clients physiologically, therapists can achieve synchrony with their clients, reflected in the tempo of interactions between the participants (Lord et al., 2015). It is an outward expression of coordinated biorhythms—a matching at the level of language use, vocal tone, skin conductance, pauses, and other nonverbal behaviors.

As they work to understand their clients' worldviews and convey warmth, prizing, acceptance, sincerity, and congruence, emotion-focused therapists try to distill the essence of what clients are saying (Bohart & Greenberg, 1997) and understand their emotional logic. This is more than a superficial, cognitive understanding of their clients' narratives; it is a deeper understanding of their lived experience, the sense they have made of it, and how they have incorporated it into their ways of being. If therapists sit in judgment and question or critique how clients have adapted, exploration of clients' inner subjective landscapes may be limited and the space for new emotional understanding to emerge restricted. Using a criterion of commensurability, as they listen to clients' stories EFT therapists ask themselves whether their clients' emotional reactions and logic fit with what clients have shared of their stories. In the absence of this fit or a sense of commensurability, EFT therapists work with clients to further explore their experience and histories to allow them to be seen, heard, named, and understood more clearly.

As clients share their stories, explore the impact of events, and identify what is problematic, emotion-focused psychotherapists attend to how clients treat their emotional experience. They observe whether clients are accepting, empathic, and nurturing of themselves—whether they listen to their own feelings and emotions, whether they take care of themselves and are self-protective and self-enhancing—as opposed to neglectful and rejecting of their experience or overly controlling and managing such that they are out of touch with what they need and overly oppressive. Therapists watch how clients express their feelings and react to them, especially in chair work and their day-to-day lives.

Noting clients' ways of being with their experience, therapists share their observations with their clients to see whether the observations resonate for them. If clients agree, then EFT therapists might propose ways of working, such as two-chair work, to address issues of excessive control or self-interruption, or systematic evocative unfolding, to better understand problematic reactions. However, if clients reject these observations, EFT therapists do not push in the moment. Instead, they wait for other opportunities when evidence of clients' negative treatment emerges to once again note what their clients are doing. It can take time for clients to gain sufficient distance from their own experience to see it freshly and through a different lens; moreover, they may need to internalize more compassion and care for themselves to recognize the negative impact of their behavior. When they are ready, there is a sense of *experiential recognition*—a sense of a gestalt shift and a commitment to change negative ways of relating to themselves. It is important for clients to agree that the ways they are treating their experience are problematic and to express a desire to change. Agreement on the goals and tasks of therapy is fundamental to a good working alliance and to working together productively to address clients' problems. Full empathic understanding of clients develops over the course of therapy.

ATTENDING TO CLIENTS' PROXIMAL ZONES OF DEVELOPMENT

Four different client processes are the focus of experiential therapy: narrative development for cognitive-affective understanding, emotional processing, change in negative relationships with self, and development of a greater sense of agency and confidence in the self. At different times in therapy, clients may be more focused on making sense of their experience and developing a life narrative, whereas at others they may be learning to process their emotional experience to differentiate and modulate it, and at yet others they may be internalizing a capacity for empathy toward self and others to transform their relationships with self and others. In the process, clients become more agentic and differentiated.

Depending on clients' developmental histories, some may need to address all four tasks, whereas others may need to focus on only one or two of them. The more negative and traumatic clients' early experience, the less likely they are to have developed a coherent life story, adequate emotional processing capacities, the capacity for empathy toward self and others, or a sense of confidence in themselves. A healing therapeutic relationship begins to provide the context for clients to develop these capacities. Initially, clients may not be able to receive and respond immediately to the therapist-offered conditions of empathy, acceptance, and prizing, but they may develop the capacity to receive them over the course of therapy (Watson & Greenberg, 2017).

To be empathically attuned and responsive, therapists need to trust clients and recognize their proximal zones of development. It is helpful to be alert to the primary task that clients are working on at different points in therapy. For example, clients may not be able to attend to, differentiate, and reflect on their emotional experience. Thus, a primary task for these clients may be learning how to label and understand their organismic experience. Other clients may not have a coherent narrative of what has contributed to

their distress. These clients need time to tell their story to make sense of it before they can process its impact.

MECHANISMS OF CHANGE

Identification of mechanisms of change in psychotherapy has been fueled by new and exciting developments in the fields of developmental neurobiology, psychology, and psychiatry. Siegel (2012) observed that “our social experiences can directly shape our neural architecture” (p. 15). Numerous theorists are in agreement that social interactions impact our biology throughout life by supporting, modulating, or changing it. Thus, one of the best ways to facilitate changes in individuals’ emotional experience, and its processing and regulation, is through a healing relationship characterized by empathy, acceptance, congruence, warmth, and prizing.

Research on the relationship conditions reveals that they, and especially empathy, are essential to successful therapy across different approaches (Elliott, Bohart, Watson, & Greenberg, 2011; Wampold & Norcross, 2011). However, in EFT the relationship conditions, and especially empathy and acceptance in the context of warmth and congruence, are viewed as active ingredients of change. Empathy with acceptance, warmth, and congruence serves four important functions in therapy, including developing a positive working alliance, deconstructing clients’ internal perspectives and subjective worldviews, developing enhanced affect regulation and processing capacities, and, through the internalization of the therapist’s attitudes, developing more positive self-organizations and a stronger and more resilient sense of self (Watson, 2002, 2016; Watson & Greenberg, 2017).

INTERPERSONAL FUNCTION OF EMPATHY

Empathy, acceptance, warmth, and responsive attunement delivered congruently help develop and maintain a positive therapeutic alliance in therapy. To be effective, it is essential that therapists understand their clients' goals and objectives in order to negotiate the work of therapy. Understanding their clients' goals and objectives enables therapists to be maximally responsive and to tailor their interventions to their clients' concerns. And being empathic enables therapists to track shifts in clients' experiences and modify their responses, which is especially important if clients are having difficulties engaging in therapy or are not ready or willing to change. By monitoring the impact of their interventions on clients and remaining sensitive to the overall quality of the alliance, empathic therapists can be alert for ruptures as well as moment-to-moment shifts in the relationship during a session and over the course of therapy.

Clients feel safe when they are understood and accepted. They feel supported and more able to become aware of and reflect on their experience. Feeling safe, clients can focus on their concerns in the session, turning their attention inward while remaining confident that their therapists are not judging but rather are following along attentively with respect and prizing. This type of exploration enables clients to look at experiences previously denied or avoided and integrate them with their understanding of themselves and their worlds.

A feeling of safety in relationship with another provides the optimal conditions for clients to begin to regulate their emotions. Porges (2007) posited that affect—a biobehavioral process—is regulated interpersonally. Positive social interactions and interpersonal behaviors regulate body states and behaviors. According to Porges's polyvagal theory, the vagus nerve, which transmits information between the heart and brain, serves as a brake that can be applied or released to either calm or activate the individual to protective action. Our bodies and brains have the capacity to neuroceive a state of safety. When this occurs, there is an inhibition of protective action

and individuals feel calm and soothed. *Neuroception* describes how neural circuits discern safety, danger, or life threat on the basis of visceral information outside the realm of awareness. A state of safety and calm is communicated by means of posture, gaze, attention, vocal quality, care, warmth, and attunement to the client's experience. It is hypothesized that the cultivation of safety in the therapeutic relationship contributes to the activation of the vagal break, resulting in a lowering of the client's blood pressure and sense of stress and threat. Creating a sense of safety for clients requires therapists to be fully present in the session (Geller, Greenberg, & Watson, 2010; Geller & Porges, 2014) as they offer empathy, acceptance, warmth, and congruence.

Feeling safe in relationship allows clients to trust and rely on the collaboration of their therapist and to use the relationship to grow and challenge themselves to acquire new ways of seeing and being with themselves and others. Thus, the relationship provides healing and serves as the bedrock for emotional exploration and development and changes in how clients relate to self and other.

AFFECT-REGULATING FUNCTION OF EMPATHY

Ludwig and Field (2014) observed that relationships regulate optimal stimulation and modulate levels of arousal, thereby attenuating distress and the impact of stressful events. It is hypothesized that within close interpersonal relationships, people's behavioral, physiological, affective, and biochemical rhythms become synchronized and more coordinated over time (Ludwig & Field, 2014; Schore, 2001; Siegel, 2012). This process of synchronization is proposed as an important corollary of longer term psychotherapy treatments with clients who are highly negative and intolerant of their affective experience. Over time it is likely that their

biorhythms become synchronized in the presence of their therapists if they are experienced as a caring and benevolent other.

Affect regulation and development of empathy are proposed to interact (Schipper & Petermann, 2013). One of the ways that empathy works in psychotherapy is that it facilitates clients' developing improved affect regulation capacities along with improved empathy toward self and other. In addition to promoting neurobiological processes, emotion-focused psychotherapists actively work with clients to process their organismic and affective experience. Therapists use reflections to mirror their clients' affective experiences so they can be differentiated, labelled, and understood. This process modulates clients' levels of arousal as they learn new ways of expressing their feelings and how to reflect on them and use them as a guide for future action (Watson & Greenberg, 2017).

Experiencing empathic attunement and reflection helps to regulate emotions. Attentive listening and attunement to clients' inner experience helps them modulate the intensity of feelings and soothes them in moments of distress. Social, developmental, and neuropsychologists (DeSteno, Gross, & Kubzansky, 2013; Feshbach, 1997; Schore, 2001; van der Kolk, 1994, 1996) have recognized the important role of interpersonal experiences in the development of affect regulation. It is in interaction with caregivers that human beings learn to process and regulate their emotional experience, learning to attend to and label it and developing ways to modulate and express it optimally to promote well-being (Schore, 2001; Siegel, 2012).

Human beings experience a sense of relief and comfort when they feel understood by another, especially when they are experiencing intense and painful emotions. The expression and symbolization of emotions soothes and modulates them in the same way as rating them on a scale of 1 to 10 does. Clients who come to therapy are often experiencing acute and chronic conditions related to dysregulation in their affective systems. An empathic, accepting, congruent, and prizing other can provide clients with the

conditions to regulate their emotions both within the session and in the long term (Watson & Greenberg, 2017). Clients' level of security in relationship and their level of self-criticism can mediate the impact of the therapeutic relationship on outcome; Watson et al. (2014) showed that insecurely attached individuals responded better to treatment when they experienced their therapist as empathic, whereas those who were more self-critical did not respond as quickly.

DECONSTRUCTIVE FUNCTION OF EMPATHY

Emotion-focused psychotherapists reflect their clients' subjective experience in a tentative and probing style. The objective is to communicate that clients are the experts on their inner experience and to encourage them to check what they are saying against their inner felt sense to determine its fit and accuracy. As clients hear their therapist's reflections, they are able to reflect on and review their feelings, perceptions, and ways of being in the world. Their assumptions are revealed. They become more aware of the subjectivity of their perceptions and assumptions and more hypothetical in how they think about people and events, opening up a range of alternatives (Watson, 2016).

INTERNALIZING THE THERAPIST'S ATTITUDES

By attentively listening, accepting, and empathizing with their clients, therapists model positive ways of being for their clients. Barrett-Lennard (1997) suggested that the therapeutic attitude of empathy leads to the development of self-empathy and compassion in clients. The therapeutic attitude that conveys empathy, acceptance, warmth, and congruence helps to model and build more positive ways of being for clients. Clients internalize their therapist's attitudes and develop positive, nurturing introjects and

ways of responding to themselves that are affirming, accepting, protective, and soothing. There are changes in clients' self-concepts as they become more self-accepting and less judgmental of themselves and their experience and more self-confident and self-protective (Barrett-Lennard, 1997; Bozarth, 2001; Rogers, 1975; Watson, 2002, 2016).

DIFFICULTIES IN THE THERAPEUTIC RELATIONSHIP

Given the importance of the relationship in EFT, it is important to consider specific challenges that therapists might encounter. Therapists need to offer a "good-enough" level of empathy and understanding to clients. Too much empathy and understanding may reflect fusion and inhibit adequate exploration and differentiation of experience, whereas too little empathy can lead to frustration and compromise clients' sense of safety, prompting them to withdraw and shut down as they try to defend themselves or manage their relationship with their therapist. A good-enough level of empathy, acceptance, and prizing provides clients with sufficient safety as well as the impetus to share and reflect more on their experience as their therapist works to understand them. This in turn helps clients articulate their experience more clearly and fully.

It has been suggested that there are individual differences in the capacity to feel empathy. Wu, Li, and Su (2012) found genotypic differences in the capacity of people to experience empathy, with natural variants in the oxytocin receptor gene for trait empathy. Some people with specific genotypes performed better in terms of trait empathy than others, and there were gender differences showing that women had higher empathy ratings than men with the same genotype. The authors cautioned that these findings are preliminary and need to be replicated, but they are suggestive of the need to be aware of individual differences in training therapists.

Although it is likely that therapists self-select on this variable, some may need to work harder than others to experience similar levels of empathy, both cognitive and emotional, with clients. Moreover, the capacity to be empathic may be honed by therapists' cultural contexts, with other-focused cultures being more attuned than cultures with a greater self-focus. However, the study by Cheon et al. (2013) suggested that the capacity to be empathic is malleable and subject to influence such that it can be cultivated over time.

Another variable that can impact therapists' capacity to empathize with their clients is how positive they are feeling before a session. Duan and Kivlighan (2002) found that therapists who felt positive before a session were less able to respond empathically to their clients' negative moods during the session. They suggested that these therapists might be motivated to protect themselves from their clients' negative moods so as not to jeopardize their positive feelings. In contrast, therapists who were more anxious before the session were more empathic than those who were less anxious. The more anxious therapists were more in tune and able to perceive their clients' emotions more accurately during the session.

Loss of differentiation from their clients can cause therapists to lose focus and become too distressed by their clients' narratives and issues. When this happens, it can be helpful to seek out other therapists to aid them in working through and managing their distress. The loss of empathic capacity when a therapist feels challenged by a client because the client is either complaining or blaming the therapist for the treatment not working can be especially difficult. At these times, it can be difficult to maintain a focus on the other and empathize with his or her concerns and not feel useless or unhelpful. These negative feelings require therapists to actively decenter by letting go of their feelings, the need to help, or the need to be seen as competent and valued. It can be helpful to remember that clients' complaints are often a reflection of their own frustration at their progress

and may even herald and support growth as clients express their negative feelings and reactions in the context of a safe relationship.

CASE STUDY

The following case study illustrates the role of the relationship conditions in promoting change. Cathy[1] was in her early 40s when she presented for treatment with severe depression. She was married with two children. She felt stalled at work and unable to progress on a project she was working on. Her family of origin was fractured. She had sporadic contact with her three sisters, one of whom had been institutionalized. Her parents had divorced when she was a teenager; her father had been physically abusive and her mother depressed and disengaged from the family.

After her parents divorced, Cathy moved in with a boyfriend. She continued her education while working part time. She met her husband when she was at university. Their relationship was strained. He was highly avoidant, and Cathy continually felt disappointed and resentful of his lack of involvement with the family. She assumed major responsibility for parenting their two boys, one of whom was a talented athlete who required a lot of attention and support to pursue his goal of becoming an international tennis player. Cathy was very controlling and demanding of herself, while at the same time undermining her objectives. She was conflicted about her relationship with her father, to whom she remained attached in spite of his abusive behavior.

In therapy, Cathy refused to engage in two-chair dialogues, fearful that she would lose control, so her therapist continued with empathic reflections. Initially Cathy had difficulty when her therapist reflected what she said. She would shake her head and say, “Please use my words.” However, even when using the client’s words, the therapist’s reflections were experienced

as disruptive. Responsive to her client's distress, the therapist moderated the frequency of her reflections. Over time, Cathy was able to tolerate reflections using her words. This was a cue to the therapist to increase the frequency and use more exploratory reflections. Cathy responded positively to the use of different words to capture slight variations in meaning that opened up her experience more fully. More confident, she shared how hard it had been to hold on to her own experience and bodily felt referents when her therapist reflected her experience.

Cathy struggled with intense mood swings. She and her husband quarreled often, remaining locked in conflicts that she felt she had to win. She considered separating but wanted to hold the marriage together for the sake of the children. Internalizing her therapist's empathy and acceptance, she was more able to see her husband's point of view and began to understand his triggers and ways of coping as a result of losing his parents as a child. She was better able to control her emotions and did not become so angry. She attributed these changes to therapy but was still frustrated with her work situation, continuing to criticize herself for not moving forward. She was frustrated that therapy had not helped her achieve her career goals. As she developed a more compassionate and nurturing relationship with herself and stopped looking to others for care, she developed better boundaries with others and began seeking out more interesting opportunities at work.

This case example shows how the therapeutic attitudes of acceptance, prizing, congruence, and empathy facilitated change. Responsive to her client's needs and capacities, the therapist moderated her empathic responses over the course of therapy. The client developed a stronger sense of self, becoming more agentic, self-protective, and nurturing. She learned to process her affective experience and regulate it more effectively and became more empathic toward herself as well as her husband. As a result,

they quarreled less and were able to reestablish intimacy and emotional connectedness, leading to a more stable relationship.

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[1]The author verifies that she has concealed client identity by disguising details of the case or by combining details from multiple cases.

6
THERAPEUTIC PRESENCE: THE FOUNDATION FOR EFFECTIVE EMOTION-FOCUSED THERAPY

SHARI M. GELLER

Emotion-focused therapy (EFT) is founded in the therapeutic relationship, with an overall therapeutic approach involving both following and guiding (Greenberg, 2011). EFT therapists practice from a person-centered style (Rogers, 1957), which involves entering the client's internal frame of reference and responding to it empathically, combined with a more guiding process directive experiential and gestalt therapy style (Gendlin, 1996; Perls, 1969) to deepen experience. EFT is built on a genuinely valuing, affect-regulating, empathic relationship in which the therapist is fully present, highly attuned, and sensitively responsive to the client's experience. This type of relationship with the therapist provides a powerful buffer to the client's distress through the coregulation of affect. A relationship with a present and attuned therapist who mirrors the client affective experience provides interpersonal soothing, and this promotes the development of regulation of overwhelming, disorganizing, and painful

emotions (Geller & Porges, 2014). Over time the interpersonal regulation of affect becomes internalized into self-soothing and the capacity to regulate inner states (Stern, 1985). In addition to being curative in and of itself, this type of therapeutic relationship is also seen as providing an optimal environment for promoting the therapeutic work of exploration and task resolution.

Emerging research is informing us that therapeutic presence (TP) is a necessary and preliminary step to developing and sustaining a strong therapeutic relationship and facilitating effective change for our clients (Geller, 2017; Geller & Greenberg, 2012; Geller, Greenberg, & Watson, 2010; Hayes & Vinca, 2011; Pos, Geller, & Oghene, 2011). While all EFT therapists would agree that the therapist's presence is important and the relationship is central, there is at present minimal focus on training on cultivating TP. This chapter provides a glimpse of what TP training focuses on: cultivating presence prior to and when approaching a session, as well as using your presence in session with your clients to optimize your EFT therapeutic technique and deepen and sustain the therapeutic alliance.

WHAT IS THERAPEUTIC PRESENCE?

Therapeutic presence is a way of *being* with the client that optimizes the exploratory and task-related work of EFT. It involves bringing your whole self and being present with clients on multiple levels, physically, emotionally, cognitively, relationally, and spiritually (Geller, 2009, 2013a, 2013b, 2017; Geller & Greenberg, 2002, 2012). TP involves being grounded in one's self while receptively taking in the verbal and nonverbal (i.e., body) expression of the client's in-the-moment experience (Geller & Greenberg, 2002, 2012). TP can also be viewed as a way for therapists to monitor their own experiences in therapy (Geller, 2013a).

Through an enhanced sensitivity to clients' experiences, EFT therapists can use their selves and their attuned bodily awareness as a tool to understand and respond to their clients. Therapists can also sense how their responses and interventions are facilitating their clients' therapeutic process and the therapeutic relationship. Therapists' responses then emerge from a felt place of being attuned in the moment with one's self and with clients. The aim in responding is not to try to make something happen but rather to sense what is happening. The result is the cocreation of new experiences, with neither partner leading or following but rather a synergistic emergence of something new.

Background Research on TP

Therapeutic presence is the first step to developing empathic attunement and a strong therapeutic alliance, and to promoting successful engagement in therapy (Geller, Greenberg, & Watson, 2010; Geller & Greenberg, 2012; Geller & Porges, 2014; Hayes & Vinca, 2011; Pos, Geller, & Oghene, 2011). We know that the therapeutic relationship is the single most consistent predictor of successful therapeutic outcome (Norcross, 2011). Yet what contributes to the relationship is less clear. The research thus far is suggesting that TP is a positive predictor for the therapeutic alliance (Geller et al., 2010; Pos et al., 2011).

The development of a measure of presence, the therapeutic presence inventory (TPI, therapist and client versions; Geller et al., 2010), allowed a comparison of presence in EFT with other modalities such as person-centered therapy (PCT) and cognitive behavior therapy (CBT). Research supported that clients felt that their therapist was more present in EFT and PCT than in CBT. As with research on the therapeutic alliance, research on TPI reveals that the client's experience of their therapist's presence matters more than the therapist's perception of their own presence. Clients who experienced their therapist as present had a positive alliance and a

successful session outcome (Geller et al., 2010). It is valuable then to be skillful in communicating presence so that clients receive their therapists' presence. That can be enhanced through therapists' attunement to self, which is the basis for attuning to others (Siegel, 2007). Presence is also conveyed through body posture, gestures, and entrainment of breath and prosody (vocal tone) in rhythm with clients (Geller & Porges, 2014).

Research has also suggested that TP is predictive of the relationship conditions of empathy, congruence, and unconditional regard (Geller et al., 2010). Presence is related to yet distinct from empathy (Pos et al., 2011; Geller & Greenberg, 2002, 2012), and presence precedes empathy (Hayes & Vinca, 2011). Presence is a necessary precondition to being empathic and sustaining a positive therapeutic relationship (Geller et al., 2010; Hayes & Vinca, 2011; Pos et al., 2011). This view is echoed by Rogers, particularly toward the end of his life when he wrote,

> I am inclined to think that in my writing I have stressed too much the three basic conditions (congruence, unconditional positive regard, and empathic understanding). Perhaps it is something around the edges of those conditions that is really the most important element of therapy—when my self is very clearly, obviously present. (Quoted in Baldwin, 2000, p. 30)

Drawing on both the client-centered view of relationship and on gestalt therapies that value the I–Thou relationship, therapeutic presence in EFT has come to be seen as a necessary way to be attuned to affect as emotion occurs in the here and now. EFT therapists need to keep their fingers on their clients' emotional pulse moment by moment, and that requires the therapists to be present in the moment. Presence in EFT involves both attunement to and resonating with clients' experience, both taking in and absorbing clients' experience but also extending out and communicating what is understood. A research-based model of TP (Geller & Greenberg,

2002) was developed that can help guide our understanding of this essential way of relating.

Model of TP

Our empirically validated model of TP involves three overarching qualities: (a) how we *prepare* ourselves to be present with our clients, both in life and in session, (b) the *process* or what we do in-session when we are present, and (c) our embodied *experience* of presence (Geller & Greenberg, 2002, 2012). Preparation for presence in a therapy session happens in life and just prior to the session. The process of therapeutic presence includes being open and *receptive* to the clients' experience, *inwardly attuning* to one's bodily resonance with the client's experience, and *extending and contact* with the client from this place of receptivity and inward contact. The experience of therapeutic presence includes all of the following four qualities: being *grounded* in one's self; being *immersed* in the moment with the client; continuing to be connected to a larger sense of *expansion*; while always being in service of the client's healing or *being compassionately with and for the client*.

TP as a Foundation for Effective EFT

TP is an essential stance in EFT. From an experiential and neurophysiological perspective, TP creates safety for clients (Geller, 2017; Geller & Greenberg, 2012; Geller & Porges, 2014; Geller, Pos, & Colosimo, 2012). This serves to deepen the therapeutic relationship and to support clients as they engage in the work of therapy and EFT tasks and modalities. It also helps to attune therapists' responses and use of interventions to be optimally timed for clients, to promote the greatest efficacy.

For therapists, TP promotes a connection to themselves and to their clients that is both emotionally regulating and supportive of growth and well-being. TP also serves to increase their effectiveness as EFT therapists. TP allows (a) attunement and recognition of primary and secondary emotions; (b) fine-tuned attention to the moment-to-moment experience to help provide useful information and to co-ascertain which emotions are adaptive, maladaptive, or obsolete responses to past situations and need to be transformed; (c) effective use of EFT case formulation by keeping therapists following the pain compass that will guide to the core emotion scheme, and (d) the flexibility to read the moment so therapists can respond and intervene with the greatest impact.

TP CLINICAL SKILLS

Being skillful at TP involves a commitment to cultivating presence in one's life and relationships. This includes strengthening the in-body and relational qualities of TP such as grounding, immersion, expansion, and being with and for the other. Summarized in this section are the skills of approaching the session with presence as a part of the preparation phase, as well as in-session skills that reflect the process of presence in-session, as informed by the TP model. Throughout the session EFT therapists are (a) *receptively attuned* with their client while (b) *attuning within* themselves. This blend of experiences informs their understanding and how they are (c) *responding*, while promoting *contact* with their clients to activate their clients' sense of safety and deepen the relationship. This process involves tracking clients' *moment-to-moment* experience: both how they are feeling and how they are receiving their therapist's interaction with them (Geller, 2017).

Preparing Prior to the Session

Preparing for TP begins before starting to see clients for the day. This means therapists take time to open up the space, gather thoughts, get nourished, and be ready to receive their clients. Taking time between sessions to release emotional residue and open to the next person can also support this experience of presence. Research supports that just 5 minutes of centering or becoming present prior to session can improve the therapist's presence and the outcome of the session and reduce clients' psychological distress (Dunn, Callahan, Swift, & Ivanovic, 2013). Some tips for preparing and approaching the session with presence follow.

Intention

Intention setting is powerful, as it can act as a guide for where you want to go. Intention primes the body and the brain for that which it intends, in this case to be present. This includes taking a few moments prior to a session to put aside preconceptions and distractions and arrive into the present moment, rather than use it to check messages, texts, e-mails, and so on. It is also important to take care of your own hunger, thirst, or other bodily needs. This will allow you as an EFT therapist to be in a position to receive your client, without judgment, preconceptions, or agendas.

Setting intention can be as simple as inviting yourself to be present at the beginning of a session or therapy day. This can include standing in stillness, feeling the soles of your feet as they touch the floor to invite a sense of grounding, and taking a few deep and slow breaths. You can visualize letting your stress leave your body through the soles of your feet as you exhale, and energy and focus arriving in your body as you inhale. You can also invite words to support your intention such as "letting go of stress" as you exhale and "arriving into now" as you inhale.

PRESENCE Acronym

The PRESENCE acronym was developed to reflect all of the qualities of TP, including being in contact with yourself and your client simultaneously. It can be used before each session to invite the experience of presence. Practice is essential in supporting access to the experience of presence, so explore this acronym at different times both outside and prior to session to see if it is helpful to you.

- ***P****ause* (put aside what you are doing to just rest in this moment)
- ***R****elax into this moment* (soften your facial and body muscles)
- ***E****nhance awareness of your breath* (take three deep inhalations and exhalations)
- ***S****ense your inner body* (bring awareness to what you are feeling in your physical and emotional body)
- ***E****xpand sensory awareness outward* (seeing, listening, touching, and sensing what is around you)
- ***N****otice what is true in this moment* (both within you and around you, without judgment)
- ***C****enter and ground* (feel your feet on the ground and the center of your body)
- ***E****xtend and make contact* (open your eyes and ready yourself to approach the next moment or open the door for your client while staying connected to yourself and your breath)

Space Between Sessions: Transition Moments

Pausing and taking time between sessions to transition can support a letting go of what came before and allow you to be clear to receive your next client. The best way to support this is to book time in between sessions (e.g., 10–15 minutes) to complete notes, get nourished, and have a few moments to be still. When we slow down transitions we realize there are three components:

1. Noticing and letting go of what came before
2. The space between events (this is the time to pause with a few mindful breaths)
3. Arriving at a new moment, role, or opportunity—with intention

Being intentional about transitions, both in sessions and in life, can help you consciously let go and clear a space for yourself and your clients, which allows presence to arise more easily in a session.

Receiving Clients

With presence, EFT therapists are receiving their clients, actively listening to all of their ways of expressing (verbal and nonverbal), and attuning with them to invite an experience of feeling heard, felt, and seen (Geller, 2017). Therapists are listening to *what* their clients are saying, as well as *how* they are saying it: attending to clients' body posture, when their voice rises or falls away, when their breathing is deep or shallow, the twitches in their eyes, or the tension or softness in their face. (See Geller, 2017, for a more detailed account of what these different expressions indicate.)

When receiving clients, therapists are using their selves as an means to empathically attune to the emotional world of the clients, which means listening for their core pain by attending to both primary and secondary emotions. Therapists want to keep empathically unfolding the *relationship between narrative, internal experience, and body language.* Attending to verbal cues as well as gestures can be a guide to understanding clients' experience. For example, when a client is clutching her chest while she speaks about her ex-husband, it is possible she is beginning to touch the grief surrounding the ending of her marriage.

Clients' vocal quality (pitch, tone, and rhythm) can be another doorway into their experience (Rice & Kerr, 1986). For example, an

increase or change in vocal pitch and frequent pauses are good indicators a client is feeling anxious about what is being shared (Laukka et al., 2008). An increased pitch as well as volume and speed, can indicate your client is experiencing anger (Scherer, Johnstone, & Klasmeyer, 2003). Listening to clients' vocal quality in context of what they are sharing can guide therapists to understand their current emotional state. Vocal rhythm (prosody) and vocal quality also indicate whether clients are feeling safe (Geller & Porges, 2014; Porges, 2011). In contrast, when the vocal tone is loud and booming (or monotonous and rambling) it can indicate clients are disconnected from their experience. The voice trailing off may reflect they are tentative about sharing their experience or they are highly emotional and feeling guarded. EFT from the start relied on the client vocal quality scale (Rice, Koke, Greenberg, & Wagstaff, 1979), which specified vocal features of productive vocal qualities (focused and emotional) and unproductive ones (external and limited) voice.

Listening for patterns in the breath can also provide information on clients' experience. Deep and slow breathing can indicate that clients feel relaxed, heard, and met by their therapist. Shallow breathing may signal anxiety and irregular breathing; short exhalations may suggest the client is feeling unsafe, triggered, or threatened. A sigh can indicate a wide variety of emotions and mental states ranging from relief to boredom, fatigue, or dismay. Understanding a client's sigh in the context of what is being shared helps to decipher the meaning.

Attuning to clients' body posture can provide a window into their experience. A closed or tight posture such as arms crossed can indicate that the clients are held back, defensive, and disconnected. An upright yet open posture with a relaxed vitality in the body suggests clients are feeling open and engaged. Reading bodily cues can also indicate when a primary emotion holds greater emotional charge and meaning than the words alone convey. It can also illuminate a discordance between what clients are

sharing and what they are feeling. When noticing such a disconnection, the therapist should pause and access the clients' emotions. Inviting clients' awareness to their expressed body posture may bring them more in line with their emotional experience. For example, my client Jen (not her real name) shared "I am happy that my daughter is moving into her own home," yet her leg was shaking and her eyes were glazed and looking downward. I reflected to Jen that her body was expressing something, possibly sadness or fear, which opened up further unfolding of her grief and fear at this pivotal life change.

When therapists are receiving clients, it is also helpful to attend to facial expression and eye gaze. Therapists can attune to signs in clients' eyes, such as moisture, a downward cast (which could indicate sadness or shame), or eyes widened in fear, among others. In contrast, a soft eye gaze can indicate that clients feel safe and at ease. Relating with the eyes between the therapist and client is quite powerful as well. A shared gaze evokes the warm, accepting embrace of human connection, while meeting the pain and vulnerability being shared.

Emotions are expressed in facial expressions in an overt way as well as in microexpressions, which may flash for just a brief moment and reflect concealed emotions (Ekman, 2003). Subtle emotions are also revealed through miniexpressions, which remain a bit longer and are confined to one part of the face. Softness in the face indicates a sense of calm, safety, and connection. Tension or a furrowed brow might signal that clients are feeling distressed or triggered. A quiver of the lips or downward dropping of the mouth suggests there is sadness or emotional poignancy; paying attention to what is being expressed is crucial here.

To strengthen your ability to attune with your client, you can try the following:

1. Watch a therapy tape (or foreign movie) with the sound off (or speed on slow) to see if you can identify the client or the actor's

experience. Then turn the sound or subtitles on to see how close your understanding was to their actual experience.

2. Mirror your client's (or friend's) facial expression, eye gaze, body posture, breathing patterns to try to get a felt sense of their experience from the inside out. From a neurophysiological experience, this is said to activate mirror neurons in yourself, with your partner, to give you a sense from the inside out of their experience (Iacoboni, 2009; Siegel, 2007).

Attuning Inwardly

As EFT therapists receive their clients' moment-to-moment experiences, they are also attuning inwardly so they can understand all that is being received. With TP, a person's body is like a tuning fork. The inward information is a combination of clients' experiences and therapists' knowledge of their clients and of EFT theory, which integrate to informs the therapists' response. In essence, the therapist is listening to the client's body with his or her body and listening to his or her own body to determine how to respond.

As therapists attune inwardly they may notice twinges of pain or bodily sensations, images or words that are emerging in resonance with the client, or a guiding voice indicating which intervention or response to offer. EFT therapists can also attune to how they may not be present (i.e., be distracted) and invite attention back to the moment. This scan of one's inner experience occurs in a split second once the ability to consciously practice presence becomes stronger.

There are multiple sources of attention therapists can turn to internally. Listening to emotions felt in the body as they resonate with clients can provide therapists with both an empathic understanding and a clue for a marker for an EFT intervention. For example, a quiver in their chest or moisture in their eyes may inform therapists that clients are feeling sad. An

accelerated heart rate or tight, anxious feeling in the chest may be a resonance with the clients' anxiety. If that accelerated heart rate or tight anxious feeling is felt in the context of the clients talking about their fathers' strict stance at home, it may be a marker for an empty-chair task (if it is also in a moment when clients seem safe and open to engage in the work of therapy with you).

Attending to breathing patterns also provides cues of what is occurring in the session. A restricted breath may reflect that the therapist is absent or feeling disconnected or that the client is emotionally disconnected. Therapists can actively use their breath to entrain with their clients' breathing patterns to deepen the connection and to more astutely read their clients' experience.

Watching for imagery can help as empathic indicators to what clients' experience is. For example, an image of my client alone on an island emerged inside as he spoke about caring for his disabled son and aged father. When I reflected to him this feeling of being alone and isolated, a tear formed in his eye and he nodded, saying, "No one is ever there for me." Combined with knowledge of his family history, I recognized this was a marker for an empty-chair task with his mother, who he described as cold and demanding that he be the one who cares for his younger siblings.

There are many facets of internal expression with which therapists can check in, such as emotions, body sensations, breathing patterns, images, and insights. With presence there may be certain aspects of the therapists' inner world that call for attention more than others. TP requires that therapists have an embodied sense of self-awareness and capacity for interoceptive (sensing inwardly) awareness. Embodied self-awareness is the ability to pay attention to ourselves, including our experiences, bodily sensations, movements, and inner sensory world, in the present moment (Fogel, 2009). Presence requires therapists' willingness to trust what they sense and feel: If deeply attuned to their clients, therapists' immediate sensory experience

will reflect what is most prominent and important in their clients' experience and will guide them in facilitating change.

Generating the ability for self-attunement is promoted by practices that enhance embodied self-awareness. There are a couple of brief practices; more can be found in Geller (2017).

1. *Mindfulness meditation (MM), body scan, or mindful walking.* These practices help to attune inwardly to your experience. A basic MM practice follows:
    - Sit in an upright, yet relaxed position.
    - Invite your awareness to your breath. Find a place in the body, the belly, or the chest where you can experience your breathing.
    - Notice the rise and fall of the belly or chest in rhythm with your inhale and exhale
    - When the mind goes off or distracts (which it will), name one descriptive word (*thinking*, *worrying*, *remembering*) and gently invite your attention back to the breath.
    - Practice for 10 minutes to start, slowly increasing to 20, then 30 minutes.
    - Be gentle with yourself around the level of distraction, knowing that you are building your neural muscles for focus and attention each time your invite your awareness back from distraction to the breath.
2. *Listening to your body in relationship.* When you are in a dialogue with someone or when that person is sharing his or her experience with you, practice listening to your own body at the same time. What do you notice in your emotions? Breathing pattern? Posture? Images or guiding words that arise?

Responding and Promoting Contact

Responding with TP means reading the state of the client, noticing internally what is emerging, and then responding in a way that facilitates the therapeutic process. When in a state of presence, therapists learn to trust what emerges from that state of flow and connection. They may also receive emotional or bodily cues that indicate how to respond. They can include internal cues such as feeling in "flow" (Csikszentmihalyi, 1990), tired, bored, tense, distanced, sad, and happy. It can also include cues in the client safe, such as tightness, overwhelm, sad, fear, or hurt. When that occurs, EFT therapists can go through a process to make internal assessments:

(a) If it is their own issue that is triggered, then what is needed is to return to the moment (e.g., self-regulate or put aside issues for the moment).
(b) If it is therapeutically important that the therapist be open to something occurring in the client that needs attending to, such as with an empathic gesture or a marker for an EFT intervention, or recognize the need for a relational repair in the case of a rupture.

EFT therapists can also assess the following from external cues in the clients:

(c) Clients' emotional experience in the moment and how the therapists should respond to deepen their experience, regulate, or offer an EFT intervention (e.g., a downward cast and a tear forming while talking about their sister may be a possible marker for an empty-chair task).
(d) If clients are open or ready to receive a response or intervention, or if they are in a closed state, then attend to

what is getting in the way of their therapeutic process (e.g., issues in the therapeutic relationship, difficult emotions in them, resistance, and lack of safety, which may be a marker for a relational repair or an emotional regulation skill).

With TP, EFT therapists are constantly using their bodies to read the emotional state of the clients and the relationship, which informs their responses.

CLINICAL VIGNETTE: USING CUES TO INFORM YOUR UNDERSTANDING AND RESPONSE

The following is an example of how both cues from the therapist and cues from the client in a couples' session can promote an empathic understanding and response.

> Sam and Syd were seeing me for the fourth session of EFT couples therapy after Sam had spent some of the couple's savings in an investment. Syd angrily yelled at Sam in a high and sharp tone for not consulting with him. I noticed in my own body that I was pulling back, my body was leaning away from the client, my back was against the chair, my breath was restricted, and I felt a sense of agitation. I first checked in to assess whether I was personally triggered or reactive in some way but quickly discerned that this was not the case. I realized my body was telling me that there was a disconnection, and an insight arose from that sensation that possibly Syd was not accessing his primary emotions of hurt and low self-worth. I validated his upset and then asked him to check inside to determine what he was really feeling, perhaps feeling hurt or not being valued in some way. A tear formed in Syd's eyes as he took a breath; he said, "Yeah, it hurts me that you don't care about what I think and feel, and it makes me feel worthless, like

I don’t matter.” I could feel my body open, soften, and move forward in a caring gesture.

Our bodies’ reactions in the moment offer vital sources of information. Our body starts reacting emotionally even before we bring it to consciousness (Damasio, 1999; LeDoux, 1996). The tight and pulled-back feeling that my body was expressing during the session helped affirm my read that Syd was not yet at his primary emotions. Assessing that my pullback was a response to the secondary/instrumental emotion of anger allowed me to register and reflect his primary hurt. This was validated by the way my body softened and naturally moved forward in a caring stance once he expressed his hurt. His core emotional experience pulled care and compassion from me.

ENHANCING NONVERBAL CONTACT

Contact is key to relating with presence and the way the therapeutic relationship is sustained. Contact includes the way therapists approach and relate with their clients in a way that supports their feeling together in relationship, working together to further their growth. Promoting contact begins with attunement, yet is expressed verbally through empathy and congruence and nonverbally through synchronization. EFT practitioners have a good grasp of empathy and congruence, which are the verbal ways they promote contact. Yet there are also nonverbal ways they can do so. This involves using the body intentionally to show the clients you are with them and to bring you both into connection. The following are some tips on how EFT practitioners can promote contact and express presence nonverbally.

Using Nonverbal Cues to Promote Contact and Safety With and for Clients

EFT practitioners can promote contact in their clients through neurophysiological expressions of safety (Geller, 2017). According to the polyvagal theory, the brain and the body are in bidirectional communication, both within ourselves and among people (Geller & Porges, 2014; Porges, 2011). Being mindful of how we interact with clients so that they feel safe with us includes the following:

- prosody (rhythm) in the voice,
- soft facial expression,
- soft and direct eye gaze,
- open and forward-leaning body posture, and
- visual focus and attention attuned to the client.

Pay attention in your interactions with your clients and with others to these markers of presence (Geller, 2017). If you notice you are tight in your body or expression, invite your body and posture to adjust to a more present-centered focus, so you can continue to nonverbally invite your clients to feel safe with you.

Entrainment Breathing

Therapists can align their breathing patterns with those of clients to further promote connection, through entrainment breathing. This type of breathing includes mirroring inhalation and exhalation with the inhalation and exhalation of the client. Entrainment breathing creates a neurophysiological synchronization of rhythm in the brain and body among people (Cozolino, 2006; Geller & Porges, 2014; Porges, 2011; Siegel, 2010). This both supports the therapist's empathic attunement with the client's emotional experience, as well invites clients to feel safe as their nervous systems come into rhythm with their therapist's calm and grounded presence.

A MODEL FOR OPTIMIZING THERAPY WITH TP

The following is a quick guide to optimizing EFT sessions with therapeutic presence. An elaboration of these steps can be found in the book *A Practical Guide to Cultivating Therapeutic Presence* (Geller, 2017).

1. Presession: Before clients arrive, engage in a 5-minute practice utilizing the PRESENCE acronym.
2. Beginning the session:
    - Approach clients with openness and receptivity, bracketing preconceptions, judgments, and therapy plans.
    - Attune with clients, inviting a brief mindfulness practice to arrive into the session together.
3. In session:
    - Receptively listen to clients, attuning with your body to clients' emotional experience.
    - Read clients' moment-to-moment experience: verbally and nonverbally what they are expressing, their vocal quality, gestures, breathing patterns. Notice what is poignant for them or when they are shutting down.
    - Attune to yourself, listening inwardly to how the client's issues are resonating inside, what is arising in resonance with what they are sharing. This includes checking in when you are not present and inviting yourself to reset your attention and return to the moment
    - Respond or offer an empathic or EFT task based on markers that you are receiving from clients and what you are attuning to within yourself.

- Read and attune with clients as to how responses/interventions are being experienced by them.
- Entrain your breath to theirs to read their experience and promote contact.

4. Closing session: Have a mindful moment together with clients to absorb what they have learned; you may offer postsession homework or awareness practice.
5. Transitioning to the next session or the next part of your day
    - Take a few minutes to intentionally close the session internally (finish notes, take a walk, stretch) to release residual emotions you may be carrying from the session.
    - Recenter and reground: engage, utilizing the PRESENCE acronym, before approaching your next client or the next moment in your day.

CONCLUSION: PRACTICE MAKES PRESENCE

TP provides an important foundation for EFT; there are direct and active ways to develop this quality further. Neuroscience is validating rapidly how our experience can actually change our neurological structure in lasting ways (Hanson, 2009; Siegel, 2010). Each and every time we experience presence, in our personal life or in relationships with others, it leaves a memory or imprint in our brain and the body. So repeated practices of presence allow therapeutic presence to become familiar and be accessed more easily over time. Luckily, our everyday life and our relationships provide many opportunities to do so!

There are growing resources and suggested practices accessible for cultivating therapeutic presence (Geller, 2017; Geller & Greenberg, 2012; Siegel, 2010). Therapists can also discover their own way of cultivating in-

the-moment awareness, in relationship. This includes an awareness of the barriers to bringing one's self in the moment intimately with another who is suffering, while staying grounded, open, and receptive. Feeding the capacity for presence, through intention and practice, supports presence to be more of a trait quality when in session with clients.

It is essential to balance the *doing* mode of therapy with the *being* mode to have the greatest impact for clients' healing. Engaging with others with grounding, receptivity, nonjudgment, and acceptance, with a finely attuned attention, is the key to activating safety. With safety, clients can feel more present and the therapeutic relationship can expand to places that are profound. Ultimately, therapists' EFT tasks and interventions will be more effective and their ability to attune to what is emotionally poignant will be enhanced.

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7

HOW CLIENTS “CHANGE EMOTION WITH EMOTION”: SEQUENCES IN EMOTIONAL PROCESSING AND THEIR CLINICAL IMPLICATIONS

ANTONIO PASCUAL-LEONE AND UELI KRAMER

This chapter explores the sequential model of emotional processing proposed by Pascual-Leone and Greenberg (2007). We first present a case illustration and then describe the common emotions and sequences that clients seem to have during productive emotional processing. Next, we review process-to-outcome research conducted on this model of emotional processing, highlighting implications for treatment. Finally, we discuss how the model of change can be translated into a heuristic for practicing therapists. A map of client process allows therapists to orient to features of client emotion and focus on experiences missing from clients’ process.

WHAT KINDS OF EMOTIONAL EXPERIENCES ARE THERAPEUTIC?

Greenberg and others (Greenberg, 2015; Pascual-Leone, Paivio, & Harrington, 2016) have identified emotional transformation as a unique form of emotional processing, which Greenberg eloquently described as "changing emotion with emotion." In practice, the process represents a coordination of several subtypes of emotional processing that include awareness, regulation, and reflection (Pascual-Leone et al., 2016); emotion-focused therapy (EFT) uses a process-guiding style to create change by evoking affect in order to promote emotional processing and access to new meaning (Greenberg, 2015). Thus, after accessing emotion, the focus shifts to transforming certain experiences by using emergent and alternative emotions to expand a person's affective repertoire. For EFT and beyond, *productive sequences of emotion* have been proposed as a potentially universal change process, one that may ultimately reflect pathways of adult emotional development (Greenberg, Auszra, & Herrmann, 2007; Pascual-Leone et al., 2016).

SEQUENTIAL MODEL OF EMOTIONAL PROCESSING

As Greenberg and Paivio (1997) described in their seminal book, clients in therapy often present with (secondary) emotional reactions to the deeper and more fundamental (primary) feelings they are suffering. Moreover, primary emotion that is maladaptive (i.e., dysfunctional and dreaded states that are usually core to presenting client issues; e.g., low self-worth, trauma) is transformed by the client's accessing and evoking primary adaptive emotion by the mobilizing force, for example, of adaptive anger or the healing process of underlying adaptive sadness over loss. This transformation process often occurs in the working phase of treatment, once the client has managed to work past more symptomatic secondary emotion. Although the exact process cannot be applied formulaically because it is contingent on the personal experience and meaning of each individual, both

process and experimental research has supported the idea that there are indeed a series of specific and prototypic pathways toward emotion resolution.

Moreover, reviewing the literature on emotion makes it clear that some qualitative kinds of emotional experiences are productive (e.g., *only* certain kinds of anger, certain kinds of sadness), whereas others represent stagnation or ongoing expressions of distress (Greenberg et al., 2007). This presents a conceptual puzzle for clinicians, as it may not be so much an issue of which emotions are productive (e.g., Is it productive to express anger? What about sadness and crying?); rather, the issue is one of quality (e.g., What are the unique features of productive anger? What does productive vs. unproductive sadness look like? See Chapter 9, this volume).

EMOTIONAL CHANGE "ONE STEP AT A TIME": A CASE EXAMPLE

Although productive emotional experiences are useful, they turn out not to occur as isolated change events and instead unfold following a predictable sequential pattern of emotion. A narrative account of how client change occurred over the course of therapy helps illustrate the sequential process of emotion. This case, which was part of a clinical trial of EFT (Greenberg, Warwar, & Malcolm, 2008), was also featured in a recent study on the client's emotional progress over time (Pascual-Leone, Yeryomenko, Sawashima, & Warwar, 2017).[1]

Jeff was a 50-year-old lawyer who had been married for 15 years and had a 12-year-old daughter. He presented as depressed, with features of social anxiety, and reported drinking alcohol to soothe himself when he had feelings of shame and inadequacy. He often had difficulty knowing what he was feeling or expressing. His wife and daughter had complained about his anger; he would easily become irritable and sometimes got angry with them. He also reported feeling that he had a short fuse and that he was

easily angered when he felt others were putting him down; for example, he snapped at others when he began feeling worthless or ashamed. What brought Jeff to treatment was an awareness that he had feelings of unresolved anger and hurt toward his father, who had been both physically abusive and highly critical.

When Jeff began therapy, he was easily overwhelmed by his feelings, and in Session 2 he graphically described the self-interruption of his own internal process: “I can only get so far. I’m afraid to let myself go there; my body stops. It’s like a blind is drawn down and says, ‘that’s enough of that!’” The therapist helped Jeff work through this emotional block using chair work and empathic responding to his vulnerability, a step that gave Jeff access to underlying emotion.

Initially, Jeff would become overwhelmed by feelings of worthlessness and shame and would break down in uncontrollable sobbing and global distress. The therapist introduced a self-soothing exercise in Session 3 (i.e., “Imagine a safe place . . .”), which they returned to throughout treatment as needed. With each session, he became more emotionally regulated when processing his childhood trauma. In Session 5, Jeff articulated his chronic feelings of inadequacy, saying, “I have to monitor everything I say . . . because people will just . . . disregard me as a nutcase.”

Soon after this progress in emotional awareness, Jeff’s work in therapy moved on to focus first on the unresolved feelings of rage and the rejecting anger he felt over his father’s physical abuse of him as a child (Sessions 3 and 7: “He’s repulsive”; “I just want to get rid of him”). Thus, the next major task in therapy was for Jeff to develop his ability to tolerate and soothe his distress without resorting to rageful anger, which was often secondary emotion. Initially he was unable to do this, but by Session 7 he had developed that capacity, which helped him feel a sense of entitlement to his unmet needs for love and feeling safe. In Session 7, Jeff poignantly reflected, “I’m missing . . . the love that only a parent could give a child.”

After that, when Jeff was more able to allow his underlying vulnerability, the treatment focus advanced again to address his extreme feelings of worthlessness and being unlovable—the primary maladaptive shame connected to his childhood abuse. To that end, the therapist helped Jeff access, experience, and articulate these intense feelings, now with more purpose. Interventions such as unfinished business dialogues, in which he imagined confronting his father, as well as recalling and exploring related episodic memories, were key processes. Later this feeling was transformed into a more primary and adaptive anger toward his father, which was followed by primary adaptive grief, for the years he lost in a dysfunctional relationship with his dad, and a different kind of grief, for the little boy who never had a safe place to grow up.

As treatment concluded, Jeff came to experience assertive anger toward his father, and by Session 11 he had articulated and experienced the important unmet need to be lovable and feel loved by his father. He expressed very clearly that as a little boy he had desperately needed to feel safe and loved, as well as a sense of healthy entitlement: “I deserved to feel safe and loved.” In Session 12, during an imaginal dialogue, Jeff spontaneously imagined how his (deceased) father might have expressed deeper love for him and repentance for having been so abusive (“It really wasn’t about you. . . . I wish I had been a better father. . . . You are my son; I love you. . . . Really, we both missed out in the end”). This imaginal exercise and enactment of a caring father by the client himself was the experience and expression of a highly adaptive state of self-compassion. Jeff found himself forgiving his father, experiencing a dramatic change in perspective. He accepted the abuse as part of his past and engaged life with a new sense of personal agency. The 14 treatment sessions ended in a good outcome, according to an evaluation 2 weeks posttreatment, that was maintained at 18-month follow-up.

MAPPING OUT THE SEQUENCES OF EMOTIONAL CHANGE

It is common in the discussion of emotional processing in EFT to refer to a "schematic model" using more abstract categories from emotion theory. For example, in a sequence of change, secondary emotion is followed by primary maladaptive emotion, which in turn is followed by primary adaptive emotion (Greenberg & Paivio, 1997). However, 20 years of process research later, EFT is in a position to be more specific in its theory and describe the emotions that most commonly are observed to represent these broader emotion categories. Identifying specific emotions operationalizes the initial model of emotional change and makes it more useful in the hands of clinicians. Moreover, it makes thinking about emotion in this way more accessible to clinicians of any orientation in a jargon-free manner.

Taking prior theoretical work by Greenberg and Paivio (1997) as their point of departure, Pascual-Leone and Greenberg (2007) used task analysis to develop a model of client process that captured key states and the productive transitions between them. That study asked, What are the psychological steps by which clients work through their distress? By coding emotion states in session videos of EFT for depression and interpersonal injuries, an empirical model was produced that described a multistep sequential pattern of how emotions unfold and that was subsequently shown to predict positive outcome sessions. This research helped establish that certain emotional events are particularly helpful change processes. In the 10 years that followed, subsequent evidence for this model was garnered from 24 studies and more than 300 clinical cases conducted for a range of both treatment approaches and disorders, although this chapter focuses on findings relevant to EFT. The model is shown in Figure 7.1.

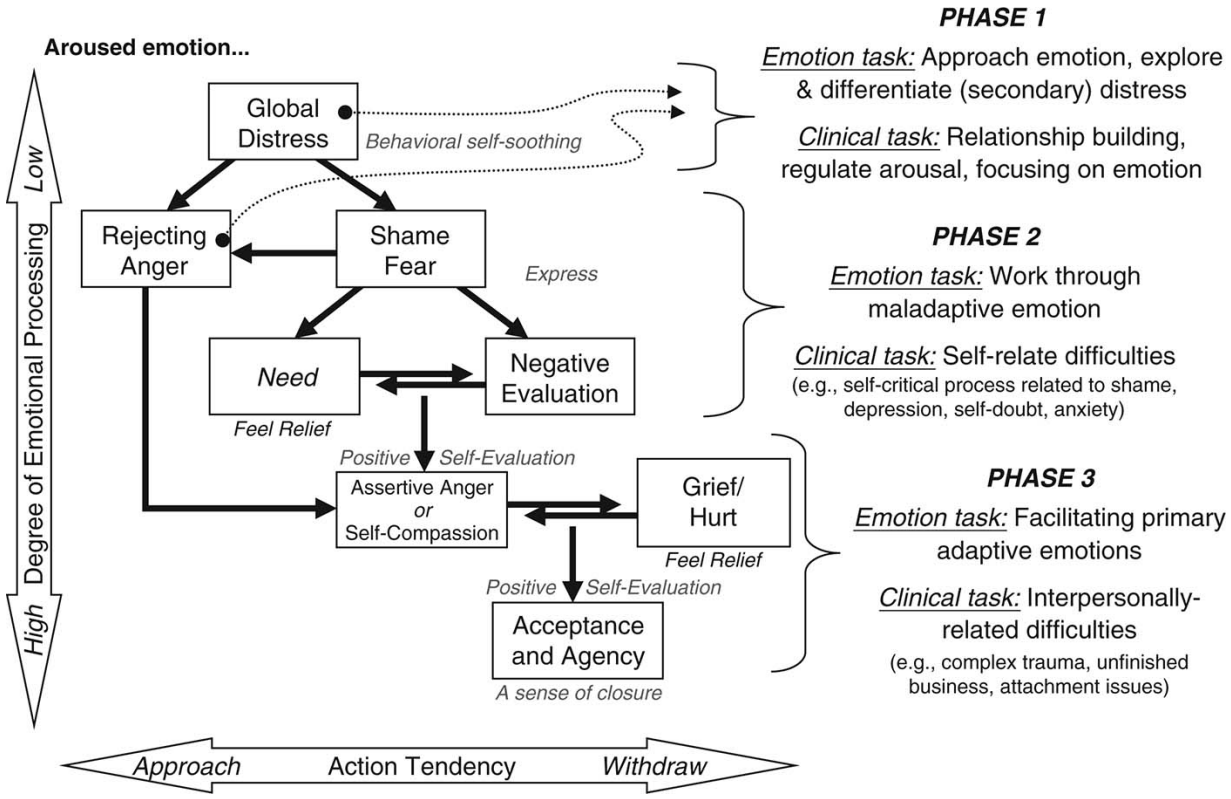

Figure 7.1. The sequential model of emotional processing. Adapted from "Emotional Processing in Experiential Therapy: Why 'the Only Way Out Is Through,'" by A. Pascual-Leone and L. S. Greenberg, 2007, *Journal of Consulting and Clinical Psychology*, *75*, p. 877. Copyright 2007 by the American Psychological Association.

Whereas the case of Jeff (above) gives a narrative account of how one client processed emotion in the context of working through his difficulties, the remainder of this section specifies and isolates each of the steps in that process of change. To illustrate the emotion states, we offer examples taken from Jeff as well as a number of other clients,[2] emphasizing that these are common patterns of change.

Global Distress

According to the model, the sequence for emotional processing in a productive session begins with *global distress*, a term coined by Pascual-Leone and Greenberg (2007) to refer to undifferentiated negative feelings (a type of secondary emotion, e.g., helplessness, symptomatic anxiety); see Figure 7.1, Phase 1. Individuals in global distress are often highly aroused but unable to clearly articulate the cause of their distress, and they lack a sense of direction in regard to understanding and resolving their personal difficulties. Individuals overwhelmed or stuck in distress must first manage and differentiate their core pain before they can progress through the model. The first example is from the beginning of Session 2 in therapy with Erin.

Erin: I always feel like crying. And that comes in my upper throat and my eyes. I don't, ah . . .

Therapist: Can you tell her that? Can you say, "Mom, I just have to look at you, and I feel like I want to cry"?

Erin: I guess. (speaking to imaginary image of mother:) Um . . . Mom . . . I just have to imagine you in that chair, and I feel like crying. (sobs)

Therapist: Yeah, "I feel so sad." It's OK. It's all right. "There's just so much sadness I feel."

Erin: There's a lot.

Therapist: Can you tell her what you're sad about? Are there any words that come with the sadness? Or is it just there?

Erin: Hmm, that's a tough one! . . . Yeah, I just feel sad. [arousal, but little meaning]

The second example is from the beginning of the seventh session of therapy with Monica. In this example, the client is obviously upset and falls apart quickly, with a whining tone in her voice.

Therapist: How are you feeling today?

Monica: (teary eyed and seemingly confused) I feel terrible today. (voice cracks)

Therapist: Are you?

Monica: Yeah . . . I am a mess.

Therapist: Tell me what's going on.

Monica: (shrugs hopelessly) I burst into tears 10 times. I don't know, I just . . . (teary and high-pitched voice) . . . I feel depressed. I have no energy. (sniffle) I'm finding it really difficult to just get on with normal things. I feel really—I feel tired. I'm just not my—not myself at all.

Therapist: So what's going on for you?

Monica: I'm not sure. Just normal irritating things happen, and . . . I feel all alone, and stuff like that.

Shame and Fear

As the healing process moves forward, the initial distress is ultimately differentiated into core maladaptive emotions in the form of shame or fear (or both); see Figure 7.1, Phase 2. These experiences are of enduring and familiar types of pain (e.g., "that same old feeling," a dreaded state, chronic vulnerability). Unlike global distress, these are highly personal and idiosyncratic states always anchored in some specific autobiographical context, and clients often experience these maladaptive emotions as a hauntingly familiar pain (e.g., "the same old story"; see Chapter 11, this volume). Individuals in states of shame and/or fear have an all-too-poignant awareness of what they see as the cause of their distress, which is often expressed in themes of feeling incompetent, inadequate, or lonely. As an aside, although "loneliness" is a salient clinical presentation, that kind of emotional pain often is still not fully differentiated (i.e., it is usually part of global distress). When loneliness is differentiated, it often is maladaptive

because it actually entails a deeper sense of shame (e.g., “I’m alone because I’m inadequate [or unlovable]”) or fear (“I am incapable [or will not survive alone]”), which captures the more fundamental concern. In short, although loneliness is painful, when it is unhealthy, that is because of its connection with maladaptive shame or fear.

Following is an example of prototypical shame and fear in Session 5 from the case of Jeff, described earlier. The therapist introduced a two-chair dialogue, and the client speaks critically to himself in the second person. As the client talks slowly, he holds his head in his hands:

> *Jeff:* Um. I can’t give an example. Everything you say is just a bit off, you know . . . off, of how other people see things . . . or . . . talk about things. (voice cracks, sobs heavily)
>
> *Therapist:* It’s just really . . . it hurt to say that. . . . What’s the sadness? Can you say the words?
>
> *Jeff:* (covers face, rubs eyes, sniffles; long pause)
>
> *Therapist:* It’s just a feeling of inadequacy that gets pulled . . . or . . . ?
>
> *Jeff:* Well, I have to monitor everything I say, even while I’m saying it, because I’m . . . I know, or feel, that everything I say is just a little bit off, just doesn’t . . . You know, people will just do a double take when I speak or disregard me as a nutcase.

Rejecting Anger

The model also shows that global distress is sometimes elaborated along an alternative path, to rejecting and destructive anger (secondary emotion, but with a potentially complex relationship to primary assertive anger, in that meaning elaboration can yield assertive anger); see Figure 7.1, Phases 1 and 2. Rejecting or blaming anger pushes away and is less differentiated in meaning than more productive forms of (e.g., assertive)

anger. As such, rejecting anger simply creates distance from the source of emotional pain. In distinguishing this reaction from a more productive form of anger, it helps to consider what the individual is fighting for. Often individuals in a state of rejecting anger (i.e., rage, disgust, hate) are mobilized and have a clear sense of what they do not want (rejecting, pushing away from), but it remains much less clear what they are pursuing. For example, compare rejecting anger—"I don't know what I want, but it's not that!"—with assertive anger—"I know what I'm fighting for, and I'm fighting for my rights!" Thus, in a prototypical statement of rejecting anger, Jeff said of his father (Session 7), "I'm disgusted; I want to get rid of him" and, on a different occasion (Session 3), "He's repulsive; I'd like to punch him out." What initially makes this emotion adaptive (in a rudimentary way) is that it is an agentic rejection of some noxious experience, as opposed to a shrinking away or closing down, which would be characteristic of maladaptive shame and fear.

Summing Up: Early Expressions of Distress

Emotion states up to this point in the model (i.e., global distress, shame and fear, rejecting anger—the top half of Figure 7.1) are all early expressions of distress rather than expressions of working through distress (Kennedy-Moore & Watson, 1999). The notion that they are "early" expressions conveys that they are prerequisite steps to change, an unavoidable part of initial engagement and arousal of painful feelings. Indeed, as discussed below, these states have been observed as part of the therapeutic process, whether one is observing either unproductive (poor-outcome) sessions or the early sequences of productive (good-outcome) sessions. The later emotional states seem to be what discriminates between productive and unproductive therapy.

Negative Self-Evaluations and Existential Needs

In a critical step (middle of Figure 7.1), the model highlights that maladaptive emotion in the form of shame or fear necessarily entails both an unmet existential need (for either attachment or esteem) and a fundamentally negative self-evaluation (i.e., an affectively driven core dysfunctional belief about the self). These two aspects of experience are in direct conflict and create a seemingly impossible situation. This step poses a dialectical contradiction and is the point at which a client's self-critical process (e.g., related to shame, depression, self-doubt, anxiety) is worked through. An unmet need is at the core of primary emotions, in this case maladaptive emotions, but they need to be identified and clearly articulated. Similarly, although unhealthy or hostile ways of treating oneself (negative self-treatment) are characteristic behaviors associated with maladaptive emotion, the more fundamental issue is the experience of oneself as inherently negative. The new meaning construction in resolving this is ephemeral at first, encapsulated in a novel moment of positive self-evaluation or affirmation (e.g., "I do need love, I just never got it . . . so maybe that wasn't actually my fault?"). Thus, expression of unmet existential needs (e.g., a wish for attachment, personal agency, survival) is the gateway to deeper and more adaptive emotional experiencing that will follow.

In short, identifying and symbolizing a core unmet need and resolving the ensuing contradiction often usher in a categorically new experience, and this represents the latter part of the model; see Figure 7.1, Phase 3. These new emotional experiences lead the client to a sense of self as deserving and mobilize him or her to directly address unmet needs. This step is an advanced affective meaning process and takes the form of key emotions that are both primary and adaptive. On the one hand, the client experiences assertive anger (fighting for one's needs) or self-compassion and soothing (tenderness and caring for oneself), while on the other hand, the client confronts grief over a loss. Meanwhile, these phenomenologically different

lived experiences, assertive anger and self-compassion, serve the same function in this process, in that individuals in either state embody a new positive self-evaluation and address their existential need with agency.

Assertive Anger

Assertive anger essentially has enough differentiation to embody a positive self-evaluation and the clear assertion of that evaluation or of some personal need. This means that assertive anger is not just about pushing something noxious away. More than that, it is about setting boundaries and engaging in a fight for one's rights and needs. Prototypical statements that represent assertive anger are "I won't accept this, I have value! I have been mistreated" or "I am different from you. I exist, I deserve. . . ." Expressions of this state are both very specific and clearly adaptive. They are also anchored in concrete autobiographical events. For example, a client in EFT with borderline personality disorder (Kramer & Pascual-Leone, 2012) engaged in a two-chair dialogue with her mother, with whom she had a repeated sense of being dismissed and ignored. The client, speaking from the role of herself as a 6-year-old child, asserted against her imagined mother, saying, "It is my right to play here. This is *my* space, and I have the right to play here, and right now I need you to see that."

Self-Compassion

The state of self-compassion appears in the form of explicit self-soothing, attributed self-nurturing (as when the client role plays a significant other or talks gently to himself or herself), or acknowledgment and reflection on existing resources (e.g., available social support, past personal successes). Examples are when a client spoke to herself reassuringly from the role of her parents, saying, "I love you. It's going to be all right" (Carla, Session 10) and when another client spoke to herself

and considered her loved ones, saying, “You deserve to be treated well. You have your husband who loves you, your sister . . .” (Monica, Session 7).

Grief and Hurt

The counterpoint to assertive anger or self-compassion is the experience of grief and hurt, in which the individual recognizes loss or woundedness yet is able to express this pain without collapsing back into the negative self-evaluation, resignation, or despair characteristic of earlier states. Assertion, compassion, grief: These are the emotions through which fear and shame are undone and long-standing interpersonal difficulties (e.g., complex trauma, unfinished business, attachment issues) are resolved. The following is an example of grief and hurt taken from Jeff’s therapy (Session 7). The client’s voice is very soft; he has been crying, and he sniffles:

> *Jeff:* You know, in many ways I never had a family. If it weren’t for . . . you know, extended family, it wouldn’t have been much.
>
> *Therapist:* Yeah, um-hum . . . you’re missing that in your life.
>
> *Jeff:* Well, I’m missing that particular type . . . of love. I guess, that . . . (voice breaks; covers face and begins to sob) . . . the love that only a parent could give a child.
>
> *Therapist:* So there’s nothing that can replace that, there’s nothing that can substitute that . . .
>
> *Jeff:* Well, not from my experience. I had aunts and uncles, who I know loved me, but it was never the same . . .

The expression of grief and hurt in this context marks a second moment of dialectical tension, wherein adaptive forms of anger and sadness act as opposite sides of the same coin. On one side, individuals push forward in the present, asserting their value and needs through a healthy sense of entitlement, while on the other side, they retreat to mourn the loss

of attachment experiences or missed opportunities from the past. As before, individuals often transition between these opposing experiences, and when they are adequately explored, aspects of both contribute to an emerging sense of resolution. Just as clients in assertive anger or self-soothing may shift into hurt and grief, they may easily shift back again. Again, a client succinctly illustrated this by stating, “This is where I start to get angry. I feel the anger in the place where the sadness was” (Monica, Session 6).

Thus, clients move from one of these two model components to the other, a gestalt switching between figure and background. A shift between states is illustrated in the following excerpt in which a client transforms assertive anger into grief (Greg, Session 3). In this segment, the therapist directs the client into an unfinished business task in which the client talks to his imagined sister. Initially he is relaxed, yet remains businesslike:

Therapist: It sounds like that comes from being angry . . .

Greg: (nodding) Yeah, yeah, yeah . . .

Therapist: Can you tell her how angry you are?

Greg: Oh! She knows how angry I am!

Therapist: Tell her again.

Greg: Well, I’m really angry. I’m angry enough that I don’t want to see you. And I would, ah . . . be very happy not to see you ever again. [frowns sincerely; he is genuine]

Therapist: What happens inside you when you say that?

Greg: Um . . . oh, tremendous sadness. (shakes head, sighs deeply)

Therapist: Sadness.

Greg: Yeah, because we have been, since 2006 . . .

Therapist: Speak from there. Tell her about the sadness.

Greg: Well, it just is, uh . . . (long pause) . . . It means we won't ever get together again, to have a swim, to have a barbecue, to . . . talk . . .

Therapist: So it's like, "I'm sad about losing you."

Greg: Yes. I'm very sad about losing you (nodding slowly, closing his eyes) I, I, ah . . . Oh! (sighs deeply, opens his eyes, and turns to address the therapist) . . . she more than anybody.

Acceptance and Agency: Moving Toward Resolution

Completing the nonlinear sequence described above leads clients to resolution in the form of acceptance and agency. In the change process described above, although expression is necessary, venting is not sufficient because the most central part is actually explicitly symbolizing the embodied meaning of a lived emotional experience. Taken as a whole, the model's nonlinear and multistep pattern of emotion has been identified as a form of emotional transformation, leading clients toward the resolution of personal difficulties in the form of letting go and acceptance (bottom of Figure 7.1). Following is an example of this state taken from the Session 10 of Carla's therapy. Although there are many forms this state can take, the example is prototypical. The client's emotional tone is very soft, with a bittersweet air of reflection. One has the sense that the client experiences this as positive and feels a sense of relief, although there is a sadness that goes with it, as if she is accepting reality:

Carla: It feels like I can breathe again. . . . It feels like that ball inside my chest has loosened.

Therapist: OK, so take a deep breath and see if you can breathe into that ball in your chest. Just notice if anything comes up that you want to say to your dad. See if there is anything you want to say good-bye to, that will never be again.

Carla: I guess . . . I'm gonna try to say good-bye to that part of me, that child, that was hurt and was defenseless. I'm not going to ignore her; she'll always be there, and if she wants to say something, I'm gonna listen. But I'm not that child anymore.

Therapist: Right, right . . .

Carla: I'm an adult now. I have control over my own destiny. I'm not . . .

Therapist: It's like, "Goodbye to being defensive, goodbye to that."

Carla: No, no, correct. Goodbye to that. Goodbye to being a victim.

DO EMOTIONAL SEQUENCES RELATE TO OUTCOME?

EFT interventions that facilitate various emotional transformations (e.g., focusing, enactment tasks, chair work) have been studied in detail using this model. However, to appreciate the broader significance, it is important to know that the model has also been studied in a number of other treatments, including clarification-oriented therapy, attachment-based family therapy, short-term dynamic therapy, dialectical behavior therapy skills training, and a manualized general psychiatric treatment (for a review, see Pascual-Leone, 2018). Furthermore, the model has been examined in clients with clinical problems including major depression (Choi, Pos, & Magnusson, 2016), complex trauma (Khayyat-Abuaita, 2015; McNally, Timulak, & Greenberg, 2014; Paivio & Pascual-Leone, 2010), generalized anxiety (Timulak & McElvaney, 2016), social anxiety (Haberman, Diamond, & Shahar, 2015), adjustment disorder (Kramer, Pascual-Leone, Despland, & de Roten, 2015), and personality disorders (Kramer, Pascual-Leone, Rohde, & Sachse, 2016).

Emotional Transformation Predicts Good Moments and Good Sessions

Pascual-Leone and Greenberg (2007) presented two studies that each examined in-session examples of global distress in experiential psychotherapy in the treatment of long-standing interpersonal difficulties and depression. The first study presented the sequential model of emotional processing, and the second verified this model in an independent sample of clients with depression and interpersonal difficulties. In summary, these studies offered empirical support for several ideas. Namely, when confronted with distress about personal problems, individuals who optimally process their emotion do four things: (a) engage in emotional exploration; (b) explore both the initial presenting distress and then specific types of productive emotion (e.g., assertive anger, grief, self-compassion); (c) generate those productive emotions through the exploration of personal distress rather than by circumventing any initial bad feelings; and (d) clearly articulate an unmet existential need, offering a gateway for the emergence of adaptive and productive emotional experience, a predictor of good-outcome events. Finally, the research implies that emotional processing according to the model predicts more lasting, positive changes than haphazard or unordered emotional explorations.

Initial studies of this model were seminal in highlighting the role key emotions have in producing good process effects, such as an insight, change in narrative, or deeper experiencing. However, building this argument requires larger intermediate outcomes, such as postsession symptom change. In a study of sudden treatment gains over a week, Singh (2012) found that the sessions that led to sudden gains did not differ significantly during early stages of the model but rather that the critical issue was whether a client had additional experiences of assertion, grief, or self-compassion. These findings support the idea that clients need to “arrive” and work through distress before they can “leave” or resolve it (Greenberg, 2015).

Emotional Transformations Predict Final Symptom Change

Khayyat-Abuaita (2015) examined clients in EFT for complex trauma, which treats past childhood abuse (e.g., sexual, physical, emotional). She found that changes in emotion earlier compared with later in treatment explained 58% of the variances in good versus poor outcomes. Moreover, the emotional changes also correctly predicted 80% of final outcomes. In fact, when change in frequency of primary adaptive emotions increased by one unit, the chances more than doubled that a client's treatment would end in a good outcome. Choi and colleagues (2016) also examined emotion in EFT specifically for depression, contrasting the sequential processes in good- versus poor-outcome cases in a sample of clients using sophisticated pattern analyses. Primary adaptive emotions, and even specific in-session sequences of emotion, were related to good (over poor) treatment outcomes. Studies like these underline that clinicians should gently reach past clients' presenting distress to foster certain specific and emotional experiences.

WHAT KINDS OF CHANGES CAN THERAPISTS OBSERVE DURING TREATMENT?

Therapists can also use the model to understand and anticipate clients' progress. The specifics tend to be useful here for therapists, because they are examples of what might be expected in a good-outcome case. This section describes what therapists might see happening in treatment.

Patterns of Emotion During Single Sessions

EFT therapists follow a client's emotional process moment by moment. But part of this is with the understanding that emotion somehow builds over time and culminates in what presumably is a tipping point in a dynamic system contributing to some larger units of change. Pascual-Leone

(2009) showed how these nonlinear patterns of moment-by-moment change relate to the unfolding of good psychotherapy outcomes. Looking at regression slopes over time for each of the 34 cases, he showed that when clients worked with their emotional distress, therapeutic changes appeared to advance steadily in an overall linear fashion. However, regarding single qualitative shifts in emotional state, which he called *emotional transformations*, Pascual-Leone found that clients increased their ability to dynamically shift from one set of feelings and meanings, or one self-organizing framework of action, to another, something he described as better *emotional flexibility.*

Finally, when tracking emotion in a given session, many therapists notice that clients occasionally suffer micro moments of *emotional collapse*, when they make initial advances into primary adaptive emotion but then, after some effort, regress into earlier expressions of distress. Pascual-Leone (2009) showed that the duration of a client's momentary collapse (i.e., setback) became significantly shorter over the course of a good therapeutic event, reducing in length by about one-third (32%) from the first episode of collapse to the last. This saw-toothed pattern shows that clients advance "two steps forward, and one step back" and is a reflection of building emotional resilience. For example, the pattern of moving two steps forward, one step back is illustrated when a client accesses primary grief and collapses back into secondary emotions of distress, but then finds her focus again as she works toward articulating the deeper meaning of a loss.

Patterns in Emotion Over the Course of Treatment

McNally et al. (2014) selected one of the most successful outcome cases from an EFT treatment study of depression for an intensive single-case analysis, elaborating a detailed narrative account of how the female client progressed over 16 sessions of therapy. Findings demonstrated a progressive process of emotional transformation across early, middle, and

late treatment sessions in a manner predicted by the Pascual-Leone and Greenberg (2007) model, and which was followed by a complete recovery from depression maintained at 18 months posttreatment. Observations based on the model also converged with independent observational measures of productive emotion (Greenberg et al., 2007).

Ratings in Sessions 1 through 5 showed the early phase to be mainly nonproductive and more aroused. Specifically, in these early sessions global distress was the predominant state, with only fleeting expressions of primary adaptive emotions. In the working phase, Sessions 6 through 11, increased activity was seen across all types of emotion, and although the amount of global distress was reduced, it was still the most prevalent, followed by shame and fear, then assertive anger and other more productive emotions. Both the working and later phases showed an increase in emotional flexibility, although occasional collapses into global distress were still observed even in later sessions. The end phase, Sessions 12 through 16, held dramatic reductions in global distress as well as shame and fear, which became the most prevalent emotions. However, other emotions were also increasingly apparent, including assertive anger, self-compassion, and, for the first time, grief and hurt. By the end of therapy, this progression through the model was associated with several indices of the client's good treatment outcome.

Using a more quantitative approach, Pascual-Leone and colleagues (2017) conducted two separate intensive single-case studies (i.e., Carla, Jeff) coding every emotional event in the entire course of each treatment. The cases were selected from a randomized clinical trial of EFT for interpersonal emotional injuries (see Greenberg et al., 2008) because they were considered among the best-outcome cases and are used as examples in training workshops. Statistical analyses for each case tested for patterns of emotion both within sessions and across treatment.

In the case of Carla, progress within each session showed moment-by-moment gains that prior research has shown to be important to both session and final treatment outcomes. However, a new contribution of this case analysis was that Carla cycled through the model multiple times, rather than only in a single key session. For this reason, Pascual-Leone and colleagues (2017) described her pattern as "practice makes perfect," referring not only to the successful in-session processing but also to its rehearsal or consolidation. Even so, that recapitulative process did not carry over, in the sense that she tended to start almost all sessions at the beginning of the processing model (i.e., in the state of global distress), nor did the within-session process seem to speed up in its recovery from global distress toward more advanced emotional states with successive sessions. Thus, on its own, each session appeared markedly productive, although the study did not observe those gains as impacting subsequent events from one session to the next. Still, Carla's pattern of change was consistent with the understanding of emotional change as something that needs to be activated and reactivated before creating lasting structural change—the "emotional push-ups" described by Pascual-Leone (2009). Indeed, the narrative description of Carla's treatment provides some evidence of the emotional practice or training in resilient responding before establishing stable change.

The case of Jeff, described at the beginning of this chapter, was also subjected to detailed analyses by Pascual-Leone and colleagues (2017). Similar to the case studied by McNally et al. (2014), Jeff's emotional processing also showed a pattern of gradual advancement through the emotional processing model across the sessions. Findings indicated that each session began and ended with progressively less global distress and more primary and productive emotion. Thus, the average level of emotional transformation improved with each session, moving "one step at a time." This indicates that the process added up in a stepwise manner, augmenting across multiple treatment sessions. Indeed, Jeff progressively changed his

clinical presentation a bit each time he engaged in a new session. The narrative account of Jeff's change over time provides insight into the different steps that he went through, overcoming one emotional challenge at a time as he moved through his series of sessions toward a successful treatment outcome. In a pattern that was the opposite of Carla's, although there was little change observed within any given session with Jeff, his pattern over a series of sessions illustrates the model from the beginning to the end of a treatment outcome. Thus, identifying the potential patterns of longer term emotional change helps clarify for therapists the various ways a treatment may be on track.

Emotional Development Is Recursive Within Sessions and Across a Treatment

The studies we discuss here highlight that moment-by-moment processes a therapist can attend to in sessions are often the same as those unfolding across the treatment as a whole, except at a larger temporal scale. This means that moment-by-moment case descriptions can assist therapists in monitoring clients' emotional processing at various treatment levels. Such descriptions can also offer an informed context for interpreting any divergence from what seems to be the optimal treatment process.

A study of EFT for social anxiety disorder (Haberman et al., 2015) coded emotion over the course of treatment and concluded that as successful treatment progressed, maladaptive shame was essentially being resolved by way of increasing primary adaptive emotions. Khayyat-Abuaita's (2015) study of complex trauma also demonstrated the dynamic shifting of emotional processes from the beginning to the end of therapy. By comparing early and late in-session stories about trauma, she was able to show that the amount of primary adaptive emotion clients experienced increased from a total of 8 seconds per session at the beginning of therapy to a total of 4 minutes per session at the end of therapy. The findings of

Haberman et al. and Khayyat-Abuaita are important because they describe changes that therapists can palpably observe in session. This helps provide some framework for what should happen in a treatment that is en route to a successful outcome.

In another kind of study, Choi and colleagues (2016) examined nine EFT cases involving clients who suffered from self-critical depression and further confirmed that the emotion-to-emotion pathways indicated in Figure 7.1 indeed signal productive sequences. For clinicians, this means that if a client makes those specific shifts, therapy is on track. Interestingly, the authors also identified sequences that were characteristic of poor outcomes, and as expected, they involved being stuck at the top of Figure 7.1.

Together, these findings on emotional processing across treatment point to a very similar pattern of process that was previously observed within single session events. This suggests that the pattern of emotional development repeats itself and may be scalable across an entire treatment, a fractal or complex pattern of change that is self-similar across different scales. This speculation invites the exploration of an intriguing new direction for understanding how change happens from a dynamic systems perspective and points to novel formulation of how adult emotional development unfolds over time. For therapists, this means that staying in the moment, while being mindful of the sequences in this emotional processing model, can help map out good treatment and inform one's choice of interventions.

FACILITATING CHANGE: HELPING CLIENTS SHIFT BETWEEN EMOTIONS

Research on EFT for complex trauma (Harrington, 2016) recently showed that the working alliance, in the early phase of therapy, was the best predictor of a client expressing primary adaptive emotions later on, during

the working phase of therapy. Studying an experiential treatment for personality disorders, Kramer and colleagues (2016) showed that in the first 20 minutes of a session, both empathic understanding and the therapist's "process directivity" were moderately strong predictors of clients subsequently engaging and grappling with their experiences of fear and shame. This suggests that when therapists judiciously guide the process, they facilitate clients' exploration of core maladaptive emotion.

Research has also asked what specific interventions facilitate adaptive emotion (i.e., assertive anger, self-compassion, grief and hurt). Singh (2008) reexamined sessions of 26 client–therapist dyads from the EFT videos used by Pascual-Leone and Greenberg (2007). He showed that in the context of clients working with painful emotion, 86% of the effect that therapists' experiential focus had in deepening their client's subsequent experience was explained (fully mediated) by the client having and expressing the emotions of assertive anger, grief and hurt, and self-compassion. Moreover, these process events occurred in a temporal order: In response to client distress, when (a) therapists focused on deepening the client's experience of emotion (i.e., attending to and exploring its bodily feeling, then elaborating its emerging meaning), then (b) clients subsequently experienced adaptive emotions, which was followed by (c) the good session event of deeper client experiencing. Singh further asked what interventions therapists were using when clients worked their way through the sequential model of emotional processing. When therapists responded to client arousal with interventions focused on emotion, and specifically on expressions of needs or wishes, these targets of intervention had large and significant effects and were unique in lending themselves to therapist processes that were predictive of good outcomes.

Singh (2012) was able to replicate the 2008 findings on the focus of therapist interventions in his follow-up study on sudden gains. When interventions in the critical session were compared with those in other

sessions (unrelated to sudden gains, but within the same treatment case), interventions were significantly more likely to focus on unmet client needs. Thus, focusing on the core need that is inherent in a client's emotion seems to offer what Pascual-Leone and Greenberg (2007) described as a gateway to deeper and more adaptive emotion (see also Greenberg, 2015; Greenberg & Paivio, 1997). For therapists, this means that a specific way to help clients access primary and adaptive emotion, particularly when they are in distress, is to focus on identifying deeper personal needs that are unmet and otherwise remain only implicit aspects of clients' core pain.

Kramer and Pascual-Leone (2016) offered single-session two-chair interventions from EFT to undergraduate students who suffered from self-criticism either with or without concomitant anger problems. In a quasi-experimental design, the researchers introduced a self-critical dialogue and added a written task that encouraged participants first to identify their unmet needs and then to express healthy assertive anger. The intervention helped facilitate emotional processing in both groups. However, even when they were given the extra support, anger-prone self-critical individuals had more difficulty in accessing and articulating their underlying needs compared with those who were only self-critical. The clinical implication is that even simple interventions, like just asking clients to identify their deeper needs, can help them with healthy self-assertion. It also suggests that people with anger problems may have an especially hard time doing this.

Finally, the model provides some general clinical implications for the order of operations or clinical phases when working with emotion (see phases and operations in Figure 7.1, at right). Consistent with ideas put forth by Greenberg and Paivio (1997), the initial task of working with emotion in Phase 1 is approaching one's feelings enough to explore them, and we would say that differentiating the meaning of (global) distress is a key objective. Thus, the clinical tasks for this phase of psychotherapy involve providing an empathic relationship that focuses on emotion while

keeping arousal in a tolerable range. In some sense, this first phase is essentially where client and therapist choose to productively engage emotion.

In the next phase, Phase 2, the client elaborates and works through maladaptive emotion (Greenberg & Paivio, 1997), and the current model specifies that doing this not only entails experiencing fear or shame, or both, but also requires the articulation of certain components (e.g., identifying a need, being aware of one's negative self-evaluation). As Paivio and Pascual-Leone (2010) highlighted, self-related difficulties such as self-criticism, self-blame, anxiety, and doubt often must be worked through before clients can move on to successfully address interpersonal or attachment issues. Then, in Phase 3, clients elaborate and experience various adaptive emotions and their contradictions (e.g., anger vs. sadness). This phase represents a central aspect of working through interpersonal issues and difficulties related to significant others (e.g., unfinished business, interpersonal trauma).

USING THE MODEL AS A PROCESS MAP

A complete case formulation involves conceptualizing a client's core concern, identifying the most promising areas for growth, and developing a plan for interventions. Although Pascual-Leone and Greenberg's (2007) model provides explicit direction in identifying core concerns and areas for growth, particularly on a moment-by-moment level, it does not provide direction on which interventions to use (see Pascual-Leone & Kramer, 2017). As such, the sequential model is especially useful as a research-based step-by-step tool for therapists, as part of the broader process of complete case formulation outlined by Goldman and Greenberg (2015) in their book on the topic. Thus, the main clinical implication is that this model offers clinicians a map specifically for understanding client emotion,

which can help therapists quickly orient themselves in session and over the course of treatment (Goldfried, 2010). This is one aspect (perhaps the most difficult) of the continuous process assessment associated with case formulation in EFT (Goldman & Greenberg, 2015). Thus, in the nonlinear and seemingly chaotic struggle of working through painful emotion, Figure 7.1 offers a process map for therapists to navigate their clients through what research suggests to be canonical patterns of emotional change, patterns that (so far) seem to be supported across experiential, psychodynamic, and dialectical behavior treatment approaches.

Of course, this is a map for following client emotion, and it does not prescribe specific interventions, which will vary from treatment to treatment and case to case. Even so, a process model that organizes and guides one's clinical observations to better discern "where is my client right now?" and "what emotional experiences should we be optimally working toward?" provides a valuable framework for facilitating emotional transformation. So, whereas the current model maps out client process from the perspective of emotion, a complete approach to case formulation should also connect the map both to a client's target concerns and personal narrative and to specific interventions for therapists to use in facilitating clients through this process (see Goldman & Greenberg, 2015). Even so, using this model as part of the clinical tools for conceptualizing the process paths of clients has been explored in several books on EFT (see Goldman & Greenberg, 2015; Paivio & Pascual-Leone, 2010; Timulak, 2015) and has been applied to therapy using other treatment approaches (Pascual-Leone & Kramer, 2017).

CONCLUSION

Client emotional processing represents an important puzzle in understanding human change processes and the role of psychotherapy in

facilitating that change. However, simply put, some episodes of emotional activation are productive, whereas others are not. In this chapter, we reviewed a collective program of work that represents a frontier for the future development of EFT. First, the notion that sequences of emotions that change emotions, operationalized by Pascual-Leone and Greenberg's (2007) model, can now be spelled out by identifying specific emotions in a model with objective criteria: highlighting global distress and rejecting anger as secondary emotion; citing shame and fear as the most predominant forms of maladaptive emotion; and identifying assertive anger, grief, and self-compassion as the most common and central forms of primary adaptive emotion. Second, studies on the kind of therapist interventions that create in-session effects have shown that empathic understanding, process directivity, and a focus on both emotion and unmet needs have medium to large effects in predicting the subsequent emergence of productive emotional experiences. Third, a range of empirical research on EFT, among other treatments, has shown that the model positively relates to clinical outcomes in both the short term (i.e., session outcomes) and the long term (i.e., posttreatment symptom outcomes). Finally, we have underscored the promising future direction of this model as a process map of client emotion, which therapists can use as a tool when developing clinical case formulations.

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[2]The authors verify that they have concealed client identity by disguising details of the cases or by combining details from multiple cases.

8
RELATING PROCESS TO OUTCOME IN EMOTION-FOCUSED THERAPY

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Before and since Greenberg published his 1986 article on change process research, process researchers have focused on explicating the processes of change that predict positive outcome in experiential psychotherapies such as emotion-focused therapy (EFT; Greenberg & Watson, 2006). Within that process research literature, EFT researchers in particular have been validating the emotion-focused theoretical model of change (Elliott, Watson, Goldman, & Greenberg, 2004). This research was largely in response to what Wampold (2001) articulated, that if a psychotherapy is to be truly validated, one must demonstrate that change processes assumed to be responsible for change actually occur in that therapy and can predict clients' improvement.

Many chapters in this volume (see Chapters 5, 6, 7, 9, and 11) address fundamental processes that psychotherapy researchers have been examining in relation to outcome in individual experiential therapies like EFT. In this chapter, we focus most closely on the process of experiencing as well as on

other processes that closely relate to or impact this variable. We compare and distinguish experiencing from other processes, such as other emotional processing concepts (e.g., emotional arousal, regulation). We also relate experiencing to empathy, the alliance, and perceptual processing, as well as to other client or therapist effects impacting experiencing–outcome relationships. Finally, we offer several implications of the research on experiencing for clinical practice.

THEORY OF EXPERIENCING

Experiencing is a psychotherapy process first introduced by Carl Rogers (1961). Later more fully articulated by Gendlin (1962), experiencing was eventually well operationalized by Klein, Mathieu-Coughlan, and Kiesler (1986) in the Experiencing (EXP) Scale. *To experience* means to have firsthand knowledge of states, situations, emotions, or sensations. In opposition to Platonic–Descartian views that propose perfect or objective ideas that can exist independent of the body, experiential approaches like EFT are influenced by phenomenological thinkers (i.e., Heidegger and Merleau-Ponty) who viewed experience as inextricably based on the embodied process of living (Lakoff & Johnson, 1999). Experiential therapies like EFT are grounded in these phenomenological and humanistic principles that emphasize human agency in the adaptive and dynamic construction of one's own reality. And from an experiential therapy perspective, this agency is best facilitated when individuals have aware access to their subjective embodied information—their fundamental lived data of in-the-moment phenomenal experience.

Several literatures (infancy, neuroscience, philosophy) support the importance of embodied experience in forming the coherent sense of self so important to our well-being (Damasio, 1999; Stern, 2005). We now know that our earliest development of a coherent self does not necessarily require

conceptual cognitive capacities, or even memory (Neisser, 1988). Rather, it requires only here-and-now innate processes, such as movement, perception, and emotional experiences. Experiential therapies like EFT therefore emphasize focusing on facilitating clients' experiential process to promote self-change and well-being. This includes helping clients to be better aware of experience (sensations, perceptions, feelings), to find symbols to represent experience in consciousness, to reflect on and make meaning of experience, and to use new experience as information to solve problems and to live genuinely and adaptively.

TESTING FUNDAMENTAL ASSUMPTIONS RELATED TO EXPERIENCING IN EMOTION-FOCUSED THERAPY

Experiential therapies like EFT assume that psychopathologies are emergent sequelae of clients' emotional processing difficulties. Readers can refer to a chapter on experiential therapy for descriptions of these problems (Elliott et al., 2004). Poor access to one's experience is one such identified emotional processing difficulty. For Rogers (1961), optimal experiencing was considered ideal in-therapy behavior (Kiesler, 1973; Klein et al., 1986), and he also defined a fully functioning person as someone who could dynamically integrate affective and rational aspects of experience and use this integrated experiential complex as an "online" source of information to inform present behavior (Gendlin, 1962; Gendlin & Zimring, 1955; Rogers, 1958). Conversely, limited experiencing was assumed to maladaptively contribute to pathology (Kiesler, 1973; Klein et al., 1986) because a limited experiencer avoids experiencing ongoing internal events (feelings and conflicts); expresses experience impersonally, generally, and abstractly; and relates to his or her environment using ideas of self rather than in-the-moment experience. Thus, optimal experiencing was considered the goal of therapy (Kiesler, 1973; Klein et al., 1986).

Whereas Rogers and Gendlin defined experience globally as anything potentially available to consciousness, from an EFT perspective the goal of good experiencing is to have good awareness of, good regulated contact with, and the capacity to reflect and make meaning of one's emotional material in particular. Deepening experience during emotional narratives has therefore been suggested as one change goal of experiential therapies, and measuring clients' capacity to process emotions using the Experiencing Scale (Klein et al., 1986) has been suggested as a potentially good way to measure emotional processing (Goldman, Greenberg, & Pos, 2005; Pos, Greenberg, Goldman, & Korman, 2003).

To demonstrate experiencing as a change process, however, a long-standing argument related to client experiencing had first to be resolved. Some (e.g., Orlinsky & Howard, 1978) argued that experiencing was not an improvable skill but an immutable trait. So to show that experiential therapies helped clients process their feelings, it first had to be demonstrated that emotional experiencing deepened during experiential therapy, not because this therapy attracted clients with this experiencing trait, but because treatment helped deepen emotional experiencing.

Studies by Pos et al. (2003) and Goldman et al. (2005) demonstrated this using the Experiencing Scale (Klein et al., 1986). Because the EXP Scale is a venerable measure of the experiencing process, we describe it more fully here. Low EXP levels mark limited experiencing, whereas high EXP levels mark optimal experiencing. The EXP Scale is a 7-point ordinal rating scheme that has been used to explore the importance of experiencing across different therapies and populations (see Hendricks, 2002, for a review). At Level 1 EXP, clients' narratives have an objective and intellectual quality, and clients give no evidence of the personal significance of the events they describe. A client who intellectualizes may use this type of narrative. At Level 2 EXP, clients give nonverbal or behavioral evidence of personal involvement in their external emotion narratives but do not use

emotion vocabulary or refer to their internal states. For example, a client at this level may say, “He entered the room, and I ran out.” At Level 3 EXP, external events remain clients’ primary focus, but personal reactions now begin to appear in language; for example, “He entered the room, and I felt trapped, so I escaped.” At Level 4 EXP, clients show an optimal shift inward with references to their internal world, feelings, and associations to events—for example, “I just died inside when he entered the room. I would have sunk into the floor and disappeared if I could.” Clients speak from direct contact (Perls, Hefferline, & Goodman, 1951) with their experience, as opposed to about it. At Level 5 EXP, clients pose and explore questions about the meaning of their felt reactions—for example, “Why does he still haunt me? Maybe he reminds me of my ex-partner.” At Level 6 EXP, clients express felt shifts that mark altered experiences—for example, “He used to really bug me, and this time, nothing.” Finally, at Level 7 EXP, shifts that have occurred in one domain of personal experience fluidly broaden to impact a wider range of personal experiences—for example, “Even right now as I tell you this, I can feel how different it is, and it was like that with my boss this morning, too, and even my brother last night.”

Pos et al. (2003) showed that increases in EXP during clients’ emotion narratives (“emotion episodes”; Korman, 1998) across 34 short-term experiential therapies for depression (EFT and client centered) better predicted outcome than clients’ pretherapy disposition to emotional processing and experience at therapy onset. Goldman and colleagues (2005) also showed that increased EXP related to core themes of treatment across therapy predicted good outcomes, and more powerfully than the working alliance. Pos, Greenberg, and Warwar (2009) then further strengthened the evidence by showing that for 74 depressed clients, increased emotional processing by midtherapy (on average around Session 8) predicted improvement in depressive symptoms at termination. In fact, EXP during working-phase emotional narratives of therapy is the most robust EXP

measure yet found to predict final outcomes in experiential therapy for depression.

Not only do increases in average EXP predict clients' improvement after experiential treatments like EFT, but particular levels of EXP also appear to be markers of good process and outcome. For example, achieving Level 4 or 5 EXP relates to good outcomes, as does Level 6 EXP (Goldman, 1997; Pos, 2006; Wong, 2016). Further, the proportion of Level 6 EXP some clients show at midtherapy best predicts their resilience 18 months after experiential therapy for depression (Pos & Wong, 2016; Rinaldi, 2015). Maybe Level 6 and Level 7 EXP are markers of the emotional transformation (Teasdale, 1999) that EFT strives to achieve.

Experiencing and Emotional Arousal

The process of emotional processing measured as experiencing during emotion narratives has also been related to emotional arousal. EFT theory assumes that because emotions function automatically and implicitly, they must be aroused in therapy to be salient enough to be adequately processed in awareness. Therefore, arousal and experiencing in therapy should be related; the Yerkes–Dodson law (Broadhurst, 1957) suggests that arousal that is too low (disengaged lack of affect or overintellectualizing) or too high (underregulated affect interfering with meaning making) does not relate to good performance. An important clinical issue related to arousal is when it is productive (see Chapter 9, this volume; Carryer & Greenberg, 2010). Pos, Paolone, Smith, and Warwar (2017) recently showed that for 32 depressed clients, expressed emotional arousal measured with the Client Emotional Arousal Scale III—Revised (CEAS–III–R; Warwar & Greenberg, 1999) was not directly important to outcome but was indirectly important because it led to deeper experiencing (arousal was almost perfectly mediated by experiencing). Thus, it appears that emotional arousal does the job of increasing the experiential signal so that deeper emotional

processing or experiencing will occur. Therefore, productive moderate arousal, not arousal in general, may be what really counts in promoting experiencing and good outcomes (Carryer & Greenberg, 2010; Greenberg, Auszra, & Herrmann, 2007).

Experiencing and Emotion Regulation

The above discussion points to another important process goal of EFT treatment—helping clients regulate distressed affect (Pos & Greenberg, 2007). As clients approach their feelings, they must tolerate and regulate them before they can adaptively transform them. Several studies suggest that a reciprocal relationship between experiencing and emotion regulation may be present. Two studies examined emotion regulation and experiencing for 66 clients who received either short-term EFT or cognitive–behavioral therapy (CBT; Prosser, 2007; Watson, McMullen, Prosser, & Bedard, 2011). Emotion regulation was measured using a new measure called the Observer Measure of Affect Regulation (O-MAR; Watson & Prosser, 2004) that measures clients' affect regulation using five subscales that capture emotional awareness, how modulated emotional expression is, and how well emotion is reflected upon. Because all of these processes best occur if emotion is well regulated, high O-MAR scores mark productively regulated emotion.

These researchers also compared whether the EXP Scale or O-MAR directly predicted outcomes for these clients. Watson and colleagues (2011) found that at midtherapy, clients' EXP was important to good outcome only if their emotions were regulated (EXP mediated by O-MAR), and Prosser (2007) found that late in therapy, clients reported the importance of therapist empathy only if their emotions were well regulated (empathy mediated by O-MAR). So the O-MAR points to the importance of well-regulated emotion to both productive emotional processing and experiencing empathy from the therapist. Interestingly, Pos et al. (2017)

found that emotional arousal measured by the CEAS–III–R was helpful only if it facilitated experiencing, whereas Malin and Pos (2015) found that early therapist-expressed empathy facilitated later client experiencing.

Combined, these studies suggest interrelationships among emotion regulation, experiencing, and therapist empathy. We feel this research reconfirms that emotional arousal helps only if it is well regulated, which the O-MAR does capture well. We also argue that when clients put feelings into words to make sense of them, their orientation to their internal world increases and their fear of experiences subsides (i.e., emotion regulation increases). Also, as therapists express empathy, clients feel they and their experiences are valued, which likely regulates feelings of fear, isolation, and potentially shame—for example, "I feel calmer because I know you understand me."

Experiencing and Emotion Schematic Change

In EFT, the brass ring of emotional processing is to change the pathogenic emotion schemes underlying clients' presenting problems—for example, transforming maladaptive shame into pride and self-confidence. In order to transform pathogenic emotion schemes across therapy, a necessary initial step is to first deepen clients' experience of activated maladaptive emotion schemes, related often to their chronic unmet needs. These schemes will eventually be later transformed by activating experiences of primary adaptive needs and emotions that can act as antidotes to maladaptive emotions. This reminds us of clinically useful emotion scheme distinctions, which, although well received now transtheoretically, were first introduced by EFT theory in the 1980s (adaptive, maladaptive, primary and secondary; see Greenberg & Safran, 1987). Desired emotion schematic changes suggested by EFT theory are as follows:

- helping clients decrease secondary or self-protective emotion scheme expression (e.g., helping a client not use puffed-up anger to avoid feeling hurt),
- leading clients to experience their core pain (maladaptive emotion schemes; e.g., helping a client experience core feelings of being unlovable),
- helping clients experience their unmet needs (e.g., a need for love), and
- leading clients to experience helpful primary adaptive emotions (e.g., expressing adaptive anger at a parent for not showing love they deserved and needed).

Although the EXP Scale measures a global tendency to attend to emotional information, it does not measure the expression of particular emotion schematic content, such as whether a client is expressing adaptive, maladaptive, or secondary emotions. Therefore, change in activated emotion scheme types is not captured by the EXP Scale. For this reason, two studies examined the relative importance to outcome of either EXP levels or expression of particular emotion scheme change across therapy measured with the Classification of Affective-Meaning States (CAMS; Pascual-Leone & Greenberg, 2005; see also Chapter 7, this volume). In one study, the extent to which self-critical depressed clients expressed experiences of primary adaptive, maladaptive, and secondary emotion was examined. Increased expressions and experience of primary adaptive emotion and less expression or experience of secondary emotion did predict good outcomes, as assumed in EFT theory (Choi, Pos, & Magnusson, 2016). Sequencing from secondary to primary adaptive emotions predicted outcomes as well, again validating the importance of particular emotional sequences suggested by EFT intervention models (Elliott et al., 2004). And because depressive relapse is so prevalent (Burcusa & Iacono, 2007), in a more recent study we asked whether CAMS versus EXP codes during

emotion episodes in the working phase of therapy best predicted outcome at follow-up 18 months posttherapy (Pos & Wong, 2016; Wong, 2016). For clients entering therapy externally focused and with little emotion vocabulary, decreasing secondary emotion and increasing adaptive emotion measured using the CAMS predicted their long-term resilience. In contrast, for clients who entered therapy internally focused and who likely sought change in painful emotions, Level 6 EXP best predicted their resilient long-term outcomes. This suggests that Level 6 EXP, itself, is also a potential measure of emotion scheme change.

Experiencing, Empathy, and the Alliance

Another assumption in experiential therapies like EFT is that if therapists provide a strong, genuine, empathic relationship, clients will turn their attention away from relationship concerns and toward the task of experiencing and processing their feelings. This assumption has been validated by process researchers as well. First, Pos et al. (2009) showed that working- and termination-phase alliances predicted outcome only indirectly by supporting increases in average EXP that followed. Further, Goldman et al. (2005) showed that increases in theme-related EXP across therapy predicted outcome better than the early working alliance. Also, first-session observer ratings of therapist-expressed empathy not only predicted the alliance reported after that first session but also predicted EXP during emotion episodes in working-phase sessions (on average 8 sessions later; Malin & Pos, 2015). So expressing empathy and having a strong alliance together support emotional experiencing to predict good outcome in experiential treatments of depression like EFT.

Experiencing Measured as Perceptual Processing

Another measure of experiential processing is Toukmanian's Levels of Client Perceptual Processing (LCPP; Toukmanian, 1986, 1994). This measure is influenced by the constructivist focus (Schneider & Shiffrin, 1977) on how feelings are processed, as well as by cognitive science's views on automated processing (i.e., not involving conscious mental effort) versus controlled processing (i.e., slower reflective processing that allows broader, differentiated views of in-the-moment experience). Slower, reflective, controlled perceptual processing is believed to be necessary for ongoing perceptual development and change in one's internal schemes. The LCPP therefore emphasizes the positive role of controlled reflective processing in deepening experiencing.

Missirlian, Toukmanian, Warwar, and Greenberg (2005) used the LCPP to measure clients' perceptual processing during emotion narrative segments occurring in experiential treatments and showed the therapeutic benefit of attending to one's affective experience in a controlled and reflective manner. At mid- and late therapy, the LCPP significantly and positively predicted client improvement. The LCPP also distinguished resolution from nonresolution in gestalt two-chair interventions in a small sample (Toukmanian & Dunbar, 1991). Pointing to the importance of integrating conscious reflection into experience, the LCPP may therefore be an alternative measure of Level 5 EXP. So the LCPP provides another means of capturing clients' experiential process.

Experiencing and Narrative Process Change

Emotional experiencing unfolds moment to moment within the context of personal narratives (Angus & Greenberg, 2011). It follows, then, that narrative and EXP processes must also be related. The Narrative-Emotion Process Coding System (NEPCS; Angus Narrative-Emotion Marker Lab, 2015) is a relatively new behavioral coding system (Boritz, Bryntwick, Angus, Greenberg, & Constantino, 2014) that articulates emotion and

narrative process markers of clients' emotional change (see Chapter 11, this volume, for a complete description of the NEPCS).

Using the NEPCS, Boritz et al. (2014) found that recovered depressed clients during experiential treatment displayed more "discovery story" narratives expressing access of new adaptive understandings of themselves, others, and their situation. These discovery stories suggest Level 6 EXP. Therefore, in a session, high proportions of narrative change markers would likely correlate with the proportion of Level 6 EXP. This has not been examined to date. Because Goldman (1997), Pos (2006), and Wong (2016) all found Level 6 EXP during emotion narratives to be a significant predictor of termination and follow-up outcomes, relating Level 6 EXP to NEPCS change narratives might clarify both as emotional change markers. Conversely, nonrecovered clients appeared to express more midtherapy problem markers (over- or underregulated abstract, empty, same old, or unstoried emotions). Problem markers suggest many possible EXP levels (1, 2, 3, or 4). One might reasonably argue that NEPCS problem markers would be less likely to be statistically associated with EXP. This also is yet to be investigated. Research using an older narrative coding system (Narrative Processes Coding System; Angus, Hardtke, & Levitt, 1996) hinted this. Higher proportions of autobiographical memory were not found to relate to EXP in depressed clients (Hilborn, 2014). It appears, then, that the manner of telling emotional stories is what may mark optimal emotional experiencing.

Client and Therapist Variables That Impact Experiencing

One interesting outcome from Pos (2006) related to client factors. When clients entered therapy low in EXP, the effect on good outcome of increasing average EXP was twice as large as for clients who entered therapy higher in EXP. Following this, Wong (2016) explored for which clients generally increasing average experiencing (measured by EXP) might

best predict outcome. It was assumed that clients who are generally emotionally distant from experience when they enter therapy may be most helped by generally deepening access to their feelings in therapy (EXP increases). Alternatively, transforming emotion scheme types (measured by the CAMS) might better predict outcome for clients struggling less with being distant from feeling and more with problematic maladaptive emotions such as shame or fear. In fact, Wong found that deepening EXP during the working phase of therapy did predict reductions in depression for emotionally distant clients and not for emotionally less distant clients, but only when considered alone (i.e., without CAMS codes being concurrently considered).

When the CAMS measure of emotion scheme types was concurrently considered in the working phase, more expression of secondary emotion best predicted maintained depression even for emotionally distant clients (Wong, 2016). More access to primary adaptive emotions best predicted reductions in depression for these experientially distant clients as well. This showed that although the Experiencing Scale does capture important emotional processing dimensions, it does not capture some emotion schematic changes that the CAMS measure does capture. We would argue that CAMS measures of secondary emotion capture experiential avoidance that is a powerful predictor of poorer outcomes. Because the CAMS categories of rejecting anger and general distress are combined to measure secondary emotion, these emotion states may be more useful to attune to than Level 2 EXP, which also captures avoidance somewhat.

Other early client influences on later EXP are also suggested. For example, when clients start experiential therapy with difficulties in the early alliance, those with higher early EXP (in Session 2) are those who recover from that early alliance trouble (Wong, 2013). Clients' early capacities to regulate feelings as measured by early affect regulation (measured with the O-MAR) also have predicted early- and midtherapy EXP. Therefore, EXP

may identify clients with early emotional processing advantages during experiential therapies.

The language therapists use also influences clients' EXP processes because the way people symbolize experience in language impacts the experiences they have (Kiesler, 1973). That is why therapists make linguistic distinctions when rating using the EXP Scale. A study by Adams (2010) showed, for example, that the degree to which therapists' empathy articulated clients' internal experience (Level 4 EXP) predicted clients' subsequent level of experiencing during experiential therapies. Clients often express their experience in external terms using language that would be rated at Level 3 or lower on the EXP Scale. If a therapist instead empathically reflects the client's internal experience at Level 4 language or higher, this would increase the likelihood of the client shifting from external to internal referents. Clients are therefore likely to follow their therapist in turning inward. And this inward turn has been found to be associated with significantly greater client improvement (Adams, 2010; Goldman, 1997; Pos, 2006).

Pointing to the possibility of an interaction between client and therapist factors, Wong (2013) found that clients who had Session 1 alliance difficulties, but who eventually had good outcomes, expressed higher early-therapy EXP. Confounded with this, however, they also had therapists who had expressed more evocative empathy in Session 1. It is hard to say whether the therapist empathy in Session 1 evoked their clients' experiential tendencies or whether the clients themselves evoked empathy from their therapist because in Session 1 they already were expressing these experiential propensities. Angus and Kagan (2007) contended that when a client provides evocative and descriptive narratives of his or her experiences, the therapist has greater opportunities to empathically resonate with and attune to the client's feeling state. This suggests that therapist empathy likely interacts with EXP, which has yet to be established. Future

research must clarify what therapist interventions help increase client experiencing. Perhaps therapists with more facilitative interpersonal styles (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009) help clients access their experiences better.

CLINICAL APPLICATIONS

So what does the above review mean for clinical practice? Most generally, it offers some useful guidelines for therapists in optimizing clients' important experiential processes in experiential, and likely all, psychotherapies. The first ramification for clinical practice is the importance of being able to perceive and identify the client processes of emotional experiencing, arousal, and regulation, as well as the emotion schematic types clients are engaging in, in order to intervene effectively with clients. In a marker-driven psychotherapy, perceiving macro markers for interventions such as chair work is only one dimension of clinical concern. Micro markers of client process are also important for therapists to perceive.

Psychotherapy process literature offers therapists means for orienting to important client processes in therapy. And knowing process coding measures such as the EXP Scale or O-MAR helps therapists intervene to optimize client processes. This is consistent with Goldman and Greenberg's (2014) views that process diagnosis is very important in EFT case formulation, because facilitating clients' moment-by-moment experiential process is a constant EFT task and goal. Next, we discuss four process areas in clinical practice that are relevant to the process research reviewed: (a) using language effectively for experiential processing, (b) creating optimal conditions for emotion arousal and regulation, (c) working effectively with emotion typology, and (d) optimizing clients' reflection and narrative meaning construction.

The “Languaging” of Experience

One thing the Experiencing Scale has taught us is the importance of accessing the client’s internal world (Level 4 EXP). Empathy using experience-near language optimizes clients’ access to their internal experience. For Rice (1974), this meant therapists should use concrete, sensate, connotative, and autobiographical language. So when a client states, “My boyfriend sometimes treats me well and sometimes treats me badly,” the EFT therapist might reflect, “So when you wake up in the morning, you wonder, ‘Will I be loved today?’” as opposed to saying, “So he’s very inconsistent with his affection.” Although both may be accurate, the first reflection evokes and draws the client’s attention to a possible internal experience, whereas the second promotes an external focus on the behavior of the boyfriend. Using “I” language can also effectively guide experience internally.

What emotion therapists choose to reflect using empathic reflection is also important. We know from process research that core primary emotions, whether adaptive or maladaptive (pain), are more useful to reflect than secondary anger or hopelessness. So if clients indicate nonverbally that they are upset, a therapist’s responding “That must hurt and leave you feeling lonely” (reflecting deeper pain) will help clients’ experiential process more than responding “He can’t seem to love you steadily,” a reflection likely to evoke unhelpful secondary critical anger.

Optimal Conditions for Emotional Arousal and Regulation

Emotional arousal is helpful when it leads to better emotional processing through contacting experience, but only if arousal is modulated enough to allow clients to reflect on their experience. Inadequately aroused clients cannot identify what they feel or experience. But when too aroused, clients cannot adequately reflect on experience (Carryer & Greenberg,

2010; Greenberg et al., 2007). Process scales describing arousal and regulation markers (EXP Scale or O-MAR) help therapists identify productive levels of arousal, as well as markers of when clients' emotional experience may benefit from regulation. Also, in the literature concerning using EFT with clients with personality disorders and other distressed clients with difficulties with emotion regulation (Pos, 2014; Pos & Greenberg, 2012; see also Chapter 17, this volume), strategies for "safe" emotional arousal have been identified. For example, using psychoeducation, matter-of-fact tones of voice, and humor and tweaking chair work may all be helpful in this regard.

Do not forget that EFT therapists also use genuine empathic and accepting relationship skills to meet clients' unmet needs for safety, acceptance, and contact. This, too, can emotionally regulate clients' fear, shame, and loneliness—for example, "It's so painful to be alone, and for so long. I'm so glad to be here to help you now." This understanding of the importance of balancing emotion arousal and regulation has facilitated EFT being more broadly applied to more distressed populations (e.g., complex trauma, Paivio & Pascual-Leone, 2010; personality disorders, Pos, 2014; Pos & Greenberg, 2012; eating disorders, Dolhanty & Greenberg, 2009).

Effective Work With Emotion Typology

EFT theory has long espoused therapists being able to identify the emotion type clients are engaging in in the moment, as each emotion scheme type calls for a different means of intervention (Greenberg & Watson, 2006). Because of this, emotion scheme types are themselves micro markers for appropriate and differentiated intervention. Adaptive emotions are supported and expressed, whereas protective or interrupting secondary emotions are viewed as blocks to primary feelings that should be worked through or passed. Maladaptive emotion calls for transformation to adaptive feelings, often by accessing valid but yet unmet needs.

The core difference between EFT and cognitive–behavioral approaches is that EFT does not view reason or logical argument as the best means for emotional transformation. Activating, experiencing, and expressing primary adaptive emotion and needs connected to adaptive emotions are considered a more productive means for changing problematic emotion states. So emotional change is presumed to arrive through clients newly experiencing and expressing adaptive emotions. Problematic older emotions related to painful life stories are transformed as new, adaptive emotional events become consolidated in memory with older problematic memories. Reconsolidated memories are newly altered by these adaptive emotional experiences in therapy—for example, "So now you can remember how good it feels to fight back, rather than using all your energy on reacting to the critical script you hear in your head." The emotional reconsolidation literature validates this EFT view of change (Dudai, 2004; Lane, Ryan, Nadel, & Greenberg, 2015).

Experiencing can aid effective processing of these emotion scheme types. First, because the function of secondary emotion is to obscure deeper uncomfortable emotion, deepening experiencing of secondary emotion is not considered the best strategy. Often a more helpful harvest from experiencing secondary emotion is in discovering the cognitions that motivate experiential avoidance of deeper pain. So in general, instead of deeply experiencing any secondary emotion, therapists instead can use empathic redirection (Greenberg & Elliott, 1997) to point to underlying primary feelings. In this intervention, the therapist validates the secondary emotion but then redirects the client's attention to deeper needs and feelings—for example, "I hear that feeling helpless is scary, but deep helpless feelings are there."

Goldman and Greenberg (2014) wrote that it is important for therapists to follow a "pain compass"—to listen for clients' core pain that often is their primary maladaptive emotion legacy of early painful experiences.

These emotions are intensely uncomfortable or are experienced as confusing overreactions in the present. When clients experience primary maladaptive emotions as confusing or mysterious, the emotions have likely been activated outside of awareness. In EFT, this is termed a *problematic reaction point*, and a therapeutic form of intervention is called *systematic evocative unfolding* (SEU; see Elliott et al., 2004). In SEU therapist and client experience the "meaning bridge" (Watson, 1996) that makes sense of a current painful emotion in terms of past situations. The client can then orient to how present moments have linked to painful historical events. In CBT language, using SEU may provide clients with a deeper understanding of an emotional stimulus or trigger.

Often, activated maladaptive emotion marks coactivation of painful memories of early existential fears and shame. EFT therapists must help clients both experience and express this core distress before emotional transformation occurs. This is because, as Greenberg (2002) noted, only if "one arrives at a place can one leave it": Only through reexperiencing and reprocessing core maladaptive emotions can they be transformed. During this transformation, therapists help clients experience unmet needs that leave them vulnerable to reexperiences of these core primary maladaptive emotions. Once therapists validate clients' right to have these needs met, new experiences of primary adaptive sadness and anger at not having needs met can provide the emotional antidote that transforms these problematic states. For example, when a therapist supports a client in realizing that a child's need for love is valid, the client may find it easier to be adaptively angry at another for not having provided that love.

Another important way that experience transforms primary maladaptive emotion is by the therapist providing clients with corrective emotional experiences (Alexander & French, 1946). By the therapist providing empathy, genuineness, and unconditional positive regard, clients

experience having met their needs for support, connection, and unconditional regard.

Eliciting and activating the experience of primary adaptive emotion constitute a core emotional change process in EFT. Process research has shown that if therapists help clients experience their internal world, clients are more likely to access the adaptive emotions that help them improve during experiential therapies like EFT (Choi et al., 2016; Greenberg, 2002; Wong, 2016). To do this, therapists must have strong emotion knowledge of universal situation–emotion links and the related needs and concerns connected to all emotions. When therapists help and support clients' experience of their valid needs, these experiences lead clients to also experience emerging primary adaptive anger that can support clients' requests for these needs being met. Alternatively, clients may access primary adaptive sadness at the loss they experienced as a result of needs not being met in the past. We have found that experiences expressed in therapy of either adaptive hurt and grief or adaptive anger help clients resolve their depression (Choi et al., 2016).

Optimal Reflection and Narrative Meaning Construction

The manner in which people symbolize (usually in language) our implicit experiences impacts our conscious experience of ourselves. We use reflective thought and narrative processes when we symbolize experience in awareness, and as we do this, a dialectical dialogue constantly occurs between our implicit experiences (sensory, perceptual, neurophysiological, memory) and our reflective processes that are interpreting, explaining, and constructing conscious meaning from those experiences. From an EFT perspective, therefore, we engage in a continuous construction of identity in narrative form. And, as Kiesler (1973) reminded us, how we articulate and give meaning to our experiences continuously impacts the subsequent experiences we have. Thus, meaning making, reflection, and narrative

processes are both causes and products of our experience and identities. Narrative and experience are therefore inseparably linked. Perhaps this is why many process markers of EXP levels are in fact narrative or language markers. For clinical purposes, this means that understanding narrative themes and narrative processes is important because, one can argue, these are valid markers of the depth of experiencing. In-depth experiencing means in-depth narratives. Chapter 11 in this volume further explores and highlights the interwoven relationship of narrative and experience during therapy.

Finally, note that EFT therapists distinguish cognition from meaning making as related but not identical concepts. Meaning making implies more than rational processes, and we agree with Damasio (1994) that emotion and reason are most accurately conceptualized as inseparable phenomena. *Meaning making* is the term EFT therapists use to communicate this experiential blend of affect and cognition. And within the CBT world, Teasdale (1999) distinguished propositional meaning (logic) versus implicational meaning (integrated cognition and affect), suggesting that change in implicational meaning is what helps good outcomes in psychotherapy to occur.

CONCLUSION: HAS EFT THEORY BEEN INFLUENCED BY PROCESS RESEARCH ON EXPERIENCING?

In closing, let us reiterate how experiential and narrative process research, general emotion research, and application of EFT to newer, more difficult populations such as clients with trauma, personality disorders, and eating disorders, continue to inform EFT theory and practice to yield rich findings that can advance our knowledge of how to help people through psychotherapy. For the most part, research has provided strong validation of EFT concepts and premises, just as Wampold (2001) suggested it should.

This has made the EFT community more confident of the validity of its tenets and practices. Still, as an integrative treatment with a long tradition of self-realization, narrative construction, growth, and change, EFT will continue to both produce and make use of research on processes in psychotherapy as EFT continues to facilitate a dialectic of mutual influence between theory and practice.

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9
FACILITATING OPTIMAL EMOTIONAL PROCESSING

IMKE R. HERRMANN AND LARS AUSZRA

Emotion-focused therapists follow their clients' in-session process in a moment-by-moment fashion. Certain key questions are constantly in the back of our minds, asking us to look closely at the process, at how people are doing what they do. For example,

- Is the client just talking about her or his feelings or experiencing what he or she is talking about?
- Will experiencing or expressing more of this type of emotion be helpful or not?
- Will the way the client expresses and experiences this emotion help him or her to take a productive next step? In other words: Is this emotional expression a sign of distress or a sign of working through of that distress (Kennedy-Moore & Watson, 1999)?
- And what could I do to help the client experience his or her emotions in a more therapeutically helpful way?

It is the answers to these questions that guide our next response to the client. Just like paddling on a wild river, what we see, hear, and feel helps us navigate the flow of emotion process. Helping therapists find answers to these questions, and making them better navigators of the client's emotional processing process, is the focus of this chapter.

EMOTIONAL PROCESSING IN EMOTION-FOCUSED THERAPY

There is a vast and growing body of research aiming to elucidate the nature of effective client emotional processing within therapy. Various clinical theories about emotional processing have been posited (Baker, 2007; Foa & Kozak, 1986; Fosha, 2002; Greenberg, 2015; Greenberg & Safran, 1984, 1987; McCullough, 2003; Rachman, 1980; Teasdale, 1999). Emotional processing is used as a theoretical construct across therapeutic orientations aiming at specifying what emotional experiences and ways of dealing with them in therapy promote positive change. As outlined in previous chapters, change, in emotion-focused therapy (EFT), is hypothesized to occur by helping clients move from secondary symptomatic emotion (e.g., hopelessness) to primary maladaptive emotion (e.g., shame, fear) and by deepening the primary maladaptive emotion to get to the associated unmet need, thereby generating more adaptive primary emotions (e.g., anger, sadness; three-step sequence; Greenberg, 2015; Greenberg & Paivio, 1997). Deepening of experience here is thus a twofold concept: (a) deepening as an in-session movement from secondary to primary emotional experiences and (b) deepening as a process that involves a focus on bodily experience and creation of new meaning.

In trying to help therapists identify and promote productive emotional processing, it thus seems useful to divide the concept into three dimensions, namely emotion activation, emotion type, and manner of emotional

experience. In this vein, we discuss both what research has told us about each dimension and how to engender such processes in therapy.

Research on emotional activation has shown that it seems to be a necessary but not a sufficient condition for change, and whether it is beneficial in the therapy process or not seems to depend on a multitude of factors (Greenberg & Pascual-Leone, 2006; Kennedy-Moore & Watson, 1999; Whelton, 2004; Wiser & Arnow, 2001). There is evidence that emotional activation in emotionally meaningful contexts combined with some form of meaning making seems to be facilitative of positive change and symptom reduction (e.g., Auszra, Greenberg, & Herrmann, 2013; Goldman, Greenberg, & Pos, 2005; Herrmann, Greenberg, & Auszra, 2016; Missirlian, Toukmanian, Warwar, & Greenberg, 2005; Myers Virtue et al., 2015; Warwar, 2005; Warwar & Greenberg, 2000). This suggests that clinicians should focus on facilitating moderate levels of emotional arousal in their clients, helping them to engage in a continuous cycle of contacting, expressing, and making meaning of their emotional experience.

Knowing which type of emotional experience to promote, activate, and deepen and which to validate and yet bypass is one of the most fundamental concerns for the emotion-focused therapist. It has been shown that differentiating what types of emotions are being activated in the session is of relevance for successful therapy outcome (Herrmann, Greenberg, & Auszra, 2016; Pascual-Leone, 2009; Pascual-Leone & Greenberg, 2007). Pascual-Leone and Greenberg (2007) empirically supported the “the three-step model of emotional transformation in EFT” (p. 885) as described previously, using advanced cognitive-affective meaning states as defined by their measure, Classification of Affective-Meaning States (CAMS; Pascual-Leone & Greenberg, 2007; see also Chapter 7, this volume). To be able to categorize activated emotional expression independent of a meaning dimension, the authors developed a coding scheme, the Emotion Category Coding System (ECCS; Herrmann & Greenberg, 2007; Herrmann,

Greenberg, & Auszra, 2007). It allows for the reliable categorization of "pure" activated expressed emotions in the therapy hour into the categories primary adaptive or maladaptive, secondary or instrumental emotion, independent of emotion label (e.g., anger, fear, sadness, shame, and so on) and context.

Results of a study relating emotion types to outcome (Herrmann et al., 2016) on a sample of 30 clients receiving emotion-focused treatment for depression underlined the role of emotion types as process variables and targets of clinical intervention in contrast to individual tendencies or traits. Results stressed the importance of reducing secondary reactive, mostly symptomatic, emotionality during treatment. Moreover, it was shown that it seems significant for clients to experience their core painful primary maladaptive emotions at moderate levels, to work through them, and to access adaptive emotional resources. And the more frequently this is done, the better. Interestingly, results also showed that reducing secondary, symptomatic emotions is important, but only to the extent that the client succeeds in subsequently accessing primary adaptive emotionality. This supports the significant role of primary adaptive emotions in transforming primary maladaptive emotions. Clients who had the most success in therapy (upper 25%) showed an increase of 30% in the proportion of primary adaptive emotions over the course of therapy (Herrmann, 2012).

PRODUCTIVE EMOTIONAL PROCESSING

For many years the concept of depth of experiencing as measured with the Experiencing Scale (Klein, Mathieu-Coughlan, & Kiesler, 1986) has been regarded as a gold standard to measure emotional processing (for more information, see Chapter 8, this volume) and has served as an operational definition of emotional processing when applied to *emotion episodes* in several research projects within the EFT framework (see Chapter 8).

Although depth of experiencing proved to be very useful in operationalizing aspects of the EFT model of productive emotional processing, the distinction between different types of emotion is not captured by it, and it focuses solely on verbal expression not specifically activated emotion.

To more specifically depict productive emotional processing in a moment-to-moment fashion, Greenberg et al. (Auszra & Greenberg, 2007; Auszra et al., 2013; Greenberg, Auszra, & Herrmann, 2007) developed the Client Emotional Productivity Scale (CEPS). Based on EFT emotional processing theory and informed by a survey of experts in the field of working with emotion in therapy, as well as key findings from research on emotion processes in the study of therapeutic change, CEPS operationalizes therapeutically productive manner of processing of activated primary emotional experience in the therapy session. So far, two empirical studies have been conducted relating client emotional productivity (CEP) to therapy outcome and classical process variables such as client-expressed emotional arousal (EA; Warwar & Greenberg, 1999) and the working alliance (WAI; Horvath & Greenberg, 1989). In an intensive analysis of four good and four poor outcome cases, Greenberg et al. (2007) explored the relationship among CEP, client-expressed emotional arousal, and outcome in experiential therapy of depression. Findings showed that it seems to be the productivity of expressed emotion in general, as well as the productivity of more highly aroused emotion, rather than the frequency of highly aroused emotion alone that is crucial in facilitating therapeutic change. Auszra, Greenberg, and Herrmann (2013) replicated this study on a larger sample, investigating the importance of CEP, EA, and WAI and outcome in a sample of 74 clients who also received experiential treatment for depression. Results showed that CEP predicted a significant reduction of depressive and general symptoms over and above that predicted by beginning-phase CEP, the WAI, and working-phase EA. Working-phase CEP emerged as the sole, independent predictor of outcome for both

depressive and general symptoms. These results suggest that productive emotional processing goes beyond the mere activation and expression of emotional experience and that it is the ability to process activated primary emotional experience in a specific manner that is associated with psychotherapy success. It is “how” an activated primary emotion is experienced in therapy that makes a difference.

FACILITATING OPTIMAL EMOTIONAL PROCESSING

On the basis of the research discussed previously, it seems to be useful for clinical purposes to describe optimal emotional processing in EFT along three dimensions, namely *activation*, *emotion type*, and *manner of processing* as used in the client emotional productivity model (Auszra et al., 2013; Auszra, Herrmann, & Greenberg, 2016; Goldman & Greenberg, 2015). In the following paragraphs, these dimensions are outlined. First descriptions for each dimension are given to aid therapists in the identification of productive and nonproductive emotional processing in their clients, followed by directions as to how to tailor interventions in response to clients’ current emotional processing. We discuss how to promote deeper emotional processing in the client.

Activation

As outlined previously, for optimal emotional processing to occur, emotion schematic processes need to be activated, so that inherent information can be extracted, clients can be moved by adaptive action tendencies, and schemes are amenable to change when maladaptive. Activation implies that clients not simply talk *about* or intellectualize, but rather express emotion and speak *from* their activated emotional experience. This can be indicated by nonverbal emotional behavior such as expressive

and action tendencies like making a fist, shrugging, sighing deeply, crying, and so on, as well as emotional voice quality (see Vocal Quality Scale; Rice & Kerr, 1986). When no emotional behavior is present, a focused or contact voice quality (Rice & Kerr, 1986) and indicators that the client's focus is on symbolizing his or her subjective felt flow of experience as referent (Klein et al., 1986) are signs of emotion scheme activation.

Generally speaking, there are three steps in facilitating emotional activation in EFT (Greenberg, 2011). First, there is empathic responding based on the therapist's empathic attunement, offering reflections and guiding attention from this inner experience of attunement. Second, there is focusing on bodily felt experience (Gendlin, 1981, 1996). And third, there is the use of imagination or chair-work interventions, drawing on episodic memory. However, when clients are very blocked in accessing emotion, we need to review the relationship and ask ourselves as therapists, "What can I do, or stop doing, in order for the client to feel safer?"

Type

Research findings have shown it is useful to not treat all emotions the same, but to differentiate and intervene accordingly. In EFT, we differentiate primary adaptive, primary maladaptive, secondary, and instrumental emotions. On the basis of the definitions and descriptors given in the ECCS (Herrmann et al., 2007), each is briefly outlined here.

Secondary Emotions

A secondary emotion is not a person's first fundamental emotional response to an internal or external stimulus, but rather a secondary reactive response to a more primary emotion, which can be adaptive (e.g., anger at violation) or maladaptive (shame of being unlovable; Greenberg & Paivio, 1997). A secondary emotion is not associated with a primary need, and it

obscures the more primary experience. Secondary emotions are often part of the symptom the client suffers from (e.g., anxiety, depression, hopelessness, helplessness, irritability). There are two main classes of secondary emotions: (a) an emotion as a secondary response to another more primary emotion (e.g., feeling scared or ashamed but expressing anger; appears most often) or to thought (e.g., feeling anxious after excessive worrying) and (b) an emotion *about* another emotion (e.g., feeling guilty about feeling angry or feeling ashamed of one's fear).

Secondary emotions cover primary emotional experience (with no sequential ordering apparent to observer or client). When this is the case, there are several indicators that help us identify secondary emotions in contrast to primary emotional experience:

- The expressed emotion does not fit the implicit evaluation of the situation. For example, a client might at core feel ashamed or afraid in a situation but expresses anger, disgust or contempt. This will not help him respond adaptively to the situation and get the need met that is implicit in the primary emotion. This secondary anger usually has a strong external focus, uses you-language, often expresses a sequence of accusations, and/or uses swearing or name-calling (e.g., "rejecting anger"; see Pascual-Leone & Greenberg, 2007). It does not have the empowering, boundary-setting quality of primary adaptive anger, but rather comes from a stance of standing with one's back against the wall, lashing out at the other in pain. Accordingly, a client might feel violated, but expresses sadness or helplessness instead of anger.
- The emotional expression has a fused quality, when more than one emotion appears in a fused manner, creating a qualitatively new emotional state and obscuring the more primary underlying (adaptive or maladaptive) emotion or emotions. Neither emotion is fully acknowledged and allowed separately; two action or

expressive tendencies are present, as in crying and angrily accusing at the same time often with a whining or complaining quality or when one emotion like sadness is fused with hopelessness, creating a sarcastic or resigned quality, often underlined by expressive tendencies like shrugging or shaking the head.

- The emotion is global, with no clear action tendency and/or fuzzy labels like *upset*, *bad*, *down*, *resigned*, or *frustrated*. It is not differentiated into more specific emotions like, for example, fear, shame, anger, and loneliness.
- The emotion is a reaction to thought (e.g., secondary fear/anxiety in anxiety disorders). The emotion-producing thought is part of the secondary processes (e.g., rumination, worry) that obscure one or more underlying primary emotions.
- Here are some examples for secondary emotional expressions: A client said with tears running down her face with a "whining" quality in her voice: "I can't take this anymore. I want this to change. I just want to feel good again!" Both a painful emotional quality as well as an angry/frustrated quality are present in a fused manner in the emotional expression. Also, when a client faced with a demeaning critical side said in a low voice: "I mean she's right . . . (shrugging her shoulders) . . . it's like 'what's the use' . . . I just want to lie down in bed and never get up again." This is considered to be secondary hopelessness or resignation. Another example of a secondary emotional expression: A client said to her mother in the empty chair with tears in her eyes, but a clear and agitated voice: "I just don't get you! It's always someone else's fault, it's never you! You never take responsibility for anything!" This anger expression would be considered secondary, as the focus of the anger is on accusing the other, and it is slightly fused

with pain/hurt as indicated by the tears. Emotional expressions that would be classified using CAMS as “global distress” by Pascual-Leone and Greenberg (2007) are also examples of secondary emotional experiences.

Primary Emotions

According to the EFT model, a *primary emotion* is a person’s first scheme-based emotional visceral response to a stimulus situation (Greenberg & Paivio, 1997). It orients the person to their environment.

Primary Maladaptive Emotions

Primary maladaptive emotions also are a person’s first automatic emotional response to a situation, but they are based on aversive learning experiences (Greenberg & Paivio, 1997), often due to failures early on in the dyadic regulation of affect (Schore, 2003; Stern, 1985) and do not prepare the individual for adaptive action in the present. They once represented an attempt at optimal adaptation to difficult circumstances, but as circumstances have changed, they are no longer adaptive. For example, experiences of separation from a partner and resulting feelings of abandonment might activate intense feelings of fear of “not being able to survive alone” developed from experiences of abandonment or loss in childhood. This fear in the abandoned child had an adaptive aspect and might have motivated the child to actively seek out supportive attachment relationships and triggered caretaking behavior in adults. However, it leads to current maladaptive behavior in the adult, as the core fear is no longer appropriate to the current situation, rather it is an obsolete response that has not changed despite changed circumstances. Maladaptive emotions are often described by the client as a “familiar, old feeling”; they tend to be chronic of nature and have thus become part of a person’s identity.

Although any emotion can be adaptive, maladaptive, secondary, or instrumental, it appears that fear of not being able to survive alone (being unprotected), fear of being disconnected from others, sadness of loneliness/isolation based on experiences of abandonment, and the shame of feeling unworthy are the most prevalent maladaptive emotions that arise in affective disorders (Greenberg & Paivio, 1997; Greenberg & Watson, 2006). For example, a client when faced with his own self-criticism sunk into his chair, eyes cast down, and said in a low and focused voice (Rice & Kerr, 1986), "I feel so like a nothing . . . so worthless . . . (starting to cry) . . . like a little boy sitting in the corner . . . naked, knowing that he is nothing . . ." This is an example of primary maladaptive shame. Another client said about her children growing up and leaving home ". . . It scares me so much . . . it's difficult to hold it together . . . I feel like a bath ball being thrown into a bathtub . . . dissolving . . . falling apart . . ." This is an example of primary maladaptive fear. Other primary maladaptive emotions appearing in therapy are deep helplessness resulting from experiences of abuse and hair trigger rage (Greenberg, 2011).

Primary Adaptive Emotions

Primary adaptive emotions can be defined as those automatic emotions in which the implicit evaluation, verbal or nonverbal emotional expression, action tendency, and degree of emotion regulation fit the stimulus situation and are appropriate for preparing the individual for adaptive action in the world, helping to get the person's needs met (Herrmann et al., 2007). Examples are sadness at loss that reaches out for comfort, fear at threat, anger at violation that is empowering or protecting, grief that lets go of what is irrevocably lost, or disgust at intrusion. Primary adaptive emotions strengthen attachment bonds, affirm the self, and facilitate coping with the situation (Greenberg & Paivio, 1997). When working with the representation of a degrading parent in empty-chair work, a client said in a

clear assertive voice: “I did not deserve to be treated like this! I was a good boy!”, accompanied by some small gestures of assertion like puffing up of chest. This would be seen as primary adaptive anger/assertion. Similarly, when a client who suffered sexual abuse as a child and never got support from his mother, who was most often away on business trips, accessed sadness about not having had a warm and safe childhood and started crying, this was considered an expression of primary adaptive sadness.

Instrumental Emotions

Last, instrumental emotions are learned expressive behaviors or experiences that are used to influence or manipulate others (Greenberg & Paivio, 1997). This process might be conscious or nonconscious. The emotion can be manipulative and/or have a secondary gain. Typical examples are the expression of anger to control or to dominate, or “crocodile tears” to evoke sympathy.

Deepening From Secondary to Primary Emotion

As has been discussed, it is vital to help clients move from the secondary emotions they often present with symptoms, to primary maladaptive, and finally to primary adaptive emotion in therapy. Many interventions have been developed to support this transformation process, and describing them is beyond the scope of this chapter. However, it is what therapists do in a moment-by-moment fashion that is core in facilitating transformation and productive process. Some ideas are given next.

To start with, secondary experience is real experience and needs to be validated before we can bypass it and invite our clients to go deeper. A core element in deepening experience is empathic exploration. We want to guide clients’ attention toward primary aspects of their experience that are as yet out of awareness or not yet fully formed in awareness. In this, we follow the “pain compass” (Goldman & Greenberg, 2015; Greenberg, 2015;

Greenberg & Watson, 2006) toward the most painful aspects of experience, toward the "core pain" (primary maladaptive emotion). Therapists will thus always reflect primary aspects of their clients' experience, and in their reflections, they will put more primary aspects of experience at the end of their reflection (e.g., "So there was a resigned feeling, but you also felt really hurt . . ."). They will also reflect the quality of the primary emotion in their own voice quality. Empathically conjecturing into primary aspects of experience can also shift clients' attention toward primary emotion, as in "I hear you saying 'Overall it wasn't so bad,' but I imagine you must have felt pretty alone . . . like nobody is there for you . . ." Sometimes it can even be helpful to explicitly ask the client if she or he feels another emotion underneath/apart from the secondary emotion that is being expressed.

When two primary emotions like sadness and anger are mixed, and the client thus gets stuck in secondary complaint, working to differentiate both emotions is vital. Sometimes it can be very difficult to deepen from secondary to primary emotion, for example, when clients are really stuck in secondary anger. Here it might be in place to actually point out to the client what is happening in the process (e.g., "You seem to be really stuck in the anger, and as we explored, it does not empower you, but rather leaves you feeling helpless and unable to move on") and explicitly saying that to find a solution, it is important to look "underneath" the anger toward the more vulnerable aspects of experience. And, of course, sometimes, when clients touch on primary experience (e.g., primary maladaptive pain or primary adaptive anger or sadness) and then quickly move back to secondary experience or no experience, bringing this process to awareness and working directly with the interruption can be necessary and helpful.

Arriving at Primary Experience

When clients arrive at their primary maladaptive experience, at their core pain, an important step in therapy has been accomplished. It is

important to communicate to the client, implicitly and explicitly, that “it is okay to be here,” that it is important to hear what this emotion has to say. It is vital to validate this experience in the sense of “given what you went through, no wonder you feel this way,” not trying to ‘make it good’ for the client, but to see him or her in his or her pain and make space for it. This is the place the client has to arrive at before he or she can leave it (Greenberg, 2015); metaphorically speaking, the client has to arrive at and explore the bottom of the lake, before he or she can come up again. Primary maladaptive emotions have to be processed in a mindfully aware manner as is described in the next sections.

Preparing for the Upcoming Primary Adaptive Emotion

Therapists always have open eyes and ears for aspects of primary adaptive emotional experience; this is particularly important once clients have arrived at their core maladaptive emotions. Therapists will pick up elements in content, voice, and body in the client’s expression that point toward more adaptive experience and shift the client’s attention accordingly. In this the therapist is like a gardener, waiting for and noticing the slightest hint of green coming from a seedling pushing upward, immediately giving it his or her attention, watering it to help it grow. When the therapist is empathically attuned to the client’s emotional experience, her or his focus and voice quality will automatically reflect aspects of the upcoming primary adaptive emotion, which helps the client allow and fully express the new experience, helping it grow stronger. When anger/assertion comes up, for example, the therapist’s voice might become louder and sharper—however, not too sharp, always just one small step ahead of the client. Similarly, when sadness comes up, the therapist’s voice might become softer, his or her pace slower, and so on. Therapist reactions facilitating elaboration and expression of primary emotions, such as “Can you speak from the tears?” and “Can you speak from the anger?” as well as

elaboration of needs connected to emotions like “What do/did you need?”, “What did you miss?” (in sadness), and “What do you want?” (in anger) can be very helpful. The overall goal is to support the client in organizing more resiliently and using the adaptive information and action tendencies inherent in primary emotional reactions.

Manner

This dimension is concerned with *how* clients deal with their activated primary emotions in a moment-by-moment fashion. It helps us answer the questions: Does my client experience a primary adaptive emotion in such a way that he can extract the useful information inherent in the emotion in the service of problem resolution (emotion utilization)? Or, is my client’s emotion being processed in such a way as to enhance transformation of primary maladaptive emotion toward more adaptive emotion (emotion transformation)? Generally speaking, is my client processing a primary emotion productively, namely in a *mindfully aware manner* from one moment to the next? Based on the CEP model (Auszra & Greenberg, 2007; Auszra et al., 2013; Greenberg et al., 2007), the following seven criteria have to be met: Clients have to attend to, symbolize, be congruent, accept, regulate, show agency, and differentiate their primary emotional experience (Auszra et al., 2013; Greenberg et al., 2007). An explanation of each category and related interventions to facilitate *the next step* (Greenberg, 2015) toward more productive processing can be found next. It goes without saying that what is required consistently from the therapist is attunement to affect and emotion-focused empathy.

Attending

When clients verbally symbolize or nonverbally express emotion (e.g., emotional behavior like sighing, clenching one’s fist, emotional voice or

tears), we assume that they attend to it, unless there are clear indicators that they don't: For example, although one client visibly expressed some form of anger (clenching his fist), he was not aware of what he was feeling (saying he felt nothing).

When clients do not attend to emotional experience, therapists empathically reflect the emotional expression to draw attention to it in a nonconfrontational way; for example, "There's a deep sigh . . ."; "You shrug. I am not sure exactly what that means"; "As you say that, I hear anger in your voice. Is that right?" At times, focusing interventions can be useful to promote attending to emotion.

Facilitating Attending to Blocks to Emotional Processing

Besides drawing attention to emotional responses, therapists might sometimes draw attention to processes that prevent attending to and processing of emotion. This might be the case when clients diminish, invalidate, shake off, talk away, or otherwise protect from their emotional experience, and empathy and empathic refocusing are not sufficient to establish a focus on and deepen primary emotion. Often, drawing attention to implicit process and making it explicit opens the possibility of exploring its origins or function and adapting the internal and external conditions in such a way that the emotion can be allowed and attended to fully. For example, the therapist might say,

> I am not sure whether I am right, but just now when you talked about your husband and how he is not there for you, I sensed that some sadness came up, and then it seems like you held your breath, and it was gone. Is that right? Can you do it again?

Client and therapist might then explore together what prevents the client from staying with the sadness. When fear of the emotion is preventing productive processing, the safety in the therapeutic relationship has to come into focus, and the therapist needs to help the client experience more control

over the process itself (e.g., by allowing the sadness a bit and then moving back out). In other cases, the client might need a better rationale for how "feeling bad leads to feeling good." Sometimes, however, the interruptive or protective process is more powerful or more automatic. In these cases, directly working with the interruption in a two-chair dialogue can be very helpful (e.g., "Come over here, tell him not to be sad." "Take away his sadness. How do you do this?").

Symbolization

Once an emotional reaction is attended to and felt in awareness, it has to be symbolized in words or some other fashion to be able to fully comprehend its meaning, use the informational value inherent in primary emotion, and reflect on it to create new meaning, which in turn helps people develop new narratives to explain their experience. Symbolization means that clients have to be engaged in a process of describing their experience in words or some other form. In contrast, a lack of symbolization occurs when a client attends to and acknowledges a nonverbal emotional expression (e.g., sigh, tears) but cannot identify its meaning. A client may, for example, shrug and say, "I have no idea what my tears are about."

Therapists serve as *surrogate information processors* (Greenberg, Rice, & Elliott, 1993) who continuously facilitate symbolization of emotional reactions by different empathic responses (see Chapter 5, this volume), using their corresponding inner felt flow of experience as a referent and source of possible symbols to offer to the client. For example, a client might say, "When I realized she had left the party and not even told me she was leaving, I felt so bad . . ." Therapist: ". . . so bad . . . somehow abandoned . . . ?" Client: "Yeah abandoned, I didn't know anyone . . . but also like I just wasn't important to her . . ." Therapist: ". . . like I wasn't important to her the way I wish to be . . . so sad . . ." (nod from the client). When clients are missing words for what they feel and fall silent, for

example, when crying, therapists try to “speak the unspoken” for them, offering words and talking into the silence (Gendlin, 1996), constantly checking for nonverbal expressions of agreement from the client to make sure they are on the right track.

Congruence

Therapists pay attention to emotion incongruence. The verbal symbolization and the nonverbally expressed emotion have to match. For example, smiling brightly while talking about feeling powerless and full of despair or expressing anger in a meek voice indicates incongruence and that the emotion is not fully allowed and experienced.

When therapists sense incongruence, they are drawn toward it and reflect it in a nonconfrontational way. Therapists are careful not to damage the therapeutic bond by being intrusive or by shaming the client. The skill lies in pointing out incongruities in a way that is validating and invites the client to allow emotional expression. Thus, when a client smiles while talking about a deep loss, the therapist might say something along the lines of “. . . and you are smiling while you talk about this . . . and really it is so sad . . .” If the incongruence remains, the therapist invites the client to become curious and explore the genesis and meaning of the incongruence.

When primary adaptive emotions start to form in chair work (e.g., assertive anger against an abusive father) but are expressed incongruently (e.g., client smiles while asserting himself), therapists can suggest the congruent expression as an experiment, as in “Can you say that again without smiling: ‘You had no right to treat me like that!’?” If this is in the proximal zone of development of the client, expressing it will help the anger/assertion grow stronger. If it’s not, obstacles can be explored and worked with (e.g., “I can’t say it like that, it makes me feel guilty”).

When clients are highly vulnerable and/or insecure or self-conscious, and masking their vulnerable feelings is the only way they can handle it, it

is not indicated to reflect an incongruence to the client.

Acceptance

Acceptance refers to the stance clients take toward their emotional experience. This involves accepting both the emotion and themselves for having the emotion. Therapists have to pay attention to signals that point to nonacceptance of emotional experience, which can be indicated by clear signs of discomfort when confronted with feelings (e.g., moving nervously in the chair, squeezing back tears, moving to a more rational or conversational level of discussion). Lack of acceptance can also be indicated by clients negatively evaluating the feeling (e.g., “What’s the use of getting angry?”) or themselves for having the feeling (e.g., “Fear just makes me feel weak, and I don’t want to feel this way”).

Acceptance of painful, dreaded, “forbidden” or shameful emotional experience is generally facilitated by a safe, validating, understanding therapeutic relationship. In addition, it might also be useful to empathically explore beliefs about and to identify the negative “voices” associated with the nonacceptance of certain feelings (e.g., “Feeling like this is a sign of weakness and you cannot be weak”). It can be helpful to validate the clients’ struggle to accept vulnerable feelings (“No wonder you are struggling with that, given that your father always told you real men don’t cry”). It is important for therapists to acknowledge and validate the fear or nonacceptance of the emotion and then to focus back on the feared emotion.

Regulation

The level of emotional arousal in the client needs to be such that he or she is able to develop and maintain a working distance from the emotion (Gendlin, 1996), so that he or she can cognitively orient toward emotion as information, thus allowing for an integration of cognition and affect. Unrestricted arousal of specific emotions can be a highly therapeutic

experience. However, intense emotional activation is a disruptive negative experience when the client feels like he or she is falling apart. Indicators that clients are overwhelmed by the intensity of their emotional arousal include: difficulties maintaining or losing contact with the therapist, inability responding to the therapist's interventions (e.g., dissociating), and failed attempts to down-regulate the intensity of their emotional response by themselves.

In general, improving implicit emotion regulation is the main focus in EFT. Implicit emotion regulation is facilitated by the empathic relationship, consistent empathic attunement of and validation by the therapist, as well as awareness of, allowing, symbolizing, and accepting emotional experience. At times when clients are overwhelmed by the intensity of their arousal in the session, therapists provide more explicit regulating interventions such as asking the client to breathe, grounding exercises, reestablishment of contact and anchoring him or her in the present moment when dissociating, introducing a self-soothing dialogue, or a safe-place exercise. When clients regularly get overwhelmed by their emotions outside the therapy room, teaching explicit emotion regulation skills can also be necessary.

Agency

Judging whether an emotional expression is productive also involves assessing the self-perceived role clients take in the emotional change process. Clients need to take responsibility for their emotion as opposed to taking the stance of a passive victim. This involves acknowledging their emotional responses as their own personal construction. Another way of putting it: A client should have the emotion as opposed to the emotion having the client. Indicators for *not* taking responsibility for felt emotion include the following:

- Attributing responsibility for felt emotion to external sources such as other people's actions, for example: "He (husband) always

criticizes me. He makes me feel so bad, so small." This client locates the source of her pain exclusively outside herself, rather than owning the pain as part of herself as in: "When he criticizes me, I feel so small. It instantly opens this old wound, and then I go to this dark place inside."

- Assigning responsibility for resolution of problematic situations to others (e.g., partner, therapist, medication).
- Resigning to the emotion, treating it as an affliction about which nothing can be done ("I just always feel worthless, what can I do about it").

Generally speaking, the more clients experience (not only understand) their core pain as stemming from past wounds (e.g., being shamed by a parent; being abandoned) and/or problematic internal processes (e.g., self-criticism) and come to feel valid in their emotions and needs, supported by the attunement and validation of the therapist, the likelier they are to own their emotions and needs and take responsibility for their emotional and behavioral reactions. Additionally, therapists facilitate responsibility for the emotion in their clients by inviting the client to speak from an "I" position, for example, saying "I feel angry" rather than "It makes me angry" and focusing on other peoples' behaviors. In their reflections therapists will formulate accordingly, for example, "It sounds like when she (wife) says something critical to you, it touches this wound in you (humiliation by parents) and you start feeling worthless and then you lash out at her rather than showing your pain." In this formulation, the locus of responsibility and of control is placed more in the client, not in the external world, and emotions are connected to sources and meaning and to each other. In the same manner emotions can also be connected to the needs of the client (". . . and then you lash out at her, but really you need her to appreciate your efforts"). Willingness to actively work with emotion is often a function of the therapeutic alliance. Persistent passivity on the part of the client might

call for an alliance dialogue or experiential teaching on the nature of EFT therapy and the role of the client.

Differentiation

Finally, therapists pay attention to changes in the degree of differentiation of emotional experience. For emotion utilization and/or transformation to occur, a client's primary emotional experience has to become differentiated over time. This implies that either the client is verbally differentiating an initial emotional reaction into more complex feelings or meanings or into a sequence of other feelings or meanings, or that new feelings or aspects of the feeling emerge. In other words, clients' level of emotional awareness should increase (Lane & Schwartz, 1987) and not get stuck in basic symbolizations of distressing feelings such as "feeling bad," "not well," or "afraid." For example, a client started to tear up and look away when imagining his grandmother in the empty chair and said: "I feel so bad, I never visited her, after granddad died . . . I feel so ashamed . . . I just couldn't, I couldn't take it . . . I couldn't tolerate seeing the pain in you (to grandmother) . . . it was just too much." In this instance, the client differentiates his experience; the emotional process is highly fluid. Differentiation also entails a change in the manner of experience, that is, an emotion is more fully allowed, more freely expressed, or its expression changes. For example, in chair work a client first freezes in fear, then starts to cry, fully allowing the painful experience. Here the emotional process is moving forward and fluid, without the client explicitly verbally differentiating his experience. Generally speaking, a therapist has to look for some signs of "movement," either verbal or nonverbal, indicating that a client's processing is not stuck or blocked.

The differentiation criterion thus introduces a time perspective, and in part looks at progress based on improvements on the other six dimensions. So points raised in the previous sections are all relevant here. At core,

therapists facilitate emotion differentiation by adopting a curious attitude and a highly exploratory style, both verbally and nonverbally, continually inviting clients to go to and stay with their internal experience, explore the "edges" of their experience, focusing on primary emotion. So "I feel worthless" might differentiate into the following:

Therapist: . . . worthless . . . like in his eyes I am no good . . . ?

Client: Like no matter what I do, I will never be the son he wants . . .

Therapist: . . . like I am just the wrong son . . .

Client: Yeah . . . not wanted, like a hassle to deal with . . . it makes me want to be invisible . . .

Therapist: . . . just wanting to disappear . . . feeling so unloved . . . so alone . . .

Client: (tearing up) Yeah, I was so alone . . .

CASE EXAMPLE

As optimal emotional processing is very much concerned with moment-to-moment process, we focus on one session and look at it more closely through the lens of EFT processing theory. Our analytical comments about the case appear in brackets.[1]

When the client, a 40-year-old woman working as a secretary, first came into therapy, she had spent several weeks in a psychiatric hospital for the treatment of depression, but her mood had not improved substantially. She felt very low most of the time and was very critical of herself, for not being strong enough and not being able to handle her workload, procrastinating things she had to do. In general, she often felt empty and was very much at loss as to what caused her to fall into depressed states time and again.

After creating a safe bond, the focus of therapy became activating emotional experience, raising the client's emotional awareness and helping her symbolize her emotional experience and make sense of it. The 10th session unfolded like this:

Client: (in an external voice) It was a really nice wedding, everybody was friendly . . . and I was in a good mood . . . I don't know why I got so low . . . I still feel low. [verbal statement of undifferentiated global negative emotional experience]

Therapist: And as you talk about this, you feel low . . . is it okay to speak from that place? [exploratory question, inviting client to bring attention to bodily felt flow of experience to activate, symbolize and differentiate it]

Client: (in low voice) I don't know, I don't know why I feel low . . . I don't really feel much . . . it's more like . . . everything is so pointless. These moods just come and go, there isn't much I can do about it. [expressing secondary hopelessness in a nonagentic manner]

Therapist: So it's like "what's the use . . ."? . . . like a resigned feeling? [empathic understanding] (client nodding) And I hear you saying "these moods just come and go." But somehow, you said that you got there in a good mood, and then something happened and you felt low. So there is a process going on inside you that ends up with you feeling low. Is it okay for you to go there and look at it more closely, to see what happens inside you and see how this can change? (client nodding) [therapist reframes client's experience in terms of emotion process, thus supporting the client's agency in this process] Is it okay to just stay with this, maybe close your eyes and pay attention to your body . . . [keeping focus on bodily experience] and go back to the scene you were talking about . . . (using evocative voice) Everybody being so happy and loving and the bride's

parents being so emotional . . . smiling faces . . . everybody seeming so connected . . . belonging . . . [therapist provides an evocative reflection (see Chapter 5, this volume) of the emotionally relevant scene in evocative language, accessing episodic memory to help gain access to underlying primary emotion schemes]

Client: (tearing up, focused voice) . . . I don't know . . . it's just . . . this would never happen for me . . . my parents would be like this with my brother, but not with me . . . they are never happy for me or interested . . . it's just when I saw them there together, I felt like such an outsider . . . [begins to focus internally, starts to assume a more exploratory attitude toward her emotion; emotional experience appears to move toward a more primary emotional experience]

Therapist: (with soft voice) . . . like an outsider . . . not belonging . . . so unloved . . . [empathic conjecture, supporting symbolization of primary maladaptive experience in proximal zone of development] (client crying silently, nodding) Can you stay with that feeling? It is an important feeling . . . so painful . . . so unloved . . . [affirming empathic response to help client stay with feeling and keep attending to it] Can you speak from the tears? [invitation to symbolize primary maladaptive emotional experience and explore it]

Client: (emotional voice) I don't know . . . it's just sad . . . lonely (crying silently) . . . I feel like nobody would ever want to be with me . . .

Here the client interrupts her experience by criticizing herself, and the therapist introduces two-chair work. The client attacks herself as being "whiny," "too fat," and "useless." As a reaction to the criticism, the client goes into a state of undifferentiated resigned hopeless. To deepen and differentiate her experience, the therapist asks her to pay attention to her bodily experience.

Client: It feels like there is a part of me dying down there . . . Like I can't breathe . . . (client starts tearing up) [access to more primary painful emotional experience]

Therapist: (in soft voice) I am dying down here . . . [empathic understanding], tell her (critical side) what it is like for you down there, when she attacks you . . . [facilitating expression and differentiation of emotional experience]

Client: . . . It is so dark . . . so hopeless . . . (tearing up)

Therapist: (soft voice) . . . so dark . . . yes, such a dark place . . . so hard to be there . . . [empathic affirmation] (pause; therapist nodding) Can you give these tears a voice? What would they be saying? [empathic exploration, facilitating differentiation towards the more primary experience]

Client: . . . No matter what I do, it's never okay . . . it's never good enough.

Therapist: . . . Never good enough . . . And that leaves me feeling like "I am not good enough . . .?" [empathic conjecture toward the more primary maladaptive aspects of experience underneath the secondary hopelessness]

Client: Yeah . . . like I am worthless . . . I'm not okay, never okay . . . (tearing up)

Therapist: . . . so this is the painful place . . .

Client: . . . I just feel so worthless . . . unlovable . . . like I just want to hide and disappear . . . I can hardly tolerate it . . . I just want to give up and just not feel . . . [differentiates primary maladaptive experience]

Therapist: . . . So worthless and unlovable . . . so hard to feel this . . . [empathic affirmation] Can you stay with that painful feeling, even though it is difficult, because it is important. It is this terribly painful place you go to, and then you start giving up and feel empty. But really, deep inside there is this feeling of being worthless and unlovable [supporting

tolerance and acceptance of primary maladaptive experience, linking primary and secondary emotion, thus supporting agency] Can you tell her (pointing toward critical side) what it is like for you, when she attacks you, when she puts you down? “When you attack me, I feel so . . .” [facilitating expression and agency]

Client: When you attack me, I feel so worthless and unlovable, and then I just want to disappear . . . not do anything . . . everything becomes so hard . . .

The therapist now invites the client to express her unmet need.

Client: (soft voice) I need you to stop doing this . . . I need you to help me feel okay.

Therapist: (in slightly stronger voice) I need you to stop putting me down and tell me that I am okay the way I am? . . . that I am lovable the way I am? [supporting owning of the need and expression of newly forming more adaptive self-organization in a congruent manner]

Client: (stronger voice) Yeah . . . I need you to tell me that I am okay the way I am . . . to support me . . . to make me feel lovable . . . to be on my team!

The client expresses her need again in a more assertive way. The critical voice reacts with more contemptuous criticism. The client switches back to the self-chair.

Client: (shaking head) This is impossible! You are destroying me! I can’t live like this!

Therapist: (with slightly sharper voice) I can’t live like this, you are destroying me! . . . I want to live! [supporting newly emerging more adaptive self-organization in an agentic way]

Client: (with stronger voice) Yes I want to live! This is no life; you are sucking it out of me!

Therapist: I want to live! And I don't want this anymore! Stop doing this to me! [empathic conjecture, supporting newly emerging primary adaptive assertive self-organization]

Client: Yeah, I want you to stop.

Therapist: See what fits, but do you feel it "I want you to stop?" (client nods) Can you speak from that place and say it with a stronger voice? "I want you to stop!" [supporting congruent expression of assertive anger]

Client: (in louder, stronger voice, sitting up) Stop putting me down! Help me in all of this or leave me alone! [expressing primary adaptive anger]

When the client switches back to the critical side, seeing and hearing the deeper need and assertion, she softens into respect and compassion for the self.

In the following sessions, the client was able to address the unfinished business with her father, who had been invalidating of her emotions and needs and had put her down for being vulnerable. Over the course of therapy she was able to assert herself against her father and allow sadness about never having had the support and appreciation she needed. Self-critical work also came back into focus in the form of a motivational split, when she faced her problems with procrastination. When she was able to assert herself against her pushy and degrading inner voice, she was able to more easily handle tasks she had to do.

CONCLUSION

Using the metaphor of a canoe on a river, client and therapist are the team navigating the river of emotion processing. Unconditional positive regard for the client and presence of the therapist are like the canoe itself. As therapists we cannot see the territory directly; empathic attunement to

the client's experience gives us eyes to get a sense for what is going on around us on this river. Different forms of empathy and their use to differentially facilitate different aspects of productive processing then could be seen as the paddle in our hands, both guiding and supporting the client on his or her journey. Looking at the dimensions of emotion type and manner of processing outlined in this chapter helps us adjust our next stroke to what is needed to keep the canoe steady and facilitate a mindfully aware manner of processing, and to navigate currents toward where the team wants to go, toward clients' primary adaptive emotions and needs. In this way, client and therapist might become better navigators of process in EFT.

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[1]The authors verify that they have concealed client identity by disguising details of the case or by combining details from multiple cases.

10
TASK ANALYSES OF EMOTIONAL CHANGE

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The task-analysis research methodology is a defining feature of emotion-focused therapy (EFT) and is closely tied to the therapy practice. The research method was developed by Greenberg (1984) to study microchange events in therapy. It involves identifying important "markers" of an emotional problem and then intensively studying the states between the marker and the problem resolution. During this process, the researcher alternates between observing the data and conjecturing about the required states to construct a model of the steps necessary to resolve the problem (Greenberg, 2007). The resultant models can subsequently be empirically validated.

The initial models, such as the model of two-chair dialogue for conflict splits, empty-chair dialogue for unfinished business, and systematic evocative unfolding at problematic reactions, described the important macrostructure of these emotional processing difficulties (Greenberg, Rice, & Elliott, 1993; Rice & Greenberg, 1984). The recent task analyses reported in this chapter add to these original models by analyzing specific problematic emotions separately, adding specificity to which experiential states occur as people process their emotions.

Although these models are described in a linear manner, they typically do not unfold linearly. Instead, people tend to progress through them in a manner that looks more like two steps forward, then one step back (see Pascual-Leone, 2009). Each stage of each model is thought of as a "component of competence," required to reach a later stage, rather than an orderly progression. It is also important to realize that although these models provide a guidepost to what may happen, they are always considered secondary to the therapist being present and following the process humbly as it unfolds and attending to the nuance of each client's experience.

ARRESTED ANGER

The model of resolution of arrested anger was developed and validated by Liliana Tarba (2015) under the supervision of Leslie Greenberg. Arrested anger is a contributor to depression. When anger is denied, its adaptive capacity is lost, leading to the diminished ability to effectively overcome violations and obstacles. This results in feelings of resignation, powerlessness, and hopelessness (Greenberg & Watson, 2005).

Tarba (2015) identified 13 stages involved in resolving arrested anger. Here we describe five of these stages that were deemed essential: (a) marker of arrested anger, (b) expression of assertive anger, (c) empathic

and insightful understanding of the other/self-critic, (d) expression of primary adaptive sadness, and (e) letting go/forgiving the other/self-critic.

Marker of Arrested Anger and Fear of Anger

Arrested anger refers to the expression of anger that has indicators of suppression, collapse, or hopelessness. This typically includes statements that refer to anger or to violation and injustice and that are expressed in a disempowered, hopeless manner. Thus, the anger comes across more as whiny blaming or complaint than as a powerful assertion of boundaries.

Following the initial expression of arrested anger, clients typically voice their fears or blocks to expressing anger, such as simple expressions of "What's the point" and the fears of confrontation such as "I don't want to get into any confrontations or upset anyone."

Assertive Anger

Once clients have expressed their fears of the anger, they are more able to shift to expressing their assertive anger. *Assertive anger* refers both to assertiveness against a person's own negative self-treatment, such as when clients push back against their own internal critical voice, and to expressions of anger that set boundaries with others. This typically takes the form of holding others to account for violations. Behaviorally, these assertive expressions are exhibited as strength and have a sense of being freely expressed without hopelessness. For example,[1]

Client: I'm angry at you and I needed—I needed the love and you weren't there to give me any love. You were busy working all the time. [slightly later] Your idea of love was putting food on the table and clothes on our back—that was your idea of—of love. It had nothing to do with, ah, hugs and kisses and verbal acknowledgment, it had to—you felt you were showing that you loved us, that you were doing your job as a provider, that's what you felt. And you thought that was enough and it wasn't enough, not for me!

Therapist: Right, yeah. How do you feel? Tell him!

Client: Oh, I'm angry! Very angry! You know!? (Therapist: Because I needed . . .) I needed—I needed to, to, be hugged once in a while as a child you know?

Understanding of Self-Critic or Significant Other

The second stage is characterized by an empathic, reflective understanding of either the person's own negative self-treatment or the actions of the other. This can involve understanding the other's point of view or acknowledging and taking responsibility for one's own complicity.

Sadness of Grief

This category reflects the grief at having missed out on getting what they needed from the significant other. This stage is characterized with intense crying and expressions of pain in an internal and focused voice.

Client: I'm sad about it because there was a time you know that we were very close and we did everything together and . . .

Therapist: Tell her what you miss.

Client: I miss our friendship. I miss the things we used to do together.

Therapist: Tell her again, "I miss what I had with you."

Client: Yeah, I miss what I had with you and I realize that, you know, things change as time goes on, but I never thought they would change like this. I never thought that we would become to the point where we didn't like each other.

Letting Go and Forgiveness

In the final stage the person expresses letting go of the hurt or unrealistic expectations of change, or forgives the other for any past violation.

Client: [Speaking as the critical other] I did the best that I could at that time and—under the circumstances and um—(sniff)—and that's all I did—could have done—was the best.

Therapist: Anything else you want to tell her?

Client: (sniff) I'm really sorry I let you down.

Therapist: Okay—come back here—okay—she says she did the best she could—she's sorry.

Client: [Speaking as the self] (sigh) I guess you can't ask for more than somebody thinking they are giving their best.

Therapist: Mm-hm, so what do you want to say to her?

Client: (sigh) Maybe you're being too hard on yourself, um, and you should allow yourself to be human—and can make mistakes at times—and to be able to ah, to forgive yourself. I forgive you! You have to forgive yourself and accept that you did your best.

Auxiliary States

In addition to these primary processes, it was noted that people oscillated between these necessary states and several other nonessential stages. These include avoidance of emotion, hopelessness, self-interruptions, self-criticism, and self-invalidation.

Concluding Comments

Tarba (2015) found that accessing and expressing *assertive anger*, *understanding*, *grief*, or *forgiveness and letting go* were related to symptom remission. Together these components accounted for 64% of the variance of overall symptom change. Assertive anger and forgiveness/letting go both also uniquely predicted outcome, suggesting that these states specifically, and not just emotional expression generally, are important in reducing symptoms. This study confirmed the role of adaptively expressing and processing primary feelings of anger in the resolution of arrested anger in depression rather than by passing or regulating anger.

SHAME

The model of shame was developed by Sara Miller under the supervision of Leslie Greenberg (Miller & Greenberg, 2016). Shame is one of the most common primary maladaptive emotions (Greenberg, 2015) and forms a central focus in the EFT theory of depression. A person with a shame-based, self-critical self-organization would voice being "not good enough" as their central experience.

Marker of Core Shame

The marker for underlying shame is expressions of self-criticism or self-contempt, memories of traumatic abuse, and/or multiple experiences of humiliation. In the case of abuse memories, the client accesses, articulates, explores, and/or narrates memories of past abuse or maltreatment. In the case of self-criticism, the person is articulating a defect of the self; commonly this would include criticisms indicating that the self is either too stupid, fat, or ugly. In the cases of self-contempt, the expressions include the sense of looking down on the self with dismissal for failing a fundamental standard and are inherently less valuable. Statements of self-criticism and contempt are spoken in a harsh, critical tone. For example:

Client: Your personality is garbage. [Spoken with vicious tone.]

Client: Nobody likes you because of the way you are.

During this phase, the therapist works to heighten the expression of self-criticism and self-contempt to access the underlying shame scheme or help the client symbolize the abuse memory.

Accessing Shame and the Pain of Shame

The second stage is characterized by accessing the feelings of shame that are associated with the previously accessed self-contempt. In contrast to the harsh demeanor of self-criticism and contempt, shame is expressed with a sense of shrinking away and hiding the self. During expressions of shame, people will typically hang their head down and look away from the other. People often use a word like *embarrassed* for mild shame, whereas for intense shame it is common for people to describe the experience as feeling like they want to shrink into the floor and disappear or just run away and hide.

Client: You know I feel very small, no confidence, I feel like uh nothing, like a big zero.

Client: I felt so guilty to be alive.

Many clients move into an expression of how painful the experience of shame is. Clients may also enter into secondary emotional reactions to the shame, such as hopelessness, or anxiety about the shame, or a stuck experience of pain. One common experience of this is when the self “collapses,” which is experienced as the self giving up and collapsing into a state of hopelessness.

Therapist: Can you tell me about it?

Client: It hurts like hell to have someone say that, but as they say, them’s the facts.

Unmet Need

Once the person has accessed the state of shame, then the person is able to articulate the unmet need that is implicit in the emotion. In the case of shame, the person can access the need for acceptance and validation of his or her identity, “I needed to be accepted as I am,” or agency, “just allowed to be myself and to make mistakes.”

Primary Adaptive Emotions

The final stage in the model was the accessing of primary adaptive emotion. The most important primary adaptive emotions in the resolution of a core maladaptive shame scheme appear to be *pride* (“I’m good

enough as I am"), *self-assertion* ("I matter"), *adaptive anger* ("I'm angry at you for what you did to me"), *grief* ("It's so sad to realize that I missed out on that for so long"), *self-compassion* ("You did the best you could, you were so young and didn't have anyone to help you"), and *adaptive guilt* (i.e., moving from a stance of pervasive shame to one of guilt regarding specific actions and taking steps to repair damage). In some clients, adaptive anger appears to be an initial step that allows them to access self-compassion.

INSECURITY

This model of insecurity was developed by Sharbanee, Greenberg, and Watson (2015), who conceptualized an insecure "weak me" sense of self, in which the person views themselves as weak, dependent on others for survival, and preoccupied with the availability of others for support (Greenberg & Watson, 2005). The central experience of this organization would be described as lonely and being unable to survive alone.

In attempting to discriminate between the insecure and shame-based self-organizations, we ended up with some overarching model components that seemed to apply to all clients, including working through a form of negative self-treatment, then attempting to work through the historical origins of the self-treatment in unmet needs. Within that overarching framework we also noticed specifics that differentiated the insecure and self-critical self-organizations.

The main two components, negative self-treatment and unmet interpersonal needs (i.e., unfinished business), have been considered distinct tasks in EFT (Greenberg et al., 1993). One novel piece of the present model is the consideration that these two components may be sequentially related. In particular, resolving the self-treatment process by accessing *self-assertion* or *pride* may be a necessary precursor for resolving the unmet interpersonal needs.

Insecurity: Anxious/Lonely Marker

The initial marker here is anxiety or loneliness imbued with hopelessness. In the following example, the person expresses both of these states, saying that she feels an interconnected mix of anxiety and loneliness, explicating the concept of insecure self.

Client: I know there's loneliness in there and it could be I'll go to that.

Therapist: Uh-huh, 'cause, you know you feel lonely. Do you feel that now as you talk about it?

Client: (sniff) Yeah, yeah, the sadness. (sigh) Um uh, not knowing um . . .

Therapist: Yeah, not knowing, being just somehow inside, being unsure.

Client: Yeah um unsure, uneasy um—I—I've noticed also my um, I don't know if it's anxiety um (sigh)—my breathing has been, like I feel I'm suffocating sometimes (laugh).

Therapist: Mm-hm. You're feeling a little bit, can you describe that? Like, sort of a scary feeling?

Client: Yeah, shaky, scary um, like not knowing where it's going to take me or . . .

Therapist: Mm-hm, or just sort—sort of a sense of uncertainty about the future.

Client: Yes, yeah, because there's nothing set up.

Therapist: [shortly later] Right. so it's like, it's almost like you've entered into new territory, right? And—and like, like, well okay, what are—are the rules?

Client: Yeah, I'm confused about that and that's I guess that's where the loneliness comes in.

Negative Self-Treatment and Negative Self-Referential Emotion

The next state differentiates the loneliness from the *negative self-treatment*, which includes the ways that clients criticize, push, silence or neglect themselves, or wall themselves off from others. This negative self-treatment results in some form of negative self-referential emotion, such as shame or worthlessness. In this example, the client *self-silences* her needs, which leaves her feeling *worthless*.

Therapist: What's it like to feel all alone?

Client: Um (sniff) just—in a—in a world where I'm all alone and I'm trapped. (sigh)

Therapist: You feel trapped in there.

Client: Yeah, not um, meaningful as a human being and not counting at all. Just trapped inside.

Therapist: Okay, come back to this side—trap her, make her feel trapped. Somehow you're able to do that—push her down—how do you do that?

Client: Um, you don't, um, deserve anything. You don't, um, deserve anything or anybody.

Therapist: Mm-hm. Tell her you're, what is it, you're worthless.

Client: You're worthless, you don't count, just be there for your family and forget about you.

Therapist: Forget about your needs. What do you say to her, what is it like, you're selfish if you?

Client: Um, yeah, um you don't need all that time to yourself when other people need—can use more help or can use you in other ways um . . .

The negative self-treatment always serves some protective function by preventing a feared outcome. In this case the person self-neglects out of fear that if she asserts her needs, then others will leave her. Sometimes the fear underlying the negative self-treatment may remain implicit. This client in another session voiced a fear of abandonment that could result from asserting her needs.

Client: Because I feel—it's not feeling—I have no self-worth for myself then like if I don't want to—I'm afraid to tell her because I'm going to lose a friend maybe.

Need From Self, Pride, and Self-Assertion

The negative self-referential emotion implies that the person has an unmet need from themselves, such as a need to let themselves just be, or to accept themselves. By acknowledging and expressing these needs, people can access feelings of self-assertion of their worth ("I do matter"), or of pride ("I am acceptable as I am"). Self-assertion or pride are the adaptive emotions that transform the negative self-referential emotions of worthlessness and shame. Self-assertion and pride are in response to the person's own self-treatment, and therefore distinguished from assertive anger later in the model, which is directed at others.

Here the client shifts from self-silencing (pushing herself aside and neglecting her needs with "you don't count"), to expressing self-assertion ("I want to feel my feelings and needs").

Therapist: Okay, come back and switch over—so what do you feel when she says these things, kind of just "you're being selfish" and "you don't deserve that"?

Client: Um—I disagree. Um I'm going to um (crying) I'm going to feel my feelings. Um, I want to allow for me to feel what is right. [self-assertion]

Therapist: Tell her, I want you to allow me to feel.

Client: Allow me to feel what is right and what my needs are. [self-assertion]

Therapist: What do you say, what do you want from her?

Client: To accept me unconditionally and, um to, just to back off and let me be me. Let me run my life the way that's right for me. [self-assertion]

Unmet Needs From Others

The self-assertion or pride marks a partial resolution of the negative self-treatment. The next component is addressing the psychogenetic origins of the self-treatment in the history of unmet needs from significant others. This transition between components can happen in multiple ways. In some situations, the experiential work would start as an empty-chair dialogue with an attachment figure, then the negative self-treatment component would have arisen as an interrupting process. In this case the therapist would need to guide the client back to the attachment figure, saying, "What do you want to say to your mother/father/other now?" In other times, the experiential work started with the negative self-treatment in a two-chair dialogue. In this case, then, the link to the attachment history would often need to be guided by the therapist in the form of "Where did this come from?"

In the present example, the client presents in the subsequent session by making that link herself between the feeling of being lonely and unloved with her history of having that need for support and connection being unmet by her parents.

Client: Um, I guess I'm sad because of um I never heard it. [lonely]

Therapist: Uh-huh. Tell her "I wanted to hear you loved me."

Client: I wanted to hear you loved me. I wanted you to (sniff) to say it. [need for connection]

Therapist: Mm-hm, mm-hm. Tell her about what it was like to not hear it.

Client: Um, it was lonely and um—just understanding who I was. [need for connection]

Therapist: Mm-hm. You felt alone. What was it like to feel like that?

Client: Um—(sigh) uh, not mattering what I—I said and what I wanted. [worthless]

Therapist: Not to matter. I imagine you felt, I'm not quite sure . . .

Client: Um worthless, I guess. I was feeling worthless and um, not being um, a strong individual; or um having to please, to please her and dad first before um myself.

Therapist: Uh-huh. So you sort of put yourself aside, is that it?

Client: Yeah, I put myself aside and uh that was painful [referencing self-silencing] or um, I didn't know how to be myself—it was uh—no self feelings.

Therapist: Mm-hm. You didn't feel as an individual and you want—more like wanted her approval.

Client: Right, yeah. I wanted to make sure that she said "yeah, that's good, that's right, um that's what's best for you, or do what I think." [need from other]

Adaptive Interpersonal Emotions

The shift to the adaptive self–other emotions follows from feeling the unmet need. When the person feels the unmet need ["I needed you to love me"] and feels sufficiently entitled ["my needs matter"], which was expressed as self-assertion or pride in the self-treatment section, then that leaves them feeling angry at

the other for not meeting the need. It also allows them to grieve for what they missed ["it's sad that I didn't get that love for all those years"] and allows them to feel compassion for their younger self ["I deserved to be loved, to have someone hold me"].

Assertive Anger

Client: Whether it was good or bad for me, I put my feelings aside, part of me was shut down.

Therapist: Uh-huh. What about your resentment toward her for shutting you down?

Client: I uh, I resent you shutting me down. I'm—that was um, you put a lot of pain into me, it was painful and um just being confused and not knowing whether I—I mattered or not.

Therapist: Do you feel that now when you talk about it?

Client: Um, no just, that it was wrong what she did. She just shut me out. You know, I know now that it was wrong for you to make me feel that way and not have patience with me.

Therapist: So it's like you should have had more patience with me.

Client: Yeah. You should have had more patience. You should have given me more time, just given me more time to allow me to develop who I am. You know, it wasn't allowed.

Therapist: What's happening for you now?

Client: I feel I have um strength and um that uh you need to hear this and it feels important for me to tell you this, um, because at the time it wasn't my problem and I didn't bring it on.

Grief

The expression of assertive anger in this example is quickly followed by grief, the expression of sadness at having missed something that they needed. Grief here does not have any of the sense of hopelessness that is found with the lonely sadness that is in the initial marker.

Client: Um, I feel worth—um, I have respect for myself um as a person. [self-assertion]

Therapist: You feel more respect in yourself.

Client: Yeah, right, that's who I am and um uh I forgive her and—um . . .

Therapist: What happens when you say that?

Client: I—I feel sad. (crying) [grief]

Therapist: Tell her why you feel sad.

Client: Um (crying)—I um, I feel sad that um, I missed—missed a lot. [grief]

Therapist: Tell her what you missed out on.

Client: Um (crying)—um (sigh) a good relationship between you and I. [grief]

Therapist: Tell her how you would have liked it to have been between the two of you.

Client: I wanted you to um (sniff) just to accept the way I was (crying), the way I am.

Self-Soothing

In this example, the client doesn't express self-soothing, but it could have easily followed with the direction of the therapist to give her younger self what she missed out on (see the subsequent self-soothing section). This could have looked like the following:

Therapist: Come over here, and can you see your younger self there? How do you respond to her?

Client: You are fine just the way you are! There is nothing wrong with you.

Therapist: And what would you do to comfort her?

Client: I would just put my arms around her, and tell her that I love her just as she is.

Relief

The expression of these adaptive emotions is often followed by expressions of relief and a sense of agency that the person can cope better going forward.

Therapist: I wanted to hear that I was okay.

Client: That I was um okay as I was, um, it feels good to let that out, I um, I feel strong again.

Content Subtypes

The central distinguishing feature between insecure and self-critical self-organizations is whether they orient around attachment or identity needs. In both types of self-organization there is a self-treatment and a self–other component. Further, for both attachment and identity needs, there is a self-treatment that focuses on approaching a desired state, and one that focuses on avoiding an undesired state. For example, for attachment needs people could neglect their own needs, to prevent other people from leaving them—therefore approaching the desired attachment state of closeness. Conversely, they could wall-off from others to avoid the undesired attachment state of being hurt by others. These distinctions are depicted in Table 10.1.

TABLE 10.1
Experiential States Observed During the Processing of Attachment and Identity Concerns

	Negative self-treatment	Fear of	Self-referential emotion	Need from self	Need from other
Attachment focus (approach)	Self-silencing/self-neglect “My needs don’t matter”	Abandonment “Others will leave me”	Unimportant/worthless	Self-care (prioritize own needs)	Support/prizing
Attachment focus (avoid)	Wall self off “Don’t let anyone in”	Close others “Others can’t be trusted”	Isolated	Trust others/Let others in	Reliable/trustworthy
Identity focus (avoid)	Self-criticism “I’m too stupid/fat/ugly”	Humiliation/Rejection “Others will reject me”	Shame (defective)	Accept self	Validation/acceptance
Identity focus (approach)	Push self “I can’t relax, keep going”	Failure to succeed “I won’t make it”	Exhaustion	Trust self	Less pressure

Concluding Comments

Some of the main findings of this model are supported by converging evidence. First, the observation that self-assertion/pride is a necessary component for the resolution of the unmet interpersonal needs mirrors the observation that EFT treatments tend to focus on two-chair dialogues more early in treatment and empty-

chair dialogues later in treatment. It was also noted in the initial model of empty-chair dialogues (Greenberg et al., 1993), where there was an "optional resolving of a conflict split" section. This corresponds to the finding that sufficient self-assertion/pride is a "component of competence" required to access assertive anger and grief.

VULNERABILITY—EMPATHIC AFFIRMATION TASK

This section describes empathic affirmation at the marker of *vulnerability* based on a task analysis by Ellen Keating (Keating & Goldman, 2003) under the supervision of Rhonda Goldman. The task was initially described by Greenberg et al. (1993) and elaborated by Elliott, Watson, Goldman, and Greenberg (2004), and it also overlaps with the process described by Warner (1998). Yet despite its relatively long history, the task has not been researched as extensively as other EFT tasks. The previous presentations of the task were rational models that hadn't been verified. The present task analysis provides this verification and adds additional elaboration to the past models.

Vulnerability Marker

The initial marker is the expression of intense vulnerability. This is a state of being emotionally wounded or hurt and feeling fragile. This state can be related to shame, with expressions of being deeply flawed and defective, such as "It's me . . . what's wrong with me?" or a sense of isolation and disconnection such as "It's always been like that. They're hand in hand. I'm alone." These expressions are especially notable by their poignancy, often heightened by the use of vivid imagery and metaphor, and accompanied by a vulnerable vocal quality with a smaller, fragile-sounding, broken voice. Such evocative images have included "[I'm in] a thousand pieces inside" or having "hit the iceberg, I'm sinking." The moments of intense vulnerability have a sense of the person being completely exposed and seem to pull for the therapist to metaphorically hold the client in a delicate manner. There is a sense of reluctance to these expressions as well, as if the client is hesitant to expose the vulnerable parts of themselves.

Initial Deepening

In the presence of the therapist's empathic responding, people proceeded to *initial deepening* of their vulnerability. This involves elaborating on their metaphors and images with increasing specificity and concreteness. For example, clients shared that they feel like a "ship that hit the iceberg and crashed," while another said, "It's like living in black and white, when everyone else lives in color." This increasing specificity frequently also included conveying their sense of isolation in their pain "(there is) no one to care," as well as their personal responsibility for their plight, "It's me, and I just sit there in the mud."

Touching Bottom

The deepening continues to a point that seems like touching the bottom, where the person's pain is felt in its full intensity. This pain can be focused on either feelings of defectiveness, for example, "I'm just so ugly," or the disconnection in relationship to others, such as seeing oneself "alone on the playground." At this stage, core fears often emerge. Fears are related to either annihilation, the never-ending state of emotion (i.e., "Maybe I will never stop crying" or "maybe it is true that I am damaged, ugly, or otherwise unacceptable"). These feelings of pain are often accompanied by more global distress and despair about their situation, with

statements such as “I can’t see any way out of this,” “I can’t stand all the pain,” “I feel so fragile,” or “It’s like my life is just a waste!” These statements are expressed in a manner that feels small, fragile, and like they are breaking.

Therapist Operations During the Deepening Stages

To facilitate the deepening during these first stages, the therapist responses communicate that the pain is seen and validated, and they also function to soothe the pain. The therapist validates the pain by acknowledging it as it arises (e.g., “this is the bit that hurts,” “let the tears flow”), along with any sense of hopelessness or despair (“it’s hard to have hope now”). It is important that the therapist also affirms that they see the extent of the pain, by communicating that the person’s distress has been fully seen. As one therapist said, “There’s a very deep part of you that’s really being, feeling very, very wounded.” During these phases, therapist reflections tend to include more doubling statements than in exploratory work, keeping the therapist much closer to the client’s current experience.

It is important that therapist responses also provide a soothing or holding function. This is done by using a manner that is much slower and gentler than that used in the usual empathic exploration parts of therapy. The slow and gentle manner helps to provide a sense of holding, presence, and safety required to deepen the experience of pain. The therapist can further facilitate the soothing function by reminding the person to breathe, which communicates that they can stay with the pain and survive. The combination of the validating acknowledgment of the pain and these soothing statements and manner permit the deepening of the pain.

Turning Back to Growth

The *touching bottom* phase is usually followed automatically by the client’s *turning back to growth*, whereby the person displays their intrinsic growth tendency toward hope. This growth movement includes expressions of unmet needs as well as adaptive emotions. These can initially be simple statements of need such as “I need help” or “I want to go to a better place,” showing an initial movement away from the deep despair. These initial statements can be followed by stronger statements of hope and resiliency, such as “I can try again,” “I foresee breaking through,” “[I feel] strong enough now,” and “I feel like I dove off a cliff, and I wasn’t sure I was going to make it. It’s okay now though. I feel relief.” These statements are matched with a shift in verbal tone and expression from fragility to strength and self-efficacy.

As the person begins to express more growth and hope expressions, the therapist reflects and dwells on these adaptive tendencies as they arise. This can be doubling statements such as “It’s a feeling that I’m strong enough now . . . I feel better about myself” and statements that acknowledge the emerging hope, such as “That’s your hope for yourself.”

Appreciation/Reconnection

Once the person has moved from their distress to a stronger self-organization, they frequently acknowledge the support from the therapist by thanking them or acknowledging the sense of connection or reduced isolation. During this stage the clients thanked the therapist for “compassionate listening” and for “really caring.” Another client reported, “I mean, it’s really good that someone is able to listen.” This was an important addition from the rational model that highlights the deeply interpersonal nature of this task and sets it apart from other tasks in its emphasis on the relationship between client and therapist. In every event

studied, the person would “hit rock bottom,” only to reemerge and express a need to reconnect with the therapist.

During moments when the client is expressing appreciation for the connection, the therapist acknowledges this appreciation and expresses their own feelings about having witnessed the client’s pain. This could be by saying that the therapist felt privileged or honored to be able to be there for them, and glad that they were able to support the client. At times, this creates a corrective emotional experience as it addresses the underlying maladaptive emotion, that is, “If anyone ever sees the real me, they would see how ugly and unlovable I am, they would leave,” by providing a new emotional experience, “My therapist sees the real me and still feels close and compassionate toward me.” This also represents a disconfirming of pathogenic beliefs at a higher conceptual level, that is, “Now that you saw the worst part of me, you still like me.” In such moments it is important for the therapist to draw on genuineness while being straightforward and direct.

Resolution

The resolution is marked by a new sense of self and a clearer perspective. Clients expressed that they now felt more whole and had a more positive view of themselves. This frequently included having an intention to be more compassionate with themselves in the future. One client said that they felt they were special, whereas another said that they wanted to “put an effort to nurture that side of me, because it will save me.” This new sense of self is frequently accompanied by a feeling of clarity, saying “it just makes total sense” and that they have “got to the source of where a lot of it was coming from” and was now “seeing things in a new way.”

In the final stage, the therapist validates and reflects the pain that was felt, as well as affirming the new sense of wholeness and positive intention for the future, for example, “I’m glad you’ve been able to make a little bit of connection to the lovely side of you,” that it seemed important “to recognize . . . how connected these things are,” and that the client now seems to have renewed strength to “fight back.”

Concluding Comments

The present task analysis confirmed the rational model that was previously reported by Greenberg et al. (1993) and Elliott et al. (2004) and added points of elaboration. Most notably, the present model elaborated on the interpersonal aspect of the task. This included emphasizing to a greater degree the importance of the client’s expression of appreciation to the therapist and the therapist’s response of affirming the connection or expressing their privilege at witnessing the client’s pain. For transcript examples see Elliott et al. (2004) and Greenberg et al. (1993).

ANGUISH—SELF-SOOTHING TASK

The task of self-soothing has been developed relatively recently within the EFT community, yet it has quickly come to be seen as a task of central importance for emotional transformation. When there has been some form of distress that was consistently not responded to, the person is left with an ongoing sense of distress of having their need unmet and despair around it getting met in the future. It is this state of *anguish* around a stuck familiar and old sense of despair that is the marker for self-soothing.

The stuck old and familiar despair of anguish is centrally about a past unmet need. This contrasts with the previous marker of vulnerability, where there is a present need as they are currently at their most exposed and fragile. This distinction is important, as the present need during vulnerability requires an interpersonal holding response from the therapist. Attempting to respond to the marker of vulnerability with a self-soothing task could leave the client feeling abandoned or as if their pain is too great for the therapist to handle. In contrast, because *anguish* is about a past unmet need, the client is able to use imagery and enactments to provide the soothing of their past pain.

The soothing of anguish also needs to be distinguished from a more superficial coping type of soothing of secondary emotions. When people attempt to soothe a secondary emotion, it does not have a transformative quality of meeting an unmet need, but rather has a coping quality of shutting down or avoiding the sense of distress. This latter type of "coping" soothing is often seen as a skill or behavioral technique in other therapies, whereby clients learn, often outside of sessions, how to "put a lid" on an out-of-control feeling, for example, by taking a bath or making a cup of hot tea. Although EFT sees this as potentially useful, particularly with clients who begin the process struggling with severe emotion dysregulation that can prevent productive exploration of emotion altogether, most often the capacity to transform primary emotions, rather than the capacity to cope alone, is what EFT therapists are helping develop over the course of therapy.

The self-soothing task has been investigated using task-analysis by two different groups of researchers: Goldman and Fox-Zurawic (2012) and Ito, Greenberg, and others (Ito, Greenberg, Iwakabe, & Pascual-Leone, 2010). The model presented here is a composite of the essential elements of the two models. In the model by Ito et al. (2010), the marker was limited to anguish around anxiety and loneliness. In the Fox-Zurawic study, the marker was anguish related to any primary maladaptive emotion (shame, loneliness, or fear) that was coupled with the stuck, familiar despair such as hopelessness and helplessness.

Marker of Anguish and Familiar Despair

The marker for anguish is an overwhelming painful primary emotion of loneliness, shame, or fear, indicating an unmet need for love, validation, or protection. The expression of these primary emotions is fused with a sense of hopelessness or helplessness, leading it to feel stuck and familiar. In contrast with the vulnerability marker (Greenberg et al., 1993; Keating & Goldman, 2003), where the marker is more acute, in the sense of "I'm breaking now," the sense of intense pain and stuckness in the anguish marker indicates that things have been like this for a long time, with the client being aware that they have long had a need that has not been met and feeling hopeless about it being met. This typically involves expressions such as "That kind of love is something I've never had."

In this example, the marker of *anguish* is evident as the client accesses a primary emotion, in this case *shameful inadequacy* expressed as a sense of not being good enough. The expression also has a sense of *familiar despair* in that it is experienced as being an old, stuck familiar state.

Therapist: So, hearing all that, all the things that are wrong with you then brings up this tremendous sadness in you for what you've never had. Can you put it into words, what you've never had?

Client: I've just never had—just this um, this feeling that I'm okay. (sobbing)

Therapist: To be regarded as okay, to be seen.

Client: That I'm enough, or . . . (tears)

Therapist: That I'm enough, to be seen as good enough.

Client: Never felt that I'm just enough.

Protest or Interruption

Clients will frequently interrupt or protest, either expressing the need or fulfilling the need by expressing care, validation, or support. In a sense, clients are angry that they have never had this need met and that they must resolve this inside themselves. This can be likened to the infants observed in Bowlby's early childhood attachment studies who would cry in protest on the loss of attachment with the caregiver (Bowlby, 1973). As the clients have no experience of having their needs responded to, they are unable to imagine the need being met. This can take the form of a negative self-evaluation, such as "But I don't deserve love and support," or of expressions of hopelessness, such as "No one would ever love me."

Therapist: So, it's like you've never been validated, never been able to be seen as good enough, this is what you grieve for—someone to tell you that you're good enough. So who is it you want, who is it you would want to tell you?

Client: I don't know who could. [protest]

Therapist: But you'd sort of like someone there.

Client: If they were to tell me I don't think I'd believe them. I don't know who could.

Therapist: But you'd sort of like someone there.

Client: If they were to . . . I don't think I'd believe them. [protest]

Therapist: And so it's like now you can't imagine someone telling you that in such a way that you'd believe them, but somehow at the same time it's what you really need, someone to say that you're okay in such a way that you could believe them.

Primary Emotion and Unmet Needs

Following the protest, the clients express their primary emotions more intensely, typically either a sad loneliness, shame and inadequacy, or fear. Frequently, at this point clients will spontaneously access negative episodic memories of not receiving the love, validation, or protection that they needed when they were younger. Accessing these early episodic memories can also greatly increase the experience of the *primary emotion.* These episodic memories can be accessed by questions such as, "Is there a time that you remember early on, feeling like no one was there for you? Try to go back and really be that younger self now. What it is like to be so alone?"

By experiencing the primary emotion, the client will be able to access their unmet need for love, validation, or protection. This can be facilitated with questions such as "What do you need from them to feel less unloved," and encouraging the client to express their needs in the form of "I needed you to . . ." This effectively differentiates the initial fused state of familiar despair into the components of hopelessness in the protest and the underlying primary emotion and unmet need.

Therapist: So, can you imagine saying to somebody, I don't know who it would be, I need to be adequate and need to be, I need to be okay, can you tell me I'm okay?

Client: I just need to, I dearly want to know that I'm okay. [unmet need]

Therapist: To know deep in your heart . . .

Client: And to believe, not just um, hearing the words to feel . . . [unmet need]

Therapist: To feel it all the way through, to know that it's true.

Client: To know that it's true. [unmet need]

Therapist: That that's at least as true, or maybe more true than the sense of ugliness and . . .

Client: Than the inadequacy, I know I've made, that how I've lived my life has kind of validated the fact that I'm useless . . . [primary emotion]

Therapist: And what you really needed all along was someone to say, "Well, actually you're okay, you're not ugly or not stupid, you're not, or what, you're acceptable, you are good enough."

Client: Uh-huh, that's right, good enough. [unmet need]

A discriminating feature of people who resolved versus people who didn't in the Ito et al. (2010) analysis was that the resolvers stated their needs and grieved the loss of not having had the need met. The clients who came to feel stronger, relieved, with more self-understanding by the end expressed sadness at having missed getting the care or protection that they now felt they had deserved to get.

Seeing Hurt and Self-Compassion

Once the client has expressed their unmet needs, they are usually more able to provide that need by role playing a caring other. Role playing a caring other allows the client to witness their younger self's expressed pain. It is witnessing their pain that evokes compassion toward the wounded self. This can be facilitated by statements such as "How do you feel toward her as you see her there, in so much pain? Tell her."

In this example the client had previously said that she couldn't imagine another person being caring toward her. But she had said that she believed that God did care and value her. Therefore, the image of God is used as the caring other who is able to fulfil the unmet need for care and validation.

Therapist: Can you come over here [to other chair] and be God? This is the compassionate figure, parent, whatever, God, can you look at her and feel compassion for her?

Client: Uh-huh. [seeing hurt] I'm just so sorry that you feel unloved and that you're unneeded and unwanted because it's nothing farther from the truth, nothing could be further from the truth. [caring support]

Therapist: So it's not true that you're ugly and all those bad things. (Client: No.) So what is the truth, tell her what is true.

Client: The truth is that as I look at you . . . As I look at you, you make me smile sometimes, you make me shake my head and say oh gosh what's she up to, but it's always with love, always with love. I watched you struggling and your pain and . . . I'm just . . . all the time loving you, you're more than just okay, to me that you're perfect as you are.

Therapist: Tell her how she's perfect, tell her what's perfect about her.

Client: You do, you try not to hurt anybody because you were hurt, and you don't try to hurt people, and I watch you sometimes and, and you make me laugh when I see . . .

Therapist: How does God see you?

Client: I think God just sees me as a . . .

Therapist: Sees your beautiful soul.

Client: As a feeling person, I think that's what, like how God, I don't think that . . .

Therapist: It doesn't matter, so tell her that it doesn't matter how you look, I accept you as . . .

Client: It doesn't matter how you look, and it never has, cause I just I look at you and you're mine, and no matter what. How you thought you looked ugly, and now you're feeling old and done, and I just look at you and just see you as this blessing that's just how you are.

Therapist: A blessing.

Client: Just my girl, that's what you always will be, and I look at, and I see goodness and your good soul. And you're searching you're . . . just, maybe just stop searching and just . . .

Therapist: Accept yourself for who you are, it's what you want for her, for her to accept herself for who she is, and stop looking to other people.

Client: Stop looking at the other people but just look at yourself and accept, because you're good, you have so many good qualities that other people see and enjoy, so when people are in your life and they're being genuine, and they appear happy.

Therapist: So can you look at her and say I love you and I accept you . . .

Client: I do love you and I've always accepted you for who you are, no matter what you've done, I still love you, you're still lovable.

Relief, Resilience, and Understanding

After the expression of compassion, support, or validation, the client typically moves into a state of relief, which can generalize into a feeling of resilience going forward, and a renewed understanding. This resilience can be facilitated by encouraging the client to focus on the experience of receiving the compassion expressed from the other. This can be achieved by asking questions of the person, in the child/experiencing position, such as "How does it feel to hear your parent/adult self tell you that they love you and are here for you?" and "Can you take in the feeling of being soothed and cared for? What does that feel like?"

Therapist: Just feel what this feels like . . . is that okay?

Client: It's kind of nice. [body felt relief]

Therapist: Okay, come over here? [Client changes chairs] How does it feel to hear that?

Client: That was, um kind of nice, that was nice to hear that, too I'd kind of forgotten all about that, what that means I kind of . . .

Therapist: [shortly after] Can you just slow yourself down, and just feel what this feels like?

Client: (leans back) It's kind of nice, it's kind of good to get.

Therapist: You really need that don't you, that kind of sense of validation.

Model Variants

There are some variants of the model that can be used when clients have difficulty either accessing compassion toward the inner child or accessing an image of a caring other. In these cases, it is useful to try variants of the imagined soothing agent/object.

Self to Inner Child

In the basic version of the task, the client speaks as their adult self responding to the pain of their younger "inner child" self. This can be facilitated by asking the client to "see yourself in the chair as a small hurt/lonely/scared child and speak to that child."

Self to Universal or Known Child

One variant that can be used when the client has trouble expressing compassion to their younger self is to imagine another child that they could feel compassion toward, and express the compassion to them. This could take the form of a child that they know, or potentially a "universal child" that isn't known to them. After they have begun to express their compassion toward that other child, then it can be more easily expressed to the self.

Idealized Parental Figure to Inner Child

Another variant that can be used when people have difficulty imagining a caring other responding to their needs is to invoke the image of an idealized version of their significant other. This can be done by asking the client to imagine them "not as they were, but as you needed them to be," then asking them to speak to the wounded self. The example in this chapter is similar to this variant, with God acting as an idealized parent.

CONCLUSION: MAJOR FINDINGS ACROSS THE MODELS

We conclude by considering how some of the findings could potentially generalize beyond the models that they arose in. Together these models suggest that awareness of agency in a negative self-treatment may have an important role in resolving several negative self-states. This was seen in the shame model with the importance of awareness of the impact of an agentic negative self-treatment. These findings mirror the role of awareness of agency within the self-interruption splits (Elliott et al., 2004).

The present findings also highlight the important distinction between ways of working with emotions that are present focused, compared with those focused in the past. This was highlighted both by the distinction between the highly interpersonal resolution steps for *vulnerability*, a present-focused unmet need, and the model of *anguish*, which is distinguished by its focus on a past unmet need. This distinction mirrors the distinction made in the insecurity model, between the segments working on the present-focused *negative self-treatment*, and the past *unmet needs from others*. In addition, there is an intriguing idea in the insecurity model of a possible sequence in which people need implicitly or explicitly to solve negative self-treatment before they can feel entitled to having had their unmet need met in primary relationships.

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[1]The authors verify that they have concealed client identity by disguising details of the case or by combining details from multiple cases.

11
NARRATIVE CHANGE PROCESSES AND CLIENT TREATMENT OUTCOMES IN EMOTION-FOCUSED THERAPY

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Clinicians and researchers from a wide range of specialty areas within psychology (Angus & McLeod, 2004) have increasingly drawn on the concept of narrative to conceptualize the processes entailed in generating explanations of everyday events and organizing them into a coherent life story. Personal stories capture a complex interplay of lived actions, outcomes, feelings, beliefs, and intentions that have been directly experienced by a narrator. As such, they carry a form of evidential truth that fictional accounts simply cannot supply: We draw on personal stories, and the emotions they represent, to understand ourselves, others, and the world around us. Time plays a key role in personal stories, as temporal organization allows us to select, encode, and ascribe meaning to past events and to create expectations about the future.

Accordingly, the term *self-narrative* (Baumeister & Newman, 1994) has been used by personality researchers to refer to the development of an overall life story, perspective, or view of self, in which discrete events are placed in a temporal sequence and are meaningfully organized along a set of intrapersonal and interpersonal themes. As such, processes of self-identity construction entail the articulation and organization of emotionally salient personal stories, along plausible interpersonal and sociocultural plot lines, that result in the emergence of a self-narrative that coherently connects the lived past with the ongoing present and probable future (Angus & McLeod, 2004) As Bruner (2004) pointed out, by giving form and structure to even disconnected experiences and memories, narrative allows us to make meaning of experience and offers a space for self-reflection. Moreover, narrative expression offers a wide experiential space to connect with others and reflect on personal experience, which seems to be particularly helpful—perhaps necessary—under stressful circumstances.

In the context of psychotherapy, clients often seek out personal counseling when they are faced with a radically challenged sense of self and can no longer make sense of their own personal story. Narrative disruption (Dimaggio, 2006) can take different forms: Narratives may be reduced to a single dominant theme, blocking different, more adjusted meanings; there may be narrative dissociation, whereby relevant aspects or dimensions of the life story remain unintegrated (e.g., a personal relevant story emerges without any emotional resonance); or there may be narrative disorganization, in which narrative coherence is seriously impaired, with the client jumping from one topic to another, making it difficult for both therapist and client to make meaning out of the account. Additionally, as noted by Angus and Greenberg (2011), personal stories are given significance, and become salient for us, when infused with emotions. Conversely, the meaning of an emotion is more fully understood when

organized within a coherent narrative framework that identifies what is felt, and about whom, in relation to a specific need or issue.

Drawing on a narrative-informed approach to psychotherapy theory, research, and practice, Angus and McLeod (2004) concluded that psychotherapy can be characterized as a specialized, interpersonal activity entailing emotional transformation, meaning construction, and story repair. Helping clients to disclose their most emotionally salient personal stories is one of the most effective means through which psychotherapists come to know and understand their client's most important life experiences. Accordingly, client disclosure of salient autobiographical memory narratives can provide emotion-focused therapy (EFT) therapists with opportunities to heighten client awareness of emotions (Angus & Greenberg, 2011); deconstruct limiting cultural and social norms (White, 2004); and construct new personal meanings for the articulation of a more integrated, agentic view of self (Gonçalves, Matos, & Santos, 2009). Polkinghorne (2004) argued that it is a client's sense of personal agency that is the essential ground for the production of unique, unexpected outcome stories (White, 2004) that profoundly challenge and destabilize the client's "Same Old Stories" (Angus & Greenberg, 2011) and lead to the emergence of a more coherent self-narrative account (Angus & Kagan, 2013; Cunha et al., 2017) that instantiates a more positive, proactive view of self (Gonçalves & Ribeiro, 2012). In addition, it is important to note that psychotherapy researchers (Gonçalves & Angus, 2017), using two conceptually distinct, narrative-informed process coding measures—Innovative Moments Coding System (IMCS; Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011; Gonçalves et al., 2017; Mendes et al., 2010) and Narrative-Emotion Process Coding System (NEPCS; Angus et al., 2017)—have independently identified client self-narrative reconstruction as predictive of recovery from depression in EFT.

In this chapter, we first describe the development of NEPCS (Angus et al., 2017), along with significant clinical research findings emerging from the intensive analyses of EFT sessions. Next, we identify research findings highlighting the importance of client self-narrative change in the final phase of EFT sessions and discuss the implications of these findings for effective therapeutic practice and treatment outcomes.

NARRATIVE AND EMOTION INTEGRATION IN EFT

According to the narrative-emotion process model (Angus et al., 2017), clients often seek therapy when they experience distressing discrepancies between felt emotions, actions, and their autobiographical view of self. Therapeutic change and meaning construction occur through the narrative organization and transformation of emotional experience, for heightened self-reflective understanding and the emergence of a more agentic view of self and self-narrative reconstruction (Angus, 2012). According to Angus and Greenberg's (2011) theoretical conceptualization of narrative-emotion integration in EFT, there are two interrelated therapist tasks that are foundational to effective therapy outcomes: (a) the development of a secure therapeutic bond and moment-to-moment empathic attunement to client within-session process indicators for (b) the implementation of process-guiding interventions that enhance story disclosure/coherence and emotional engagement/transformation for the (re)construction of self-narratives that meaningfully capture, and reflectively integrate, a new, more coherent view of self as an agent of change.

To further enhance narrative-emotion integration in EFT, Angus and Greenberg (2011) originally identified a set of clinically derived, narrative-emotion integration markers for implementation in EFT. Similar to EFT microprocess markers, narrative-emotion process markers provide EFT

therapists with a process-diagnostic map to help guide the implementation of moment-to-moment interventions in therapy sessions. Through further empirical evaluation and testing (Paivio & Angus, 2017), 10 empirically validated narrative-emotion process markers have now been identified (see Table 11.1), and each NEPCS marker differs in the degree to which clients disclose specific autobiographical memories, symbolize bodily felt experiences, express emotion, engage in reflective meaning making, or articulate self-narrative identify change. These markers are theoretically connected with specific process-guiding intervention strategies (Carpenter, Angus, Paivio, & Bryntwick, 2016; Macaulay & Angus, in press; Paivio & Angus, 2017) that facilitate productive engagement in autobiographical memory disclosures, emotional differentiation, and reflective meaning making in therapy sessions.

TABLE 11.1
Narrative-Emotion Process Coding System 2.0 (NEPCS)

Marker	Process indicators	Examples
	Problem	
Same Old Storytelling	Expressing dominant, maladaptive, overgeneral views of self and relationships, marked stuckness.	*She was never concerned about me, she was only concerned with herself. Behave, be good, don't cause me any trouble.*
Empty Storytelling	Describing an event with a focus on external/behavioral details, lack of internal referents or emotional arousal.	*I was crying on the floor. The lady next door, her daughter was our babysitter, she was 16. She made me some eggs with cheese on top.*
Unstoried Emotion	Experiencing undifferentiated, under- or overregulated emotional arousal, without coherent narration of the experience.	Therapist: *Sad, so sad.* [25 sec pause, client stares at ceiling] *Are you holding back right now?* Client: *Yes. I can't be on the bus with tear-stained eyes.*
Superficial Storytelling	Talking about events, hypotheticals, self, others, or unclear referents in a vague, abstract manner with limited internal focus.	*The way that she talked to me and treated me in front of friends, and family. Even like my sister and father, just things that she says and does.*
	Transitional	
Competing Plotline Storytelling	An alternative to a dominant view, belief, feeling, or action emerges, creating tension, confusion, curiosity, doubt, protest.	*I have three healthy children, a house, we're not wealthy but we're okay, and I sort of go . . . why am I not . . . happier? I don't know.*
Inchoate	Focusing inward,	*. . . things seemed OK on the outside. But*

Storytelling	contacting emergent experience, searching for symbolization in words or images.	*inside, there's* . . . [closes eyes, frowns] *a, like a* [silence] *black hole or a void, or . . .*
Experiential Storytelling	Narrating an event or engaging in a task as if reexperiencing an autobiographical memory.	*I walked and walked and walked like I was in a fog. It was raining and dark, and I got wound up, and I just had to walk it off. I was soaking wet but didn't care.*
Reflective Storytelling	Explaining a general pattern or specific event in terms of own or others' internal states (thoughts, feelings, beliefs, intentions).	*There was nobody who cared, and so eventually I stopped showing them how I felt. Somewhere between there and here I stopped feeling it.*
	Change	
Unexpected Outcome Storytelling	Describing a new, adaptive behavior (action, thought, feeling, response) and expressing surprise, pride, relief, contentment.	*I was so anxious, but instead of wallowing in it like usual I thought "what can I do?" So I [did] the muscle relaxation stuff . . . it felt so good. After, I felt like a different person.*
Discovery Storytelling	Reconceptualizing, or articulating a novel understanding of the self, others, key events, or change processes.	*I've been thinking about the theme of being uninvited in the world. I think, I never did it consciously, but I realize that I've seen myself as an intrusion for a very long time, and now it feels different . . . I do belong.*

Note. Adapted from *Narrative Processes in Emotion-Focused Therapy for Trauma* (pp. 90–91), by S. C. Paivio and L. E. Angus, 2017, Washington, DC: American Psychological Association. Copyright 2017 by the American Psychological Association.

NEPCS Problem Markers

NEPCS problem markers identify underregulated, overregulated, or unintegrated emotion within client storytelling episodes that are often incoherent, rigid, undifferentiated, or repetitive. Marker-guided therapist interventions are identified to help clients access, symbolize, and contextualize painful emotions and autobiographical memories for the identification of maladaptive emotion schemes, enhanced emotional regulation, and autobiographical memory reprocessing (Macaulay & Angus, in press; Paivio & Angus, 2017). Narrative-emotion process problem markers include Same Old Storytelling—repetitive, unproductive intrapersonal and interpersonal patterns emerging from the activation of core maladaptive emotion schemes (Greenberg, Rice, & Elliott, 1993); Unstoried Emotions—states of undifferentiated affect and unregulated emotional states; Empty Storytelling—clients' detailed recounting of personal events that are stripped of lived emotional experience; and Superficial Storytelling—talking about events, hypothetical situations involving others in a vague, abstract manner with limited internal self-focus and low experiencing levels (see Table 11.1).

NEPCS Transition Markers

In contrast to problem markers, NEPCS transition markers demonstrate how EFT therapists can help facilitate client movement toward greater narrative and emotion integration (Macaulay & Angus, in press; Paivio & Angus, 2017) through heightened self-reflection and the expression of differentiated emotional responses within the context of more coherent, specific, personal narratives (see Table 11.1). NEPCS transition markers include Inchoate Storytelling—heightened client self-reflection on emerging bodily felt experiencing; Experiential Storytelling—episodic memory and emotion integration; and Reflective Storytelling—the identification of new ways of understanding and taking action intra- or interpersonally. These NEPCS transition markers also highlight

opportunities for therapists to identify and enhance emerging readiness for change.

NEPCS Change Markers

Finally, NEPCS change markers refer to how EFT therapists can identify and further elaborate client storytelling markers (Macaulay & Angus, in press; Paivio & Angus, 2017) that represent evidence of productive narrative-emotion integration. NEPCS change markers include Unexpected Outcome Storytelling—reports of new emotional responses and actions; and Discovery Storytelling—the emergence of a more flexible, coherent, emotionally differentiated view of self and self-narrative reconstruction. Client engagement in NEPCS change markers not only indicates the occurrence of tacit experiential change processes in therapy sessions and significant personal relationships, but also represents the explicit articulation of a more compassionate, agentic view of self and adaptive self-narrative reconstruction (Angus & Kagan, 2013) that instantiate new preferred ways of being in the world (see Table 11.1).

Both transition markers and change markers in the NEPCS are similar to what Gonçalves et al. (2017) termed *innovative moments*, that is, the emergence of exceptions to the problematic self-narrative involved in client's suffering. For instance, if a client is feeling sadness as a secondary emotion to anger, and during a two-chair task is able to access feelings or primary adaptive anger, this would be an innovative moment. Innovative moments occur in two developmental levels—a low level, in which a distance or differentiation from the problematic self-narrative emerges, and a high level, in which some elaboration of the change process takes place. Although transition markers are similar to low-level innovative moments, high levels are coincident with change markers in NEPCS. As an illustration of low- and high-level innovative moments, we present examples retrieved from the well-known EFT case—Lisa (Angus,

Goldman, & Mergenthaler, 2008; Gonçalves, Mendes, Ribeiro, Angus, & Greenberg, 2010). The first example represents a low-level innovative moment during an empty-chair dialogue with her father:

Lisa: (crying) I feel that I always had to be a good girl in front of him . . . but then again it feels like a phony act.

Therapist: Uh-huh. Can you tell him that I don't want to be phony?

Lisa: I don't (want to be phony), it um, makes me feel really uncomfortable.

The following example, represents a high-level innovative moment, where Lisa narrates a contrast between her problematic self-narrative and her present and more adjusted self, elaborating the process underlying the change between the parts of the self. This excerpt occurs toward the end of therapy, during an empty-chair dialogue with her husband:

Lisa: I feel bigger and . . . and taller and . . . I feel that I can . . . stand up for myself.

Therapist: Mm-hm . . . what happens when you say that "I feel I can stand up for myself."

Lisa: Because um I'm an adult and . . . I can make my own decisions . . . and I'm not going to take . . . and put up with you say to me . . . because I don't deserve . . . to hear that . . . or be treated that way.

Therapist: What do you deserve?

Lisa: Um . . . I deserve to feel what I feel and . . . and . . . ah . . . do what I . . . want to do is, is right for me and my kids—I'm going to stand up for myself, um, I deserve that—I'm a good person and I'm not going to let you step on me anymore.

Next, we center on the application of the NEPCS to EFT, complemented with some findings from the innovative moments research.

APPLICATION OF NEPCS TO EFT OF DEPRESSION

Boritz, Bryntwick, Angus, Greenberg, and Constantino (2014) applied the NEPCS to one early-, one middle-, and one late-stage videotaped session selected from 12 depressed clients receiving EFT. Statistical analysis examined the association between the proportion of NEPCS markers occurring in sessions, contextualized by therapeutic outcome (recovered vs. still depressed at therapy termination) and stage of therapy (early, middle, late). Findings established that EFT clients who recovered from depression at treatment termination evidenced a significantly higher overall proportion of NEPCS change markers, whereas clients still depressed at therapy termination evidenced a significantly higher proportion of problem markers, such as Superficial/Abstract Storytelling, in the middle stage of therapy.

In terms of NEPCS transition markers, EFT recovered clients evidenced significantly higher proportion of Inchoate Storytelling overall, indicating greater depth of new emotional processing in their therapy sessions (Boritz, Barnhart, Angus, & Constantino, 2017). Additionally, there was a significantly higher proportion of engagement in Competing Plotline Storytelling for recovered clients at midphase of therapy. This is likely linked to the active interventions of empty-chair and two-chair tasks that are used in EFT during working-stage sessions. In terms of specific NEPCS change markers, Discovery Storytelling was significantly associated with recovery for EFT clients, and a positive trend was also observed for Unexpected Outcome Storytelling. Taken as a whole, the evidence of significantly higher proportions of NEPCS key transition markers (i.e., Inchoate and Competing Plotline Storytelling) and change

markers (i.e., Unexpected Outcome and Discovery Storytelling) demonstrates increased narrative and emotion integration and self-narrative change for EFT clients who recover from depression (Angus et al., 2017). This is consistent with the innovative moment research, as good outcome cases are characterized with a progressive presence of innovative moments along treatment, particularly of the higher developmental level (Mendes et al., 2010; Mendes, Cunha, Gonçalves, Angus, & Greenberg, 2011).

NARRATIVE MARKERS IN THE CASE OF SARAH: AN INTENSIVE SINGLE-CASE ANALYSIS

To further describe narrative-emotion marker patterns in EFT treatments of depression, we applied the NEPCS to early-, mid/working-, and late-phase videotaped sessions selected from the case of Sarah[1] (pseudonym). Sarah was a 35-year-old German immigrant to Canada who received 18 sessions of EFT as part of the York I Depression Study (Greenberg & Watson, 1998). Sarah sought treatment after the dissolution of her 8-year marriage and met criteria for major clinical depression. In particular, she felt socially isolated and disconnected in personal relationships, especially with her parents, and pressured to conform to limiting gender roles in her current life. At treatment termination, Sarah demonstrated clinically significant recovery from depression on the basis of her pre–post Beck Depression Inventory scores.

In terms of overall NEPCS research findings, there was a significant decrease in the proportion of NEPCS problem markers (early: 66%; mid: 30%; final: 34%) along with a concomitant increase in proportion of NEPCS transition (early: 14%; mid: 25%; final: 23%) and change markers (early: 20%; mid: 29%; final 36%) over the course of Sarah’s EFT treatment. It is important to note that even though NEPCS problem markers predominated in Sarah’s early-phase EFT sessions, she also provided

emerging evidence of early readiness for change in the context of Unexpected Outcomes Storytelling, an NEPCS change marker.

The innovative moments research found similar results when analyzing this case with the IMCS (Mendes et al., 2011). Innovative moments were already present at the beginning of therapy, increasing significantly during midtherapy and maintaining high levels until the end of therapy (amount of the session occupied by innovative moments: early: 11%; mid: 33%; final: 38%). Moreover, Sarah demonstrated a significant increase of high-level innovative moments (early: 6%; mid: 27%; final: 31%) compared with low-level innovative moments (early: 5%; mid: 5%; final: 6%).

Additionally, consistent with other NEPCS findings for the EFT recovered sample as a whole, NEPCS transition markers, in particular Competing Plotline and Inchoate Storytelling, increased in midphase sessions, with Unexpected Outcome and Discovery Storytelling change markers finally predominating in late-phase sessions. The following therapy session excerpts illustrate Sarah's movement from NEPCS problem (Same Old Storytelling) to transition (Inchoate Storytelling, Competing Plotline, and Reflective Storytelling) and change markers (Discovery Storytelling) in the context of her EFT therapy sessions. In particular, the impact of EFT chair task interventions such as two-chair tasks and EFT therapist empathic evocative reflection, for enhanced emotional awareness and self-narrative coconstruction, is highlighted in the examples that follow.

In her early-phase EFT sessions, Sarah identified feelings of anxiety and self-doubt in social interactions and relationships. She struggled to articulate and understand these feelings, and to understand them in relation to her early experiences in her family. Her feelings of stuckness are illustrated in the following example of Same Old Storytelling in Session 3:

> *Sarah:* (sighs) It also seemed like I never really could go to my parents with anything, like no matter what it was, if I had

any kind of problem in school . . . there were a few years in between when I had a really terrible time at school and I felt, I . . . I never attempted to go and speak to my parents because I just felt that they just wouldn't be able to relate to this or understand it. I figured well my dad would be saying something along the lines of, "Well, um, you have to separate like the head and your feelings" ha ha, and you know "it doesn't matter what's going on, that you just do your thing."

Therapist: So you just didn't feel there was anybody at all you could go to, that would understand you. [empathic reflection]

As her treatment progressed, Sarah recognized that messages she had received in her family and at school that encouraged her to defer her needs in the service of others were contributing to her feelings of self-doubt and stuckness. She characterized herself as a caretaker who privileged the needs of others, usually of the men in her life, above her own. This tendency to put others first led to feelings of self-doubt and guilt at asserting her own feelings and preferences, and fear of losing others' acceptance or approval. She felt this contributed to her withdrawal from others, which contributed to her loneliness and depression. However, she still struggled to integrate this awareness with present-focused emotional experience, evident in this example of the NEPCS transition marker Reflective Storytelling in Session 4:

Sarah: I think, well naturally this still affects me now. (Therapist: Mm-hmm) A lot of times I don't really have . . . the courage like to come forward with things because I just expect like not to be heard, or people not to be able to relate to it to understand it, so rather than, trying, I'm just so afraid of, getting the same treatment and rejection that I just remain in the same mode (Therapist: Right) I constructed back then.

From the perspective of the innovative moments model, this is a low-level innovation, in which the client is able to reflect on her problematic self-narrative, thus creating distance from her "Same Old Story." As therapy progressed, Sarah became aware of and began to more deeply explore her competing thoughts and feelings about her situation in the context of Competing Plotline Storytelling. Sarah began to experiment with asserting her wants and needs and validating her emotions in Session 10, in the context of an EFT empty-chair task. An example of a Competing Plotlines Storytelling marker is included here for illustration:

Sarah: I always felt that there is something wrong with me—and over the years I just didn't know anymore so I just said yes to everything (laugh) and then did it my own way.

Therapist: So tell them kind of like I bought the goods I bought your . . .

Sarah: I bought the goods and didn't get what I was looking for (laugh) because for some things you have to sit back and then plan and then take all the different aspects into consideration but then with other things like if it feels right and just do it without thinking about it.

Therapist: So it is almost like you are saying how I do things sometimes.

Sarah: It's okay if it works for me (laugh).

Therapist: Tell him that it works for me.

Sarah: It works for me and that's okay that's alright and if it doesn't work for you well it's just how it is.

From week to week, Sarah noticed shifts in her awareness and behavior, which was surprising and exciting for her and felt almost like "magic." In the final phase of EFT, Sarah began to explore her own interests, which she previously had not felt able to do. She developed an increased awareness of how in the past she has tried to always please others

(Same Old Story), but is now starting to assert her wants and needs with others—Unexpected Outcome Storytelling that is the basis for the emergence of a new view of self and self-narrative change (Discovery Storytelling):

> *Sarah:* I have to make sure that . . . everyday . . . I do like my own thing and the good thing right now is . . . I'm all on my own and . . . all these things are happening, it's almost like, like magic . . .
>
> *Therapist:* Yeah, you say it feels like magic, because it's just sort of falling into place and yet it sounds like you're being very different out there.
>
> *Sarah:* Yeah . . . I'm definitely starting to change [Unexpected Outcome Storytelling] . . . it just really seems like the right time, right place (laughs), right people . . . [shift to Discovery Storytelling]. I don't even have to push that hard . . . before I always had the feeling that I'm pushing so hard or banging my head against the wall and nothing seems to happen, and right now it's just so easy . . . do I have a magic wand all of a sudden? . . . like [I'm] seeking the opportunity, and yeah like just wanting . . . that change.

This represents in the innovative moments model a high-level innovation, characterized by a positive contrast between the problematic past ("before I always had the feeling that . . .") and the current changing situation ("right now it's . . ."). As these contrasts emerge in psychotherapy, the client feels an increasing agency and progressively identifies herself with the new self-narrative that is taking shape, at the beginning not without surprise and perplexity ("Do I have a magic wand all of a sudden?"). As her treatment nears its end, Sarah is able to reconceptualize her Same Old Story and accept that the changes she has been experiencing are not magic but rather the product of her hard work.

As evidenced in the case of Sarah, NEPCS problem markers—such as Abstract/Superficial, Empty, and Same Old Storytelling—highlight the presence of client emotional avoidance strategies in EFT sessions. When emotion is inhibited, restricted, or remains unsymbolized and unintegrated, there is less exposure to distressing or threatening emotional experiencing, while at the same time undercutting the possibility of new emotional awareness, transformation, and self-narrative change. Accordingly, as evidenced in Sarah's therapy sessions, movement toward productive narrative-emotion processing in EFT involves shifts from emotional avoidance, and stuckness in the Same Old Storytelling, to accessing, exploring, symbolizing, and reflecting on emergent emotional experiencing (e.g., Inchoate Storytelling and Reflective Storytelling) for enhanced narrative-emotion coherence (e.g., Experiential Storytelling) and transformation (e.g., Unexpected Outcome Storytelling) in therapy sessions.

In the context of working with emotions, it was the enhanced expression of new emergent emotional responses (Inchoate Storytelling), for further symbolization (Reflective Storytelling) and narrative integration (Experiential Storytelling), that challenged the basic pattern and premises of Sarah's Same Old Story and the emergence of Competing Plotline Storytelling in EFT working-phase sessions. Not surprisingly, it was also during EFT working-phase sessions that Sarah was encouraged to engage in two-chair and empty-chair interventions for the resolution of Unfinished Business and self-critical conflict splits that are definitive of Competing Plotline Storytelling. As evidenced in the case of Sarah, when clients are able to articulate and reflect on positive shifts in emotions and actions (e.g., Unexpected Outcome Storytelling), a more agentic view of self (e.g., Discovery Storytelling) emerges in late-phase EFT sessions. As such, our NEPCS change-marker findings highlight the critical therapeutic role of helping clients to notice, narrate, and reflect on (e.g., Unexpected Storytelling) salient intra/interpersonal change events as the basis for the

articulation of a new, more agentic and empowered view of self and self-narrative change (Discovery Storytelling) in EFT therapy sessions. From the perspective of the innovative moments model, we can see how innovations evolved, from the low to the higher and more developed ones. Sarah's high-level innovative moments involved the emergence of new facets of the self that emerged previously as an outcome of the increased engagement in empty-chair and two-chair tasks that fostered a heightened sense of self-empowerment and self-assertion, as these therapeutic tasks facilitate an enriched affective, cognitive, and narrative processing of her emotional experience (Greenberg, Auszra, & Herrmann, 2007; Paivio & Angus, 2017).

IMPLICATIONS FOR EFT PRACTICE, TRAINING, AND RESEARCH

Cohering with the identification of microprocess markers in EFT, narrative-emotion storytelling markers provide EFT therapists with a process-diagnostic map to help guide the implementation of moment-to-moment interventions in therapy sessions. As noted earlier, the creation of a secure, relational bond and sustained therapist empathic attunement (Macaulay & Angus, in press; Paivio & Angus, 2017) is viewed as an essential relational precondition for the effective implementation of narrative-emotion process-guiding interventions in both EFT for depression (Angus et al., 2017; Angus & Greenberg, 2011) and complex trauma (Macaulay & Angus, in press; Paivio & Angus, 2017) therapy sessions. Narrative-emotion problem, transition, and change markers have been theoretically and empirically linked with specific process-guiding intervention strategies (Macaulay & Angus, in press; Paivio & Angus, 2017) that facilitate productive engagement in autobiographical memory disclosures, emotional differentiation, and reflective meaning making in therapy sessions.

More specifically, NEPCS research findings suggest that effective EFT therapists help clients to more fully access and symbolize painful emotions (Inchoate Storytelling) for further reflection and new understandings (Reflective Storytelling, Discovery Storytelling) in therapy sessions. Heightened narrative coherence and client self-reflection are further facilitated by a narrative retelling of troubling events that aids in the identification of specific situational contexts, and cues, to organize, contain, and explain distressing emotional experiences (Experiential Storytelling). The NEPCS transition marker Competing Plotline Storytelling highlights client reports of shifts or changes in their Same Old Stories resulting in states of emotional incoherence, confusion, and puzzlement that helpfully resolved through engagement in empty-chair or two-chair role-play interventions and self-narrative reconstruction.

Importantly, Unexpected Outcome Storytelling markers help EFT therapists to notice, and further elaborate, clients' expression of surprise, excitement, contentment, or inner peace in response to experiencing new emotional responses and/or taking positive action in the context of fulfilling personal needs and goals. It is when EFT therapists help clients to break free of their maladaptive emotion patterns that have defined their Same Old Stories, and experience and report new, more adaptive emotions (Inchoate Storytelling) and action tendencies (Unexpected Outcome Storytelling), that EFT therapists can help clients to articulate a new view of self that highlights their role as agents of present and future change (Discovery Storytelling) and preferred story outcomes. In terms of future directions, further specifying key therapeutic strategies that facilitate client moment-by-moment process shifts—from NEPCS problem to transitional and change markers—in the context of EFT role-play interventions and working-phase sessions is the focus of our current NEPCS research program (Angus et al., 2017; Paivio & Angus, 2017).

In turn, research findings from the innovative moments model can also help EFT clinicians to track client narrative innovation in sessions and enhance meaning transformation and the articulation of a new view of self and others. As EFT therapists move more deeply into the client's emotional experience, they foster symbolization and integration of core needs embedded in primary adaptive emotions, depicted within high-level innovative moments (Cunha et al., 2017). Therefore, we encourage EFT therapists to further the elaboration of contrasts between the former problematic self-narrative and the new, more adjusted ones, that develop as emotional differentiation and integration is taking place. Recent research (Fernández-Navarro et al., 2018) has further suggested that along with the elaboration of contrasts, the identification of the process of change between past and present is particularly helpful in a sustained narrative transformation. The articulation of these two dimensions (contrast and process) was termed *reconceptualization of the self* (Gonçalves et al., 2017). It was hypothesized (Cunha et al., 2017; Gonçalves & Ribeiro, 2012) that reconceptualization is central for self-narrative change, as it promotes a bridge between the problematic past and the changing present, involving the client's engagement with a preferable self-narrative, and by its repetition in the final phase of therapy, allowing a progressive identification with the new emerging self-narrative, consolidating change.

CONCLUSION

Angus (2012) suggested that it is the interplay between narrative, emotion, and meaning-making processes that enables EFT clients to organize and symbolize emotionally personal stories, as an integrated, coherent self-narrative. Taken together, intensive IMCS and NEPCS research has suggested that it is client exploration and differentiation of primary adaptive emotions and action tendencies—in the context of EFT

chair-task dialogues and autobiographical memory storytelling—that supports heightened self-reflection, meaning transformation, and readiness for change during EFT therapy sessions. It is in moments when clients begin to break free of the maladaptive emotions, which have defined their Same Old Stories or maladaptive self-narrative, and experience and report new, more adaptive emotions (Inchoate Storytelling) and actions (Unexpected Outcome Storytelling), both captured in the IMCS as high-level innovative moments, that EFT therapists can help clients to articulate a new view of self that highlights their role as agents of present and future change (Reconceptualization/Discovery Storytelling) and preferred story outcomes.

It appears that when EFT clients begin to narrate and reflect on positive intra/interpersonal shifts in emotional responses and actions emerging from experiences of therapeutic change, a new, more agentic view of self begins to emerge in late-phase EFT sessions. As such, both NEPCS change marker findings and IMCS highlight the critical role for EFT therapists' process-guided facilitation of first noticing, and then facilitating clients to narration and reflection on salient intra/interpersonal change events, as the basis for the articulation of a new, more agentic and empowered view of self and self-narrative change (Reconceptualization/Discovery Storytelling), after the resolution of role-play chair dialogues. As previously noted, the capacity to narrate, understand, and integrate our most important life stories—as a coherent self-narrative—is key to adaptive identity development and the establishment of a more differentiated, flexible view of self. In fact, McAdams and Janis (2004) argued that our internalized self-narratives may have as much impact on guiding actions and behavior as dispositional traits, suggesting that when EFT therapists help their clients to emotionally transform their Same Old Stories and construct new, more agentic and

adaptive self-narrative representations, they are in fact impacting the personalities of their clients and supporting enduring change.

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[1]The authors verify that they have concealed client identity by disguising details of the case or by combining details from multiple cases.

12
EMOTION COACHING IN ACTION: EXPERIENTIAL TEACHING, HOMEWORK, AND CONSOLIDATING CHANGE

SERINE H. WARWAR AND JENNIFER ELLISON

How many times have you tried to provide a client with psychoeducation that has not seemed therapeutic, or tried to teach your client something that you think is very beneficial and he or she loses interest in your seemingly clear and lengthy explanation? Experiential teaching (Goldman, 1991) plays a fundamental role in emotion-focused therapy (EFT) and is a multifaceted skill that needs to be thoughtful, attuned, and well timed. It is guided by relevant process markers and engaged in at various points in therapy. Experiential teaching requires close *attunement* to the client's moment-by-moment in-session process and core enduring pain. It means both collaboration and responsiveness to the client's between-session use of tasks, as well as sensitivity to a client's questions, concerns, difficulties, and style of emotional processing.

EXPERIENTIAL TEACHING USING AN EMOTION COACHING FRAMEWORK

EFT proposes an integrative view of the therapist as an emotion coach (Greenberg, 2002, 2015), and experiential teaching is conducted from within this emotion coaching perspective. Emotion coaching (Greenberg, 2015) is a central component of EFT, and the term *coaching* is not distinguished from *therapy* but rather is viewed as a way of working with emotion in therapy. The therapist and emotion coach are synonymous in EFT, and coaching involves both EFT components of leading and following. Emotion coaching also requires therapist presence (Geller, 2017; Geller & Greenberg, 2012) and occurs in teachable moments in the client's "zone of proximal development" (Vygotsky, 1986).

In this chapter, we offer a frame of how the EFT therapist carries out experiential teaching from within an emotion coaching framework. Emotion coaching relies on seven major principles of emotional change that have been established on the basis of research, theory, and practice. The therapist's role is to coach clients in these principles: (a) increasing awareness of emotion, (b) expressing emotion, (c) enhancing emotion regulation, (d) reflecting on emotion, (e) changing emotion with emotion, (f) corrective emotional experience, (g) deliberate regulation, and (h) automatic regulation (see Chapter 3, this volume). These principles act as a general guide for experiential teaching and help the EFT therapist understand the distinct goals of emotion coaching at various times throughout treatment. In this chapter we focus on emotion coaching interventions in relation to providing rationales, in-session teaching, between-session homework and practice, and interventions that consolidate therapeutic work.

What Is Emotion Coaching?

An emotion coach is a facilitator who helps motivate clients to move from where they are to where they want to be (Greenberg, 2002; Greenberg & Warwar, 2006); the mutually agreed-on goals provide the destination. An emotion coach is seen as following a client's emotional experience, as well as leading the client in the direction of deeper experience, while being fully present in the moment with and for the client (Geller & Greenberg, 2002, 2012).

The concept of emotion coaching is based on the premise that individuals have sources of growth and possibility within them. Given the right conditions or environment, individuals turn toward what is positive and nurturing for them. Emotion coaching helps guide self-directed people toward their internal strengths, possibilities, and resources. The emotion coach has an influential impact on a client's in-session process and what clients direct their attention to by using positive and appreciative language in thoughtful and specific ways to facilitate change.

The importance of therapist responses on the client–coach relationship is demonstrated in a study that examined the moment-by-moment effect of therapists' responses on clients' successive responses and showed that the depth of experiential focus in which a therapist responds to a client's previous statement is likely to have a significant effect on the depth that the client expresses his or her next statements (Adams & Greenberg, 1996). This study found that clients were 8 times more likely to shift to an internal focus after a therapist's response focused them internally rather than externally. Furthermore, clients were inclined to follow the therapist's focus of what was attended to in the client's experience. This study suggests that therapists can influence a client's processing by the way in which they respond. The emotion coach's role is to offer responses that provide beneficial direction to clients regarding where to focus their attention.

The influence of a coach's moment-by-moment responses on a client's responses is of particular significance in research that shows that more

internal responses are related to better therapy outcomes. Ellison (2006) found that therapist focus on emotion in session, not only in EFT but also in cognitive behavior therapy and interpersonal therapy, predicted increased client depth of experiencing. In addition, the therapist's focus on client emotion, as opposed to a focus on client thoughts or interpersonal behaviors, during episodes of emotion was associated with better treatment outcomes. Warwar and Greenberg (2000) found that high emotional arousal, in addition to reflection on emotional experience, distinguished good and poor outcome cases, indicating the importance of combining arousal and meaning construction. In addition, deeper experiencing as well as higher arousal in the middle of therapy was related to better client outcomes (Missirlian et al., 2005). Thus, these studies highlight that an important function of the EFT coach in facilitating change is to help clients experience deeply and make meaning of that experience.

Principles of Emotion Coaching

Emotion coaching in EFT is guided by two main higher order principles: (a) offering a *therapeutic relationship* and (b) facilitating *therapeutic work* (Greenberg, Rice, & Elliott, 1993). In EFT the coach–client relationship is equivalent to the therapeutic relationship, and the first principle is based on a high degree of empathic attunement, responsiveness, therapist presence, and a validation of the client's experience. The therapeutic relationship creates an environment of interpersonal soothing and the development of emotion regulation via the experienced presence of the therapist in session as well as the internalized presence of the therapist between sessions (Greenberg, 2015). In addition to being present, the therapist responds with different types of empathy that helps clients access and symbolize their emotions (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg & Elliott, 1997). Watson (see Chapter 5, this volume)

discusses the role of empathy in more depth in her chapter on relational processes in this book.

Another important aspect of the coach–client relationship is establishing an alliance by collaborating on the goals and tasks of therapy. This promotes the experience that *the two of us are working together to overcome the problem.* An important way that goal agreement in EFT is achieved is by being able to stay with and symbolize the enduring core pain from which clients have been suffering, as well as develop an agreement that working together to symbolize the client's core emotional pain is part of the path to resolving this pain.

The client's current process and state help to determine the relevance and timing of experiential teaching and balance following and guiding. If clients are aware of and working deeply with their internal experience, the therapist follows and supports clients' processes. If clients are dealing with their issues in an external and superficial manner, the therapist guides clients to attend to their internal experience and engage in different types of emotional processing activities that will deepen experience and promote movement in the type of emotional processing difficulty currently being experienced (Greenberg & Warwar, 2006).

PSYCHOEDUCATIVE AND DEVELOPMENTAL FRAMEWORK

EFT uses a psychoeducative model within a developmental framework to guide experiential teaching (Goldman, 1991; Greenberg & Warwar, 2006). Experiential teaching needs to be highly relevant to that which is emerging in session. Hot emotional learning in therapy is facilitated through hot teaching within *teachable* moments, when the client is offered homework suggestions while he or she is emotionally aroused, that fall within the client's "zone of proximal development" (Vygotsky, 1986). Experiential teaching in EFT is often uniquely devised to fit the client and

the circumstance. The emotion coach proposes experiments in the spirit of "try this" and "what do you experience?" within the frame of "the two of us are working together to overcome the problem" (Greenberg, 2015). In-session and homework suggestions must always be within, not too far ahead or behind, the person's capacity to stretch his or her ability to identify, tolerate, experience, or understand what is being suggested. Within this framework, it is "hot" emotional learning that is facilitated rather than purely informational or cognitive learning. Hot experiential teaching or *teachable* moments promote a next step or accelerate in-session opportunities for client change.

Experiential teaching is never offered in a prescribed manner or according to an agenda. For example, when clients have deeply experienced, differentiated, and made meaning of their experience of worthlessness, which in turn starts to transform this state, only then will in-session teaching about how to support the newly emerging state of feeling deserving and worthwhile be useful. The need to fit experiential teaching to the client's emotional and motivational state is greater in EFT than it is in learning approaches such as cognitive or behavioral therapy. In the latter, psychoeducation is often offered in a prescriptive manner to achieve predetermined types of change, through modification rather than self-reorganization. If the coach provides psychoeducation that is too far ahead of, or too far behind, where the client is, no development takes place. Teaching that will move the client's experience forward when the client is ready is a key aspect of what the emotion coach is aiming for in EFT (Ellison & Greenberg, 2007; Greenberg & Warwar, 2006).

TASK COLLABORATION AND COMPLETION IN EXPERIENTIAL TEACHING

In-session tasks in EFT do not require *compliance*, just as homework tasks in EFT do not require *adherence* (Ellison & Greenberg, 2007). Therapeutic progress is not seen as depending on between-session task completion given that the main therapeutic actions of client mastery and positive growth in EFT are conceptualized and observed as occurring experientially in session, and in-session and homework tasks are then offered to promote further growth. If a client declines an in-session task, then the emotion coach considers various factors, such as the quality of the therapeutic alliance, whether an insufficient rationale has been offered to the client, and potential processing blocks in the client and/or process. For example, has the coach offered a sufficient rationale for therapeutic task engagement as well as a sufficient elaboration of the task–goal relationship? Does the client feel safe in the therapeutic relationship and trust in the coach's competency and own emotional awareness to participate in the task? Perhaps the task is too far ahead of the client's present zone of proximal development.

If the client does not engage in agreed-on homework between sessions, the emotion coach again evaluates the therapeutic alliance as well as any misunderstanding and/or misalignment between the client's overarching therapeutic goals and their perception of the utility of the task. For example, did the client defer to the therapist rather than collaborate with the therapist during design of the homework task? When the task is experienced by clients as misaligned with their goals, the therapist moves toward following the moment-by-moment process to become more attuned to clients while listening for processing markers that may have blocked task completion (e.g., hopelessness marker arising between sessions when task attempted). Implicit here is the therapist's perspective that clients are experts of their own processes.

Assessment of motivational readiness for in-session tasks or homework is thus crucial. Any signs of resistance or opposition are taken as

motivation in their own right that serve a protective function and are therefore worked within a framework of acceptance. When homework is offered, it is important to communicate to the client that if for some reason it does not fit to do it between sessions, this is completely okay. Any signs of *opposition* are validated, explored, and elaborated, and the anxiety about doing or not doing the homework becomes the focus (Ellison & Greenberg, 2007).

OFFERING RATIONALES

An important part of experiential teaching in EFT involves offering situation-relevant rationales throughout therapy. These strengthen the therapeutic alliance by ensuring that clients feel safe to engage in tasks, as well as address client concerns and promote agreement on the goals and tasks of therapy (Elliott et al., 2004). We have found that for many clients, providing moment-by-moment rationales is essential for addressing doubts about the value of exploring painful emotions or engaging in chair dialogues, and thus we use rationales often throughout therapy to support the therapeutic relationship (i.e., bond, goals, and tasks of treatment) as well as the therapeutic work. In addition, rationales aid in developing a client's emotional intelligence throughout the therapy process by providing psychoeducation about the role of emotion in human functioning and dysfunction.

The following sequence of steps has been developed when offering rationales (Greenberg, 2010, 2015): (a) empathize with the client's underlying emotional experience, (b) reformulate the presenting problem in emotional terms, (c) give a rationale as to *why* we work with emotion, and (d) give a rationale as to why we work with emotion the *way* we do. Following this sequence helps the therapist stay in the client's zone of proximal development as the first step is focused on understanding the

client's experience, and the latter steps focus on providing rationales that are responsive to the client's concerns and understanding of what helps and why it helps in therapy.

The following is an example of a therapist using these steps to provide a rationale to a client who is dealing with a self-critical depression. This rationale was prompted after the therapist asked the client, "Can you put words to how the shame feels in your body?" In response to this the client asked, "How is focusing on the pain going to help?"

> *Therapist:* So the painful thing we have agreed to work on is that you experience an intense feeling of shame that can be unbearable at times. As we have seen, it appears that your depression is related to your harsh critic who beats you up and leaves you feeling very depressed. Underneath your depression your emotions are telling you how this is affecting you and what you need. To transform your feeling of shame, we have to go into it and have you feel it. I know it is painful to go there, but you need to experience the shame for us to be able change it and heal it. We need to get this emotion network up and running for it to be responsive to change. A very effective way to activate the shame so we can change it is to work directly with your harsh critic using a two-chair technique. Are you willing to try this? We will work at your own pace and comfort level. Can you put the critical part in this chair and put words to the harsh criticisms?

As you can see by this preceding example, this rationale is marker guided and given during a teachable moment. Also, the rationale is given interactively, allowing clients to contribute their feelings, concerns, and questions. What follows are markers of when to give rationales and further examples of how and when the emotion coach offers rationales in EFT work.

How Can Therapy Help?

One of the most common markers for offering a rationale is when clients want information. This marker can occur very early on, for example, when a potential client calls you to ask if therapy can help with their depression, anxiety, or trauma. In response to a depressed client asking about how EFT can help with depression, the emotion coach offers specific information that is tailored to the client's specific presenting issues as seen in the examples below.

> *Therapist:* Symptoms of depression such as lack of motivation, feeling dissatisfied, or sadness are secondary to the painful feelings underneath, which are avoided, numb, or stuck. This may occur when painful feelings are overwhelming or distressing. Underneath the depression are the painful feelings that need to be accessed and given a voice. If we can access these feelings, we can change them and this will alleviate your depression.

If a client has had a past loss, the coach may provide a rationale that ties in this loss:

> *Therapist:* Sometimes when people don't have an opportunity to grieve adequately, the depression covers up the overwhelming feelings of grief that have been set aside, and in therapy we will work through them together.

As seen in the previous examples, the role of the emotion coach is to be sensitively attuned to clients and to provide specific rationales for different presenting problems, such as depression or anxiety, as well as capturing the idiosyncrasies of the client's issues.

What's the Good of Going Into the Past if You Can't Change It?

Another common marker that calls for a rationale is indicated by the question of how going into the past is helpful. Clients often fear painful, difficult emotions in which they have been previously stuck and do not see the point of revisiting them, especially if they believe exploration will be unproductive. Here is an example of a therapist response in relation to this.

> *Therapist:* It must be very scary to imagine revisiting those painful memories of your childhood. Although you may not be able to change the past, you can change how you carry the past around within yourself. For example, we cannot change your abusive childhood, but we can change your feelings of worthlessness about the unfinished business that is causing you pain and heartache.

In addition, expressing to clients that there is evidence that memories can be changed when you rework emotional memories is valuable (Lane, Ryan, Nadel, & Greenberg, 2015).

Why Focus on Emotion?

A common marker for a rationale is indicated by some version of this question. The following is a possible response. Note that a therapist may not give all of this information at once in a single monologue, but rather as a part of a conversation with the client.

> *Therapist:* Emotion motivates you to get your needs met. Emotion gives you valuable information about what you need. For example, sadness tells you that you lost something important and can help you to let go of what is irrevocably lost and organizes you to something new; anger empowers you to set boundaries and feel deserving when you have been violated; loneliness tells you that you need to feel connected and motivates you to reach out; and anxiety tells you that you feel unsafe and that you need protection. When we are not aware of what we feel, we are also not aware of

what we truly need. Emotion tells you what is important and reminds you of it, especially if you are disconnected from or don't remember what it is that is important.

When offering rationales, it is beneficial for the therapist to use a specific example that is relevant to the client. For example, "Remember when you were sad and you reached out to your husband, your sadness told you that you needed support and connection."

Why Are Feelings More Important Than Thoughts?

This is a common question asked by clients who think that understanding their problems is more important than working them through emotionally. The rationale offered here conveys that emotions are evolutionarily based aids to survival.

Therapist: Emotions are usually faster than our thinking brain, and often we act before we think. For example, sometimes we can sense or feel a dangerous situation before we hear or see it. There is a difference between knowing something conceptually versus experientially. For example, sometimes our emotions know more than we do. Our emotional system was designed to help us survive. It tells us what's good for us or bad for us in the world and helps us respond quickly. Also, our emotional system operates differently from, and in addition to, thinking processes.

In offering a rationale to a client, it is important to find an analogy that the client can relate to or is from the client's environment. Here is an example of this:

Therapist: You meet somebody and you have a gut feeling about him or her. Although there is no rational reason to mistrust this person, your gut is shaky and tells you not to get too close. In this way, our gut gives important information, a

type of information that your thinking brain on its own is not able to provide.

When clients are having questions about the process of therapy and use of various therapeutic tasks, it may be necessary to provide a rationale. This may include problems in engaging in chair work or developing task agreement, or when clients are scared and need more support in therapy.

Client: I feel like I am hanging from a sailboat mast with one hand flapping in the wind and I might fall. This emotion stuff is all very new to me and scary.

This marker indicates that the client needs some scaffolding to support him or her as seen in the following therapist response.

Therapist: I'm really happy you told me how scary this is for you. It sounds like you are feeling alone and that you may fall and there will be no one to catch you. I am here with you and I will help you step by step. Let's talk about what the scariest part of this is for you.

This previous example highlights how it is important to understand the unique difficulties that clients are experiencing prior to giving a rationale. Offering rationales is important in experiential teaching and, like all aspects of emotion coaching, the therapist is process-diagnostic about the rationale being provided and engages in coaching that is experiential and marker-guided.

IN-SESSION EXPERIENTIAL TEACHING AND BETWEEN-SESSION HOMEWORK AND PRACTICE

A distinctive feature of EFT is that different modes of processing and tasks are engaged in at different markers of specific types of emotional processing problems. The main therapeutic action of emotional change is seen as occurring in sessions within the therapeutic relationship through

experiential teaching and task engagement. Homework is then used to enhance and carry forward in-session emotional work and helps to deepen and consolidate changes.

The EFT emotion coach is continually assessing clients' current emotional states and providing experiential teaching that fits momentary client states (Greenberg et al., 1993). In-session client processing helps to determine the relevance and timing of between-session homework. Therefore, the presence of in-session markers offers indication and direction for client readiness within the session, and in-session experiential processing provides guidance for client–therapist collaboration on homework tasks.

Experiential teaching tasks and emotion change principles that are engaged in are determined and adapted by stage of treatment and are client-state dependent. Early therapeutic work typically focuses on the *arriving* steps of emotion coaching, such as emotion awareness, acceptance, and regulation, whereas middle and later phases of treatment focus on the *leaving* steps of emotion coaching, such as transforming core maladaptive emotion schemes and consolidating new narrative views of self. A therapist may promote an internal experiential focus when the client is processing in a highly cognitive manner with little or no emotion. On another occasion the active expression of a feeling may become the focus, such as when clients have historically disowned their emotions and would benefit from encouragement in expression of emotion. The coach may help a client make meaning of his or her emotions following the client's experience of primary adaptive emotion and need expression. At yet another moment, the therapist may focus on the client–therapist interpersonal connection when the client is in need of soothing and support with newly emerging emotion. The coaching tasks of guiding the client in attending, inward experiential searching, active expression, interpersonal contact, or self-reflection are some of the different modes of processing that are promoted through in-

session work and carry forward to experiential learning opportunities between sessions.

APPLICATION OF EMOTIONAL CHANGE PRINCIPLES THROUGH EXPERIENTIAL TEACHING

There are seven major principles of emotion change (see Greenberg & Goldman, this volume, Chapter 3). Each of them guides experiential teaching and facilitates in-session task selection and between-session homework suggestions. The manner in which the principles are applied in the facilitation of in-session and between-session tasks is demonstrated through brief case examples. The experiential learning tasks promote in-session and between-session emotional change, particularly the experiential skills of client contacting, accepting, and using emotional information and resources. For detailed steps of emotional change tasks and exercises, readers are encouraged to refer to Greenberg's (2015) *Emotion-Focused Therapy: Coaching Clients to Work Through Their Feelings*.

Principles 1 and 2: Emotion Awareness and Expression

The principles of emotion work that facilitate awareness and expression are combined here given that they are interconnected processes that often occur concurrently. From the first session, the emotion coach embodies an attitude toward emotion that is welcoming, curious, and accepting. This attitude is a precondition of successful emotional change processes throughout treatment as it is a foundational skill on which all other change-producing principles rest. For example, clients who are able to turn their attention to their internal experiences and name those experiences, as well as their associated needs and action tendencies, are consequently

able to more fully and flexibly experience their emerging emotion states during chair-work interventions aimed at transforming emotion.

The emotion coach applies gentle, persistent empathic encouragement of a client's approach toward and tolerance of his or her internal, bodily felt emotional experience in the here and now (Greenberg, 2010). A primary goal here is to facilitate the client's processing style toward one that is more broadly and fully informed by experiential knowledge, not solely, for example, by intellectual knowledge. Attending to, becoming aware of, and symbolizing in words one's core emotional experiences allows access to important information that reason alone does not provide.

In-session and between-session tasks in EFT generally focus first on promoting awareness and expression of emotion as well as emotional processes that interfere with this awareness and expression, such as disowning of aspects of experience or self-protection in the form of interruption of emotional experience. Early experiential teaching may involve assessment and facilitation of emotional processing in the form of describing various components of emotion, such as an emotion label, physical sensations, action tendency (e.g., flee when afraid), what the emotion is about, and the need. For example, is the client able to name an emotion that they experience? If not, the emotion coach will offer empathic reflection and conjecture to facilitate naming. How rich is the language of their description? Is it vivid and detailed, possibly including metaphors and imagery, or it is more concrete and unelaborated? The coach may use empathic evocation to deepen the client's experience. Are clients unaware of how to attend to their internal experiences? In this case, the coach may begin with helping clients to attend to their physical sensations, something typically more familiar to people, before moving to their bodily felt sense. Are clients able to attend to and name a physical sensation, but not yet able to articulate the bodily felt sense of their experiences? Do they implicitly or explicitly articulate a need associated with their emotional experiences? A

focusing task can be helpful in both of these cases. Perhaps they feel a sense of “stuckness” between sessions, in which case accessing a need associated with their emotion that may mobilize action may be helpful. Much of the experiential teaching that occurs in EFT, both in session and between sessions, involves awareness tasks that ask clients to attend to one or more of the components of emotion noted previously. Learning how to become aware of, name, and express emotion, in and of itself, is a successful treatment outcome for some clients.

Focusing interventions (Elliott et al., 2004; Gendlin, 1982) are often used early on and throughout the EFT process to teach clients how to (a) make contact with and focus on their inner experiences; (b) increase their emotional awareness by articulating what they are feeling from a bodily felt referent; and (c) access core needs, which provides motivational direction. Brief focusing interventions are frequently embedded throughout EFT interventions, such as chair work, to facilitate deepening of experience and are used frequently within EFT process work. A recording of a therapist-guided in-session focusing exercise can be helpful for between-session use by the client to support and enhance the client’s ability to increase their emotional awareness and expression.

As early as the second session, the emotion coach may suggest that the client pays attention to and records in an emotion diary any emotions that emerge between sessions, only after such emotional experiencing has occurred in session. If a client is seemingly unable to express an emotion, it does not necessarily mean that the client does not have awareness of his or her emotion. There may be processing blocks that have been present for many years, such as an interruption of emotion that has developed as a result of having grown up in a home where emotional *expression* was discouraged or criticized. Common experiences that clients express here include explicit rules about emotion, such as “crying is weak,” and implicit rules that were learned, such as “once an emotion starts, it never stops.” The

emotion coach must be attentive during assessment to a client's inability to attend to, name, and describe an emotion, which is different from blocks to expression. Accordingly, the therapeutic relationship and coach's stance of being empathically attuned to and validating of the client's experience are paramount to this work if the client is to feel safe enough to allow and express feelings that are often uncomfortable, frightening, or painful or that may be perceived as shameful or weak if expressed.

In-session and between-sessions awareness tasks also involve coaching clients in attending to their emotional experience, emotions that may not yet be fully in awareness, or emotional experiences that are actively avoided, unacknowledged, or disowned. Some processing markers that indicate that it would be helpful to use experiential teaching to promote emotion awareness and expression include: little awareness of, or attention to, internal emotional experience; restricted awareness of various emotion experienced (e.g., "all angry," "all afraid"); avoidance/self-interruption of emotion; inability to name an emotion; experiencing of an unclear felt sense; lack of awareness regarding presence and impact of inner critical or catastrophizing part of self; and the presence of interpersonal boundary violation by others and unexpressed needs of the client.

Principle 3: Reflection on Emotion

The change principle of reflection on emotion occurs after a client has accessed adaptive emotions and needs and has developed a healthier internal voice (Greenberg, 2015). Experiential coaching of reflection on emotion is important after transformation has occurred because the emotion coach helps clients organize, structure, and assimilate their newly developed self-organization into coherent stories about self, other, and situations.

Experiential teaching is often aimed at shifting one's view of self and rewriting stories that promote greater self-acceptance and compassion. The

emotion coach uses various exercises to facilitate reflection and new meaning-making during the process of transformation and after transformation has occurred. Reflective exercises are most frequently used at two times: at the end of transformative in-session experiential work and in writing exercises between sessions. In-session reflection work may involve mapping out change-producing experiential processes that have occurred in the session (see the following section regarding Mapping Out EFT Chair-Work Interventions). Facilitating a new view of self may also be promoted in session with the use of chair work in which clients are asked to view themselves in the other chair and make contact with what they feel toward and see in the transformed person in front of them. This experiential teaching exercise can be particularly change-producing because clients are not solely explaining the change in self in cognitive terms but are instead simultaneously experiencing *and* redefining their perception of the transformed self. Between-session exercises include rewriting past emotion memories with use of an emotion diary and letter writing to significant others, particularly when emotional injury has occurred and unfinished business is present.

Principle 4: Transformation of Emotion With Emotion

One of the most important and change-producing ways that the emotion coach facilitates emotional change in EFT is by *changing an emotion with an emotion* (Greenberg, 2002, 2010). When dealing with chronic enduring painful emotion, people often get stuck in an emotion state, and all organization and functioning becomes routed within this stuck state, which is often maladaptive. When clients are in stuck or repetitive painful emotion, they are unable to attend to the feelings on the edge of their awareness. In EFT the emotion coach helps clients attend to these feelings to help them experience a different, more adaptive state and shift the stuck maladaptive emotional state.

In sessions, the emotion coach helps clients to first identify and experience a primary emotion, and then together they evaluate whether the emotion is an adaptive or maladaptive response to the *current* situation. If the emotion is identified as healthy and self-enhancing, it is used as an informative guide to action. If it is identified as destructive, often it must first be regulated or soothed and then transformed. The client is encouraged to pay attention to repetitious or enduring emotion states that occur between sessions only after the client has been helped to access that maladaptive emotion state in-session. Emotion awareness homework often facilitates this process. Clients are often aware of global negative emotion states, such as feeling upset or overwhelmed, but they may not be aware of differentiated emotions they are experiencing, such as anger, sadness, or fear as well as negative patterns of emotional experience that repeatedly occur (Ellison & Greenberg, 2007).

Although emotions that need to be transformed can present in various ways, it is helpful for the emotion coach to listen to the client's narrative and think in terms of attachment and identity struggles reported by and/or implicit in the client. For example, a client's primary maladaptive emotion may revolve around themes of attachment and abandonment in that he or she frequently experiences underlying fears of rejection and abandonment by loved ones. A primary maladaptive emotion of shame is often associated with identity themes that revolve around a sense of self as incompetent, inadequate, or a failure. In these situations, in-session experiential teaching will typically involve unfinished business work with a significant other from earlier in the client's life when the maladaptive emotion scheme was formed, as well as two-chair self-critical work to transform the client's relationship with an inner critical part, respectively.

Clients often experience relief or excited vitality when they access a core need, partly because this need has been outside of awareness or disowned for a long time. In addition, this newly emerging need is

connected to a primary adaptive emotion. Homework can be given to help replace maladaptive fear with the more boundary-establishing emotions of adaptive anger or disgust, or by evoking the softer feelings of compassion or forgiveness. People may be asked to practice, as homework, accessing anger toward someone they fear or to try practicing empathy toward someone they have felt wronged by. This is done only after the newly emerging alternate feeling has been accessed in a session and is found to fit.

Therapeutic focus is typically oriented toward that which is problematic in clients' lives. Client expressions of inner strength and resourcefulness provide ideal opportunities for introduction of tasks geared toward recognition and consolidation of transformed emotions, strengths, and internal resources. For example, a client entering a session and recounting a positive, self-affirming experience during the week would provide an appropriate opportunity for the coach to ask the client to specify her strengths in the given situation, and this would optimize the client's consolidation of her internal experience, capability, and resilience. The emotion coach might also ask clients to list and record strengths and resources on a card as they arise in the session, and then carry the card between sessions and add to the list when relevant experiences occur throughout the week. This aspect of attending to and recording freshly emerging positive perceptions of self then leads very naturally into reflection on emotion and consolidating new adaptive views of self and self-narrative.

Principle 5: Corrective Emotional Experience

A key emotional change principle, corrective emotional experience, involves promoting new lived experiences that change old feelings (Greenberg, 2015). This change principle is often at work through the therapy treatment within the corrective relational experience with the therapist as well as during productively processed moments in which clients

experience new adaptive emotions. Corrective emotional experiences occur in a relational context, whether it be self–self, self–therapist, or self–other person in the client's life. These experiences often induce newly discovered self-confidence, self-competence, and self-compassion that is recognized and validated by the therapist.

The relationship between the client and the therapist, which is genuine and consistent, is the primary vehicle through which new, corrective emotional experiences occur. This type of relationship creates an ideal therapeutic environment in which the client may fully engage in the process of emotional processing, self-discovery, and new learning. An example of emotion coaching wherein this principle is applied occurs in empty-chair work involving unfinished business. In this scenario, clients may be assisted by the emotion coach to reenter in imagination a concrete scene from childhood in which they felt belittled or dismissed by a caregiver. Clients are then guided to invite the coach into the scene while they reexperience the event in which they stand up for themselves and speak the needs of their inner child. The corrective emotional experience occurs as a result of the new emotional experience in the presence of the emotion coach who has been introduced into the memory (i.e., new lived experience of an old memory) as well as in the client's new success experience. This provides a different, new, empowered experience that contrasts with the many times they have experienced the memory in past recall. In this example, the relationship promotes new emotional experience, as does the experiencing of new adaptive emotions and need expression in a historically pain-inducing concrete memory. Another example of in-session emotion coaching of corrective emotional experience is when two-chair work is used toward the end of treatment when the client sits across from the transformed self and shares emergent perception of and experience in the presence of the newfound self. This experience is often a very powerful one as it is highly

viscerally different than the experience of self earlier in treatment when the inner critical view of self was highly active.

Between-session practice of new corrective emotional experience is also important in carrying forward in-session experiential change so that the client may have opportunities to repeatedly feel successfully lived experiences in the world. One way of achieving this is for the emotion coach to suggest that clients expose themselves to historically maladaptive emotion-inducing situations so that they may practice experiencing newly emerging adaptive emotions. For example, in-session emotion transformation work may first allow a client to become aware of how he or she predictably experiences secondary anxiety when around a significant other. This awareness may facilitate further awareness of an underlying primary emotion of sadness about the loss of connection and not having the relationship he or she wishes with that person. The client may then be asked to pay attention between sessions to when the emotion of sadness is experienced, as well as consider expressing his or her need to connect. Self-soothing may also be facilitated with the client. Another example would be when a client is asked to engage with a particular family member with whom they have had difficulty saying “no” and practice accessing a new found emotional experience of being aware of and expressing one’s voice rather than deferring to the other person. Generally, homework that supports this change is developed with consideration of past situations in which maladaptive emotions were experienced in conjunction with exposing oneself to similar experiences again to practice evocation of freshly experienced adaptive emotions.

Principles 6 and 7: Emotion Regulation

The emotion coach initially assesses emotion regulation skills. The most common in-session process marker that indicates the need for deliberate regulation of emotion is when the client experiences very high

emotional arousal that is very dysregulated and cannot achieve a moderate, working distance arousal. Although it is sometimes necessary to apply deliberate regulation at moments of intense emotional dysregulation to which the therapist must be attuned and apply deliberate skills, at other times, the therapist helps clients build automatic self-soothing or an internal capacity to soothe the self (Goldman & Fox-Zurawic, 2012; see also Chapter 9, this volume).

Deliberate Regulation

Distraction and regulation should be applied when emotional arousal exceeds a 70% level because the evoked emotions will become unmanageable (Greenberg, 2015). Emotional arousal that needs to be regulated often occurs in the form of autonomic processes such as changes to breathing rhythm (e.g., rapid, uncontrolled breathing), nonverbal expression (e.g., frequent shifting in chair, shaking of hands), and changes in verbalization (e.g., rapid speech, sobbing, loss of ability to verbally share experience).

When clients enter therapy, their emotions have often been interrupted or unacknowledged because such emotions may have felt too painful or overwhelming. As a result, clients may be unaware of how to begin dealing with their emotions that seem painful, confusing, or even outside of their control. From the beginning of the first session, the emotion coach teaches the client emotion regulation skills, as needed, so that they may begin to experience themselves as capable of attending to, coping with, and tolerating their bodily reactions to their emotions without interrupting them (Ellison & Greenberg, 2007; Greenberg & Warwar, 2006).

It is of paramount importance in EFT that the emotion coach recognizes signs of emotional distress and engages in emotional soothing interventions with clients. In the early learning phases of emotion coaching, coaches will facilitate activation of emotion and may then “freeze” when

the client exhibits intense, highly aroused emotions. If this happens, it is important for coaches to regulate their own states by breathing and localizing themselves in the therapeutic task at hand so as to not leave the client alone in his or her dysregulation. The coach is highly attuned in session to any need to engage in experiential teaching of emotion regulation skills and continues this attunement and readiness to facilitate emotion regulation as evocative work proceeds across treatment. Client capacity to have a working distance from emotion, neither underregulated nor overregulated, is key to using the helpful information contained within emotion while not becoming overwhelmed by it. Hence, the emotion coach assists the client in experiencing emotion states in which the client is *having* the emotion rather than the *emotion having* the client (Greenberg, 2015).

The coach also listens for problematic dysregulation between sessions as well, particularly following highly evocative in-session experiential work in clients who have displayed in-session high arousal and were overwhelmed by emotion. In this case the coach may suggest distracting and/or grounding skills. The coach may also engage in exploration within sessions of between-session relationships or environments that frequently trigger emotions and suggest healthfully avoiding exposure to these, at least for a short time, while the client is working on emotion regulation skills. In-session experiential teaching tasks may include self-soothing, such as diaphragmatic breathing, relaxation, accessing an imagined safe place to go to when feeling overwhelmed, and empathic self-talk. For example, therapist-recorded guided exercises for the client to listen to at home may be used (e.g., in diaphragmatic breathing, relaxation, or safe place imagery). The coach may also suggest the client use deliberate attention between sessions by checking in with their inner child as well as when painful emotion and a need for calming and/or soothing arises during stressful events in daily life. Regulation and soothing may also be achieved through relationship with another person in the form of other-soothing. The

empathic, validating environment provided in session by the emotion coach is of fundamental importance in supporting the client's soothing capacity, particularly when experiential tasks are aimed at accessing painful emotions that can often result in emotional dysregulation, and other-soothing may also be achieved by engagement with an empathic and supportive other between sessions.

Automatic Regulation

Beyond the development of deliberate skills, self-soothing internal processes and dialogues promote a client's ability to be compassionate and accepting toward emerging painful emotional experience. Soothing dialogues in therapy help build clients' automated capacities to physiologically regulate emotion states as well as to self-soothe in emotional moments. Promoting clients' capacity for self-empathy and self-compassion is important for clients who experience difficulty in welcoming and being compassionate toward their painful feelings (Greenberg, 2010). Experiential teaching guides clients toward openness and interest in their painful feelings by, for example, asking them to imagine themselves as a small child who is feeling hurt and is in need of care and attention (Greenberg, 2002; Greenberg & Watson, 2005). These tasks may be therapist-guided in session or self-guided in practice between sessions. The emotion coach pays particular attention during the assessment phase and throughout treatment to discussion regarding the presence of a supportive and loving other in the client's history. When wanting to promote self-soothing, the therapist may choose to ask clients to evoke the other in their mind's imagination and/or in chair-work dialogue in future sessions at key moments. Internalizing a soothing other is a very helpful function of the EFT therapist for both in-session experiential work as well as between-session experiential practice. Clients often find it helpful to evoke their therapist when feeling distressed or overwhelmed between sessions. They

may also find it helpful, either in sessions or between sessions, to bring their wise adult self or supportive therapist as a protective other with them in imagination while recalling and/or processing a painful interpersonal event so as to further internalize a soothing self or other (see Chapter 9 for a fuller description of how to promote clients to be able to conduct self-soothing in-session through chair work).

Whether promoting deliberate or automatic regulation, introducing emotion regulation homework is an important way to support opportunities for further in-session experiential work in that welcoming and tolerance of emotion provides emotional grounding from which deeper emotional experiencing becomes possible. Between-session practice of regulation also assists in increasing the client's experiential competency to shift in and out of emotion states; clients learn experientially that emotion states come and go and that they will be able to tolerate the emotions that have felt too scary or painful.

MAPPING OUT EFT CHAIR-WORK INTERVENTIONS

Following in-session chair-work interventions with clients, we have found it helpful, especially at the end of emotional sessions or when there has been an emotional shift, to engage in experiential teaching that maps out the in-session chair-work process to help consolidate changes and carry clients forward (Warwar, 2015; Warwar & Greenberg, 2012). During chair-work interventions, a great deal of emotional processing can occur, and clients may experience high arousal as well as the activation and transformation of maladaptive emotions into newly emerging adaptive emotions and the expression of unmet needs. Although clients may feel better following a resolved chair-work intervention, because there can be a high degree of emotional arousal and transformation, mapping out the process for clients can significantly help clients with meaning making and

consolidating newly emerging emotions, needs, and positions (Warwar, 2015). For example, when a new voice emerges, “I am worthy,” in a self-critical split dialogue, it may be fragile and shaky in the beginning; thus as therapists we want to support, strengthen, make sense of, and consolidate this voice. Moreover, once the in-session chair-work process has been mapped out, providing clients with homework suggestions to promote new awareness, experience, or consolidation of new changes has been found to be highly beneficial.

Prior to mapping out the specific change processes, providing clients with a rationale about this is important. For a self-critical split, the therapist may express the following to clients: “It is helpful to get clear on the process of how you feel worthless. Let’s map this out together and try to make sense of your process.” In an anxiety split, the therapist would offer the rationale, “It is beneficial to understand your experience of how you get anxious by mapping this process out together,” or in a self-interruption, the rationale offered may be, “To clarify your experience, let’s map out this process that you just experienced where you stop yourself from expressing yourself.”

Following the provision of a rationale, an effective way to map out the process collaboratively with a client, immediately following chair-work intervention, is to take a pad of paper and position your chair next to the client so that you are sitting side by side. Exhibit 12.1 shows the final worksheet that is generated as a result of the process of mapping out a self-critical split. On the left side of the worksheet is the *self-critical part*, and on the right side is the *experiencing side*, the part that initially feels worthless. The therapist generates this collaboratively with the client by structuring the two sides of the chair-work process on the sheet and asks the client questions to generate the specific aspects of the chair-work process that just transpired in session. The mapping out process should feel simple

and intuitive to the EFT therapist as he or she follows the steps of the specific chair-work intervention that has just occurred.

EXHIBIT 12.1
Mapping Out a Self-Critical Split

CRITICAL PART (SELF-PROTECTIVE)	EXPERIENCING PART THAT FEELS WORTHLESS
Step 1 **Therapist: Let's reflect on the origin of the self-critical voice. What is the childhood wound/sensitivity related to critic? Was it self-protective? You said this critic was originally your father's voice?** Client: Yes, my abusive father who was critical and love was conditional on how I behaved. Now it's my voice.	
Step 2 **Therapist: What's the message from critical part?** Client: You're worthless. You're a failure in every way, as a father, husband, employee and so on.	
	Step 3 **Therapist: What do you experience/feel when you hear this?** Client: I feel worthless, a deep sense of shame. I feel like giving up. It's really painful. I don't want to live feeling like this.
	Step 4 **Therapist: What do you need from that critical part of you?** Client: I need to feel that I am okay just as I am, that I am lovable, that I am worth something, not just because of how well I do.
Step 5 **Therapist: How do you feel when you hear what the other part feels and needs? What is your response?**	

Client: I feel bad. I am trying to keep you from being hurt because I'm afraid others will treat you like your dad so I tell you that you are worthless so you will work hard to be lovable. I do see a lot of good in you and I do love you.

Therapist: Can you remember what you said is good about him?

Client: You are a good father, husband, friend. You're a good person and you have a good heart.

Step 6:

Therapist: How do you feel when you hear this?

Client: I feel hopeful and warm in my body.

Note. Data from Warwar and Greenberg (2012).

Step 1: Reflecting on the Origin of the Self-Critical Voice

In mapping out a self-critical split with a 41-year-old man (see Exhibit 12.1), the therapist starts off in Step 1 by asking the client to reflect on the origin of the self-critical voice, that is, "Was it self-protective?" The purpose of this step is to consolidate the meaning of the critical message as the client mentioned during the chair work that the critical voice was his father's voice.

Step 2: Articulating the Critical Message

In Step 2, the therapist asks the client to articulate the critical message that was just activated in the chair work. The therapist uses the client's words, and if the client has difficulty remembering, the therapist may prompt the client by recounting the chair-work dialogue: "When you were

in the critical chair you said, ‘you’re a failure,’ do you remember the specific critical message?”

Step 3: Consolidating Feeling and Experience

In Step 3, the therapist moves over to the experiencing side and asks the client what he experienced in relation to the critical message. The goal here is to map out the *experiencing* side’s feelings and experience using the client’s chair-dialogue words. The example that follows illustrates mapping out the rest of the chair-work process. In this example, the therapist uses questions and tentative prompts to help consolidate the experiential chair-work process.

Therapist: When you moved into the other (experiencing) chair, how did you feel in relation to hearing the message you are worthless in every way?

Client: I don’t remember.

Therapist: I recall that part feeling a deep sense of shame?

Client: Oh yes, it was very painful to hear those things.

Therapist: So the shame felt very painful.

Client: Yes.

Therapist: I remember this side saying that it feels like giving up, and that you don’t want to live feeling like this?

Client: Right, it is not an easy way to live.

Step 4: Consolidating Emerging Needs

Therapist: Do you remember what you needed from the critical part from this position?

Client: Yes, I needed to feel that I am good enough.

Therapist: Mmm hmmm. I recall you saying that you need to feel lovable, that you are okay just the way you are.

Client: Yes, I really need that, to feel that I am lovable and worth something, not just because of how well I do.

Therapist: Yes, that is something that is so important, to feel lovable and worthwhile just the way you are.

Step 5: Critic's Response to Emerging Feelings and Needs of Experiencing Side

In this step the therapist asks the client to recall what the critic's response was to the experiencing side's feelings and needs.

Therapist: What was the critic's response to feeling this deep sense of shame and the deep pain that you feel about it?

Client: The critic felt bad about this and was doing this to try to protect me. I don't think that part realized the damage it was doing. The critic also said that there was a lot of good in me and that he does love me.

Step 6: Experiencing Side's Response to Softening Critic

In this step the therapist prompts the client to recall and strengthen the "hopeful" feeling that emerged.

Therapist: What was it like to hear that?

Client: It feels hopeful that things can change, and I feel warmth in my chest.

In this mapping out process, the therapist's responses and prompts are directly generated by the critical chair-work session. Following this consolidation process, an example of a therapist suggestion for homework to consolidate self-critic work for this example may include change

homework, which is relevant when there has been a marker indicating that the client has made a change. In this example, the client has a new experience of feeling lovable, and to strengthen this the therapist may suggest that the client practice this change with a client- and/or therapist-devised exercise. “Over the course of the week, can you tell him three lovable things about him? Does it fit for you to do that?” It is important to check if the client is aligned with and capable of doing the homework that is suggested.

MAPPING OUT THE PROCESS WHEN CHAIR-WORK INTERVENTIONS ARE NOT RESOLVED

When chair-work interventions are not resolved, this mapping out process can also be used to consolidate and make meaning of the point in the process you have reached with the client. The format is the same, but the emphasis is on acknowledging which point in the process you have arrived at with the client; this helps focus the therapy process when you return to the chair-work intervention again. For example, if you were able to get to Step 2 and activate the critic, you might assign the client awareness homework to pay attention to when the critic emerges and what the negative messages are from the critic. This can be empowering as it allows clients to experience themselves as active agents of how they are self-critical and helps consolidate where you got to in the process. This mapping-out process also highlights client and critic positions, as in in-session chair work, so that the self that has often been obscured by the inner critic for many years can begin to differentiate and be heard.

Exhibit 12.2 shows an example of the mapping-out process of an anxiety split. The homework suggestion by the therapist to consolidate the chair work with this client was, “Can you stand up to the anxiety-producing part when it comes up during the week? What could you say to do this?”

The client responded by saying “Stop it, I am doing well! I don’t need your protection anymore, I’m not a child.” The therapist highlighted that one of the antidotes to the anxiety-producing part is self-assertion or anger toward that part. “You felt this [anger] in the dialogue we did.”

EXHIBIT 12.2
Mapping Out an Anxiety Split

ANXIETY-PRODUCING PART (SELF-PROTECTIVE)	EXPERIENCING PART THAT FEELS ANXIOUS
Step 1 **Therapist: Let's reflect on the origin of the anxiety producing voice. Where does this anxiety-producing voice come from?** Client: I was humiliated by kids at school. I'm afraid of screwing up in front of others. My father was anxious and made me anxious.	
Step 2 **Therapist: What is the anxiety-producing part saying? How do you make yourself anxious?** Client: It says, 'you are going to embarrass yourself during surgery. Your hands are going to start shaking. Be careful, watch yourself. Everyone is watching you. Are you shaking? Your hands have shaken before. Watch your hands to make sure they are not shaking. Oh no! Your hands are starting to shake. Are people watching?' It's very intense!	
	Step 3 **Therapist: What do you experience/feel when you hear this?** Client: I feel anxious, overwhelmed, my heart is racing. I lose my confidence and then I start to feel nervous, and then my hands start to shake.
	Step 4 **Therapist: What do you need from the anxiety-producing part?** Client: Be quiet. See that I'm not that boy who needs protection anymore. I'm a

	surgeon now. I need you to recognize my accomplishments and acknowledge them. I don't need your protection anymore! I'm not a child!
Step 5 **Therapist: What does this anxiety-producing part need from you to help it give you what you need?** Client: Stand up to me and tell me that you feel confident and that you don't need me to protect you. Get angry with me and assert yourself like you just did.	

Note. Data from Warwar and Greenberg (2012).

Exhibit 12.3 shows an example of the mapping-out process for a self-interruption. The homework to consolidate the self-interruption chair-work process was, "Pay attention to what you feel and need in relation to your husband, and see if there are small ways you can open up." This was suggested because this was the need that emerged from the experiencing side, the part that is silenced. Thus, this homework is also practice for the client and consolidates the work done in session.

EXHIBIT 12.3
Mapping Out a Self-Interruption

PART THAT STOPS YOU FROM EXPRESSING YOURSELF (SELF-PROTECTIVE)	EXPERIENCING PART THAT IS SILENCED
Step 1 **Therapist: What was the self-protective function? Where does this voice come from?** Client: My mother used to shut me down and shush me whenever I asked for anything. My father was an alcoholic and I had to take care of him. They were not interested in hearing what I had to say. I learned to keep my needs to myself.	
	Step 2 **Therapist: What do you experience/feel when you shut yourself down now?** Client: I feel numb, disconnected, and very lonely. **Therapist points out: This part is hurting you more that it is helping you now. It may have been helpful as a child, but now it is keeping you disconnected from your loved ones**. **Step 3** **Therapist: What do you need from the part that stops you from expressing yourself?** Client: I need to feel that it is okay to let people in and that people are interested in hearing what I have to say. I need positive encouragement from that part. I need to feel that the wall can be penetrated. **Step 4**

Therapist: As an example, what do you want to express over the week?

Client: I want to tell my husband that I want him to spend more time with me.

Step 5

Therapist: How do you feel when you hear what the other part feels and needs? What is your response?

Client: I feel badly, but I need you to remind me that you are going to be okay if someone shuts you down.

Note. Data from Warwar and Greenberg (2012).

SUSTAINED GAINS AND CARRYING THROUGH EXPERIENTIAL LEARNING POSTTREATMENT

Between-session tasks are well suited to an EFT approach in that in-session tasks prepare the client for, and likely increase the probability of, client-initiated activities between sessions as well as self-guided implementation of gain-sustaining activities once treatment has ended. Consequently, the implementation of experiential skills or tools that are learned during the acute phase of treatment allow clients to better equip themselves to deal with emotional pain and problems as they arise outside of sessions and posttreatment (Ellison & Greenberg, 2007).

Working toward a new way of being in the world is often not a process that is fully completed within the time frame of short-term therapy. Although emotional restructuring is viewed as leading to change in core emotion schemes and therefore to less likelihood of relapse, short-term relapse prevention skills can be important. Given that therapy alone does not always change deeply entrenched, learned responses that have developed over a person's lifetime, active engagement in self-work after

therapy has ended can be very helpful. This is the period when the client's emotion repertoire will continue to be challenged, changed, and solidified. An important factor that seems to differentiate those who relapse from those who maintain gains is the individual's ability after treatment has ended to actively use tools that they had developed in terms of emotion awareness, expression, regulation, transformation, reflection, and corrective emotional experiences within therapy. Hence, practice and consolidation of changes that occurred in therapy and between sessions during the acute phase of treatment are hypothesized to contribute to and partly determine sustained gains posttreatment (Ellison & Greenberg, 2007).

CONCLUSION: THE COACHING COMPASS

In this chapter we have offered a model of experiential teaching through the lens of the EFT therapist as an emotion coach. Emotion coaching requires a high degree of therapist in-session attunement and presence while working with sensitivity and responsiveness within the client's zone of proximal development as well as creative collaboration with the client in the use of between-session homework and practice. It is a way of working with emotions that is process diagnostic in that it assesses what state the client is in, moment by moment, and how the emotion coach can use experiential teaching at process markers of teachable moments to assist with change. The most valuable guide for the emotion coach, often referred to as the *coaching compass*, is the client's core enduring pain, and some of the most transformative work will occur at the destination for therapeutic work when the coach and client arrive at this pain. The compass will provide guidance toward the client's core issues. Experiential teaching is essential in facilitating change in EFT as it involves coaching clients on how to process and deal with their emotions differently and productively. Experiential teaching occurs most optimally in the context of a teachable

moment when emotion schemes are up and running and most amenable to change. Facilitating therapeutic work in EFT involves leading by guiding the process and facilitating different in-session tasks to deepen emotional experience moment by moment and resolve emotional problems. This combination of providing support and promoting newness, of following and leading, of validating and confirming the client's experience, and of opening new possibilities and promoting novelty (Greenberg et al., 1993) constitutes the dialectic of acceptance and change that is emotion coaching.

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III
CLINICAL PRACTICE OF EMOTION-FOCUSED THERAPY WITH SPECIFIC CLIENT POPULATIONS

13
EMOTION-FOCUSED THERAPY FOR DEPRESSION

JOÃO SALGADO, CARLA CUNHA, AND MARINA MONTEIRO

Emotion-focused therapy (EFT; Greenberg, 2002, 2004, 2008, 2012), also known as process-experiential therapy (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, Rice, & Elliott, 1993), is an empirically supported treatment for depression (Elliott, Greenberg, & Lietaer, 2004). EFT considers emotions and feelings (treated as synonyms in this chapter) to be fundamental to the construction of the self, since they provide a "gut-level" immediate source of information (i.e., a preconscious evaluation of stimuli), that human beings use to discern among competing priorities, orient to action, adapt to environments, and promote well-being (Greenberg, 2004, 2008; Greenberg & A. Pascual-Leone, 2006; Greenberg & Safran, 1989). Furthermore, emotion is considered to play an essential role in adaptive and maladaptive human functioning. For EFT, change is achieved through changing emotion with emotion and by developing the ability to experience, tolerate, symbolize, and express emotions (Greenberg, 2002; Greenberg, Rice, & Elliott, 1993; Pos & Greenberg, 2007). In this chapter

we aim (a) to describe how depression is understood within EFT, (b) to clarify how the generic principles of change within EFT can be applied to depression, and (c) to specify how the intervention in EFT for depression takes place.

DEPRESSION THROUGH AN EFT LENS

Clinical depression is one of the most common mental disorders (Kessler & Wang, 2002; Richards, 2011), standing as a leading cause of disability worldwide and the leading contributor to the global burden of disease in developed countries (World Health Organization, 2010). Major depression disorder, as well as other related forms of mood disorders, such as dysthymia, is characterized mainly by persistent depressed mood and/or by a loss of interest or pleasure in daily activities, complemented with other enduring symptoms, such as: sleep disturbance; weight variation; psychomotor agitation or retardation; lack of energy; diminished ability to think, concentrate, or decide; feelings of guilt and worthlessness; and thoughts about death, including suicidal ideation. According to the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–5*; American Psychiatric Association, 2013) depression is basically an affective disorder, which means that it disturbs the way people feel about themselves and the world.

From a phenomenological point of view, depression can be experienced in many ways. Some people go through a persistent state of despondency after a failure; others succumb to a state of exhaustion after anxiously trying to keep up with extremely high demands and expectations or even threatening conditions; others suffer from a prolonged grief after a significant loss of someone. Feeling down is frequently coupled with anxiety and agitation. The self is experienced as weak, defective, and worthless, and self-narratives tend to become rigidly dominated by these

themes and lack of specificity in episodic memories (Boritz, Angus, Monette, & Hollis-Walker, 2008; Williams et al., 2007). Hopelessness tends to prevail, feeding ideas about death and suicide (Shahar, Bareket, Rudd, & Joiner, 2006).

According to EFT, in depression the self has lost the sense of vitality and resilience, mainly by losing contact with needs and emotions (Greenberg & Watson, 2006). Problems in the adequate emotional processing of their experiences lead people to become distant from their own inner resources and needs. Inadequate emotional processing involves different but overlapping problems: (a) not fully processing previous experiences, (b) blocking emotional experiences, or (c) lingering on maladaptive experiences that remain unchanged. All these processes make it difficult to access underlying needs and primary adaptive emotions that would foster a more healthy functioning. For example, if loss is not fully processed, adaptive sadness may be difficult to access, preventing the fulfillment of a basic need for social support and caring, resulting in isolation. Or when one is confronted with violations of one's rights, by blocking adaptive anger, the needs for self-assertion and respect are not met.

These experiences leave the person stuck in the "same old story" (Angus, 2012; Angus & Greenberg, 2011) or problematic narratives (Gonçalves, Matos, & Santos, 2009; Gonçalves, Ribeiro, Stiles, et al., 2011), feeding complex and resistant cognitive-affective states characterized by hopelessness and helplessness.

EFT for Depression: An Evidence-Based Treatment

According to Division 12 of the American Psychological Association, EFT is an empirically supported treatment for depression (APA Presidential Task Force on Evidence-Based Practice, 2006; Strunk, n.d.). Three clinical trials of 16 to 20 session treatments compared the efficacy of EFT in

comparison with client-centered therapy (York I depression study—Greenberg & Watson, 1998; York II depression study—Goldman, Greenberg, & Angus, 2006) and with cognitive behavior therapy (CBT; University of Toronto study conducted by Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003). Both York I and II samples revealed that EFT clients exhibited statistically significant differences in the level of depressive symptoms at termination and at 18-month follow-up when compared with the client-centered sample, and had significantly lower rates of relapse at 18 months (Ellison, Greenberg, Goldman, & Angus, 2009). When compared with clients in the cognitive–behavioral sample, EFT clients exhibited the same levels of symptomatology improvement at treatment termination, although there were some differences at the interpersonal level (EFT clients were significantly more self-assertive and less overly accommodating or compliant to others; Watson et al., 2003). Another trial comparing EFT with CBT for depression was developed in Portugal at the University Institute of Maia (ISMAI), largely replicating the University of Toronto study; the first results suggest that EFT is at least as effective as CBT (Salgado, 2014). Finally, counselling for depression, an adaptation of EFT for UK routine practice, is currently under scrutiny (Sanders & Hill, 2014).

Major Forms of Depressive Self-Organizations

EFT for depression is based on a dialectical constructivist view (Greenberg & Pascual-Leone, 1995, 2001; Greenberg, Rice, & Elliott, 1993; Pascual-Leone, 1987, 1990, 1991). Human functioning is understood as the result of a dialectic tension between one more tacit and one more explicit mode of processing. The tacit mode is mainly affective and automatized, and thus at this level, perceptions, emotions, and feelings play a vital role, whereas the explicit processing is more rational and reflective. This dialectic is largely based on previously developed self-schemes that

provide automatized reactions to perceived events, on the one hand, and on the more consciously elaborated self-narratives developed throughout development, on the other.

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

People who are depressed tend to be dominated by specific forms of self-organization, which have an early interpersonal origin, in the formative years, involving past experiences of loss, rejection, humiliation, or abandonment. Specifically, Greenberg and Watson (2006) hypothesized that two kinds of self-organization prevail in depression: feeling unlovable or worthless, and feeling helpless or incompetent. To these two forms, we propose a third one, associated with sadness and loneliness (see also Timulak & Pascual-Leone, 2015).

A first and frequent form of self-organization in depression involves a sense of failure in meeting internalized social standards from which people derive their sense of worth and value. The self, then, is organized around a cognitive-affective sense of defectiveness, worthlessness, and hopelessness (“self as bad”; Greenberg & Watson, 2006), with high levels of self-criticism and self-coercion. This way, maladaptive core-shame is activated when processing failures, mistakes, personal defects, or social mishaps; thus, humiliation and shame become a lingering form of experience, easily and strongly activated and difficult to overcome.

A second form is dominated by a core maladaptive attachment related fear. In depression, clients often have an impaired sense of protection, becoming dominated by an intense and maladaptive fear and avoidant

tendencies of the events-to-be. This sets in an anxiety-based insecurity or a sense of a “weak self” that underlies many clinical depressions (Greenberg & Watson, 2006). In these cases, the person may feel fearful of abandonment, assuming a submissive interpersonal style, for example.

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

These forms of self-organization are usually combined in complex and varied ways. For example, a core dreadful fear of separation is commonly seen in clients that have intense self-criticism and coercion. In some of these cases, self-diminishment is actually explained by a more nuclear fear of separation, which prevents people from asserting and defending themselves at violation. Another possible combination of these three forms of self-organization involves a maladaptive destructive anger, usually related with previous history of abuse or even interpersonal complex trauma (Paivio & Pascual-Leone, 2010; Pascual-Leone, Gilles, Singh, & Andreescu, 2013). Therefore, maladaptive destructive anger can be an attempt to adapt to extremely severe conditions. Other parallel examples may exist, and it is a task for the therapist and the client to build a shared understanding of their core complex issues.

These maladaptive self-organizations disrupt the ability to process and regulate current experiences and feelings, which become overwhelming or intolerable. In depression, the person shuts down as an attempt to avoid those overwhelming feelings. During depressive episodes, people frequently do not have access to their core maladaptive and painful feelings or even to the voices disclaiming their own experiences (Greenberg &

Watson, 2006). This produces a sense of powerlessness and weakness, because they become unable to own part of their experience and lose contact with their own adaptive needs. For example, when facing a disappointment, the person may quickly feel depressed instead of accepting the negative experience and pursuing other ways of obtaining recognition, love, or success.

A MODEL OF SCHEMATIC PROCESSING IN DEPRESSION

Greenberg and Watson (2006) proposed a generic model of schematic processing in depression, depicted in Figure 13.1. We introduce here some slight adaptations to the model, extending it to cover maladaptive core sadness and giving a clearer role to narrative production. The depressive states and their core emotional schemes are usually activated by current stressful experiences, or by episodes interpreted as loss or failure. These events trigger an initial primary adaptive emotion, such as sadness at loss. Such sadness would promote healthy actions of seeking comfort and support, paving the way to compassionate intersubjective encounters that would promote acceptance, relief, and soothing; however, this tends not to happen in people who are vulnerable to depression, generating isolation and loneliness because of the activation of maladaptive emotion schemes, based on previous experiences of rejection, abandonment, humiliation or diminishment. Overall, a sense of self as lonely/abandoned (maladaptive sadness-based scheme), weak (maladaptive anxiety-based scheme), or defective (maladaptive shame-based scheme), dominates the person. As indicated in Figure 13.1, these different voices may coexist and interact, but usually one tends to dominate a person’s core pain.

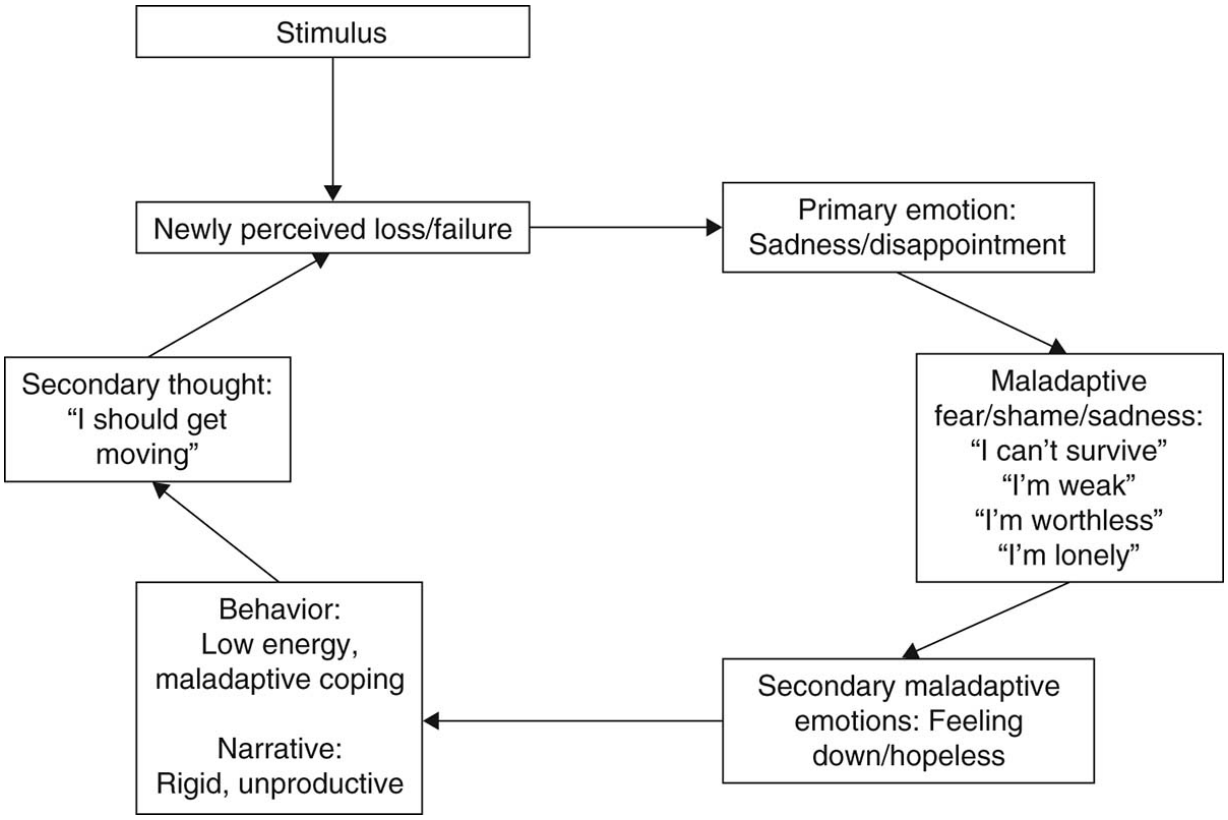

Figure 13.1. Emotion schematic cycle of responses to loss or failure leading to depression. Adapted from *Emotion-Focused Therapy for Depression* (p. 54), by L. S. Greenberg and J. C. Watson, 2006, Washington, DC: American Psychological Association. Copyright 2006 by the American Psychological Association.

All these voices produce negative self-evaluations, generating a loss of self-esteem and initiating a secondary reaction in which hopelessness and depression set in. Affectively, the person feels down, and prevalent adaptive needs are not accessed or met; narratively, the person becomes dominated by some problematic dominant narratives (Angus, 2012; Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011; Gonçalves & Stiles, 2011; Stiles, Honos-Webb, & Lani, 1999). No escape seems possible, because the person is reliving and retelling the "same old story" (Angus, 2012; Angus & Greenberg, 2011), or, by facing such overwhelming schematic memories,

the person resorts automatically, preconsciously, to a depressive state as a way of not getting in touch with those core emotions (Greenberg & Watson, 2006). Therefore, these narratives can also become “empty stories” (Angus, 2012; Angus & Greenberg, 2011). Behaviorally, the person may engage in maladaptive forms of coping, such as withdrawing from social life, avoiding daily tasks, or finding ways of numbing and escaping the ever-present bad feelings.

Finally, because the underlying core feelings and needs are not attended and resolved, the person, when trying to coach himself or herself as to how to get out of depression, fails to do so and becomes more and more self-coercive and self-contemptuous; that, in turn, increases the sense of failure and powerlessness. Usually, when the therapeutic process is started, it is this secondary process of creating hopelessness that starts to be explored, and only later does it become possible to gain access to the core painful issues.

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

CHANGE PROCESSES IN EFT FOR DEPRESSION

In depression, feelings of hopelessness or diffuse anxiety are very common forms of secondary emotions (reactions to more primary emotions); in some cases clients may also show some instrumental emotions, in order, for example, to seek support. These are usually the

result of more in-depth difficulties of emotion processing. Typically, the therapeutic work evolves from empathically exploring and working upon these emotions in order to reach to the core primary ones.

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

In a simplified view, by providing an appropriate therapeutic relationship, and by facilitating the therapeutic work, EFT for depression starts dealing with secondary emotions, such as feelings of helplessness or diffuse anxiety, paving the way to the empathic exploration of maladaptive emotions of deep shame, sadness, or anxiety (primary maladaptive emotions) and, in a later phase, to the experience of primary adaptive emotions, such as sadness at loss, pride, assertive anger, or joy. When this later step happens, it means that the person is reconnecting to the core needs of the self while being able to better cope with previous threatening, humiliating, or grieving experiences.

In EFT for depression, this process of changing toward more adaptive forms of emotion and to new and healthier forms of meaning-making is governed by the general principles of change: (a) increasing awareness of emotion, (b) enhancing emotion regulation, (c) reflecting on emotion, and (d) transforming emotion (cf. Chapter 2, this volume; Greenberg & Watson, 2006).

INTERVENTION PHASES IN EFT FOR DEPRESSION

EFT for depression is generally guided by two main intervention principles: establishing an empathic, healing relationship and facilitating the resolution of tasks (Greenberg, Rice, & Elliott, 1993; Greenberg & Watson, 2006). These principles globally develop through three phases (cf. Chapter 2, this volume; Greenberg & Watson, 2006).

The first phase is an initial stage of treatment, which is focused on establishing a therapeutic bond and promoting client awareness. This phase is centered on building a safe and empathic therapeutic alliance and relationship, as well as setting a shared focus for the process, which allows clients to shift their attention inward and become more aware of their experiences. In the second phase, which is focused on the evocation and exploration of core difficulties of emotional processing, the main goal is to help clients experience their core vulnerabilities by attending, arousing, and exploring their maladaptive schemes. Gradual exploration of these experiences allows reaching to the core experiences of vulnerability. In this phase, the therapist and client work together in order to access and process the “core pain.” In depression, this usually takes the form of a dreadful fear of abandonment or core maladaptive shame or even despair while grieving. These core issues need to be gradually accessed, aroused, regulated, symbolized, reflected, and, later on, transformed.

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

The third and final phase, focused on emotion transformation, involves the construction of alternatives by producing new emotions and building new alternatives and meanings (Angus & Greenberg, 2011; Cunha et al., 2017). This stage starts when clients have already processed their emotional difficulties. When that happens, clients are able to better understand why they have some emotional responses, what triggers them in terms of stimuli and interpersonal events, and what these responses are. Then the therapist can facilitate the development of alternative responses, which are usually rooted in core needs that were previously dismissed, blocked, or avoided. For example, accessing the need for self-protection may release an assertive anger that was previously blocked by a maladaptive fear of abandonment by that client; the need for love and support may prompt another client to seeking soothing experiences with others or even self-soothing, helping the person to better cope with losses and failures. It is in this phase, then, that clients substitute more adaptive and productive emotions for maladaptive ones. The therapist helps clients to generate these new emotional responses, as well as promote reflection upon these new forms of experiencing oneself and the world, while validating a new, emergent, and revised sense of self, which can be consolidated by a process of self-narrative reconstruction (Angus & Greenberg, 2011; Cunha et al., 2017).

MARKERS AND TASKS IN EFT FOR DEPRESSION

EFT is *marker guided*, which means that a specific marker calls for a particular task, invited or introduced by the therapist. Globally, there are six central tasks in EFT for depression, even though others can also be used if necessary (Elliott, Watson, et al., 2004; Greenberg, Rice, & Elliott, 1993; Greenberg & Watson, 2006): systematic evocative unfolding, focusing, two-chair dialogue, two-chair enactment, empty-chair work, and empathic affirmation.

Greenberg and Watson (2006) proposed that when therapists conduct emotion-focused therapy for depression, it may be useful to distinguish emotional processing problems that are more related with interpersonal issues from those that are more associated with self-to-self relations. This brings some further discrimination of the markers presented above. Interpersonal issues are usually revealed by emotionally laden statements and narratives that signal that the person has unresolved feelings and unfinished business about a present or past relationship with a significant other, usually involving loss, abuse, or neglect. When that happens, empty-chair work and empathic exploration are usually indicated for promoting a resolution for unfinished business.

Other markers associated with depression come in the form of maladaptive forms of self-to-self relationships. Typically, depressed clients suffer from either detrimental self-criticism or some form of self-neglect (Greenberg & Watson, 2006). Some others may even suffer from a blend of all of these manifestations.

Self-criticism in depression usually comes in the form of very negative statements that involve anger or contempt directed inward, and this calls for two-chair work. A variation may be self-coercion, in which clients place extremely high demands on themselves, leading them to burnout and depletion. Many depressed clients suffer from these inner attacks and collapse to these critical voices by identifying themselves with those

criticisms. When that happens, the person may feel deeply ashamed, sad, or anxious, and hopelessness and despair set in. Two-chair work helps clients differentiate two sides of their experience: the voice of the critic and the voice of the experiential self. Once they are differentiated, clients can act as the critical voice and feel the consequences of those self-assertions; then they become more aware of what they are doing to themselves with the self-attacks and start realizing how harmful these attacks are. Finally, when clients collapse in the face of the critic, becoming hopeless, two main options are left to pursue as eventual ways out of that apparent dead-end (cf. Elliott, Watson, et al., 2004). The first option calls for an empathic response from the therapist to the collapsed self, which may involve the therapist exploring with the clients how awful this dead-end looks like and how much one wants to get out of that "place," and helping clients to communicate their protest toward the critic. The other option is to invite clients to intensify criticisms from the critical chair, making them more unbearable, increasing awareness of their harm, and promoting a more adaptive response from the experiential self when switching to the other chair. In either case, the goal is to get in touch with needs and actions of self-assertion and self-protection, activating feelings of adaptive anger.

Another depressive process implies some form of self-neglect that usually involves losing contact with one's feelings (Greenberg & Watson, 2006). This happens in various ways: not knowing what one is feeling at all; having difficulty in focusing inward when invited to do so; or dismissing or downplaying feelings, considering them as not important or even signs of weakness or defect, or disregarding their intensity. These types of problems most times present themselves as markers of an unclear felt sense or problematic reactions, which call for empathic exploration, or experiencing tasks such as focusing and evocative unfolding as a way to develop an internal focus of attention.

When depressed clients become very analytical, in a dry, distant, and emotionless way, which is another form of disregarding feelings, it can also be important to do evocative unfolding and imagery work with concrete events. These clients may present some frequent signs of problematic reactions (e.g., difficulties holding in their tears in unexpected situations). Yet, even in the absence of a clear marker, evocative work may also be very useful, as a way of making episodes more alive in the here and now, and preparing the clients to focus inward, access feelings, and develop a therapeutic focus for the session.

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

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

Interpersonal issues and self-to-self problems can also be intertwined, with implications to the kind of interventions to pursue. In self-splits, the critical voice is often the internalized result of previous interpersonal experiences with critical, humiliating others, who have created an emotional maladaptive scheme of core shame. In some cases, this may also include a history of interpersonal complex trauma, which may demand some adaptations to the therapeutic work beyond the scope of this chapter (see Paivio & Pascual-Leone, 2010; and Chapter 16, this volume). When the client feels the critical reprimands as the voice of someone else, therapists

may proceed with their work placing the significant other in the critical chair (i.e., empty-chair work for unfinished business) and proceed with the usual two-chair dialogue. In that circumstance, therapists help their clients assert their own needs and feelings by, for example, setting limits to the critical voice, which subsequently tends to soften and be open to negotiation. However, this may reveal deeper core unresolved feelings, related with loss, abandonment, or rejection, which will demand empty-chair work. In some circumstances this is revealed by interruptions involving fear, such as fear of rejection or abandonment by the significant other. As Greenberg and Watson (2006) recognize, all self-to-self problems are mainly embedded in the way clients experienced past significant relationships and how self-organization took place; therefore, it is no surprise that the usual work in depression combines these issues.

THE CASE OF CLAUDIA

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

Claudia,[1] a case drawn from the ISMAI Depression Project, combines these two processes. She was a 57-year-old single woman, employed and with a college degree. When she began psychotherapy, randomly assigned to the EFT condition, she initially disclosed great difficulties in affirming herself and complained about feeling sad and lonely most of the time throughout almost all of her life. Her Beck Depression Inventory (BDI–II;

Beck, Steer, & Brown, 1996) score at intake was 25, but it increased at the first session to 31 (in a presession assessment), suggesting severe depression. She related her mood, though in vague way, to a long and unsatisfactory current relationship with a man who had had repeated affairs with other women. At the same time, she was also having difficulties dealing with the death of her mother, which happened 6 months before. Claudia had a history of great dependency toward her mother, with whom she lived almost all her life, and she also showed different forms of self-neglect and self-interruption. For example, she disregarded her own complaints. The initial assessment revealed that she had been depressed for most of her adult life, yet she was not really sure whether she was depressed and whether her complaints were relevant enough to enter psychotherapy. Nevertheless, she was feeling depressed on a daily basis, facing prolonged grief after losing her mother, and maintained a degrading relationship with her partner because of fear of living alone. She had difficulties in getting in touch with her feelings of loneliness and sadness, disregarding them as signs of weakness.

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

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

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

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

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

Client: (sigh) Yes, there is.

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

Client: You will be alone.

Therapist: You'll be alone.

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

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

Client: Yeah. That's it. Be alone, very afraid of it. [Session 4]

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

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

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

> *Therapist:* What does that part say? So what does your mum say to you? Even if it is the mother who's inside you.
>
> *Client:* "Ah! You're stupid, you do not know anything! You are never still. You only mess things up." That's what she always told me.
>
> *Therapist:* Hmm-mm. You only mess things up!
>
> *Client:* You only mess things up! [Session 4]

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

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

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

Therapist: Left by whom?

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

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

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

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

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

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

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

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

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

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

Client: Squeezed.

Therapist: Squeezed, hurt?

Client: That's it.

Therapist: Almost trampled.

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

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

Client: Always my mother!

Therapist: Of some depreciation.

Client: Always, always.

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

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

Therapist: Hmm-mm.

Client: For discrimination.

Therapist: Hurt, rejected?

Client: I think that the word would be "rejection."

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

Client (cries): It's difficult.

Therapist: It's difficult to tell.

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

Therapist: Hmm-mm, but . . .

Client: It's care, attention.

Therapist: Hmm-mm, support.

Client: Yes, that's it.

Therapist: Are you able to tell her that?

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

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

Client: I know . . . what I miss . . .

Therapist: What is it?

Client: Love. [Session 8]

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

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

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

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

Therapist: OK, but tell her now "let me grow up."

Client: Let me grow up.

Therapist: I know how to take care of myself.

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

Therapist: Take a deep breath. [Session 8]

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

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

Therapist: That you accept me . . . (. . .)

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

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

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

Therapist: Can you tell her?

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

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

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

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

Therapist: So what can you say to her?

Client: I have to live without . . .

Therapist: I will live without your support . . .?

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

Therapist: Accept that . . .

Client: Accept that you are just like that.

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

Client: To feel safety. (Therapist: OK.) I needed to feel safe.

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

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

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

Client: Yeah, yeah.

Therapist: Even without your support.

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

Therapist: I will be me.

Client: I will accept me. [She goes on reaffirming her self-acceptance and self-trust.][Session 15]

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

By the 16th session the process was terminated (according to the design of the ISMAI Depression project), and Claudia's BDI–II score had dropped to 6. In her 3-month follow-up she scored 1 at BDI–II, and in another follow-up 11/2 years after the end of therapy, Claudia maintained that same score, which suggested an enduring change.

CONCLUSION

According to EFT, depression derives from difficulties in accessing and fulfilling core emotional needs. These needs usually range from protection, assertion, and pride to a sense of love and connection with others. When these needs are not met, depression may set in as pervasive state in which the person loses vitality, resilience, and hope. In EFT, this clinical picture is explained by maladaptive emotional processes, such as lack of self-awareness, blocking of emotions and needs, and lingering on previous unresolved emotional issues. Therefore, EFT for depression evolves through the establishment of a therapeutic bond, and empathic attunement to the client, allowing the exploration of the core difficulties and problematic experiences of the person. These experiences are processed and changed later through a variety of therapeutic tasks, usually involving chair work. The goal is to reset the access to adaptive needs and emotions, helping the person to develop new meaning and direction to life.

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[1]The authors verify that they have maintained client confidentiality.

14
EMOTION-FOCUSED THERAPY FOR GENERALIZED ANXIETY DISORDER

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Generalized anxiety disorder (GAD) is a debilitating condition that has a severe impact on quality of life and general well-being. The most common anxiety disorder in primary care, it is under-recognized with only 20% to 32% of patients receiving adequate treatment (Porensky et al., 2009; Revicki et al., 2012). Estimates of lifetime prevalence of GAD in the general population range from 1.9% to 5.4%; and is more common in women than men by a ratio of 2:1 (Andlin-Sobocki & Wittchen, 2005; Brown, O'Leary, & Barlow, 2001). Most people with GAD report that they have felt anxious and nervous all their lives, indicating that there is a high probability of onset during childhood and adolescence (Andlin-Sobocki & Wittchen, 2005), with worsening symptoms during periods of stress. There is high comorbidity with other conditions, including mood disorders, addictions, eating disorders, and other anxiety disorders, as well as personality disorders (Carter, Wittchen, Pfister, & Kessler, 2001; Craske & Waters, 2005; Kessler, Ruscio, Shear, & Wittchen, 2009; Mauri et al.,

1992). This has led some researchers to suggest that the condition be seen as temporally primary to these other disorders and advocate that early detection and treatment of anxiety might have implications for alleviating the onset of these other disorders later in life (Kessler et al., 2009).

A serious disorder that impairs functioning, GAD has high social and economic costs. GAD has been found to be treatment-resistant, with only approximately 50% of patients responding to short-term treatment; many of those patients then relapse (Borkovec, Newman, Pincus, & Lytle, 2002; Hanrahan, Field, Jones, & Davey, 2013). Because only some people respond to treatment., there is growing recognition that more effective treatment is necessary to alleviate the condition in the long term. To this end, emotion-focused psychotherapists and researchers have focused on developing treatment models to more effectively treat GAD (Timulak & McElvaney, 2016; Watson & Greenberg, 2017).

THEORY OF DYSFUNCTION

In emotion-focused therapy (EFT), we propose that anxiety and worry in GAD are attempts to protect the self from being overwhelmed by painful emotions that the person is unable to soothe. They are unable to meet their needs effectively, because their feelings and perceptions are silenced, dismissed, and invalidated (Watson & Greenberg, 2017). Thus, dysfunction in GAD is seen as arising from the activation of core painful maladaptive emotion schemes of fear, sadness, and shame, and the associated vulnerable self-organizations that result from the synthesis of these schemes, together with the inability to symbolize and regulate the ensuing painful affect (Greenberg, 2002, 2011; Kennedy-Moore & Watson, 1999, 2001; Watson, 2011). In emotion-focused theory, when a person experiences anxiety, the self is organized as scared and vulnerable, because of the activation of

emotion schematic memories of harmful and painful experiences that were endured in the absence of protection, soothing, and support.

Repeated exposure to threatening, painful, and negative life events, including both large-T trauma (e.g., natural disasters, combat, sexual and physical abuse) and small-t trauma (e.g., the accumulation of relational and attachment injuries or chronic everyday stressors) that leave a person feeling helpless and vulnerable without adequate protection, soothing, and nurture, compromises a person's emotional processing and affect regulation capacity as well as their identity formation. During development, the experience of intense distress as a result of painful emotional experiences, combined with the absence of soothing, protection, and support results in the impairment of the capacity to adequately regulate and symbolize emotions. Instead, painful experience is interrupted and blocked to protect the self from anticipated dissolution and disintegration from feelings of intense distress and painful emotions of sadness, fear, and shame. In addition, without adequate protection and soothing, individuals internalize negative ways of regulating emotional experience and of coping with challenging and distressing life circumstances characterized by dismissing, invalidating, and silencing behaviors. The self is blamed for negative experiences and is rejected as unworthy of love and support. The attempt to manage feelings results in a constriction of awareness, such that individuals have difficulty representing and symbolizing their experience in conscious awareness. People with GAD are primarily conscious of a sense of undifferentiated distress at the edge of awareness—the person worries in an effort to protect themselves from falling apart due to an inability to cope with the underlying painful feelings of fear, sadness, and shame.

Thus, from an EFT perspective, an important contributor to GAD is the inability of people to process their emotions and soothe, comfort, and protect themselves when experiencing distress so as to return to a state of peace and calm (Watson & Greenberg, 2017). Lack of support and

protection when vulnerable often produces feelings of weakness, rejection, deficiency, unworthiness, sadness, and shame, all of which contribute to the development of a self that is organized as vulnerable and unable to cope. Developmentally the person's inability to symbolize painful emotions, the internalization and development of negative ways of treating the self, and an inability to soothe the resulting overwhelming emotions leads to the development of negative self-organizations. This compromises the individual's affect regulation capacities and results in worry. This insecure, vulnerable self-organization, based on core painful emotion schematic memories and negative ways of treating painful emotions, is at the heart of GAD. In therapy it is these painful emotions and negative self-organizations that need to be accessed, processed, strengthened, and transformed (Greenberg, 2011; Watson & Greenberg, 2017).

From an EFT perspective, people with GAD have difficulty processing their feelings, including symbolizing and labeling them, as well as modulating their levels of arousal and the expression of their feelings in order to cope effectively (Kennedy-Moore & Watson, 1999, 2001). During periods of intense distress, individuals are not able to discriminate among numerous different cues in their environments to establish cause and effect relationships. Thus they respond to myriad different stimuli. These triggers activate maladaptive schemes and the resulting painful emotions. Over time the experience of painful feelings of fear, sadness, isolation, and rejection are exacerbated as people with GAD do not feel that they have the resources to cope with their feelings and are not able to access adequate protection, soothing, and support to modulate their distress in the face of threatening situations.

The case of Fred,[1] a lawyer who entered treatment for GAD at age 38, provides a good example of how practitioners using EFT can help people with the condition. He presented with intense and persistent worry about his career and his family. He complained that his sleep was interrupted. He

would wake at 3:00 a.m. or 4:00 a.m. with intense feelings of anxiety and would be unable to get back to sleep as he lay awake worrying about cases and things he might have overlooked, as well as his health and his family's well-being. The feelings of tension and worry would persist throughout the day especially in meetings with clients. He would find himself nauseous at times anticipating that his clients would be demanding and scornful of his efforts on their behalf. He tended to disregard his feelings. He would minimize his tiredness and continue to force himself to work late into the evenings in an attempt to keep on top of his workload.

Fred's father had died of a sudden heart attack when he was 50, so Fred was concerned about falling ill and leaving his wife and children alone to fend for themselves. His father had been a workaholic, very demanding of himself and his children. He expected them to excel and was very scornful of weakness of any sort. Fred's younger brother had been sick as a child and Fred was expected to compensate for his brother's weaknesses. His mother was emotionally distant, consumed with caring for his younger brother. She had a tendency to downplay Fred's concerns, and as a result, he learned to silence himself and ignore his feelings, focusing on others and taking care of them. During therapy, his therapist worked with him to become more aware of his organismic experience and specifically his feelings and emotions. They focused on how he interrupted his feelings and dismissed and invalidated them as he had learned to do as a child. As he became more aware and accepting of his feelings, he began to symbolize his painful feelings, sharing them with his therapist, and he was able to address the attachment injuries he had sustained in relationship with his parents, including his father's scorn and rejection as well as his mother's emotional unavailability. He acknowledged how unfair it had felt as a child with his brother receiving all the care and attention.

REVIEW OF EVIDENCE

Studies have shown that experiential and client-centered treatments are effective in the treatment of anxiety in general (Elliott & Freire, 2010; Rogers, 1959). More recently, a number of studies have shown that EFT is effective in the treatment of GAD. Levy Berg, Sandell, and Sandahl (2009) found that interventions that focus on clients' affective and bodily experience were more effective in treating individuals with GAD than treatment as usual. Clients themselves noted that supportive, reflective interventions, as well as those that facilitated their emotional expression, were very helpful. In addition, EFT in the treatment of GAD has been studied and shown to be successful in two sets of repeated case studies at the University of Toronto and Trinity College, Dublin (Timulak & McElvaney, 2016; Watson, Chekan, & McMullen, 2017).

The overall effectiveness of EFT in the treatment of anxiety is further supported by two sets of studies looking at social anxiety (Elliott, 2013; Shahar, 2014). Additional support for this approach comes from the large number of clients with comorbid diagnoses of depression and GAD, who were successfully treated with EFT (Goldman, Greenberg, & Angus, 2007; Greenberg & Watson, 1998; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003). In addition to these studies of efficacy, EFT as a therapeutic approach has developed out of decades of research that has analyzed micro-processes in psychotherapy to illuminate the process of change and develop models of client and therapist interactions that facilitate such change (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg & Paivio, 1997; Greenberg, Rice, & Elliott, 1993; Greenberg & Watson, 2006). All this work provides a strong empirical foundation for the approach.

The general research literature on the treatment of GAD shows that not all clients respond to short-term treatments, while some clearly progress—their symptoms remitting in 24 weeks (Borkovec et al., 2002; Elliott & Freire, 2010; Hanrahan et al., 2013); other individuals require a longer

length of treatment. The exact length of treatment required for symptom remission will vary in terms of the severity of the early life conditions, as well as the individual capacities that clients bring to therapy (Watson & Greenberg, 2017). Some individuals may need time to build greater confidence in themselves and to develop an adequate understanding of what has transpired in their lives to make them feel so vulnerable and rejecting of their experience and, thus, unable to regulate their emotions.

CHANGE PROCESSES

EFT for GAD is based on the two major EFT principles of (a) building a healing therapeutic relationship, and (b) facilitating specific experiential tasks (Greenberg et al., 1993). One of the primary goals in GAD is to create a safe therapeutic relationship, so that clients can develop a stronger sense of self and internalize more positive ways of relating to themselves and their experience. As clients develop a stronger less vulnerable sense of self, they develop more confidence and trust in their inner resources, including their perceptions and feelings. Once a therapeutic relationship begins to develop, therapists and clients focus on how anxiety is generated using two-chair dialogues between a worrier (the anxiety creator) and the experiencing self, who feels the impact of the anxiety and worry. In this process, clients see that they are the agents rather than the victims of anxiety. This serves to empower them and give them a sense that they can change (Watson & Greenberg, 2017).

Following these initial steps in treatment, therapists and clients then turn to address the negative ways clients have developed to relate to and treat their emotional and sensory experience. Here, the focus is on the ways that clients interrupt their experience of painful emotion and their adaptive needs as they silence, dismiss, minimize, and negate their experiences. The objective is for clients to become more self-accepting and self-

compassionate and develop the capacity for self-soothing, and self-affirmation and validation. In parallel, therapists and clients attend to clients' underlying attachment and identity injuries and the related painful emotions that contributed to the development of clients' vulnerable self-organizations using the empty-chair tasks. The primary objective is to access clients' assertive anger at being hurt and harmed by others, and to grieve the losses of the past to transform their maladaptive emotions of fear, sadness, and shame. Finally, as clients develop greater self-acceptance and self-compassion for their vulnerable self, they are encouraged and supported to develop their capacity to soothe themselves, which further helps them transform their painful feelings. The overall objective is to consolidate a stronger sense of self, along with greater confidence in their capacities to cope, and experience a greater sense of mastery in their environments in order to enjoy more loving and connected relationships (Watson & Greenberg, 2017).

In the process of EFT, as clients share their narratives and life histories with their therapists, they begin to acknowledge their experiences and acquire a better understanding of what was hurtful and challenging for them developmentally, as well as what was lost and not received. This process enables them to access and symbolize previously disowned painful experiences, and to identify the negative ways that they relate to those experiences that were internalized in environments that lacked adequate nurture, protection, and support. Clients come to see that they do not adequately process their emotions and bodily experiences, because they fear that they will disintegrate from the intensity of the pain. They recognize too that to overcome their anxiety they need to become more aware of their organismic, bodily, and sensory experiences, as well as their emotions, and learn to tolerate their painful emotions, accept them, and symbolize them in words (Watson & Greenberg, 2017). In this process, clients access new more empowering emotions and action tendencies to transform their painful

maladaptive feelings. In this way, they come to feel stronger and more resilient, and acquire the capacity to modulate their distress, soothe their painful feelings, and express their emotions and needs to others.

Developing a Healing Therapeutic Relationship

Foundational to emotion-focused psychotherapy is the development of an empathic, accepting, prizing therapeutic relationship, in which therapists are fully present with their clients. Therapists are empathically attuned and attentive to clients' emotional experience, reflecting and mirroring it as they focus on clients' narratives, as well as their nonverbal behavior, to enable clients to symbolize experiences that are at the edges of their awareness. Accepting, warm, and empathic therapeutic relationships reduce clients' anxieties by helping them feel safe. The safety provides space for the development and elaboration of clients' narratives so that painful experiences can be identified and clients can access their dreaded feelings of fear, shame, and sadness (Watson & Greenberg, 2017).

In addition, the therapeutic relationship contributes to healing and to alleviating GAD by providing alternative more positive ways of relating to self and one's experience. As clients internalize their therapists' attitudes of acceptance, empathy, and prizing, they develop a stronger sense of self and acquire greater self-compassion and self-acceptance, providing the basis for self-soothing and self-assertive anger. Support for the important role of the therapeutic relationship in changing how clients relate to their experience comes from a study by Watson, Steckley, and McMullen (2013), who found that therapists' empathy contributed to changes in how clients related to themselves, becoming more positive in how they treated their experience. Positive therapeutic relationships also facilitate the development and enhancement of emotional processing and affect regulation capacities (Paivio & Laurent, 2001; Watson, 2002). It is important for therapists to be fully present with their clients to encourage clients to be more present with

themselves and their experiences (Geller & Greenberg, 2012; Geller, Greenberg, & Watson, 2010). This is particularly important for anxious clients, who often avoid their experiences in the present.

Strengthening the Vulnerable Self

EFT therapists work with their clients to develop more coherent life stories to make sense of their experience. In this process they see the relationship between events and their feelings and reactions. In a positive relationship with their therapists, clients develop greater confidence in themselves; they develop enhanced affect regulation capacities as well as a sense of mastery and a belief that they can cope with life's challenges (Watson & Greenberg, 2017). In our view they internalize their therapists' attitudes forming more positive self-concepts, becoming more accepting of themselves and their subjective experience. They come to value their experiences, including their emotions and perceptions, and learn to trust themselves, developing more protective and compassionate ways of caring for themselves. EFT therapists work with their clients to develop more positive self-organizations and improved emotion regulation capacities, including increased attention, awareness, and acceptance of primary emotion. EFT therapists validate their clients' experiences so that they can become more confident of their perceptions and emotional experience, thereby strengthening the clients' sense of self.

Clients' emotional processing is further facilitated with specific interventions, for example, focusing, which teaches clients how to turn attention to their bodily felt sense and symbolize it in awareness (Gendlin, 1996). In this process they are encouraged to attend to, label, and accept their feelings. As they develop more effective affect regulation capacities, clients' sense of self is strengthened further (Watson et al., 2013). Another key aspect of productive emotional processing, as well as confidence in one's ability to cope, is emotion regulation. EFT therapists help their clients

develop and maintain a working distance from their emotions (Gendlin, 1996; Leijssen, 1998) and use them as sources of information, thereby allowing the integration of cognition and affect (Elliott, 2013). Emotional dysregulation has been attributed to failures in dyadic regulation of affect early in the life cycle (Schore, 2003; Stern, 1985). The capacity to soothe the self develops by internalizing the soothing functions of the protective other (Schore, 2003; Sroufe, 1996; Stern, 1985). In EFT, therapists thus help clients contain and regulate emotional experience by providing a soothing environment. Over time this soothing is internalized as clients develop the capacity to regulate their feelings, so that they can automatically self-soothe without deliberate effort.

Working Through Anxiety Splits

An anxiety split is a way of construing the internal process of anxiety generation. Anxiety is viewed as secondary and symptomatic of more core underlying insecurity or shame. Anxiety dialogues are one of the first chair tasks introduced in the treatment of GAD to help clients manage symptoms and facilitate access to their underlying core fears and other painful emotions. As mentioned above, in this two-chair dialogue, one part of the self is labelled the “anxiety producer” who worries the self by catastrophizing. The other part is the “self” that experiences the impact of the worry (Timulak & McElvaney, 2016; Watson & Greenberg, 2017).

Intervening at this level is relatively superficial but is consistent with clients’ phenomenology and it facilitates collaboration. Clients with GAD often experience anxiety as something that happens to them; working with the worry process enables them to acquire a greater sense of agency in the process and to see that this is something they are *doing* to themselves. It is important for them to see that they are generating their anxiety for the treatment to progress. Working with worry splits is somewhat different from working with self-critical splits in depression, which are more

straightforward where feelings are evoked first in the “experiencing chair,” followed by softening in the critic as they move toward resolution. Working with anxiety-producing splits, we have found that painful primary feelings of fear can emerge in either the worry-producing chair or the chair that experiences the worry. Thus, EFT therapists need to be responsive to emotion wherever it emerges. The painful feelings that can be evoked in the worry-producing chair often reveal negative treatment of self or relational injuries that require further processing (Watson & Greenberg, 2017).

Undoing Negative Self-Treatment

Clients with GAD dismiss, ignore, and silence their emotional experience. This particular form of negative treatment of self leads to perceptions and feelings being dismissed, blocked, and rejected, and needs being ignored or discounted. This interruption of self-experience often reflects the shame of having had feelings and needs ignored. When needs are dismissed and ignored as a child, people may blame themselves and hold themselves responsible for not being good enough to be loved and protected. For example, Fred, whose case we began to describe earlier, felt it was his fault that his father did not value him and that his mother was distant. He felt that if he only performed better he would win their love and approval. In EFT, this form of self-blame is worked with using two-chair dialogues with the coercive aspect of the self that blames and neglects the self as it dismisses and silences feelings. This process reflects the neglect and disregard of emotion so prevalent in GAD. In these splits, the blaming and self-neglect, and the feelings and needs experienced in response to this negative self-treatment, encounter each other in a chair dialogue until a softening of the blaming voice occurs. This promotes greater self-compassion and self-acceptance resulting in an integration between the two sides.

Often, negative self-treatment involves one part of the self-interrupting or constricting emotional experience and expression by dismissing, ignoring, or silencing feelings. For example, Fred would often wave away his feelings, saying, “They don’t matter. They’re not important.” Clients with GAD often do not feel entitled to their feelings and self-expression. This can be exacerbated when they have been exposed to role-reversal and have borne the burden of responsibility for their own and others’ welfare. In these dialogues clients are guided to enact the ways that they interrupt their experience using physical gestures (Greenberg et al., 1993), for example, by choking or shutting down their voice, either metaphorically (e.g., caging themselves) or verbally, saying, “Shut up, don’t feel, be quiet, you can’t survive this.” Once they are more aware of this process, the experiencing side is encouraged to ask for greater acceptance and compassion, and to feel more entitled to their feelings and needs (Watson & Greenberg, 2017).

Empty-Chair Work to Resolve Emotional Injuries

Clients with GAD have usually experienced early attachment and relational injuries, including abandonment, neglect, abuse, humiliation, intrusion, and rejection by primary caregivers, siblings, and/or peers. After working on the anxiety split, the therapy moves to processing the painful feelings experienced in relationship with others. These are the painful feelings of insecurity, shame, and sadness, as well as terrifying feelings of being alone, lacking support, and feeling responsible or bad for how things turn out. These relational injuries are worked on using empty-chair dialogues with the significant others who harmed them and failed to provide adequate support, connection, validation, and protection. These dialogues involve clients imagining significant others who injured them in order to transform the core maladaptive emotions that resulted from these relationships (Elliott et al., 2004; Greenberg & Watson, 2006; Watson & Greenberg, 2017).

An important part of the healing process is for clients to access protective and assertive anger to hold others accountable for the ways in which they were harmful to the client, as well as to process their grief and mourn the loss of that which was never provided, and ultimately for clients to soothe their insecure sense of self and painful emotions of fear, sadness, and shame. Accessing and expressing anger in either empty-chair or two-chair dialogues is powerful in overcoming anxiety. However, it may not be possible for clients to fully resolve or engage in empty-chair dialogues as long as they continue to treat their experiences negatively. Clients need to feel more deserving of their previously unmet needs and become more compassionate to their wounded vulnerable self to effectively transform their sense of self and overcome their anxiety.

Accessing Self-Soothing

Promoting clients' abilities to receive and be compassionate toward their emerging painful emotional experience is an important step toward tolerating emotion and developing self-soothing. Over time clients internalize their therapists' attitudes and become more compassionate and self-accepting (Watson & Greenberg, 2017). They learn to internalize self-soothing, so that they can regulate their feelings automatically without deliberate effort. Emotions can be regulated physically by activating the parasympathetic nervous system to regulate heart rate, breathing, and other sympathetic functions that speed up under stress. These strategies are referred to as coping self-soothing. However, in addition, EFT therapists actively encourage and teach clients to develop transformational self-soothing to take care of the wounded self (Watson & Greenberg, 2017).

This is done by means of two-chair dialogues in which clients are encouraged to find ways of soothing, comforting, and validating the underlying painful emotions of fear, sadness, and shame. These capacities may need to be encouraged and stimulated, if clients did not have someone

to meet their needs for protection and care and have the opportunity to acquire them. Transformational self-soothing essentially involves clients developing compassion and caring for the insecure inadequate part of the self (Greenberg, 2015). For some clients, who have assumed too much responsibility for their own and others' well-being, statements such as "You are *not* to blame" or "You are *not* responsible" can be soothing. Being told this allows them to relax and stop worrying about the outcome of events or their impact on other people. Finally, clients consolidate their changes by developing new narratives based on feelings of being more resilient, self-accepting, and entitled to meet their needs for protection, care, and connection.

INTERVENTION STRATEGIES

As we have noted previously, the client's pervasive worry process is initially addressed through a two-chair worry dialogue task. Models of the worry dialogue have been developed by Timulak and colleagues (Murphy, Timulak, & McElvaney, 2011; Rowell, Murphy, Timulak, & McElvaney, 2014) as well as Watson and Greenberg (2017). Worry dialogues are initiated in response to the emergence of an appropriate marker of worry, for example: "Something bad will happen to my children on the school trip because I am not there to protect them." The identification of a statement that indicates worry or a sense of fear that something bad will happen is the marker to initiate the task. It is helpful to have clients express some agitation and anxiety in response to the worry statement, indicating they are experiencing it in the present. When the marker is present, and if there are no other competing markers, for instance, ones that would point to core painful feelings or negative treatment of self, the therapist can invite the client to engage in a worry dialogue.

If the client agrees and is willing, the therapist initiates the worry dialogue by asking clients to sit in the chair opposite them and make themselves worried from the “Worrying Chair.” For example, the therapist might suggest: “Can you worry yourself. How do you do that? Can you try to express your worries to the other chair?” Once the client expresses his or her worries, the therapist asks him or her to come back to the “experiencing chair” and attend to and express the impact of the worry. At this stage the therapist asks the client to attend inwardly and express their reaction to the worrying statements. The therapist might say, “What happens inside when you hear that?” Clients usually report feeling anxious and tired from the need to be constantly vigilant. The therapist then works with the client to support them to express and differentiate the felt impact of the worrying voice.

At this point, some clients may touch on core painful feelings of insecurity and recall times, earlier in their lives, when they felt afraid. For example, one client who was worried about losing her children recalled her feelings of fear and sadness when her mother died when she was 9. When this happens, the therapist can focus on processing the client’s painful feelings in the moment using reflections and empathic responding for vulnerability (Elliott et al., 2004; Greenberg et al., 1993). The evocation of clients’ painful memories and attachment wounds points to unfinished business with significant others and the need for empty-chair dialogues to resolve painful feelings they experienced in relationship with others that may have contributed to their anxiety. Empty-chair work can help clients process and heal their feelings of sadness as a result of abandonment, work through their grief at loss, and enable them to assert their needs and protect themselves in relationship with others drawing on assertive anger.

If clients are unable to articulate a reaction to the worry statements, the therapist might ask about the cost of the worry, saying, for example, “What do you lose when you are impacted by the worry?” The objective here is to

help clients access and articulate the impact of the worry and to express their needs as a result of the worrying process. Alternatively, therapists might ask, “What do you need from that part of the self that worries you? What are you missing because of the worry?” An example from one client, who was concerned about the time he spent with his children, was that the worry cost him the loss of a more playful relationship with his children. With their therapist’s facilitation, clients are able to articulate both the costs of the worry and their needs related to the worry.

After clients experience the impact of the worry (e.g., anxiety, tiredness), are able to identify its cost in real-life terms (e.g., preventing them from being care-free), and have expressed their needs towards the worrier (e.g., asking it to stop and take a break), then the therapist asks clients to sit in the “worrying chair” and see what they feel toward the scared and obstructed experiencer to see how they respond to the experiencer’s expression of need. Typically, there are two possibilities at this point: (a) the worrier softens and expresses compassion towards the experiencer, perhaps also expressing his or her own inability to control the worry and asks for help from the experiencer (e.g., “I want you to be free and to have a good relationship with your children, please ignore me. But I need you to help me, because I am frightened too”); or (b) the worrier does not soften, but instead expresses distress that it is not being heard and that the painful feelings experienced in the worrying chair are not being addressed.

Clients at this point may reiterate and reinforce the worry. For example, they may say, “I will not stop worrying you, it’s unsafe. I am scared. You need to listen.” At these times the self in the worrying chair can react with distress and withdrawal. This is a cue to the therapist to attend to and work with the client’s distress in the worrying chair and to help the client access painful feelings of neglect, abandonment, and shame. Once these painful feelings have been symbolized, markers for empty-chair work

can be clearly identified. In addition, markers for negative treatment of self will emerge as the client shows that he or she is unable to attend to and address their feelings and needs in the “experiencing chair,” but rather continues to dismiss and silence them. This response indicates that the client has internalized negative ways of responding to their feelings and perceptions including minimizing, ignoring, and silencing painful feelings in an attempt to cope and be strong. At this point the therapist and client begin to frame the work of therapy as the need to address painful attachment wounds, resolve negative ways of treating experience, and develop more appropriate ways to soothe their painful feelings and protect themselves in relationship with others.

Worry dialogues are complex processes and often do not follow the smooth progression described above or that is typically seen in depression. Worry dialogues are often the first type of two-chair dialogues initiated in the treatment of GAD. They are preliminary steps to address clients’ presenting concerns and provide access to the painful feelings of fear, sadness, and shame at the core of GAD, so that these can be transformed. Worry dialogues are a useful way to see whether clients can reassure themselves and show care and empathy for the self. Clients with GAD that results from neglect, abandonment, and painful experiences may not build the capacity to reassure themselves as quickly as some clients who have experienced an overly intrusive other. With these latter clients, it is important for them not only to access protective anger, but they may need to reassure the worrying intrusive other who has compromised their agency and sense of self-efficacy as well. In these cases, it can take a series of dialogues before the client is able to stand up for him- or herself and is able to assert themselves vis-a-vis the other and express confidence in their capacity to cope. The process of standing up to the worrier as the internalized intrusive other in these cases can be crucial in reducing the worry processes outside of the therapy room.

Transforming the Core Pain

Working with clients on their worry process is important early on in therapy, as it forges an alliance and works with the client's presenting concerns. But the core work with clients with GAD is to transform their feelings of pain and assist them in acquiring new ways of being, drawing on assertive anger and transformative self-soothing. Ultimately, the therapy needs to focus on the chronic, painful, maladaptive feelings that the client has not been able to process and express in order to meet their needs more optimally. These chronic painful feelings include a chronic sense of sadness and loneliness (e.g., "I could not bear another loss"), shame (e.g., "I feel so embarrassed and ashamed. I cannot face them"), and/or primary fear/terror (e.g., "I won't survive another trauma or abandonment"; O'Brien, Timulak, McElvaney, & Greenberg, 2012; O'Keeffe, O'Brien, Timulak, & McElvaney, 2015; Watson & Greenberg, 2017). These feelings are the result of attachment wounds and difficult histories of neglect, abandonment, criticism, and rejection embedded in clients' idiosyncratic stories. To address these, EFT therapists use empty-chair tasks to access client's core painful feelings, differentiate them, and express them in order to identify unmet needs. Accessing assertive anger can be important in transforming painful feelings of fear, sadness, and shame.

Activating More Positive Treatment of Self and Transformative Self-Soothing

In addition to healing and transforming the painful emotions resulting from attachment wounds, clients also learn new ways of relating to their experience. Through the use of two-chair dialogues, they become aware of the negative ways that they have tried to cope with painful feelings, including dismissing, ignoring, invalidating, and minimizing them. As they become aware of the negative impact of these behaviors and acquire a

stronger sense of self, they are able to access assertive anger and greater self-compassion and adopt more positive ways of addressing their painful feelings, including core transformative self-soothing based on greater self-acceptance and self-compassion. Once clients' core painful feelings are accessed in therapy and they have expressed their unmet needs, EFT therapists typically seek to facilitate the generation of adaptive emotional responses to the pain and expressed needs. Clients are encouraged to calm and soothe themselves by accessing greater self-compassion and self-acceptance (e.g., "I am here, and I will take care of you"). Some clients may need additional support to develop self-soothing strategies, including more explicit guidance and teaching. These strategies are developed using two-chair dialogues for self-soothing.

CASE VIGNETTE

In this section, we provide excerpts of a therapist's work with a GAD client in therapy to enact the worry process. The client, Joan, is in the worrying chair and has expressed core painful feelings centered on her sense of being alone, unprotected, and embarrassed and ashamed about her body. When Joan was a child, her sibling developed a chronic illness very suddenly and caused their mother intense stress and anxiety. Joan's mother, an anxious person who was easily overwhelmed, expected a lot of her. She was demanding and expected Joan to take care of herself and her sibling.

Client (in the "worrying chair" talking about a situation at work)*:* But if they do say it to you about not getting that report finished this week, are you ready for confrontation with your boss?

Therapist: Okay. So this side is worried about the conflict at work. Anything else you say to her?

Client [enacting another worry]*:* Did you sort out everything for John's (boyfriend's) birthday? Have you got enough money for that . . . for his birthday present?

Therapist: So this part is fretting about John's birthday.

Client: Em . . . Yes, I am worried whether he will he like his birthday present? And I'm worried I have spent too much money.

Therapist: Okay. Can you say that to her? "You've spent too much money!"

Client: You've spent too much money on the birthday? Em . . . Will you have enough money to survive the rest of the month?

The therapist then asks the client to sit in the chair opposite the worrying chair and invites the client to check inside for the impact of the worry:

Therapist: Yeah. Yeah. So see, see what happens inside when she says all of this . . . because it's like a list of things to do. Yes? It's a constant list in the brain. What happens inside when you get this flow of thoughts?

Client: Exhausting.

Therapist: It's tiring. Yeah?

Client: It's tiring. It's tiring trying to keep a lid on you so that everyone else can't see me falling apart inside. But . . . No.

Therapist: Yeah. Yeah. Yeah. I see. So it's like "I feel like I am falling apart inside but I can't show it? So you almost make me fall apart, but I can't afford to fall apart." Yes? Tell her.

After the client has expressed the impact of the worry, the therapist asks the client what it is that the experiencer needs from the worrier:

Therapist: What is it that you need from her?

Client: Be quiet.

Therapist: Okay.

Client: Give my brain a break.

Therapist: Yes? “Give me a break.” Yes? Tell her again . . .

Client: Give my brain a break.

Therapist: Okay. Okay. “So this is what you need.” Yes?

After clients express the impact of the worry (e.g., intense feelings of anxiety, hypervigilance, tiredness, and tension) and express their needs (e.g., to rest and to be free from worry), EFT therapists see how the worrying chair responds. In the case above, the client in the worrying chair was able to respond to the experiencing chair’s sense of falling apart and the need for her to back off. The client in the worrying chair said,

> *Client:* I see that this is tiring you. I do not want you to feel so stressed that you are falling apart inside. I want you to feel confident and strong at work so you can do a good job; but I am scared.
>
> *Therapist:* Okay, okay, so this side does not want you to feel stressed and as if you are falling apart but she is scared, yes? It’s like she is saying: “I don’t want to be stopping you; I care about you, but I am scared. I have to see that you are safe or something?” Is that it?
>
> *Client:* Yes, I don’t want her to fall apart. I want her to feel strong but I need to feel safe too.
>
> *Therapist:* So this side is scared? What are you scared about? Can you tell her?
>
> *Client* (in worrying chair): I am scared something bad will happen just like when Jilly got sick. It was such a shock.
>
> *Therapist:* Oh, so this side is fearful that someone will get sick or that something bad will happen? What was it like for you when Jilly got sick?

Here the therapist sees that the client has softened. Joan is able to see the impact of her behavior on the experiencing chair. She realizes it is not helpful but expresses that she is scared. Here the client expresses primary emotion. The therapist at this point, seeing fear in the "worrying chair," asks Joan to share her fear. The client recalls how she felt when her sibling became ill. The therapist begins to focus on helping the client to process these early memories and the accompanying painful feelings of fear and loneliness after her sibling was hospitalized and her mother spent long days away from home taking care of her sister.

Client: It was awful. It was just so sudden. I remember coming home from school and the house was empty. I went to the neighbor's house. She told me Mum had taken Jilly to the hospital and would be back after dinner. She told me that I should stay with them and eat there while we waited for Mum to return. I was shocked and scared.

Therapist: So it was quite unexpected and really strange. Here you are with the house deserted and hearing from the neighbor that Jilly was in hospital.

Client: Yes, that was just the beginning though . . . Mum spent weeks with her in hospital. I spent most of my time with the neighbors, an older couple, who never had children.

Therapist: What was that like for you?

Client: I was scared and sad. I did not really understand what was going on. I knew it was serious, but no one explained it to me. I kind of felt lost, forgotten somehow.

Therapist: So it was scary—everything changed overnight and somehow you felt lost, forgotten . . .?

Client: (tearing up) Yes, everyone kept saying I should be strong and brave and that I needed to support and help Mum.

Therapist: So it sounds as if no one was listening to you or taking care of you? You were asked to take care of

everybody else? No wonder you felt forgotten.

Client: (weeping softly) yes and it was never the same afterwards. It took so long for Jilly to recover and mum was always so worried about her. And I was too.

Here we see how the client was impacted by her sibling's illness. After her sibling fell ill, she learned to be independent and not seek care and attention, worried that she would be burdening her mum. The therapist suggested empty-chair work with her mother, so Joan could express her feelings of insecurity at the abandonment and loss she experienced and to enable her to process her feelings of fear and sadness and the resulting shame she felt when she was needy. Together they worked to address the client's negative treatment of self and how she tended to minimize her feelings and dismiss her needs, saying, "Don't be selfish; you should think of others." As she processed her feelings and acknowledged her needs for support and attention, Joan was able to be more attentive to her feelings and needs.

The client addressed her core pain in empty-chair work with her mother, expressing how hard it had been for her when Jilly became ill. She said she understood why her mother was stressed, but that she wished she had been able to see what she needed as a child, and had been able to comfort her and see how scared and sad she had been. In the empty-chair dialogue, Joan's mother was able to acknowledge her daughter's pain. She expressed regret that she had been so focused on Jilly that she had not provided the support and care that Joan needed. This represented a big step forward for Joan. She was able to forgive her mother, and be more self-compassionate and self-accepting of her own feelings and needs. She stopped trying to take care of everyone, and expected people to respect her needs and allowed herself to be vulnerable. Her boyfriend was able to support her as she made these changes, which was very helpful.

As mentioned previously, working therapeutically with the worry process is an important part of working with GAD difficulties, but as with any EFT work, the main focus of therapy is on the transformation of core painful feelings (e.g., chronic loneliness, shame, and primary fear). As part of the process of transformation, it is important that clients are able to savor receiving care and compassion when enacting it either as self or other in chair work. Equally important and perhaps especially so in the context of anxiety-related difficulties is to build the client's resilience and the sense of personal power through assertive and self-protective anger.

CONCLUSION

Working with anxiety can be more complicated than working with depression. GAD often results from years of neglect, rejection, abandonment, and emotional abuse. Thus, clients may need more time to articulate their histories and to gain an understanding of why they are reacting and behaving as they are. They also need to develop greater confidence in themselves, especially their perceptions and feelings, which have often been undermined in negative, painful environments with no support. EFT therapists are patient in providing a continuously warm, supportive, accepting, and empathic relationship, so that clients can develop a stronger sense of self, more positive self-organizations, and accomplish the work of emotional transformation. The latter accomplishment requires that clients process their painful feelings of fear, sadness, and shame as a result of emotional and attachment injuries, and, therefore, become more self-compassionate and self-accepting; this will allow them to gain access to protective anger in order to set more appropriate boundaries with others and better meet their needs in relationship.

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[1]The authors verify that they have concealed client identity by disguising details of the cases or by combining details from multiple cases.

15
EMOTION-FOCUSED THERAPY FOR SOCIAL ANXIETY

ROBERT ELLIOTT AND BEN SHAHAR

Social anxiety (SA) is a common, debilitating anxiety difficulty characterized by persistent fear of social interactions or situations in which a person might be scrutinized or judged by others (American Psychiatric Association, 2013). People with SA are terrified typically not only of public speaking but also of talking or just being seen in a range of social or interpersonal situations, including close personal relationships (Stravynski, 2007); they also experience significant distress as they anticipate interactions with other people and later ruminate over them. SA is the third most prevalent psychological difficulty, after depression and substance abuse, affecting up to 12% of the population during their lifetime (Kessler et al., 2005). SA is often comorbid with other psychiatric diagnoses, such as major depression, other anxiety difficulties, and substance misuse. It is also associated with impaired ability to form and maintain good interpersonal relationships, leading to loneliness and isolation (Alden & Taylor, 2004). In

addition, there is an increased risk of suicidal ideation and suicide attempts (Cox, Direnfeld, Swinson, & Norton, 1994).

At present, the treatment guidelines (e.g., National Institute for Health and Care Excellence, 2013; Society of Clinical Psychology, 2016) recommend various forms of cognitive behavior therapy (CBT) as frontline evidence-based treatments for SA, such as the Clark and Wells individual model (Clark et al., 2006) and Heimberg's group therapy model (Hope, Heimberg, & Turk, 2010). While these approaches have been shown to be effective (Acarturk, Cuijpers, van Straten, & de Graaf, 2009; Mayo-Wilson et al., 2014), a substantial number of clients do not respond well to CBT or remain symptomatic to some degree at the end of therapy (Davidson et al., 2004; Moscovitch, 2009). Although there is little current literature on other therapies for SA, there is clearly a need for non-CBT alternatives, including emotion-focused therapy (EFT).

THEORY OF DYSFUNCTION

In EFT terms, SA involves a set of maladaptive emotion schemes developed as a result of being chronically and traumatically shamed or bullied, usually during the developmental periods of childhood or adolescence. These experiences lead to the development of primary and secondary emotion processes, in which interpersonal interactions come to be perceived as dangerous situations in which the person will be revealed as socially defective, thus cuing first shame (a primary maladaptive emotion) and then anxiety about this shame (a secondary reactive emotion), further complicated by patterns of emotion dysregulation (both under- and overregulation). The complexity and multiplicity of the different emotion processes helps to explain why full-blown SA is so debilitating and so challenging to treat. In Figure 15.1 we summarize our current

understanding of the most common processes involved in severe SA. These can be divided into *sources*, *primary processes*, and *secondary processes*.

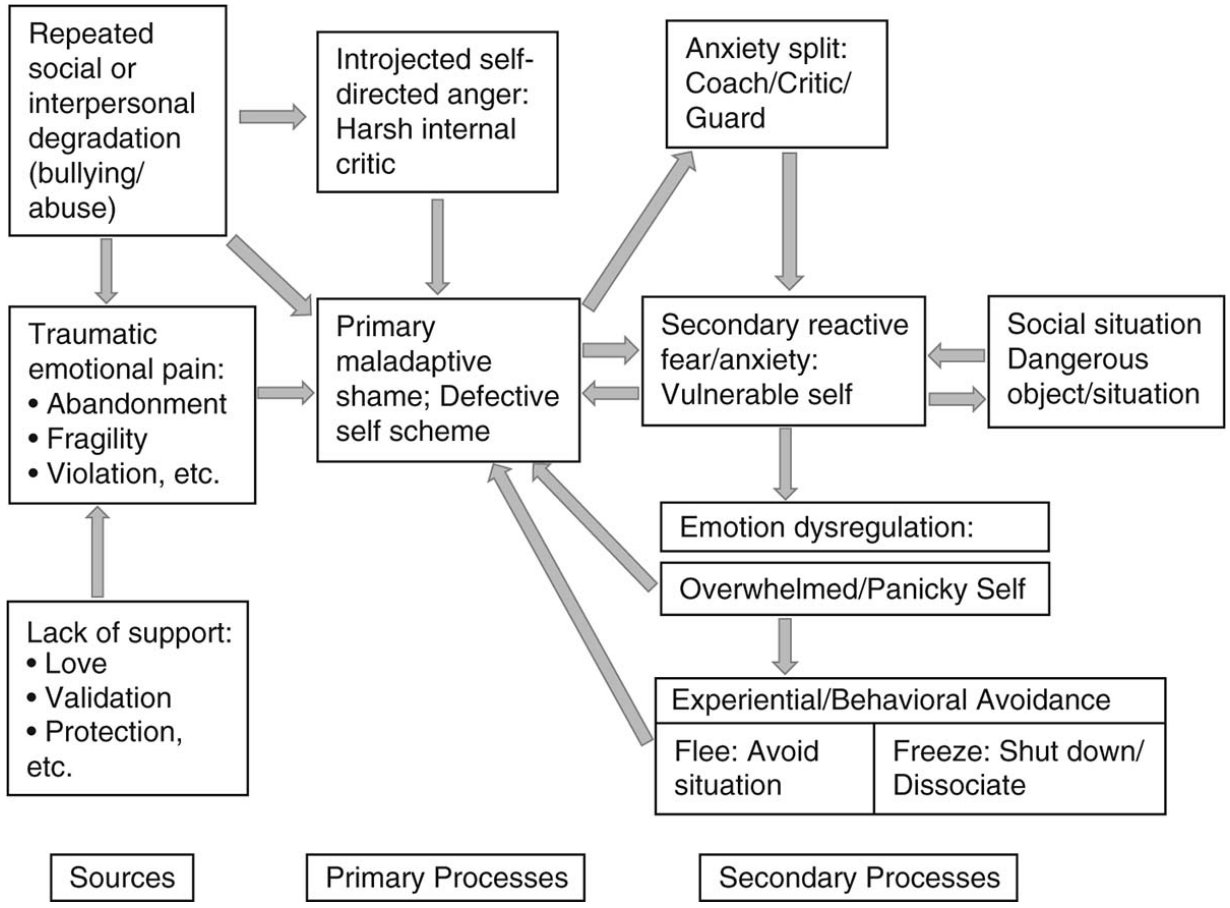

Figure 15.1. Emotion-focused therapy model of social anxiety.

Sources

We propose what is essentially a *social degradation* model of the origins of SA (cf. Garfinkel, 1956). During childhood or adolescence, the person (who may or may not have been born with an introverted or shy temperament) experiences a period of social or interpersonal mistreatment. This can take the form of some sort of repeated public humiliation in the form of bullying, or it can involve various forms of interpersonal trauma

(i.e., physical, sexual, or emotional abuse; Kuo, Goldin, Werner, Heimberg, & Gross, 2011). This degradation takes place in the *absence of interpersonal support*, including love, validation, protection, and so on, which amplifies the effects of the degradation. Often, supposedly helpful others instead act as witnesses to the person's supposed transgressions, reinforcing the degradation. This combination of social degradation and lack of support results in *traumatic emotional pain*, which typically involves shame, but also commonly fear or sadness. In the original situation, shame can be understood as an immediate primary adaptive emotional response to the degradation, consistent with the person accepting it as an accurate representation of who they are. Thus, the person not only experiences chronic interpersonal humiliation but must go through this on their own, as if they were some sort of social pariah, or had even been banished from their social unit, resulting in deep and long-lasting psychological pain.

Primary Emotion Processes

The enduring results of this social degradation process are several and include first of all a deep, generalized sense of shame. One part of the person might protest angrily against the way they have been mistreated and about their ruined self-identity, but at another, deeper level, they accept that they are radically and irrevocably defective. Over time, this comes to be symbolized as a *shame-ridden defective self*, which is experienced as the deepest truth about who they are. Each person with SA symbolizes his or her defect in their own idiosyncratic way: "stupid," "rubbish," "spacey," "not nice to look at," "unfit for human company," and perhaps most commonly, "having nothing to contribute"—to conversation, to a relationship, or to other people generally.

Along with this, there is a complementary self-organization, in the form of a *harsh internal critic*, which continually reinforces the sense of

defectiveness. This angry, self-judging aspect is an internalization of the bullies or abusive others who have mistreated the person in the past. In fact, it is this internal voice that repeatedly recites the symbolized defect ("You are awkward and socially inept," "You're so inarticulate you can't put a coherent sentence together"). Thus, the previous degradation by others now continues as self-degradation and self-shaming, and the person returns again and again to memories of the previous mistreatment, which serve as further evidence in support of self-defectiveness. At the same time, the emotional pain of the mistreatment becomes congealed around defectiveness and shame, and the person loses touch with the broader aspects of that pain, such as fear/fragility and isolation/sadness. The result is a one-dimensional experience of self as socially defective.

Secondary Emotion Processes

The shame-ridden defective self-organization leads to a set of secondary emotional processes, which together constitute the clinical presentation of SA: a socially vulnerable self that experiences secondary reactive fear/anxiety about others; a hypervigilant coach/critic/guard (CCG) aspect that generates anxiety even in the absence of others; and a dysregulated panicky/disengaged experiencer who engages in behavioral avoidance by physically removing themselves from the situation or in experiential avoidance by freezing, shutting down, or even dissociating.

To elaborate: In response to their chronic maladaptive feelings of shame about being deeply defective, the person develops *secondary reactive fear or anxiety* that others will see their defectiveness and shame them again. Thus, they repeatedly see certain types of social situations as dangerous and to experience themselves as generally vulnerable to being exposed as defective to others. Nevertheless, this is not necessarily clinical SA.

In addition, to cope with chronic feelings of shame, the person develops a hypervigilant CCG aspect of self whose role is to continually look out and warn the person about social dangers in order to prevent further degradation. This part of the self is organized around an emotion scheme of fear/distrust, and powerfully motivates the person to engage in various activities to try to keep themselves safe. Most obviously, when in an immediate social situation, such as an informal social gathering or if they have to speak up in a more structured situation such as a class or meeting, people with SA actively scan for signs of impending negative judgment, especially facial expressions like frowns or contempt. In addition, prior to entering situations, they try to anticipate and prepare possible threats, often mentally composing scripts of what they will say. Furthermore, after a social encounter they typically replay social interactions over and over to analyze and critique their performance. All of these activities are intended to help the person deal more effectively with social situations; however, their actual effect is to generate more and more fear or anxiety of others, which thus reinforces the person's conscious sense of vulnerability and implicit feeling of shameful defectiveness.

By enhancing and prolonging the person's SA, the hypervigilance of the CCG aspect leads to a chronic state of moderate anxiety, vulnerable to *emotion dysregulation*, in the form of overwhelming states of anxiety ("anxiety attacks" or "panic attacks"). These underregulated states in turn motivate the person to overregulate their distress through behavioral or experiential avoidance, as the person either flees the situation or shuts themselves down emotionally. In EFT terms, the latter is a self-interruption, but can be extreme enough at times for the person to enter a quasi-dissociated state in which they experience mental confusion or fuzziness. These dysregulated states underscore the person's sense of defectiveness and associated shame. Finally, the person becomes desperately miserable with this social isolation, finding it constricting or even imprisoning.

EVIDENCE FOR THE EFFECTIVENESS OF EFT FOR SOCIAL ANXIETY

In addition to a set of systematic case studies (MacLeod & Elliott, 2012; MacLeod, Elliott, & Rodgers, 2012; Shahar, 2014), there are now two studies of the outcome of EFT for SA. First, Shahar, Bar-Kalifa, and Alon (2017) recently reported the results of a multiple baseline design with 12 clients who were offered up to 28 sessions; they randomized clients to wait 4, 8, or 12 weeks between intake and beginning therapy. Of the 11 completers, seven no longer met criteria for SA at the end of treatment. On the Liebowitz Social Anxiety Scale (LSAS; Liebowitz, 1987) scores did not change during baseline, but showed very large and statistically significant improvements during treatment (Cohen's d = 3.14), and remained improved during follow-up.

Second, Elliott and colleagues (Elliott, 2013; Elliott, Rodgers, & Stephen, 2014) compared EFT to person-centered therapy (PCT) in a sample of 53 clients with moderate to severe SA, who were offered up to 20 sessions. The first phase of the study focused on treatment development, with unsystematic assignment of clients to treatments; in the second phase, clients were assigned randomly to treatments. Across both phases of the study, effect sizes on the Social Phobia Inventory (SPIN; Connor et al., 2000) were 1.75 for EFT versus 1.01 for PCT; for the Personal Questionnaire (Elliott et al., 2016) effect sizes were 2.22 for EFT compared with 1.05 for PCT. These differences were statistically significant and clinically important. In addition, the effect sizes obtained for both EFT and PCT were quite large and superior to effects on the SPIN found in comparable studies of CBT and medication (Antony, Coons, McCabe, Ashbaugh, & Swinson, 2006; Connor et al., 2000; Taube-Schiff, Suvak, Antony, Bieling, & McCabe, 2007).

While not definitive, these two studies provide clear evidence supporting the further development and testing of EFT as a promising

evidence-based treatment for SA, with large benefits for clients.

CHANGE PROCESSES IN EFT FOR SOCIAL ANXIETY(EFT-SA)

As we see it, the key change process in EFT-SA is accessing and activating shame so that it can be restructured within a secure, accepting, validating therapy relationship. Clients are helped to access their sense that they are defective, worthless, or inferior, then to deepen it to their core pain (e.g., deep brokenness or isolation), so that it can be transformed by experiencing and expressing adaptive emotions, such as self-soothing/compassion, assertive/protective anger, and connecting sadness (Greenberg, 2010). These adaptive emotions strengthen socially anxious individuals and help them to connect with important needs that have been missing in their lives, thus encouraging them to reestablish relationships and fulfill authentic life goals and values. In working with clients with moderate to severe SA, we have found a common change process (see Exhibit 15.1).

EXHIBIT 15.1
Phased Change Process Model for Emotion-Focused Therapy for Social Anxiety

Phase I: Making contact and beginning to explore social anxiety:

(a) Alliance formation

(b) Empathic exploration/focusing for accessing, deepening, and symbolizing experience of social anxiety (emotion scheme work)

(c) Narrative work for developing a coherent account of the social anxiety in the person's life

Phase II: Initial work with presenting secondary anxiety processes:

(a) Systematic unfolding of social anxiety episodes, leads into two-chair work on anxiety splits (secondary reactive anxiety/fear)

(b) Emotion regulation work

Phase III: Deepening: Working with primary shame processes:

- Two-chair work (with Focusing) on deeper self-critical split: defective self vs. harsh critic (primary maladaptive shame/fear)

Phase IV: Emotional change: Working with and repairing the sources of social anxiety

(a) Empty-chair work with developmentally significant degradation experiences, leads into core pain, unmet needs, leads into:

(b) Compassionate self-soothing (primary adaptive emotions: connecting sadness, protective anger, exploratory curiosity) (Repeated as needed within and across sessions)

Phase V: Consolidation and ending

- Tapering off frequency of therapy; helping client carry forward changes in their life; preparing for and processing end of therapy

Note. From "Emotion-Focused Therapy for Social Anxiety (EFT-SA)," by R. Elliott and B. Shahar, 2017, *Person-Centered & Experiential Psychotherapies, 16,* p. 147.

Phase I: Making Contact and Beginning to Explore Social Anxiety

Several things happen in the initial phase of EFT-SA. First, a strong and genuinely caring and empathic therapeutic relationship needs to be developed with the client, creating a secure emotional bond that is essential

for the rest of the work. This can be challenging because clients with SA are generally quite interpersonally vigilant. In fact, for clients whose SA centers on unstructured social situations, *alliance formation* often turns out to be a key part of the work, and may require therapists to be more active and to provide more information and structure than they are used to offering.

Second, it is useful to begin, even in the first session, by helping the client to *explore and symbolize their experience of SA*. Every client's experience of SA is different, so the therapist helps the client elaborate their unique SA emotion scheme. This includes (a) how the SA feels in their body (bodily-expressive emotion scheme elements); (b) what situations it refers to and that trigger it (situation/perceptual elements); (c) the meanings they attach to their SA, what they tell themselves about it, and how they symbolize their social defects (symbolic/conceptual elements); and (d) how they cope with their SA and what it tells them to do (action tendencies).

Third, therapist and client begin to construct a *narrative* of where the SA fits into the person's life, including the story of how it originated or developed over time, and the life projects that are currently being compromised by it. Through this early narrative work, the therapist also hears the major task markers presented by the client and begins to develop a collaborative case formulation with the client.

Phase II: Initial Work With Presenting Secondary Anxiety Processes

From this point forward, the change process in EFT-SA involves a step-by-step deconstruction of the client's SA, working backwards through the etiological processes depicted in Figure 15.1. In other words, the therapist begins with the client's presentation of fear/anxiety in interpersonal and other social situations. The therapist asks the client to unfold a specific example of a social situation in which the person was afraid. This leads quickly into work on their *anxiety split process*, that is,

the process by which a CCG part of themselves generates and heightens their fear of others.

An important feature of EFT-SA is the need to help clients manage within-session *episodes of emotion dysregulation*, which commonly occur when they begin working with anxiety splits. As noted in the etiology discussion earlier, the CCG aspect at times overwhelms the vulnerable self-experiencer, which leads to in-session anxiety episodes, to which clients respond with experiential or behavioral avoidance, including emotionally shutting down, experiencing mild dissociation, or even leaving the session. If mishandled through therapist passivity or lack of strong empathic affirmation, these will become relational ruptures. On the other hand, if the therapist is able to actively and sensitively work with the client, these can become therapeutic opportunities, in that they help the client experience directly how they generate their SA. Phase II is completed when the CCG itself softens into anxiety, revealing a protective but often childlike quality of vulnerability.

Phase III: Deepening—Working With Primary Shame Processes

Phase III opens with the client beginning to face their core defectiveness, which the secondary processes explored in Phase II had been interrupting. The therapist helps the client explore the specific nature of the danger that CCG has been trying to protect the person from. This leads to an exploration of the underlying primary maladaptive shame and specifically the sense that they are fundamentally defective as a human being. This level of shame brings clients to a deeply vulnerable state, which is very difficult for them to stay with; thus, it requires close tracking and actively communicated empathic affirmation to hold the client emotionally. The therapist’s genuinely unconditional positive regard and active prizing of the client is essential here, as is continuing to work with the client’s immediate or delayed secondary reactions to their primary shame. This

work takes courage and active engagement on the part of both client and therapist, supported by chair work, focusing, and emotion-regulation efforts.

Once therapist and client are able to help the client stay with their primary shame, the next step is helping the client look at the deeper self-critical split by which they shame themselves through harsh self-criticism and self-contempt. Regardless of the developmental origins of the SA, the person continues to treat self in the here and now as defective and broken. Thus, the therapist helps the client to work with their harsh internal critic and its introjected, self-directed anger and contempt. This helps them experience directly how their sense of defectiveness, like their fear of others, is an internal, self-generated process.

Phase IV: Emotional Change—Working With and Repairing the Sources of Social Anxiety

Sometimes working with the deeper anxiety and self-critical splits is enough to generate emotional transformation through mobilizing protective anger, connecting sadness or self-compassion. In other instances, the work moves on to the developmental sources of the SA. If it is not already obvious where the harsh internal critic voice and its introjected anger and contempt have come from in the person's life, all it takes at this point is a bit of focusing by the client for them to contact episodic memories of repeated experiences of social or interpersonal degradation from others, generally in the form of bullying or abuse. At this point in therapy, it becomes apparent that the client's SA is really a form of complex trauma (Paivio & Pascual-Leone, 2010), and client and therapist begin working in earnest on this *unfinished business* from unresolved relationships and, in particular, unexpressed feelings and unmet needs left over from these relationships.

In this, client and therapist follow the standard deepening process in working with unfinished business, helping the client move from secondary protest and complaint about their mistreatment to their *core traumatic pain*, or what hurts the most, about the degrading experiences they went through. Following Timulak (2015), we have found that this core pain most commonly takes one of several forms: First, there can be intense feelings of *fragility or exposure*, which points to a generalized maladaptive existential fear of shattering or dying. Second, what hurts the most can be a sense of having been fundamentally *violated or injured* by degrading treatment by others, leaving the person full of shame and self-disgust ("damaged goods"). However, in our experience, a third form of core pain is most often present: a deep sense of having been *abandoned or rejected* by others, as if their defectiveness was so great as to cause the person to be entirely cast out of or shunned by their social unit, leaving them stuck in a deep sense of emptiness, loneliness, and disconnection.

Once the client accesses their core pain, the next step is to enter into *transformative self-soothing* (Goldman & Fox, 2010; Sutherland, Peräkylä, & Elliott, 2014). In this process, the therapist accepts the core pain and helps the client identify what it needs, which in turn activates an appropriate, primary adaptive emotion in the client. Thus, fragility or exposure needs protection and safety, which points to *self-compassion*, as if re-parenting oneself as a frightened child. Alternatively, violation helps the person activate *protective anger,* which helps the person to reassign the fault for the degradation and make better boundaries in current relationships. In addition, abandonment/isolation transforms into *connecting sadness*, which motivates the person to seek others in the face of their fears. These adaptive emotions as resources help clients address their core pain.

Phase V: Consolidation and Ending

These new, emerging emotions form the basis of new, more useful self-organizations, leading to far-reaching changes in emotion schemes for self and others, behavior change and more fulfilling interactions with others. However, addressing the traumatic pain and the primary processes of shame and harsh self-criticism does not automatically lead to change in the secondary processes of SA. Rather, there needs to be a process of working back out to the CCG anxiety split process, which has over time become a stable self-organization in its own right. Thus, we have found that it is important to support a process of helping the client to consolidate the more fundamental changes and to translate these into their current life functioning. Among other things, the therapist helps the client to use their new adaptive emotions of connecting sadness to motivate themselves to seek social situations in which to learn for the first time to really be themselves. Similarly, the client's self-compassion and even protective anger can help them to better meet the challenges of being in relationship with others, where disappointments are inevitable and boundaries are sometimes very important.

In this process of consolidation, which may last several months, the focus of the therapeutic work shifts to helping the client carry forward their internal emotional changes into their life. At the same time, client and therapist may agree to meet less often, gradually tapering the frequency of session, as they prepare for and process the end of therapy, and deal with any setbacks or emergent situations in the client's life.

INTERVENTION STRATEGIES AND CASE EXAMPLE[1]

In this section we describe in more detail the various tasks and interventions that are commonly used to facilitate these and other change processes. We demonstrate these tasks and interventions using a case example from Shahar et al.'s (2017) study.

The client was a 28-year-old man whom we will refer to as “Daniel,” currently studying abroad in Israel.[2] He was originally from Brazil and had been raised only by his mother. At the age of 8, his mother married another man, a European. Daniel and his mother moved to Europe, which Daniel experienced as a traumatic loss of his extended family and protective natural environment. Daniel described his mother as emotionally unstable and paranoid, with frequent anger outbursts, and even psychotic symptoms. As he grew up, Daniel experienced various degrading events, but the one that he recalled as most painful was being forced to move from an international elementary school to a religious Jewish school. Having been popular in the international school, he now felt different, inferior, and excluded in the religious school, yet his attempts to convince his mother to let him go back to the international school failed. When he began therapy, Daniel was in a serious romantic relationship but suffered from severe levels of SA symptoms (LSAS scores of 78).

Interventions at Phase I

The most important goal at the beginning of therapy, in addition to unfolding the narrative and exploring the current SA, is to help clients feel safe, validated, and understood. Therapists use a variety of validating empathic responses that reflect their genuine warmth and care for the client. Therapists allow themselves to taste the client’s suffering and vulnerability, and to be touched by them. For example, in the first session, Daniel talked about his first night at the new house after they moved to Europe. He could not fall asleep and called to his mother, but his new stepdad thought that “8-year-olds should fall asleep on their own,” and forced his mother to leave him alone, which left him feeling terrified. His therapist responded, “Yes, just being there alone in the room, just 8 years old, in a new country, new house, new family, away from everything that’s safe and familiar, feeling so alone and terrified.” For socially anxious clients, who usually feel prone to

judgment, a therapeutic relationship that is based on validation can be highly soothing, affect-regulating, and provides a corrective emotional experience.

Interventions at Phase II

Around the third session the marker for the anxiety split (e.g., the split in which the CCG generates anxiety around social situations) is often clearly present, and the emotional bond between the therapist and the client is strong enough to begin deeper emotional processing work. Working on the split using a two-chair dialogue task can now be suggested after a rationale for doing such work is provided. In the third session, as Daniel described a job situation in which he was anxious because he felt judged by his boss, the therapist invited him to work on this using the chairs:

Therapist: So it seems like one part of you stresses you out in these situations, calling you stupid and lazy, telling you that your boss thinks you can't spell right, whereas another part is left feeling anxious and tense . . . it's in the body right? Feeling sweaty I think you mentioned. Is that right?

Daniel: Yes (nodding). I feel like I can't talk because it might come off as . . . as stupid or something.

Therapist: Right, it sounds like it's so hard to function with this voice in your head that keeps warning and frightening you that things will go wrong, that others will look down on you.

Daniel: (nods in agreement.)

Therapist: So I suggest we try something to work with that voice, OK? Can you come over here (pointing to an empty chair located in front of the client's chair)? (Daniel agrees and moves to the empty chair which directly faces his usual chair.) See if you can see yourself there [creating contact].

How do you stress him out in this situation? Let's actually try to do it.

Daniel: (looking at the therapist.) I tell him that he's no good.

Therapist: Yeah, so tell him: "You're no good!"

Daniel: (facing the empty chair.) You're no good, and you must show him that you're competent and make the right impression.

As shown above, after initiating the task and creating contact (e.g., making sure the two sides talk to each other rather than through the therapist), the therapist coaches the CCG (catastrophizer) to express the anxiety-eliciting messages. In this step it is important to help the CCG be as specific as possible, in order to see how anxiety is generated in social situations and even to directly generate it in the session. After the client in the CCG chair expresses the most anxiety-provoking messages, the therapist asks him to switch chairs in order to explore the bodily felt feelings in response to the CCG's attacks.

Therapist: Okay, come over here (pointing to the client's original chair).

Daniel: (switches to the other chair)

Therapist: So, look inside . . . what happens inside as you hear this? Tell him how he makes you tense.

Daniel: These things that you tell me, they make me anxious.

Therapist: Like . . . it's hard to breathe . . . and . . . it's like . . . "I am so scared?"

Daniel: I can't find words in such places so I don't have much to say.

Therapist: Just like being paralyzed. So tense and anxious that you can't speak.

Daniel: Yeah, and I often start to sweat a little, and I am afraid that others can see that.

Therapist: Okay, come over here.

Daniel: (moves back to the CCG's chair)

Therapist: How do you make him sweat?

Daniel: (using a contemptuous tone) Look at you, you have nothing to say, so now he thinks you're stupid and will fire you.

The therapist helps Daniel explore the bodily felt tension and anxiety in response to the CCG's messages. The therapist uses a variety of empathic conjectures to help Daniel deepen the process and actually experience the tension in the session. As mentioned before, some clients become dysregulated in this stage and experience intense anxiety or panic in the session. It is important to help them breathe and regulate the anxiety. Such moments of therapist–client dyadic regulation can be healing, because so often these clients have been alone in this process. Other clients, however, like Daniel, are overregulated and do not feel much anxiety in the session. With them, the focus is more often on the anxiety they experience in specific out-of-session situations. Focusing is useful here to help deepen the understanding of the bodily experience of the anxiety (in this case sweating), as is coaching the CCG to describe how it elicits that response. This further intensifies the criticism and clarifies the anxiety-generating process.

Interventions at Phase III

The primary goal of this stage is to differentiate the secondary anxiety into deeper, primary maladaptive shame and defectiveness in the experiencing chair and finally to facilitate the emergence of primary adaptive anger and sadness (Greenberg, 2010). By experiencing and

expressing adaptive emotions, the self is strengthened and feels more motivated to break free from limiting avoidant processes. At the same time, the protective nature of the CCG becomes apparent and the CCG softens into anxiety. In the fifth session, Daniel described another social situation in which he was anxious, and the therapist again suggested that they work on this using the chairs:

Therapist: So come over here (Daniel moves to the CCG chair). How do you make yourself self-conscious?

Daniel: You're going to make a mistake, you're going to look bad, you'll even look ugly if you eat like that, if you drink you might spill something, I don't know . . . you look bad in front of other people when you eat.

Therapist: Right, so you need to be careful . . .

Daniel: Yeah, you need to be careful with everything that you're doing, every step you do, so that someone would not see that you can't spell and make fun of you.

Therapist: And that's going to be so painful.

Daniel: Exactly, so I always push you to be more, to be better.

Therapist: Right, so tell him, you need to be more, I expect you . . .

Daniel: I expect you to be better, to achieve, to be perfect.

Therapist: Otherwise . . .

Daniel: Otherwise everyone will see that you're not good (begins to tear up).

Therapist: Ok, can you change? (Daniel moves to the experiencing chair.) So he is sort of watching all the time, making sure you don't make mistakes. What's happening inside now?

Daniel: (on the verge of having tears but trying hard not to cry) It's hard. . . . It's hard to be supervised like that, and to be told not to do this and not to do that, and you're telling me. . . . I mean, it's hard to be myself (becoming sadder).

Therapist: Mmm, so he is the supervisor. Tell him, I can't be myself . . .

Daniel: I can't be myself and I have to pretend all the time. I feel handicapped.

Therapist: Yeah, so this is so sad right? Tell him what's most missing for you.

Daniel: I miss being free with other people (turning to the therapist). You know, without this anxiety I am actually pretty fun to be with . . . and I'm interesting.

Therapist: I'm sure. And you miss this part of you so much! I imagine, you know, it's so sad to lose that part of you.

In this segment, as the function of the CCG becomes more apparent (e.g., to watch and to supervise the self in order to be perfect and to avoid being exposed as defective), Daniel becomes more connected with the loss that comes with having to constantly pretend. In this case, adaptive sadness appears before the client experiences deep shame.

Later in the session:

Therapist: So come over here, I want you to be the supervisor. Watch him, watch everything he does.

Daniel: (moves to the CCG chair) You need to be better, you need to make sure your spelling is correct.

Therapist: And I am watching you. All the time. To make sure . . .

Daniel: To make sure you don't screw up. So they don't find out who you really are.

Therapist: What's wrong with him?

Daniel: He is no good. He has problems.

Therapist: What are his problems?

Daniel: I don't know, there is something wrong with you. You're not like everyone, you are not as good. You're just . . . fucked up.

Therapist: And if they find out this truth . . .

Therapist: They'll reject you. No one will want to be with you.

Therapist: Okay, change (Daniel moves to the experiencer chair). What's it like inside now as you hear this?

Daniel: (displays shame, looking down, shoulders slumped, silent.)

Therapist: (after a few seconds) So hurt, so painful. It's tough to hear . . . it's so degrading.

Daniel: Yeah, I just feel inferior, like I'm not worth shit.

Therapist: Yeah, I imagine this is the hardest feeling. Feeling so worthless. Just wanting to hide somewhere [= action tendency of shame].

Daniel: Right. I don't want to be here.

Therapist: To disappear somehow.

Daniel: (nods) Yeah, it hurts because I don't feel like I'm enough, and I need to be someone else that I'm not [voice indicates emerging resentment].

Therapist [supporting expression of assertive anger]: Right, it's like, "I lose my own sense of self and I'm tired of it." Tell him how you feel about that.

Daniel: I'm tired of always having to prove myself, to show that I'm not weak.

Therapist: So talk to your supervisor. What do you resent?

Daniel: I resent the fact that you make me pretend and work so hard to be someone that I am not.

Therapist: Right, so I need you to . . .

Daniel: I need you to stop doing that and let me be myself. I need you to encourage me, to tell me I am okay, that I'm just . . . good enough.

Therapist: Okay, Change.

Daniel: (moves to CCG chair) I can't encourage you. I can't act as if everything is okay, and then . . . and then you'll think everything is okay, that you're fine, and you'll make mistakes.

Therapist: And then . . .

Daniel: You'll be exposed for the fake that you are.

Therapist: And then . . .

Daniel: I don't know . . . it's going to be so humiliating.

Therapist: Right, so my job is . . .

Daniel: To make sure that doesn't happen. That it never happens!

Therapist: Yes, it's so scary . . . this possibility, this feeling of being humiliated. Can you tell him about this anxiety?

Daniel: Yeah, I'm afraid of this feeling. I can't let it happen.

Therapist: Right, so this is the anxiety that drives you. Tell him some more about what you're afraid of. What are you most afraid of?

Daniel: That people will look down on you and think that you're less than . . . and they will see this little vulnerable boy.

Therapist: Right, so that's the part I don't want you to . . .

Daniel: Yeah, I don't want anyone to see that part. You're strong, no one should see that weak part.

In this segment, as the CCG expresses the most degrading comments, the shame scheme is activated and processed, even if for a few seconds, in the experiencing-self chair. Usually at this point an adaptive emotion scheme—sadness or anger—begins to emerge, and it is most crucial for the therapist to pay attention to nonverbal signs (posture or voice quality) of that scheme and to support its emergence. As Daniel experiences shame, he begins to feel resentment for "having to be someone else that I'm not," and the therapist supports him in expressing the anger and its needs. As the client accesses shame in a context of a safe and validating relationship, sadness and anger naturally emerge as an antidote for shame without the therapist having to pull for them. These primary adaptive emotions lead to expressing basic needs that are important to Daniel's well-being and are likely to promote emotional and behavioral changes. In addition, accessing shame and subsequent adaptive anger leads to an important dialogue, in which the protective function of the CCG is expressed (i.e., to prevent humiliation) and the CCG softens into anxiety.

Interventions at Phase IV

At the beginning of this stage, the source of the SA and self-directed anger and contempt are usually already clear. For Daniel, the sources of the SA involved, first, the fear that others will see him as like his unstable/weak/vulnerable mother and, second, prior experiences of being rejected and feeling not worthy of love. In particular, he remembers the first night at his new home in Europe when he couldn't fall asleep but was abandoned by his mother and forced to remain alone. Also, being "moved like a doll from place to place" contributed to feeling "like nothing for no one."

In Session 17, during two-chair work, accessing shame in the experiencing chair led to episodic memories of being rejected and to working through the pain:

Therapist (to the experiencing self)*:* So tell him how you feel when he doubts you.

Daniel: When he doubts me, I feel so lost (begins to cry). I feel like this boy that wasn't accepted when I was little.

Therapist: Yeah, be that little boy . . .

Daniel: No one accepted me, my mom didn't accept me, my mom wasn't there for me, and my dad . . . I didn't have a dad (cries). I was just this boy that everyone leaves on the side and just . . . just not worth anything.

Therapist: Yeah . . . this boy, he suffered so much, he was abandoned . . .

Daniel: I feel like when I am getting doubted, when I am getting judged, I feel like this boy that is worthless, he is so worthless that everyone leaves him (sobs).

Therapist: Yeah . . . I must be so worthless if you left me like that.

Daniel: Like I am not worth the love, the hugging, the attention (sobs).

Therapist: It's okay, breathe . . . because this is the most painful feeling . . . because this is the core wound right? When this little boy felt so abandoned and started to ask: "How come you left me, am I that worthless?"

Daniel: Yes, and when I am judged, I feel so alone . . . I feel like again this little boy . . . When I was a little boy, I had no one not even a friend . . . not even my mom hugged me that night. It's like you're not worth your mother, you're not worth your grandmother, you're worth being alone there.

Therapist: That's all you're worth . . . Try and see your mom here and be that little boy.

Daniel: I am so angry at you! Why couldn't you . . . She wasn't sensitive to me.

Therapist: I needed you . . .

Daniel: I needed you to be there for me and . . . like . . . I was only 8!

Therapist: Right, right, tell her.

Daniel: I was only 8 (sobs)! And you were pushing me to sleep alone and screaming at me. I needed you to be there for me, and hug me and tell me things are going to be fine.

Therapist: I needed you to be by my side and show me that I am important to you.

Daniel: Yeah, show me that I am worth . . . that I am your son, that I am more important than this boyfriend that you just met.

Therapist: I needed you to soothe me and calm me down.

Daniel: Yeah, I felt like, I'm not worth the hug, I'm not worth the comfort.

The therapist and the client continue to process the deep pain and its associated needs until, at a later point, the therapist initiates a self-soothing process:

Therapist: So can you come over here? And this is Daniel now okay? Can you see this little boy?

Daniel: (sobs)

Therapist: Yeah this is so hard . . . I know . . . See if you can see the 8-year-old you there. Can you see him?

Daniel: Yeah.

Therapist: Can you give him what he needs?

Daniel: Yes.

Therapist: See what it feels like?

Daniel: Everything is fine . . . you know when you were so alone, I think it was pretty hard for mom.

Therapist: With her new boyfriend you mean?

Daniel: Yeah, she was very confused, she didn't know what she was doing.

Therapist: Right, tell him, this is very important.

Daniel: It's not that she judged you, she was confused and she also took a big step.

Therapist: So it's like . . . it wasn't your fault?

Daniel: Right, it wasn't your fault, it didn't mean that you are worthless.

Therapist: Right, tell him that again, because I think he really needs to hear that.

Daniel: You are not worthless and it wasn't your fault.

Therapist: What do you feel toward him right now?

Daniel: I am thinking like I am the protecting part right now, and I need to make him understand.

Therapist: So tell him, I need you to understand . . .

Daniel: This was a difficult situation, you were alone and removed from your grandmother, who was really your mom [his grandmother raised him], but it didn't mean that you are worthless.

Therapist: What do you actually feel inside when you look at him and tell him these things? See the 8-year-old . . .

Daniel: I feel like . . . I feel sorry for him; I am sad for him.

Therapist: So it's this warm feeling I guess . . . What do you want to do with this feeling?

Daniel: I want to comfort him . . . and tell him everything's fine.

Therapist: So tell him. Comfort him. Be his mother that he never had.

Daniel: It's okay . . . I am here for you. We'll go through this together. I'm here (turning to the therapist). This is what I needed. It's so simple. I just needed her to help me through.

At the beginning of this segment, in the context of dialoguing with the CCG, Daniel accessed the episodic memory of the first night in Europe and the feeling of not being worthy of his mother's love and attention. This was a marker for empty-chair work with her, and it was important for him to experience this shame in the context of the relationship with her, where the shame scheme was originally created. This naturally led to expressing basic needs for comfort from her and an experiential understanding that it wasn't his fault. The therapist then initiated the self-soothing process, so that Daniel could experience providing this comfort to himself and actually experience the feeling of being comforted. In Session 21, this process was further deepened using imaginal restructuring, in which Daniel was guided in imagery to go back to the religious school and provide comfort and soothing and guidance to the little boy who was alone and having a hard time adjusting. These experiences are essential, as they fulfil his previous unmet needs, thus transforming and correcting, or reconsolidating (Lane, Ryan, Nadel, & Greenberg, 2015) the shame emotion scheme into a compassion emotion scheme, resulting in more confidence.

Interventions at Phase V

In this stage the therapist and the client go back to the dialogue with the CCG to consolidate the change and help the experiencing self make plans to confront and overcome the entrenched avoidant processes, reclaim the right to connect with others in a meaningful way, and to be authentically present in social situations. For example, in Session 24, in a dialogue with the CCG, Daniel in the experiencing chair says,

Daniel: I am seeing him in the other chair and I have this sense that I am calmer than him. He's anxious to be more, more, more . . . and stressed, but when I am sitting here. I feel calm and more confident.

Therapist: So what does he need from you?

Daniel: To hear that it's okay, we are fine now.

Therapist: Yeah, tell him, see if you can help him to calm down.

Daniel: You don't need to run around anymore. You don't need to be anxious anymore, you don't need to run for something that is not there.

Therapist: And I don't need you to push me to run around . . .

Daniel: Yeah, I don't need that.

Therapist: But I see, it's so sad . . .

Daniel: (turning to the therapist) You know, it's funny because before little Daniel was sitting here (in the experiencing chair), but now he's there.

Therapist: Yes, he is the scared one . . . So try telling him, I am not the little boy anymore.

Daniel: Yeah, I am not the little boy anymore. The little boy is confident now and I grew up.

CONCLUSION

In this chapter, we have laid out our approach to applying EFT to clients presenting with SA (EFT-AS)—a debilitating fear of other people. It is our view that this approach is promising in two ways: To begin with, it provides an alternative to a common but difficult-to-treat psychological difficulty that up until now has been almost exclusively the province of CBT; this is important because in our experience many clients have either

had previous unsuccessful courses of CBT for SA or prefer a less directive, more relational approach.

In addition, it is our view that EFT-AS can help EFT practitioners extend their practice to a new, challenging and complex client population, helping therapists to develop additional skills for working effectively with all their clients: First, we can improve how we work with clients who are deeply shame-ridden and display high levels of interpersonal vigilance in sessions, putting us under a microscope. Second, we can learn how better to meet clients who are likely to be phobic of unstructured social situations (of which therapy is an exemplar) and who, therefore, demand that we become more process guiding—even though they may find chair work to be too difficult or embarrassing. Third, we can develop a wider, more flexible approach to working with clients who easily become emotionally dysregulated in sessions, including panic attacks in sessions. Fourth, we can add compassionate self-soothing to the set of therapeutic tasks we are able to offer clients. Meeting and learning from these challenges over the past ten years has made us both better EFT therapists, and we are grateful to our clients for bringing these challenges to us.

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[1]This case appeared in shortened form in Elliott and Shahar (2017). In this chapter, we describe the intervention strategies in more detail to illustrate how the change process works.

[2]The authors verify that they have concealed client identity by disguising details of the case or by combining details from multiple cases.

16
EMOTION-FOCUSED THERAPY FOR COMPLEX INTERPERSONAL TRAUMA

ULA KHAYYAT-ABUAITA AND SANDRA PAIVIO

The purpose of this chapter is to identify distinct features of emotion-focused therapy specifically of use for complex trauma (EFTT), as a resource for clinicians who are already familiar with the general model of EFT (Greenberg, 2017) and those who wish to integrate aspects of EFTT into their current practice with child abuse survivors. In this chapter, we describe the nature of complex trauma—including definition, prevalence, and long-term effects. We also depict the distinct features of EFTT compared with other treatment for complex trauma and to the general model of EFT. Additionally, we present the theory, structure of therapy, intervention strategies, as well as research supporting the treatment model, and conclude with a case example to illustrate treatment principles and the process of therapy.

NATURE OF COMPLEX TRAUMA

Type II or complex trauma, as distinct from Type I or single incident trauma, is characterized by repeated exposure to traumatic events, often at critical developmental periods, at the hands of individuals known to the victim (including family members, friends, loved ones, and caregivers). Examples of complex trauma include exposure to social or political violence, domestic violence, and childhood maltreatment. In such cases, it is common for victims to be further victimized by societal shortcomings that may be present in mental health, judicial, and social support systems (Paivio & Pascual-Leone, 2010). Research shows that exposure to multiple traumatic events is much more common than exposure to a single traumatic event (Resick, Nishith, & Griffin, 2003; van der Kolk, 2003). Complex trauma also is associated with a more complex array of disturbances when compared with single incident trauma; experts agree that the multiple symptoms experienced by survivors of prolonged and repeated trauma are not adequately reflected in the diagnostic formulation of posttraumatic stress disorder (PTSD; Cloitre et al., 2009). Thus Herman (1992) first coined the term “disorders of extreme stress not otherwise specified (DESNOS)” to describe this array of symptoms, which is more recently known as *complex PTSD*.

Childhood maltreatment is the type of complex trauma that is the primary focus of EFTT. Most typically this is defined as nonaccidental acts of commission that include emotional, physical, and sexual abuse, as well as acts of omission (including neglect) that are perpetrated against children by an adult (Dubowitz & Bennett, 2007). According to Bernstein and Fink (1998), *physical abuse* is defined as a bodily assault on a child resulting from an adult that poses a risk of or an actual injury. *Sexual abuse* refers to the occurrence of sexual contact between a child and an older person that may include coercion. However, sexual abuse frequently does not take place during threatening or violent conditions. Rather, abusers may misuse their authority or relation to the child, and the victim may recognize the

presence of abuse only in retrospect. Additionally, sexual abuse includes a spectrum of inappropriate activities, ranging from penetration to no physical contact (Finkelhor, 1990, 1994).

The definition of *emotional abuse* is less clear in the literature, but it refers to instances of verbal assaults on a child by an adult, that may include the threat of physical violence, witnessing violence, or degrading the child's sense of self-worth (Bernstein & Fink, 1998). *Emotional neglect* refers to the failure of caregivers to provide the child with basic psychological and emotional needs.

There is variability in the prevalence estimates of childhood abuse due to differing definitions and assessment methodologies. Nonetheless, studies consistently show that exposure to child abuse is common. Scher, Forde, McQuaid, and Stein (2004), for example, reported that approximately 30% of women and 40% of men experienced some form of childhood maltreatment, and 13% experienced multiple forms of maltreatment. Results of recent meta-analytic studies (Stoltenborgh, Bakermans-Kranenburg, Alink, & van IJzendoorn, 2012; Stoltenborgh, Bakermans-Kranenburg, van IJzendoorn, & Alink, 2013; Stoltenborgh, van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011) indicate worldwide prevalence rates of 22.6% for child physical abuse, 12.7% for child sexual abuse, 36.3% for emotional abuse, and 18.4% for emotional neglect. Child abuse trauma is particularly highly prevalent in clinical samples, likely because of the constellation of long-term effects, reviewed in the following sections.

THEORY OF DYSFUNCTION

Exposure to a traumatic event does not necessarily lead to the development of psychological disturbance—a number of protective factors can buffer the negative consequences of trauma, including social support, emotional health, and academic achievement (Folger & Wright, 2013;

Sperry & Widom, 2015; Tharp et al., 2013). Nonetheless, research indicates that increased psychological problems are associated with particular abuse characteristics, including frequency and duration of abuse, penetration, use of force, and close relationship to the perpetrator (Easton, Renner, & O'Leary, 2013).

Numerous studies show that childhood abuse is associated with physical as well as psychological and psychiatric problems. There are thought to be three main inter-related sources of disturbance and associated effects. First, repeated exposure to trauma typically is associated with symptoms of PTSD (intrusion, avoidance, hyperarousal, maladaptive cognitions). Second, negative experiences in attachment relationships results in enduring internal representations of self as worthless, unlovable, incompetent, or powerless, and intimate others as being untrustworthy, unavailable, or dangerous. Consequently, childhood maltreatment predicts problems in social functioning, including difficulties with intimacy, submissiveness, insecure adult attachment, and lower parental self-efficacy (Caldwell, Shaver, Li, & Minzenberg, 2011). The third source of disturbance is the absence of parental empathy and support; abused and neglected children often are overwhelmed by feelings of anger, sadness, fear, and shame and learn to rely on experiential avoidance as a coping strategy. Thus children develop a range of emotion regulation difficulties.

Cole, Michel, and Teti (1994) defined *emotion regulation* as the "ability to respond to the ongoing demands of experience with a range of emotions in a manner that is socially tolerable and sufficiently flexible to permit spontaneous reactions as well as the ability to delay spontaneous reactions as needed" (p. 76).

Dysregulation and avoidance/overcontrol are problematic because emotions are a source of information that guides adaptive functioning that is not available when emotions are overwhelming or not available (Paivio & Laurent, 2001). Emotions such as anger, sadness, fear, and shame that are

overwhelmingly intense can interfere with several areas of functioning including: learning, performance, interpersonal relations, poor impulse control, and coherent narrative processes. Adult survivors may continue to experience inappropriate automatic alarm reactions and intense emotions in situations that resemble past abusive experiences (Courtois & Ford, 2013; Paivio & Laurent, 2001).

In terms of overcontrol, abused children learn to view emotional avoidance as essential to their survival and adaptation to their environments. Therefore, they attempt to manage their traumatic and painful experiences through strategies such as dissociation, disavowal, suppression, minimization, and overcontrol of emotions. Chronic experiential avoidance, in turn, has been linked to a number of psychological problems including poor self-awareness, emotion dysregulation, anxiety, depression, the perpetuation of PTSD symptoms, and maladaptive behaviors such as substance abuse, eating disorders, and self-harm (see Hayes, Strosahl, & Wilson, 1999, for a review). Chronic avoidance of emotional experience is related to difficulties in recognizing and describing emotional experiences, referred to as *alexithymia* (Paivio & Laurent, 2001; Taylor, Bagby, & Parker, 1997).

DEVELOPMENT OF EFT FOR CHILD ABUSE AND COMPLEX TRAUMA

EFT specifically for child abuse trauma (EFTT) is based on the general model of EFT whose principles have been described elsewhere (Greenberg, 2017). EFTT focuses on the high prevalence of fear, avoidance, shame, and emotion dysregulation, which are observed in trauma survivors. EFTT developed from a study which examined the efficacy of 12 sessions of individual experiential therapy using a gestalt empty-chair dialogue for resolving “unfinished business” with significant others from the past

(Paivio & Greenberg, 1995). Therapy was based on an empirically verified model, which identified steps in the resolution process (Greenberg & Foerster, 1996) using the empty-chair dialogue intervention. Steps in the process that discriminated clients who resolved issues from those who did not included negative perceptions of the significant other, expression of previously inhibited adaptive emotion (i.e., anger, sadness), entitlement to unmet needs, and more adaptive perceptions of self and other—that is, increased self-empowerment and self-affiliation, a more differentiated perspective of the significant other, and holding the other (rather than self) accountable for harm. Clients cycle through these steps in a reiterative process over the course of therapy, gradually moving toward resolution. Results of the Paivio and Greenberg (1995) study evaluating therapy based on this model indicated large effects and clinically meaningful changes in multiple domains of disturbance. The sample in that study included a subset of clients who were dealing with child abuse trauma. Paivio conducted subsequent research examining the in-session processes for this subset of clients. Observations indicated notable differences in this subgroup compared with clients who were not dealing with childhood abuse, including the activation of fear, avoidance, and shame at the introduction of empty-chair procedure. These processes became the focus of subsequent therapeutic work. Thus two main modifications were made to the general model of EFT. First, and importantly, EFTT conceptualizes the empty-chair procedure specifically in terms of trauma work that involves both interpersonal as well as exposure processes. The empty-chair procedure was renamed *imaginal confrontation* (IC) of perpetrators to emphasize trauma processes. Second, reducing the fear/avoidance, guilt and shame activated by the IC became the primary focus of the second phase of therapy. The duration of therapy was increased to accommodate this process.

CLINICAL FEATURES OF EFTT

EFTT is a short-term (16–20 sessions), evidence-based experiential approach to the treatment of complex trauma (Paivio, Jarry, Chagigiorgis, Hall, & Ralston, 2010; Paivio & Nieuwenhuis, 2001; Paivio & Pascual-Leone, 2010). To date, EFTT is the only published evidence-based individual therapy for both men and women with histories of different types of childhood maltreatment (emotional, physical, and/or sexual abuse; emotional neglect).

EFTT is based on the general model of EFT (Greenberg, 2017; Greenberg & Paivio, 1997) applied to complex trauma. Fundamental assumptions of the general model are that (a) emotions are an adaptive orienting system and a source of information about thoughts, feelings, action readiness, motivations, and interpersonal interactions; and (b) client experiencing (attention to and exploration of feelings and meanings) is the primary source of new information in therapy (as opposed to skills training, challenging maladaptive cognitions, or interpretations). EFTT is an integrative approach that also assimilates theory and research in the areas of attachment and trauma (Bowlby, 1988; Courtois & Ford, 2013).

EFTT shares features with other treatments for complex trauma (Courtois & Ford, 2013). Most important, common features include promoting a safe environment for the client that facilitates the process of exploring trauma material, exposure to and emotional processing of feelings and memories, and addressing current self and interpersonal difficulties. EFTT also has a number of distinctive features that are characteristic of current experiential approaches (Paivio & Pascual-Leone, 2010). Most notable are the use of empathic responding as a primary intervention and means of affect regulation, EFT marker-driven intervention, and a focus on resolving issues with particular perpetrators of abuse and neglect, usually attachment figures, in addition to addressing current difficulties. It is thought that adult survivors continue to be disturbed by negative feelings and memories as well as unmet needs concerning these specific others.

EFTT is uniquely based on a refined rational-empirical model (Greenberg & Foerster, 1996) referred to earlier that specifies steps in the process of resolving past relational issues ("unfinished business") using the empty-chair intervention. This procedure is described in detail in later sections of this chapter.

Mechanisms of Change

EFTT proposes two main mechanisms of change: (a) the therapeutic relationship, and (b) emotional processing of trauma memories. Providing a safe and collaborative therapeutic relationship serves two important functions in EFTT. First, it facilitates the client's ability to access and reexperience painful traumatic memories. Second, it provides a corrective emotional experience that helps to counteract the empathic failures experienced through previous relationships with attachment figures (Paivio & Pascual-Leone, 2010).

Emotional processing of traumatic memories in EFTT involves the process of emotional transformation—changing emotion with emotion (Greenberg, 2002; Greenberg & Pascual-Leone, 2006). Accordingly, maladaptive emotions, such as fear and shame, are accessed and modified by accessing previously avoided adaptive emotion, such as anger and sadness, and associated adaptive meaning. For example, feelings of fear and shame, as well as self-blame for the abuse, that are so prevalent among survivors of childhood abuse are transformed by accessing anger toward the perpetrator and appropriately holding them, rather than self, accountable for harm. Similarly, shame can be modified by accessing sadness at the many losses endured and compassion toward self.

Phases of Therapy and Associated Therapeutic Tasks

The four phases of EFTT are: (a) cultivating the therapeutic alliance; (b) reducing self-related difficulties, such as fear/avoidance, guilt and shame; (c) resolving trauma and attachment injuries; and (d) termination. Notably, although EFTT is not a stage-based treatment, certain processes are more prominent during specific phases of treatment (Paivio & Pascual-Leone, 2010).

The first phase of therapy comprises the first four sessions. The focus is on establishing a secure therapeutic relationship, establishing a collaborative understanding of the factors contributing to disturbance, and collaborating on treatment goals and tasks with a particular emphasis on accessing and processing trauma feelings and memories An empathically responsive therapeutic relationship in EFTT provides a safe environment for clients to disclose and re-experience painful events, and helps to correct previous attachment injuries and empathic failures. The client is encouraged to disclose trauma material, sometimes for the first time, and is provided with a rationale for how future reexperiencing will facilitate resolution and reduce symptoms. Additionally, the primary reexperiencing procedures (IC with or without the use of chairs), which involve in-depth exploration of trauma issues, are introduced in session four. These will be described in the following section on intervention strategies.

Throughout this initial phase of therapy, the therapist attends to the quality of client trauma narratives, monitors the client's emotional regulation abilities, assesses the ability to explore trauma material and engage in the interventions, and identifies emotional processing difficulties that become the focus of future intervention (Paivio & Pascual-Leone, 2010).

The second phase focuses on reducing self-related difficulties that emerged in the early phase, especially during the re-experiencing procedures. These difficulties, which include avoidance of emotions, dissociation, fear, shame, guilt, and self-criticism, are obstacles to achieving

resolution of attachment injuries. Traumatic events are typically associated with painful feelings, memories, and bodily sensations that are avoided as a coping mechanism. However, avoidance of those emotions makes them unavailable for modification and eventually for resolution. As such, this phase involves helping the client, not only in identifying negative emotions, but more importantly to allow themselves to experience the emotions that were previously avoided, and to feel and process these emotions at an in-depth level. Intervention in this phase can include two-chair dialogues to resolve self-critical or self-interruptive processes, and trauma memory work that involves activating and exploring recent or distal memories of situations in which the core maladaptive sense of self was activated or developed. In both procedures, the goal is to transform the maladaptive processes by accessing alternative healthy resources, such as needs for respect or compassion toward the self (Paivio & Pascual-Leone, 2010).

The third phase of EFTT focuses on resolution of issues with perpetrators by accessing adaptive emotions (anger, sadness, grief) that have been blocked in earlier phases. By reducing fear/avoidance, shame, and self-blame in the previous phase, clients are better equipped to imaginally confront their abusive and neglectful others and express previously constricted feelings and needs. One important process is to help the client to assertively experience and express their entitlement to unmet needs and hold perpetrators accountable for harm. Another essential component is to elicit a response from the imagined other to these assertive expressions. The response could be one of repentance, which helps the client to understand and forgive the other. Alternatively, the imagined other could be viewed as incapable of acknowledging harm, and lacking empathy. Resolution in this case involves seeing them in a more realistic light, incapable of change, perhaps pathetic rather than all-powerful. The client is able to let go of expectations that the other will change. In either form of

resolution, the client feels more self-affiliative and powerful and holds the other accountable for harm. (Paivio & Pascual-Leone, 2010).

The focus of the fourth and final termination phase of EFTT is consolidating the changes that occurred throughout therapy and bridging to the future. A final reexperiencing procedure is employed to help the client experience the degree of resolution they have achieved and the changes that have occurred since the initial introduction of this procedure early in therapy. The final sessions include mutual feedback about the process of therapy—client changes in self-experience, functioning, and helpful or hindering aspects of therapy. Importantly, to help consolidate change, therapists continue to promote client experiencing (attention to and exploration of feelings and meanings) as they report experiences of discovery and change. Therapists give client feedback on observed processes over the course of therapy, celebrate accomplishments with the client, and validate possible ongoing struggles and disappointments about limited gains. Finally, this phase involves consideration of future goals and plans and normalizing the possibility of returning to therapy (Paivio & Pascual-Leone, 2010).

INTERVENTION PRINCIPLES AND STRATEGIES

Paivio (2013) identified four essential processes that are characteristic of EFT, in general, and EFTT, in particular, regardless of the session and the specific intervention being used. The four intervention principles that are essential to every session are: (a) collaborating on a focus for the session, (b) empathically responding to client struggles and pain, (c) responding to the emergence of adaptive emotion and associated healthy resources (i.e., feelings, needs, action tendencies, understandings) that can be used to modify maladaptive meaning, and (d) promoting client experiencing (i.e., attention to, and exploration of, feelings and meanings). These in-session

intervention principles are consistent with posited mechanisms of change. Advanced empathic responding and promoting experiencing are two of the primary interventions employed throughout EFTT. Empathic responding is a multidimensional construct (Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003) that involves communicating understanding of the client's internal experience, typically struggles and emotional pain, at verbal, nonverbal, affective, and cognitive/meaning levels. According to Paivio and Laurent (2001), empathic responding has three main functions that help clients to reprocess trauma material. First, empathic responses help clients to modulate the intensity of emotions—evocative empathic responses that increase arousal and soothing empathic responses that reduce arousal and distress both help make emotions available for exploration and change. Second, empathic responses help clients to accurately label their feeling. Third, empathic responses help clients understand the meaning of their emotional experience. Accurate labelling and understanding of emotional experience, in turn, contribute to greater emotion regulation and reduced distress.

Promoting experiencing refers to helping the client attend to and explore the meaning of their moment-by-moment internal experience and construct new meaning from this process. Clinicians assess client capacity for and typical depth of experiencing evident in their narrative quality—from narratives that are externally focused on behavior and events, to those that are more personal and affectively focused; to those that are more reflecting, posing and beginning to answer questions or problems about the self. Intervention involves deepening client experiencing step-by-step. Again, exploration of internal experience is the primary source of new information in EFTT. Advanced empathic responding and promoting experiencing are features of all procedures used in EFTT, including exposure-based procedures (Paivio & Pascual-Leone, 2010).

Imaginal confrontation (IC) is the primary reexperiencing procedure used for resolving interpersonal trauma in EFTT. The intervention is typically introduced in the fourth session and is used judiciously over the course of therapy according to individual client processes and treatment needs. Research indicated that on average five sessions in a typical 16-session course of EFTT contained substantial work using the IC (*SD* = 1.65, range = 10–20). In this procedure, the client is invited to imagine the perpetrator of abuse or neglect sitting in an empty chair across from them and express their thoughts and feelings about maltreatment directly to them. The procedure follows the resolution model described in an earlier section. In the early phase of therapy, the initial IC quickly evokes core processes, including fear/avoidance, guilt, shame, and self-blame, making them available for exploration and change in the second phase of therapy.

Empathic exploration (EE) is an alternative reexperiencing procedure used in EFTT (Paivio & Pascual-Leone, 2010). EE was developed as a less stressful option for the substantial minority of clients who declined to participate in the IC procedure (20%; Paivio, Hall, Holowaty, Jellis, & Tran, 2001), because they found it too evocative, confrontational, or overwhelming. EE is based on the identical model of resolution and intervention principles as IC, except that all material is explored exclusively in interaction with the therapist. Clients are encouraged to recall traumatic events, to imagine perpetrators of abuse and neglect in their "mind's eye," and express evoked thoughts and feelings to the therapist.

Additional interventions derived from trauma, gestalt, and experiential therapies (Elliott, Watson, Goldman, & Greenberg, 2004) are employed in EFTT to address specific emotional processing difficulties. Experiential focusing (Gendlin, 1997), for example, is designed to help clients make sense of unclear or confusing internal experience. Exploring trauma memories or current situations where trauma reactions are activated is used to access and restructure a core maladaptive sense of self (e.g., as worthless,

defective, dirty). In all of these procedures the objective is to access and strengthen healthy subdominant resources (feelings, needs, beliefs) so they can be used to modify dominant maladaptive processes. Additionally, emotion regulation strategies such as present-centeredness, breathing, relaxation, grounding, and mindfulness, used in other trauma therapy approaches (e.g., Chard, 2005; Cloitre, Koenen, Cohen, & Han, 2002; Linehan, 1993; Najavits, 2002) can be used to help clients with severe emotion-regulation difficulties.

RESEARCH SUPPORTING EFTT

Paivio and Nieuwenhuis (2001) examined the efficacy of EFTT using the IC procedure. Results indicated significant improvement and large effects from pre- to posttherapy on multiple domains of disturbance. These gains were maintained 9 months after therapy completion. A more recent randomized clinical trial (Paivio et al., 2010) compared EFTT with IC and EFTT with the comparable EE procedure. Results indicated significant and comparably large pre- and posteffects in both treatment conditions that were maintained at 1-year follow-up. It is noteworthy that the dropout rate in EFTT with EE was a remarkable 7% (compared with 20% in EFTT with IC), thus supporting the intended development of EE as a less stressful exposure-based procedure. Severity of trauma and trauma symptoms were unrelated to outcome and there were no differences in terms of efficacy between men and women, and types of abuse. The caveat is that EFTT is a short-term approach designed for men and women with the capacity to form a therapeutic relationship and focus on trauma material.

Several studies support the posited emotional change processes in EFTT. For example, Paivio et al. (2001) found that client engagement in the IC procedure (defined in terms of psychological contact with the imagined other, spontaneous elaboration, and emotional expressiveness) contributed

to better treatment outcome beyond contributions made by the therapeutic alliance. Holowaty and Paivio (2012) found that clients consistently identified the first IC as one of the most helpful events in therapy and acknowledging, for the first time, the depth of their pain as the most helpful aspect of that procedure. Moreover, client-identified helpful events in general were characterized by higher levels of emotional arousal compared with researcher-identified events. Mundorf and Paivio (2011) examined changes in the quality of trauma narratives written before and following EFTT. Results indicated improved narrative quality from pre- to posttherapy in terms of greater use of positive emotion words, a greater focus on the present and future rather than the past, reduced incoherence, and increased depth of experiencing. It is noteworthy that greater use of negative emotion words in early narratives predicted better resolution at therapy termination—supporting the importance of access to trauma-related feelings early in therapy. Increased depth of experiencing (meaning construction processes, insight) from early to late narratives predicted better treatment outcome. A more recent study of narrative processes in EFTT (Carpenter, 2012) found that trauma recovery was associated with client storytelling that is emotionally and experientially alive, reflective, and insight-oriented. In terms of therapist processes, another study (Mlotek, 2014) supported the importance of therapist empathic responding in EFTT. Mlotek (2014) found that higher quality therapist empathy, using the Measure of Expressed Empathy (Watson, 1999), during Session 1 of EFTT, predicted higher quality client engagement with trauma material during IC and EE during Session 4 and, in turn, better treatment outcome.

Ralston (2006) compared client processes during the IC and EE procedures in the two versions of EFTT. Results indicated comparable levels of experiencing during both procedures, which predicted outcome in both treatment conditions. Results also indicated higher level of emotional engagement with trauma material and lower levels of emotional arousal

during EE. This finding, again, supports EE as an effective but less evocative and stressful procedure compared with IC.

In sum, research supports both EFTT with IC and with EE as effective treatments and supports the posited emotional change processes in both treatment conditions. The following section presents a case example to illustrate key therapy processes and intervention strategies used in EFTT.

CASE EXAMPLE

The client in this case, Marianne, volunteered for a single session of EFTT as part of producing a DVD with the American Psychological Association (APA; 2013).[1] Prior to the session, Marianne explicitly requested no chair work, which likely was consistent with her fear of emotional experience observed during the session. Thus the following excerpts represent phases and intervention principles characteristic of EFTT with clients who, at least initially, cannot or will not participate in IC. Although Marianne currently was a highly functioning graduate student, she had a history of exposure to extreme family violence at the hands of her father that included witnessing her mother being beaten and threats with weapons. She reported symptoms of PTSD as a child (e.g., selective mutism, nightmares, being held back in school), and currently experiencing nightmares, flashbacks, and extreme distress at reminders of her trauma. Current triggers for distress and anger included her family's dismissal of her wishes concerning her upcoming marriage, which she experienced as a repetition of their dismissal of her needs as a child.

The primary focus of the session was Marianne's struggle between fear of her own emotional experience and desire to be more spontaneous and emotionally free, and conflict about whether to process traumatic feelings and memories or let them go. Dominant therapy processes included self-interruption and minimization of harm, but Marianne also demonstrated

access to internal experience and use of vivid metaphor that provide a window into her internal world. The latter are prognostic of good therapy outcome (see research review in this chapter). Interventions were aimed at helping her to allow painful trauma feelings. These interventions included validation of her fear, anger, and sadness; encouragement and evocative empathy to help access anger and sadness, memory evocation, and a self-soothing procedure—imagining and comforting herself as a child sitting beside her in her chair.

Early Phase

Key interventions during the early part of the session included providing information about the process of therapy (e.g., designed to help people come to terms with child abuse experiences, specifically feelings, this is not easy, but there is considerable evidence that this is how people heal), eliciting specific information about abuse experiences and current feelings, validating the extent of her trauma and unexpressed feelings, and negotiating a current focus.

Therapist: What is the most important feeling for you right now, or a specific memory that stands out?

Client: I don't know, I just—when I picture myself as a young girl, it's obviously a separate person from who I am now. It's almost like just a little girl in a dungeon, like it's just—

Therapist: In a dungeon. That's a—that's a very sad—a very sad image, a little girl in a dungeon.

Client: There's worse (teary but shrugs shoulders) [minimization, resignation].

In the following excerpt, the therapist acknowledges, validates, and normalizes Marianne's struggle with overcontrol and difficulties approaching painful experience. At the same time, she directs Marianne's

attention to and encourages expression of suppressed feelings through memory evocation, evocative empathy, and empathic conjecture about what she must have been feeling as a child. An important part of helping clients to express sadness is directing attention to what was missed or missed out on.

Therapist: There are worse, but it's still not a way you want your little girl to—to be raised, and to experience life from a dungeon. Can you speak from what it was like for you? I know it's hard. You're trying to—trying to hold it back, but if you can just try and get in touch with that little Marianne, in the dungeon. What is she feeling like, what does she need? Feeling lonely?

Client: Helpless. You said it before.

Therapist: Helpless, yeah. Feeling totally, totally helpless. Just shut—shut out and helpless and alone.

Client: (trying to hold back tears) I'm sorry, I don't like crying.

Therapist: I know you don't, it's hard to cry. These are hard things to remember, very hard things to remember for anyone, yeah. So how are you—how are you finding yourself trying to control it? How do you control these—just by—

Client: It's just—and out of the whole control thing, I don't know, It's just like "you're good, you're fine, it's alright."

Therapist: You're good, okay. You're good, you're fine. It's not—and it's not important, or don't go there . . . but it is important. This is who you—this is who you are, part of who you are. I know you're sad, you're sad thinking about it, it's okay. You can let yourself cry. It's a weird thing to be doing it here, but there's nothing wrong with it, it's an appropriate—just a lot of tears for that little girl. Yeah, she just missed out on a lot. Crappy . . . very, very crappy. I know, it's—

Client: (suppressing tears) I have to hold it together.

Therapist: You got to hold it together. Yeah, I'd like you to just let it—let it come because this is your truth, how sad she was, and how sad you still are for her. You missed out on a lot, a lot of good stuff. What did you miss the most, do you think?

Client: I think, you know, those happy childhood memories that people talk about.

Therapist: You missed out on that, yeah. (client nods in agreement) Yeah, children are supposed to be happy and carefree and have all kinds of happy memories. That's really—you got gypped . . . missed out on a lot of precious things . . .

Middle Phase

Once accessed and expressed, primary adaptive emotions quickly shift. In this instance, Marianne shifted to anger at her father's minimizing harm, "brushing it off," making excuses, and her mother's refusal to talk about past traumatic events.

Client: I'm just angry that, you know—

Therapist: And angry, yeah.

Client: It's like I feel responsible for it.

Therapist: Well, how unfair.

Client: Yeah, I'm like, "you did that."

Therapist: You did that to me, yeah, and now I feel responsible for it.

These are markers for introducing IC or, in this case, EE to help Marianne "express your truth" and fully resolve issues with her family. The therapist invites her "What would you want to say to your father? . . . Tell

me all the things you are angry about." Interventions validate and help her articulate the meaning of her anger, assert what she wants (an apology, acknowledgment of harm)—e.g., "How dare he minimize . . . ," "He did not put you first," "It's NOT okay, you don't want to let it go," "You deserved to grow up in a safe environment," "He is not entitled to make decisions for you."

Typical of the early IC or EE, Marianne, collapsed into self-doubt about whether she was "making mountains out of molehills" and fear of her emotional experience. Therapist validation of her struggle and concerns ("I know. This is not easy for you.") lead to Marianne reiterating her healthy desire to be more spontaneous, "it's not right to be so afraid . . ." Again, the therapist validated her struggle and supported the healthy, adaptive side of herself.

Therapist: It's not right. It's not right that you don't feel safe in the world to express yourself. And you know that that is the legacy, you know, that you have from your environment, your childhood environment growing up with all that fear. Yeah, it wasn't safe. It's like you still carry that—still carry that with you.

Client: And I want to just let it go . . . but in a happy way, not with tears. A blue sky world, but I know that's not the process.

Therapist: No, the process is you want to be free. You want to be free with the pain as well as the joy. And to learn to find a safe place, I guess, to experience some of that pain that you experienced. Weep for that little girl in the dungeon who spent all those years down there.

Client: Yeah, so that's something I have to work on, you know, kind of thing. So I just don't—like how do you go about doing it? How is it? Like what's the constructive way? I just—I am at a loss.

This was a marker for introducing a self-soothing procedure, which involved asking her to imagine herself as a child and evocative empathy to activate feelings toward self as a child. This is typically a highly evocative intervention that quickly activates painful feelings and unmet needs and helps to elicit compassion for self.

Therapist: Well, I could—I could suggest you—Maybe you could put her right here (therapist taps on the client's chair beside her). I want to have that little girl right there. What would you like to say to her?

Client: (tears well up) That's a tough one.

Therapist: Little Marianne, how do you feel imagining little Marianne there? Feel for her, sad little thing. Want to comfort her?

Client: Much—very much—I would very much like to. (trying to hold back tears)

Therapist: Comfort her, keep her safe.

Client: Yeah.

Therapist: Yeah, that's what she needs.

Client: Yeah, just keep her safe, so. (crying)

Therapist: Keep her safe, yeah.

Client: And it's okay to express whatever emotion.

Therapist: Yeah, in a safe place. Find good people, safe people. And say who you are.

Client: Yeah, so if she wants to scream, if she wants to cry, that's fine.

Therapist: Yeah. What would you say to her, "it's okay, I'll take care of you, I'll let you do that." (client nods) Yeah. That is what she needs.

Client: Yeah, and no one will be offended, no one will be hurt, just go ahead . . .

That would be great.

Therapist: That would be great. Can you feel that? And how great that would be? How much you needed that? And how much you still need that? Yeah. [direct attention to positive impact of new experience, unmet needs]

Client: If I could just let it out and not be judged or—

Therapist: Yeah, that's what you need more than anything, yeah.

Client: Yeah.

Late Phase

The late phase of the session with Marianne involved processing her experience of session and bridging to the future. Marianne expressed relief about having expressed her feelings but also uncertainty about how it would work in real life, fear of "ugly" emotions. The therapist identified rage as the ugly emotion she was particularly afraid of, validated and normalized her fear—it was new, go slow, at her own pace, choose where and when it felt safe, and possibly seek therapy.

Future sessions with Marianne likely would include IC or EE with her father. It should be noted that even though clients do not initially feel comfortable with IC, this does not preclude introducing IC once they feel stronger and become more comfortable with their feelings. Markers for introducing IC would include assertive expression of entitlement to unmet needs, or asserting boundaries with the imagined other.

CONCLUSION

Child abuse trauma is highly prevalent in community and clinical samples, and associated with a constellation of long-term effects. Disrupted affective and narrative processes are at the core of this constellation. EFTT is an evidence-based approach that addresses the range of emotional processing difficulties (e.g., emotional dysregulation, overcontrolled emotions) characteristic of this client group. There is expert recognition of the contributions of EFTT to the area of treatment for complex PTSD, and research supports the efficacy and the posited mechanisms of change (i.e., collaborative therapeutic relationship and emotional processing of trauma), and broad applicability of EFTT to men and women with histories of different types of abuse and neglect, and a range of trauma symptom severity.

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[1]For the purposes of this book, the client's name has been changed to protect her identity.

17
EMOTION-FOCUSED THERAPY FOR PERSONALITY DISORDERS

ALBERTA E. POS AND DANIELLE A. PAOLONE

Emotion-focused therapy (EFT) is an effective treatment for clients struggling with intense affective difficulties, such as complex trauma (Paivio & Pascual-Leone, 2010). Although no randomized trials of EFT have occurred to date with clients with personality disorders (PDs), this chapter reflects almost two decades of applying EFT to clients with personality pathology in clinical practice (Pos, 2014; Pos & Greenberg, 2012).

Practitioners of humanistic treatments like EFT argue against the use of diagnoses such as "personality disorder," which can unbalance relationship power dynamics, pathologize the client, and interfere with the provision of humanistic relationship conditions. While we are not concerned with whether the term *personality disorder* points to anything "real," we would still argue the benefits of paying attention to personality pathology because it therapeutically challenges the skill of EFT therapists. To address these challenges, we first describe a theoretical basis for

understanding difficulties that clients with PDs often exhibit while engaging in the more emotionally arousing EFT interventions, namely chair work. Second, we discuss principles EFT therapists can consider when working with clients struggling with interpersonal, affective, and cognitive difficulties often experienced by clients with PDs (Benjamin, 2003; Young, Klosko, & Weishaar, 2003).

The American Psychological Association (APA) Task Force on effective treatment of PDs (Critchfield & Benjamin, 2006) specifically described effective treatments as integrative and having (a) strong alliances built by therapists who can provide patients empathy, acceptance, and congruence; (b) treatment delivery by therapists comfortable with long-term emotionally intense relationships; (c) treatment interventions that match clients' functional impairment and their readiness to change; and (d) structured treatment that balances acceptance and directiveness within interventions. Finally, they noted that clients with PDs do best when they clearly understand how engaging in interventions can serve their treatment goals.

EFT, then, already fits most APA task force criteria for the treatment of PDs. It is a process-directive integrative treatment, with structured emotionally focused interventions, and offers strongly accepting and genuine, empathic relationships with therapists very comfortable with and capable of working with client affect. The additional issues of readiness to change and level of functional impairment must also, however, be considered. That is, is a client with PD pathology able to engage in normally prescribed and delivered EFT interventions? Or alternatively, does the functional impairment of clients with PDs allow them to meet the demands of the interventions offered in EFT treatment as usual (EFT-TAU)? We suggest that special considerations be entertained when using EFT-TAU chair-work interventions with clients with PDs and that additional integrative principles be considered. This will ensure that EFT

for PDs aligns with the features laid out by the APA task force (Critchfield & Benjamin, 2006) for effective and integrative treatment of PDs.

WHAT ARE THE CORE DIFFICULTIES WITH WHICH CLIENTS WITH PDs STRUGGLE?

Clients with PDs struggle with well-known problems often described *as emotional dysregulation* (McMain, Pos, & Iwakabe, 2010) due to activation of maladaptive interpersonal cycles from early attachment struggles (Liotti & Prunetti, 2010). As well, cognitive weakness in the area of self- and other reflection has been described, currently often termed as *difficulties with mentalization* (Fonagy, Gergely, Jurist, & Target, 2002). Further, general emotional dysregulation with concurrent difficulty processing experience in awareness is also noted.

Since interpersonal contexts are particularly triggering for clients with PD issues, one must first be more globally aware that application of EFT-TAU active interventions can give rise to emotionally evocative relationship dynamics when working with these clients. Also, striking the balance between staying in contact with and regulating experience is important to achieve when working with clients from these populations. That is, following the emotional activation that chair work may elicit, EFT therapists must understand how to help clients with PDs regulate experience without "getting rid of it." As such, EFT therapists have to be savvy concerning how EFT-TAU can be altered, or more carefully and thoughtfully applied, in order to offer clients with PDs the opportunity to structure, emotionally regulate, and mindfully mentalize their experiences while engaging in chair work. This chapter described how one might do this.

To begin, we describe a number of emotional struggles at play in the lives of clients struggling with a PD diagnosis. We view these difficulties as

the emotional sequelae of a fundamental developmental problem with which many clients with PDs struggle, one that we will call here *a lack of individuation* or *being unindividuated*.

The Unindividuated Client

The concept of individuation comes from the dynamic literature (Pine, 1985; Winnicott, 1974, 1992) and provides important scaffolding to EFT theory for addressing individuals with PDs. Individuation is described as a developmental process that is successful when a person learns that they are an individual, separate from others. Individuated persons have observing egos that can hold a bird's eye perspective on multiple interacting parts of self and have relationships with other differentiated individuals. Successfully individuated persons are, therefore, independent agents capable of both nonfused and nonisolated, yet differentiated, connection with others.

We need caring others to individuate successfully. In 1957, Winnicott (1957/1992) first described how an initially perfectly attuned or responsive, *good enough parent* regulates their child's affect within experientially tolerable levels. Therefore, very young infants, unable to take care of their own experiential needs, rely on others' help to become comfortable with feeling experiences. The infant literature (Sroufe, 2005; Stern, 2004) confirms this need. Once children develop locomotion, language, and cognitive ability over time, they can also begin to emotionally tolerate their parents not always being perfectly attuned to them. In fact, Winnicott (1957/1992) argued that parents at this stage of an infant's life can help their child's development by being "less perfect." Still, discovering you are a separate individual is often painful. If parents and others close to the child soothe their child during this painful period, this help is eventually internalized as the child's internal capacity to self-soothe.

Failure to individuate as an infant (Pine, 1979, 1985) can later emerge as a problem with emotional overarousal during EFT chair work. First, if a client has not been adequately helped to regulate their affect (has suffered being often painfully overaroused as a young child), they may not have the internal resilience to experience emotional pain when working in chairs. This is because *any* arousal may be experienced by such a client as traumatic over-arousal. Second, during over-arousal experiences, the client may also lose their capacity to reflect on their experience. Diminished mentalization capacity will often include not being able to reflect on experiences of being in self-conflict. This is relevant because EFT holds a theoretical view that a healthy self is multiple and multivoiced (Dimaggio & Stiles, 2007; Hermans, 2003; Stiles et al., 1997), and that self-experience is often constructed out of multiple self-perspectives that each can be associated with independent agency, specific feelings, memories, thoughts, and autobiographical narrative (Angus & Greenberg, 2011; Stiles et al., 1997; Elliott & Greenberg, 1997). This is why in EFT chair work, selves are often put into contact with each other through dialogue. Having the capacity to be aware of self-multiplicity supports "separation between chairs" (Elliott, Watson, Goldman, & Greenberg, 2004) and helps clients both sustain and optimally engage in EFT chair-work dialogues.

Another problem is that a nonindividuated client with a weakened capacity to self-reflect is vulnerable to experiencing a continuous reiterative relationship between decreased self-awareness and increased levels of emotional arousal. Most problematic for EFT chair work is that an unindividuated client is most vulnerable to overarousal and weakened self-reflection in interpersonal contexts. Since one could argue that all EFT chair work essentially creates a relational context through structuring imaginary dialogues between parts, it naturally follows that chair-work interventions have the potential to be particularly problematic for PD clients. Therefore, it is very important for the EFT therapist to notice that a particular client has

individuation problems and adjust EFT to work affectively with a client such as this. How?

Initial markers of clients' individuation difficulties emerge from their interpersonal history. Again, humanists prefer in-the-moment perspectives on clients, so history will not be too figural during early case formulation, again, to avoid pathologizing them. Still, from both an EFT case-formulation perspective (Goldman & Greenberg, 2015) and from the literature concerning archetypal early interpersonal contexts of clients with PDs (Benjamin, 2003; Young et al., 2003), it is important, when working with such a client, to listen attentively to their narrative themes of self in relationship to others. Especially helpful is if the EFT therapist can become aware of the particular problematic "dance" their client has learned from early interpersonal contexts. These problematic interpersonal patterns have been highlighted in the PD literature; so knowing this literature can give an EFT therapist some important background knowledge concerning them.

A second clue to notice, also congruent with interpersonal patterns described in the PD literatures, is that a client with individuation difficulties often responds to dominance expressed by important others in very predictable ways. Their predictable response to the dominance of another is the direct consequence of their early experiences with a dominant other, someone who, for whatever reason, did not provide an early relationship context supporting their individuation. Relevant here is that early in life a client's need to remain attached "trumps" their need to individuate (Maslow, 1943). So, even if an original problematic relationship painfully overaroused a child, that child was likely left with little choice but to regulate these early painful experiences by remaining *problematically attached*. The pain of remaining problematically attached has likely been experienced by that client as preferable to more intolerable feelings of crushing loneliness or existential survival fears should they try to individuate from another who cannot or will not permit it.

The consequence of this during EFT is that when trying to transform a problematic dominance pattern in any relationship using chair work, a client's predictable response to a dominant "other" is highly likely to emerge. If the EFT therapist tries to support the client expressing assertive boundaries toward, or their needs to let go of, a problematic, dominant other during chair work (either parts of self or actual others), these clients often will not be able to engage in this separation process. This will be because the client's deep maladaptive fears of being existentially alone are often cotriggered, and they may be unable to tolerate experiencing these fears. This core fear can interrupt their adaptive anger and boundary setting and/or their capacity to "let the other go." And, instead of asserting or letting go, they will often instead re-express their habitual problematic way of relating to the powerful other. If this occurs, what likely happens is that, unwittingly, EFT chair work can become stuck on the reef of a deep developmental affective task, one which a client such as this is not able to successfully work through—managing the existential distress that interrupts their capacity to separate and which requires soothing the distress of being a separate individual.

The above issue suggests a final problem for clients with PDs, one that has considerable emotional consequences for engaging in EFT chair work: The unindividuated client tends to function psychologically not as an individual but, rather, as part of a larger and often problematic relationship system. This means that instead of engaging in healthy relationship patterns with other healthy differentiated selves, the nonindividuated person often expresses maladaptive patterns of nondifferentiated connection with, or isolated/disconnected autonomy from, others. Let us discuss some of these patterns now.

Maladaptive Interpersonal Dances or Complementary Behavior

The best clue in identifying unindividuated clients who may have difficulties during EFT-TAU chair work will come from the clients themselves. They often report habitually engaging in a chronic, intractable maladaptive relationship pattern with another, one that feels almost like a familiar interpersonal dance they unwittingly get caught in. “I can only stand up for myself for so long, and then I always cave in.” As such, their interpersonal narratives of unfinished business (UFB) communicate subjective experiences of being helpless to impact their interpersonal worlds. And, if an EFT therapist engages such a client in an interpersonal dialogue during chair-work tasks, whether between two self states or between the client and an imagined other, their sense of being helplessly trapped inside that dance often emerges in the chair intervention. If this occurs, then chair work often stalls. EFT therapists, therefore, should understand the archetypal interpersonal dances that clients with certain PDs fall prey to, as well as the problems these patterns may elicit during EFT-TAU active chair interventions.

The actual form that problematic interpersonal dances will take depends on clients’ actual PD features. However, it will always consist of the client expressing a *complementary* social response to a dominant other’s leading social behavior. What is complementary behavior? Lorna Benjamin brought this term into broader use after she developed the structural analysis of social behavior (SASB; Benjamin, 1974). She described all agentic social behaviors as being organized by two broad dimensions that each has a positive and negative pole. One dimension is *connection*, which holds at its two poles warm love and cold hate. The second dimension is *control*, with one pole expressing total dominance and control and the opposite pole expressing freedom granting and giving control. Benjamin also described four combinations of these two dimensions: loving freedom granting (supportive empathy), loving control (teaching), versus hateful freedom granting (abandonment) or hateful control (criticism). Benjamin

assumed that agentic social behaviors elicit complementary responding social behaviors. Dominance elicits submission, teaching elicits "studenting," criticism elicits complaint, and abandoning tends to elicit withdrawal. Clients with PDs normally struggle with maladaptive interpersonal cycles composed of nonattached or cold control behaviors (Benjamin, 2003; Young et al., 2003), such as being bullied/overpowered, criticized/shamed, aggressed against/attacked, and neglected/abandoned.

An interesting dilemma for the client with a PD is that to maintain their problematic attachment pattern they have often learned to habitually respond to negative social behaviors offered to them by early dominant others in these complementary ways. If they are familiar with parental abandonment, they become expert withdrawers or sometimes precociously independent; if their parents were simply dominant or demanding, they become expert submitters. If their parents were dominant teachers, they become expert students of their parents' lessons. So a problem in EFT chair intervention is if the therapist supports the client's adaptive need to differentiate from, assert against, or disobey a problematic other in order to strengthen the client *as an individual*, a client with a PD may not be able to adaptively assert and, instead, will maintain their problematic attachment by engaging in these complementary behaviors. If this complementary behavior occurs, the EFT therapist should consider that they may be working with an unindividuated client, and that the chair work has elicited a maladaptive interpersonal cycle between the chairs. For example, the therapist might notice and say, "The more the critic criticizes you, the more you agree and submit somehow" or "the more demanding your father is, the more you try to please him."

Once a maladaptive interpersonal cycle has been activated between chairs during chair work, the core problem is that normal resolution of chair tasks described in extant EFT manuals (Elliott et al., 2004; Greenberg & Watson, 2006) becomes more difficult to achieve, or may not even occur.

This is because resolution of EFT-TAU chair-work tasks normally occurs in one of two ways: (a) the client experiences some sort of reconciliation experience with a dominant other who has softened during the course of chair work (Choi, Pos, & Magnusson, 2016; Greenberg & Watson, 2006; Whelton & Greenberg, 2005); or (b) when the other does not soften during chair work, the client stands up to and holds a dominant other accountable for whatever "crime" that other has committed. Since clients with PDs have often struggled with a dominant other who could not or would not soften, clients with PDs most often will need to resolve chair work by taking this second path. And, when a client tries to resolve their lingering bad feelings through a resolution process of setting boundaries, an EFT-TAU therapist commonly helps the less dominant or dominated side of the client to express their pain, assert their adaptive needs, and stand their ground. The client is then helped (sometimes with work on self-interruption) to ask or demand from the more dominant side that their needs be met. Separation is normally achieved by expressing primary adaptive emotion (either by distancing from the other by boundary setting with anger, or by letting go of the other through expressing pain and grief). Again, an unindividuated client may be unable to do this if it is experienced by them as threatening necessary (albeit maladaptive) attachment to their problematic other. If unable to engage further, task resolution will not occur. This pattern becomes obvious to the EFT therapist when such an individual continuously stalls or self-interrupts their adaptive assertion or grief. The chair work consistently "crashes" at this preresolution stage because, instead of asserting and separating, the client continuously engages in their normal complementary (i.e., compliant, submissive) relating style.

Important to remember as an EFT therapist is that if a client becomes too frightened to assert/grieve and separate from a problematic other during EFT-TAU chair work, then that chair work is too emotionally arousing and the client is likely unindividuated And because increased arousal decreases

the capacity to reflect on and regulate feelings, the client's capacity to maintain aware separation between their multiple parts represented in the dialogue between chairs may also falter (Elliott et al., 2004).

Also interesting is that *any* internal conflict these clients have between parts of self will likely exhibit the very same maladaptive and problematic relationship cycles that occur between the client and the problematic other from their developmental history. So, with a client such as this, internal conflict and unfinished business are often indistinguishable. *Intrapersonal* dialogue between parts of self in a self-split occurring in two-chair work may transform automatically into an *interpersonal* dialogue. This is most likely to occur if a dominant self, involved in self-conflict, functions as an internal self-identified representation of the problematic dominant other from the client's past. The EFT therapist will need to be vigilant for this problematic merging of intrapersonal and interpersonal conflict.

An example of this was expressed by one client with borderline features who, while engaged in a self-conflict split, expressed deep pain after receiving viciousness from her internal critic. She then expressed her need for the critic's support. After returning to the self-critic chair, her critic instantly "morphed" into a negative mother figure who expressed familiar judgment and criticism: "Oh, she's just a loser anyway, victory! I feel great." Luckily the therapist, confused by this, asked the client, "Who are you in this chair?" The client spontaneously answered, "Oh, I'm my mother!" The therapist quickly identified the mother who had spontaneously emerged in the critic chair as the "mother" of her self-criticism. She then nimbly switched from a two-chair to an unfinished business (UFB) intervention to stay attuned to where the client was and what she was processing. This need to shift back and forth quickly between two-chair splits and UFB chair work is likely to occur with high-functioning PD clients who can tolerate their emotional experiences with help from the therapist. Keeping track of these links between types of two-

chair interventions will be important with these high-functioning PD clients.

CLINICAL STRATEGIES

If your client has more serious PD features, what then? A number of strategies are available (Wood, Bruner, & Ross, 1976) to help an EFT therapist scaffold the client in regulating their affect, as well as increasing their capacity to reflect on and process experiences. All of the strategies help PD clients increase their capacity to experience, mentalize, and make sense of (or process) their feelings. According to Wood et al. (1976), when you scaffold a client's current functioning, you are (a) maintaining a client's engagement in a chair task; (b) simplifying the chair task to match their current level of functioning; (c) emphasizing certain aspects that support resolution, or success in the chair-task; (d) creating a context within which the client's overarousal is regulated (i.e., they are not thwarted by their limitations); and, (e) demonstrating successful modeling of components needed to resolve that chair task.

The chair-work intervention strategies that will help you scaffold those of your clients with PD or those who are otherwise prone to dysregulation are (a) engaging in chair work using not an individual but a systemic or relational model of resolution; (b) effectively using the therapy relationship to help the client regulate their affect; and (c) employing a number of regulating emotion-with-emotion strategies (Pos & Greenberg, 2012), such as using humor, expressing emotion for the client, and expressing liking for and enjoyment of the client. We now discuss each strategy in turn.

Employing a Systemic Versus Individual EFT Model of Conflict Resolution

To repeat, when a problematically attached, unindividuated client engages in two-chair or UFB chair work, maladaptive interpersonal cycles coherent with their problematic attachment will often emerge that make EFT-TAU chair work resolution very difficult.

This difficulty will only occur, however, if one attempts to resolve chair work in the EFT-TAU manner, by facilitating a subdominant aspect of the client to set limits on or assert against a problematic dominant other, or by individuating from a dominant other, within the intervention. Because this may be beyond the client's zone of proximal development (Vygotsky, 1978), more progress can be made helping these clients process emotional difficulties by changing the end goal of a chair-work task from supporting self-individuation to transforming the maladaptive interpersonal cycle that occurs between the two chairs. One aims to transform the maladaptive relationship pattern into a healthier adaptive pattern of attachment or collaboration.

There are a number of reasons why using a systemic framework, such as EFT couples strategies (Greenberg & Goldman, 2008), works when doing chair work with clients with PD features or difficulties. The first is that clients with PDs are highly motivated to improve their relationships. Helping the client understand that resolution of an interpersonal pattern problematically active in their relationships may accomplish this is effective because it increases their buy-in to engage in the task. As a result, your alliance with the client strengthens.

Second, when one uses a systemic framework, particularly a couples systemic framework (Greenberg & Goldman, 2008), system members are not pathologized. Instead, one locates the problem at the systemic level—in the maladaptive interpersonal cycle that is organizing the system's interpersonal behavior and communication. As such, any shame and blame associated with interpersonal conflict is automatically somewhat regulated. So, working with a client with PD features at the systemic level means

working with the problematic maladaptive cycle occurring between parts of themselves or between themselves and a problematic other from the past, not blaming the client or the other. This again provides important emotion regulation to the PD client in terms of how they feel about themselves during chair intervention, as well as how they feel the chair intervention is affecting their partner in the dialogue. This is important because no matter if their critic or important other is very harsh, the client's wish to remain problematically attached often gives rise to their feeling empathy toward that other. As a result, they often spontaneously wish to come to the other's rescue or express the need to be fair to that other. Therefore, these clients are more likely to engage well in a chair intervention if both parties in the dialogue are well treated.

There are two strategies that we have found useful when working systemically with a client prone to overarousal of interpersonal dynamics. Both use approximations to EFT chair work. Each has its own strengths and possibilities, and they can be blended as well. One method is working in chair work as if you are working with an "internal couple," essentially following emotion-focused therapy for couples (EFT-C; Greenberg & Goldman, 2008). The therapist uses EFT-C principles to engage with two warring parts of the self that are prone to becoming locked in an internal maladaptive cycle, as if the therapist is doing couples counseling. Using the second method, chair work by proxy, the therapist dramatically engages in expressive components of chair dialogue *for* the client. When using this second method, the client observes and experiences the dialogue at a cognitive distance and has a virtual or vicarious experience through the enactment of the dialogue provided by the therapist. We will now discuss each on these methods in turn.

Internal Couples Counseling

Doing chair work in the model of approximating EFT for couples (i.e., treating each part of the client as a partner in an unhappy couple relationship) works best for clients' internal splits. The central difference from EFT-TAU split work lies in the therapist not using the dominant self's chair to stimulate experience in the subdominant or experiencing chair. Instead, the therapist has a real genuine relationship with both parts of the self from the beginning of the intervention. Although in EFT-TAU, the therapist eventually has a real relationship with both parts of the self only once the dominant self has softened, internal couples counseling requires that this nonpathologizing, fair, and equal relationship between the therapist and the client's parts occur from the outset of the intervention.

When working with a conflicted couple, an important EFT-C principle is to interrupt the couple's maladaptive interpersonal cycle when it is activated, particularly when the couple is in an escalation phase, to point out to the couple how they participate in the maladaptive interpersonal cycle. To de-escalate the couple, the therapist actively intervenes, identifies the maladaptive interpersonal cycle, and prevents them from engaging in it with each other. Following this, an EFT-C therapist genuinely and empathically attunes to each member of the couple, fairly, and in turn. When working with a PD client, the same strategies one would use with an escalated couple are called for. First, the therapist establishes independent genuine and empathic relationships with each internal partner involved in the maladaptive interpersonal cycle. This means relating to one self at a time; another self then witnesses the relationship the therapist is having with its self-partner. In this process, therapists help clients in a number of ways.

First, they provide safety through empathic attunement, emotionally regulating whatever side they are in dialogue with. Perception of safety neurophysiologically organizes (Geller & Porges, 2014) any part to relate, share, and cope with distress in socially safe, attuned contact with the

therapist. Second, therapist empathy helps any dialoguing part access core pain and express vulnerability to the therapist, who can then validate and identify the role these experiences play in the overall maladaptive interpersonal cycle. The therapist's acceptance helps the part they are dialoguing with cognitively, and experientially orient to the larger interpersonal pattern that includes both parts' feeling experiences. The therapist thereby helps the dialoguing part to mentalize the maladaptive interpersonal cycle, by scaffolding that part's bird's eye view of the cycle, and the role that part is playing in it. This orientation to the client's internal patterns offered by therapist is also often experienced as emotionally regulating because it reduces the client's confusion about themselves.

Third, while this is occurring, the "witnessing" self also observes the therapist's modeling of empathic communication from the therapist to their dialoguing partner, and witnesses how empathic attunement of the therapist facilitates more regulated communication emerging from the dialoguing partner. Fourth, witnessing the motivation and vulnerability of the part currently in dialogue with the therapist is facilitated by the witness being under more emotionally regulated conditions. And, if the witness experiences their partner's core vulnerability and needs being expressed to the empathic therapist, a new view of that self-partner is often facilitated as well as are more acceptance and adaptive attached feelings of the witness for their self-partner (McKinnon & Greenberg, 2013). Important is that the therapist must check in with the witness partner to discover what has been perceived. Then this empathic process can be repeated with the part that first witnessed the dialogue. This fair, nonpathologizing manner of exploring the maladaptive interpersonal cycle and the roles both self-partners play within it begins to construct a shared motivation to work on transforming that maladaptive interpersonal cycle that can provide an integrating experience for the client. This can be a productive and transformative outcome because the blaming and shaming that has often

maintained the maladaptive interpersonal cycle has been interrupted and replaced by a shared “interpersonal” goal to work on the maladaptive interpersonal cycle.

What often occurs at this stage is that each self-part becomes clearer of its own role in the cycle, and the maladaptive interpersonal cycle as a whole. If both parts are willing to work on the maladaptive interpersonal cycle, a shared goal held by two parts of the self, as well as a cooperative internal state between selves, is experienced for the first time.

Pos and Greenberg (2012) offer an example of this work. The client, Eve, had a very harsh demanding self-aspect that shamed her because she was, in her own words, so dysfunctional.[1] A complementary submissive self-aspect never expressed anger toward her critic, because this complementary self-aspect was convinced by her critic that she was “dysfunctional.” As a result, this complementary self felt so much internal pain that she would cut herself to regulate. The therapist helped both sides recognize the cycle. Notice how the therapist provided both empathy and directiveness to both selves.

First she talked to the critic:

> You are like Emily Post, I’m going to call you Emily, okay? Listen, you set limits that are so high that crazy girl over there cannot possibly achieve those standards and please you. So she feels like such a loser and is so shamed that she cuts herself. Then you get madder and shame her again. Sure, you want to be normal and have a normal life, and I get that she can be a loose cannon and does blow up your life sometimes. But you play your part, Emily. The higher you set the standards, the more crazy girl can’t achieve them, the more ashamed and upset she feels, and the more likely she cuts, and makes you feel mad at her again. If you could learn to help her instead of being harsh with her, I think you might begin to work together and achieve some of the goals you have for that normal life you want. Be

more patient and set limits on your demands on her, and you may make the progress that you want.

Then she talked to the “crazy-cutter girl”:

> And you young lady, crazy-cutter girl, you have problems too. You are so used to taking abuse that it never occurs to you to set limits on anyone. You just wait for the abuse to be over. And in that process, you take more and more abuse. Finally, you end up reaching your limits and go crazy with anger and hurt. And, instead of getting mad at someone and asking them to stop, you try so much to please that you end up swallowing more abuse. Then, you start dissociating and feel you need to cut. After you cut, you feel shame again, try to fix it by pleasing more, and you’re back to taking more abuse. If you could listen to your inner anger signals and trust that they are telling you that you have taken enough, and set boundaries before you feel twisted up inside with pain and anger, if you could realize that it’s okay to set limits and that there’s no shame in not being perfect, it would help Emily see how her standards are crushing you and that you have the right to say “no” to them. And then crazy girl, you’d realize you are not so crazy, you just don’t know how to set limits. Everyone goes crazy when they go past their limits.

The client found this session extremely helpful because she finally realized that “setting limits is okay.”

Chair Work by Proxy

This is a second kind of chair-work approximation best used with a client who cannot tolerate chaotic and multiple emotions—a client who cannot engage in an emotional dialogue task beyond their canability. To help a client like this, instead of the therapist having a relationship with parts as in a couples model, the therapist adaptively expresses difficult emotions in an organized way *for* the client, “channels” the client’s adaptive emotions, and puts them in contact with an imagined other *for* the client.

The client witnesses this process at a distance. However, during this enactment the therapist must always check with and receive the client's approval on the content that the therapist intuits is important. The therapist must give the client the right to be a director and writer of the dialogue as it's progressing, so that the client is not relegated to a passive witness or audience role, so the dialogue becomes a therapist–client coconstruction. Using this method gives the client a chance to witness the therapist at a cognitive distance expressing assertive or painful emotions that they cannot express themselves. The therapist can sort and coherently connect which emotions belong to which narrative. This can provide a deeply organizing orientation to the client of their relationship dynamics. The client also witnesses the interpersonal effective expression that the therapist uses in the dialogue and learns how to emotionally express in a regulated way from that modeling. As such, the dialogue occurs virtually in an imaginal confrontation (Paivio & Pascual-Leone, 2010).

An example of scaffolding chair work by proxy occurred working with a client, K, who had borderline features and high anxiety in relation to his family. He was identified by his dominant and difficult family as the "sick one." As a result, K brought feelings of pain, fear, and shame into therapy around being rejected and dismissed by his family. In one session the therapist engaged K in an UFB as-usual intervention, in order to help K assert his need for acceptance from his family. Difficulty emerged for K during the UFB intervention when confronting E, a problematic narcissistic sibling. E had paid no attention to the fact that he had complicated the lives of all of his siblings by introducing a "predator"—M (E's female companion)—into their lives. E had allowed M to get her "claws" into his considerable financial resources and the family's private lives, and K, validly, was angry about that. The problem in the UFB intervention was that whenever K tried to adaptively set boundaries on his brother E, he imagined E automatically accusing him of being crazy. As a result, K doubted himself

and indicted himself as crazy as well. And instead of standing his ground and setting boundaries adaptively, he felt complementary submission to his brother's views, which activated in K an internal feeling of being "really fucked up." K's adaptive assertion dissolved as a result. He began feeling ashamed, hurt, self-doubting, and anxious. And in the face of both his inability to assert as well as his imagining his brother accusing him, he felt helpless and hopeless. To manage this considerable distress, K started expressing hostility and judgment, or secondary anger toward his brother. However, after he expressed this anger, he imagined his brother using it as evidence that K really was "nuts." So K's imagined brother became rigidly intransigent toward him. The intervention stalled at this point. The therapist perceived this as a marker of a client in need of EFT for PDs, and she began engaging in pseudo chair work by proxy with the client and his brother.

First, she let the client be more distant from his own anger by taking over the role of expressing adaptive assertion for the client. Not moving from her chair, she faced a chair in her office, put K's imagined brother in it and said,

> Listen, E, you need to face the facts, whether you see K as sick or not, and whether K agrees with you that he is sick or not, you have created a problem in your family. You brought M not only into your life, but the lives of all your siblings. And whether you have been brought up to do whatever you like or not, the fact is K has to deal with M because you created that reality in his life. Can he deal with that? I think so. But is he creating a mountain out of a molehill because he's a sick person? No. That I don't believe. This is a *real* problem that *you have created*, E, and K is willing to deal with it. Does he wish M wasn't a problem, yes, I'd bet on that; but my guess is he can cope with M. But what is wrong of you, E, is telling K that he's nuts because he sees the problem you created. Whatever problems K has, he's seeing you clearly about this, and he doesn't deserve to be undermined or accused by you. Face facts, you *have* brought this predator into

their lives. K just wants you to admit and feel sorry that you did it, not to get rid of M.

After taking the client's role in this pseudo chair work, the therapist turned to K and asked,

Therapist: What happens inside of you as I say that to your brother?

K: I want to defend him. [Another clue to the lack of individuation in K—in the face of what the therapist experienced as his brother's abuse, K expresses the need to be fair and expresses empathic and loving attachment to his brother E.]

Therapist: Why?

K: He has an understandable reason for having done this, he has a child with M and he wants to be a father. He is as much of a victim of her as we are.

So the therapist took this part of the client's narrative back into the dialogue. Again, not moving from her own chair, she articulated the client's empathic view of his brother so that K could witness this from a distance:

Okay, K, so it's as if your brother E were here, he'd want to say to me: "Listen, Alberta, I desperately want to be a father, this is my last chance. I don't like M either, but I don't have any choice. If I get her out of my life, I'll lose my child. I don't want to lose my daughter. I love and want my daughter in my life, and that means M is in my life. I'm not giving up fatherhood."

K nodded as the therapist communicated this more "reasonable and loving" side of his brother. The therapist then acknowledged how K's empathic view of his brother had impacted her own feelings toward E, while still holding to the task of modeling expression of adaptive anger toward K's brother as well. So, once more she articulated K's need for his brother's admission that he had created the mess:

> Yes, K, I can feel more warmth inside of me for your brother now too; but I still want to say to E: (facing E again) “I get it, you are desperately trying to hold onto your child, that makes sense to me and I feel for you as a father; and, by the way, understand that K is willing to deal with M for that very reason. He understands and loves you *and* his niece. And I’m going to say again, E, just don’t you dare accuse him of being some kind of crazy person for realizing that you’ve complicated his life with all of your romantic mess, or because he has concerns for the future because of this mess. You *have* made this mess and there *are* possible future concerns. Will K be willing to face those? I’m guessing yes, he will. But now K needs you to admit it and to express some understanding of the suffering you have caused him and the rest of your siblings. He’s not crazy, he’s adaptively angry at you. And he’s also empathic towards you. He does not deserve to be pathologized. Stop it. You *have* created this mess in your family. This is your responsibility.”

K felt emotionally regulated by the validation and accurate empathy. He kept nodding and smiling and then said that that was it *exactly*: “Yes! Thank you. But the problem is, you know, *I accuse me* of being crazy too, I do this to myself.”

This self-reflective moment of K’s was also a marker of an opportunity for *hot teaching*, when the therapist could teach K about the link between his self-pathologizing critic and the pathologizing rejection he received during his life from his family. This was the first time he had made that connection so vividly. He left the session feeling very settled and energized, and emailed the therapist afterward with comments on how helpful the session had been.

To underline, be aware that in this UFB by proxy, the therapist championed K by facing the brother for him, expressing the adaptive anger that K actually felt. She fluidly checked for K’s reaction to her expressions and fluidly addressed them without losing sight of the core task of

expressing adaptive emotion and needs to the brother. Taking over the affective task of expressing assertion for the client, and expressing things to the brother interpersonally for the client, allowed the client observing distance and the space to be an emotionally-regulated witness, as well as to experience his needs for help and support being met by a "companionate champion—the therapist." This all oriented him to and structured his experience. K found the connection made between his self-process and his family experiences orienting and helpful, and left the session not only emotionally regulated, but also relieved and opened with new awareness.

Two additional general experiential strategies will help the EFT therapist regulate clients' affect and support reflective or emotional processing abilities: effectively using the therapy relationship and regulating emotion with emotion strategies.

Using the Therapy Relationship for Change

Since interpersonal contexts are evocative for the client with PD features, the therapeutic relationship provides an important opportunity for emotional transformation, processing, and regulation. First, the working relationship is a crucible for providing corrective interpersonal emotional experiences (Alexander & French, 1946). This is especially helpful to a client trying to process habitual experiences related to chronically unmet interpersonal needs. By providing safe contact, empathic understanding, unconditional positive regard, or straightforward helpfulness, the therapist can meet unmet needs for acceptance, connection, and support and, thereby, regulate deep feelings of isolation, shame, and helplessness. These experiences can transform the client's old interpersonal maladaptive emotion schemes over time (McMain et al., 2010). Therefore, the *real* relationship (Gelso & Carter, 1985) is very important for PD-featured or complex trauma clients.

Being helpful is an especially important corrective emotional experience, particularly if it helps clients to better understand and regulate their emotional worlds. And emotional teaching is most helpful when it is hot teaching, brought into a session when the client emits markers of readiness for that specific teaching. (When the client reports that it is easier to be angry than hurt, they are ready to learn the distinction between primary and secondary emotions. When the angry client has experienced a violation, they are ready to learn the connection between being violated and experiencing anger.) A therapist well-versed in basic emotion knowledge can provide this. Also, being unflappable in the face of intense emotion, and being someone who can both accept and soothe the client's emotional distress, helps the client learn that emotions need not be feared. By learning how situational triggers, needs, action tendencies, and cognitions coherently provide the client with information about feelings they are having and why, the client learns to be more willing to process their emotional states. And as their emotional world becomes less strange (the unknown becomes known), the client's distress over experiencing emotion decreases.

Changing Emotion With Emotion

In addition to using the relationship effectively to provide corrective emotional experiences and teaching moments, another important skill when working with a client with overarousal tendencies is how to employ experiential skills that center on transforming (and regulating) emotion with emotion. Transforming emotion can be a short- or long-term strategy (McMain et al., 2010), and knowing how to transform emotion in the short term can effectively help the client regulate feelings in session when needed.

Consider again that these clients have fewer problems being emotionally aroused than regulating feelings. But also consider that, even though one does not want a client to be overaroused, an *optimally* aroused

client is best able to process emotion in their awareness, because some helpful arousal makes important needs and meaning related to feelings more salient to the client (Greenberg, Auszra, & Herrmann, 2007; Paolone & Pos, 2014) As such, a number of strategies are suggested. First of all, consistent with a corrective emotional experience, liking the client and showing the client this is so positively regulates the client's self-esteem and reduces their shame. Additionally, consider how to express empathy. An emotional vocal tone may be too evocative. It will, therefore, be important to sometimes express empathy using a voice tone that articulates core distress descriptively but not evocatively, using more of a courageous but matter of fact vocal tone that is devoid of fear.

This strategy is well articulated by Linehan's (1993) expressions "going where angels fear to tread" and refraining from "fragilizing" your client. Also helpful is to use a dialectical empathic strategy that also helps the client regulate feelings. This means reflecting more than one state of the client at a time. This helps the client orient to a larger field of emotions while holding multiple perspectives, and supports the client's capacity to mentalize about their internal states. It also demands a certain amount of cognitive distance to hold two emotion states in awareness at once, which supports emotion regulation as well.

An example of this dialectical style of empathy might be reflecting secondary and primary emotion simultaneously. "You are angry at that part for being so dysfunctional; but my guess is that her dysfunction really scares you too. She makes you fear that your life will never be normal," or

> the more you pursue him for closeness, the more he pulls away and the angrier you get at him for doing that. That anger covers your hurt, I'm guessing. When he pulls away, it hurts because you need closeness and he doesn't seem to need that as much as you do.

This helps because reflections are less evocative and more regulating if they contain descriptions of a larger field, containing multiple feeling states that are all true. Again, the overall goal is to repeatedly describe affective connections that are occurring within a larger emotional system.

Another important emotion-regulation strategy will be to use humor, to help the client engage playfully in therapy dialogues. Adding some levity can really help. “Resolving unfinished business with your mom is like winning the Olympics of unfinished business,” or “Yeah, she says, ‘you made a mistake, I can’t ever trust you again’; tell her: ‘So if I fix the past, I’ll be trustworthy. Point me to the time machine, Loretta, I’m going back to fix it.’” Laughter heals (Klein, 2003).

CONCLUSION

EFT can be successfully applied to the treatment of PDs, if therapists consider the caveats for adjusting chair-work intervention presented here—ones that scaffold the emotional processing capacities of a client with a PD who is vulnerable to emotional arousal and reduced capacity to self-reflect. The tendency for EFT chair work to trigger interpersonal dynamics and to unnecessarily arouse the client can be effectively addressed by scaffolding the client’s capacity to reflect on and regulate their emotions during chair work. This can be accomplished by using a systemic model of resolution for these tasks, using new systemic strategies such as “internal EFT for couples,” or “chair work by proxy” to transform problematic relationship cycles these clients often engage in with others. These strategies address the client’s most cherished goals and their current levels of functioning. Additional means to support clients’ capacities to regulate, reflect on, or mentalize their emotions have also been described, such as more sensitive use of the therapy relationship, hot teaching, and regulating emotion with emotion. Very deep change in clients’ most vulnerable area of emotional

processing related to interpersonal relationships can be addressed. As a result, EFT for PDs can structure and organize emotionally vulnerable clients' emotional landscapes, while helping them make effective use of transformative EFT chair interventions.

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18
EMOTION-FOCUSED FAMILY THERAPY FOR EATING DISORDERS

JOANNE DOLHANTY AND ADELE LAFRANCE

Eating disorders (EDs) are serious health conditions that involve food restriction, extreme weight loss, maintenance of low body weight, episodes of binge eating, and behaviors to compensate for the ingestion of food such as self-induced vomiting, laxative use, and excessive exercise (American Psychiatric Association, 2013).

The physiological sequelae of EDs affect every bodily system (Rome & Ammerman, 2003). A wide array of psychological symptoms also accompany these disorders (Fairburn & Harrison, 2003), as well as impaired quality of life (Jenkins, Hoste, Meyer, & Blissett, 2011), high morbidity, and premature mortality (Smink, van Hoeken, & Hoek, 2012). Long-term outcome studies show adult relapse rates up to 67% (Field et al., 1997) and adolescent recovery rates up to 57% (Steinhausen, 2002). Not surprisingly, the field has called for the exploration of new and promising treatments (Wilson, Grilo, & Vitousek, 2007).

EMOTION AND EATING DISORDERS

There are a multitude of factors contributing to the development and maintenance of an ED identified in the literature, but it is widely accepted that emotion and its avoidance are central (Harrison, Sullivan, Tchanturia, & Treasure, 2009). Long identified as low in interoceptive awareness, or the ability to identify what they are feeling, these individuals present with emotional deficits including impairment in emotion regulation (Brockmeyer, Holtforth, Bents, Herzog, & Friederich, 2013). They may present as highly overregulated with a high degree of emotion avoidance, or severely underregulated, with a chaotic pattern of ED symptoms such as bingeing, vomiting, and laxative abuse, as well as other secondary symptoms such as cutting, stealing, sexual promiscuity, and substance abuse. A central function of the ED can be seen as an attempt to manage difficult emotions (Cockell, Geller, & Linden, 2002; Dolhanty & Greenberg, 2007; Treasure, Schmidt, & Troop, 2000). While recent research suggests that difficulties with emotion appear to be a transdiagnostic risk and/or maintenance factor for psychopathology in general, difficulties with emotion seem to be more severe in this population (Svaldi, Griepenstroh, Tuschen-Caffier, & Ehring, 2012).

EFT AND EATING DISORDERS

In emotion-focused therapy (EFT), emotion is fundamental in the construction of the self and is a key determinant of self-organization (Greenberg, 2010). One of the goals of EFT is to support the development of mastery of emotional experience, to facilitate clients' ability to perceive and emotionally respond to environmental situations in healthy and adaptive ways (Greenberg, 2008; Greenberg & Pascual-Leone, 2006).

Given the central role of emotion and emotion regulation in the EDs, the application of EFT to this population provides fruitful possibilities (Dolhanty & Greenberg, 2007, 2009). EFT promotes in-session experiencing of emotion with the goal of fostering acceptance of experienced emotion, proficiency in regulating emotion and in self-soothing, and transformation of destructive or "maladaptive" emotions to more healthy alternatives. The clinician follows the individual to their emotional experience (or avoidance thereof) and guides them in the processing of that experience. Techniques include a variety of empathy tasks, as well as emotion-focused chair work. Chair tasks include processing (a) the individual's inner self-critic, (b) unfinished business in relation to a significant other, and (c) blocks or self-interruptions. Markers for engaging in tasks appear readily and frequently in the EDs and provide the clinician and client clear pathways to healing. In the domain of self-criticism, the individual's intense feeling of self-loathing, in particular in relation to her body and "feeling fat," becomes an initial marker that once processed leads to deeper feelings, for example of inadequacy, loss, and long-denied anger. Markers for unfinished business are also very amenable to processing through chair work in the frequent presentation of failures or delays in the domains of separation and individuation. And the avoidance or self-interruption of emotion, highlighted above, becomes a primary and necessary target of intervention to help the individual to begin to relearn and trust her emotions as a source of information and guidance.

This experiencing and processing of emotion in the empathic presence of the clinician affords a new sense of mastery or self-efficacy over emotional experience. The use of chair work to allow the client to hear the critical voice inside her—until now a feared, loathsome, dominating "monster" but which can become like a reassuring and trusted friend—provides an opportunity for the individual to conceptualize in a new way the most troubling of her ED thoughts and feelings. The structure of chair

work allows her to be able to get in touch with her own reactions and responses to that voice, as every ED clinician knows that any attempt on the part of the clinician to contradict the ED voice will only make it louder. Thus the approach is highly suited to supporting the motivational principles of “siding with the negative” to avoid argumentation, expressing empathy, and supporting self-efficacy (Miller & Rollnick, 2012). This exposure of the ED voice and the differentiation between it and the healthy self begins instantly to provide a road out of what can have been a seemingly hermetically sealed system. Individuals experience renewed hope in the possibility that they may recover from their ED by means of working to identify, accept, allow, and alter maladaptive emotional reactions, thereby altering dysfunctional behavior patterns and rendering the ED unnecessary as a means of coping with emotional pain.

Outcomes of EFT have been explored with adults with anorexia nervosa (Dolhanty & Greenberg, 2009) and bulimia nervosa (Wnuk, Greenberg, & Dolhanty, 2015). For example, a case report of EFT with anorexia nervosa showed an increase in emotional awareness and a decrease in alexithymia (Dolhanty & Greenberg, 2009), and clients who participated in an EFT group for ED group experienced a decrease in the frequency of bingeing and had improvements in mood, emotion regulation, and self-efficacy (Wnuk, Greenberg, & Dolhanty, 2015).

FROM EMOTION-FOCUSED THERAPY TO EMOTION-FOCUSED FAMILY THERAPY

In our experience applying EFT to eating disorder work, we found there were limitations to treating the individual and addressing their difficulties in processing and regulating emotions, in the absence of parallel work and change in the family to which they would return. A number of observations thus led us to consider a more explicit role for families in the

emotion-focused treatment of EDs, moving them from a supportive to an integral role in the emotional healing of their loved one. The first was the observation that the emotional "style" of the family appeared to have a significant impact on the individual's own emotional style. Whether emotion was expressed or not in the family, whether it was expressed directly or indirectly, in a chaotic or measured manner, and whether emotion was dealt with openly or avoided, all appeared related to the individual's own emotional style. The ability to regulate or not their emotional experience and expression, and the manner and degree to which regulation was utilized and was adaptive or maladaptive, thus had close ties to the family's emotional functioning. While this may be true of any population, this appeared to be especially true in the EDs, leading to the second observation in EFT with ED that led to considering involving families more explicitly. This was the strikingly high degree of involvement of families in the illness, regardless of the age of the individual, and the presentation of these individuals that resembled developmental delays in the domains of separation-individuation and identity formation. Individuals with EDs often live at home, and even if they do not, even if married and with children, we have found it to be worthwhile to include significant members of their family. Parents, parental figures, and other caregivers, including spouses and partners, are often involved in the arrangement of and driving to and from treatment and medical appointments, and in the day-to-day goings on of the ED individual's symptoms, lifestyle, and relationships. This is not surprising given the severe physiological, cognitive, and social sequelae of these illnesses. No surprise, therefore, that their families are highly engaged in the trappings of the illness, as well as in the efforts to deal with it, although their child's chronological age may suggest the expectation of a greater degree of independence.

This leads to a third observation that emerged from this work. Caregivers thus highly engaged in their loved one's ED illness were often

less than effective in that role. In fact, as Schmidt and Treasure (2006) noted, families often unwittingly enable the ED with a variety of unhelpful stances and behaviors. No doubt the severe and life-threatening nature of the illness breeds fear, desperation, and the abandonment of a previously adequate approach to parenting, to be replaced by one in the service of fear and with the rationalization that "I would rather have a sick child than a dead one." Related to this was a further observation that, although parents were highly engaged in the life of the ED, they and their loved one often presented as highly skeptical of having them participate in the actual treatment. Rationales for this skepticism or even refusal to be involved or to have one's parents involved in the treatment appear related to fears on the part of both individuals and their parents that it will "go badly"—that is, that it will lead to more complications rather than a good outcome, or that parents will be blamed or will blame themselves. These observations were corroborated in a research study that found that caregiver fear and self-blame predicted both low caregiver self-efficacy in supporting their loved one's recovery, as well as the extent to which caregivers reported engaging in recovery-interfering behaviors (Stillar et al., 2016).

EMOTION-FOCUSED FAMILY THERAPY FOR EATING DISORDERS

The foundation of emotion-focused family therapy (EFFT) as a treatment approach for EDs is a deep belief in the healing power of families (Lafrance Robinson, Dolhanty, & Greenberg, 2013). A transdiagnostic and lifespan model, the aim of EFFT is to enhance the role of caregivers using an emotion-focused skills-based approach. There are four core domains in EFFT: recovery coaching, emotion coaching, relationship repair, and working through blocks.

Recovery Coaching

In recovery coaching, caregivers are empowered to take on the tasks of providing meal support to their child and helping to interrupt the ED symptoms. The recruitment of caregivers to support the behavioral recovery from the ED is not new, but to date has been associated primarily with family-based therapy (FBT) in the treatment of children and adolescents (Lock & Le Grange, 2013), with the recent development of extending FBT specifically to young adults (Dimitropoulos et al., 2015). Although the nature and intensity of involvement may vary according to the child's developmental age, all caregivers in EFFT are coached to increase their involvement in their child's behavioral recovery. For example, parents are taught specific meal-support strategies, as well as tools to support the interruption of behaviors such as purging and compulsive exercising. This is done much as if they were nurses new to an inpatient ED ward. Teaching caregivers these skill sets involves psychoeducation, through lecture, discussion, and videos; as well as experiential coaching and learning via role plays. During role play, the clinician "sculpts" the parent's approach, for example, by shaping their choice of words, tone of voice, and body language. This technique comes out of the EFFT principle that children "hear" the emotions that parents *convey*, rather than what they explicitly *say*.

Emotion Coaching

To lay the groundwork for emotion coaching, the EFFT clinician provides caregivers with information about the nature of emotion, and the role of emotion and its avoidance in the onset and maintenance of their child's illness.

Emotion Basics

The emotion basics consist of the four features central to emotion: that every emotion has (a) a bodily felt sense, (b) a label, (c) a need, and (d) an associated action. Parents learn that the bodily felt sense of an emotion provides the guidepost to identifying and labelling what the emotion is, as there is a distinct feeling in the body for sadness as opposed to anger, fear, and shame. They learn the actions needed to meet emotional needs. Learning these basics enables the parent to manage their own emotions more effectively and to coach their loved one to do the same. The means of this transformation is via the emotion coaching.

Steps of Emotion Coaching

Caregivers are taught the five steps of emotion coaching. These steps are derived from the steps of emotion processing in EFT (Greenberg, 2002, 2004) and influenced by Gottman (1997). The EFFT clinician thinks of the parent's learning in the same way as they would a new psychotherapy student learning active techniques for the first time. The five steps of EFFT emotion coaching are (a) *attend*, (b) *label,* (c) *validate,* (d) *identify and meet the need,* and (e) *problem-solve*. Caregivers first learn to attend to their child's emotional experience by simply acknowledging its presence, as many parents are inclined to ignore displays of emotion out of fear of reinforcing them. Clinicians remind parents that attending to the emotion not only invites connection, it is also the first step in regulating the emotion so that it is more manageable. The second step in emotion coaching, which is naming the emotion, provides a label to a previously unnamed and unspecified emotion and actually continues the process of emotion regulation and subsequently of gaining competence with emotion.

The third step, that of validating the emotional experience, is the most important one in the process and the most difficult to master. The key to this step in the coaching process is for parents to be able to go from "but" to "because." For example, "I understand that you feel angry but you know I

had no choice" becomes "I understand that you feel angry because you didn't want to have to eat your lunch in the car with me. I imagine you also feel embarrassed because none of your friends' moms come to the school."

The fourth step of emotion coaching is to identify and meet the emotional need. The EFFT clinician coaches the parent to respond to their child's sadness with soothing, and to anger with validation and support to set boundaries. In the early stages, the parent will be responding to the emotional needs of their child, as though they were younger but using developmentally appropriate language. For example, a parent responding to their child's sadness may offer them a hug and invite connection.

With the fifth step, problem solving, parents often report that as they engage in the first four steps of the coaching, their child will often come to their own means of "solving the problem" or they will come to the realization that in fact there is no problem to be solved since the "problem" was really the experience of emotional pain. In some specific circumstances, however, such as in the case of bullying in children or unsafe relationships in adults, the caregivers must engage their loved one in problem-solving in order to address the situation practically.

These emotion coaching interventions are useful in many ways. First, as caregivers adopt this new way of relating to their child, the parent–child relationship will deepen and the parent's efforts to support their child with the behavioral symptoms will be more effective and better received. Second, as the child increases her nutritional intake and reduces the frequency of her symptoms, her parent's emotional support will help her to manage the flood of emotions that inevitably ensue in this stage of recovery. Finally, the overarching goal of emotion coaching is to support caregivers as they support their child in "internalizing" the ability to manage emotions and self-regulate.

Relationship Repair

Relationship repair is deemed an appropriate intervention for caregivers in the following situations: if the child or parent blames themselves or the other for the ED; if the relationship between parent and child is distant or hostile, making it difficult for caregivers to take on an active role in treatment; or if the caregivers identify a pattern of emotion avoidance in the family that if interrupted could support recovery. The EFFT clinician also supports the parent to reflect on and identify any possible lived traumas, separations, conflicts, or even misunderstandings that could have contributed to the child's avoidance of emotion that may in turn have contributed to the development or maintenance of the illness. In these instances, caregivers are coached to support the child with her pain first by using the steps of emotion coaching and then by expressing healthy accountability, via an apology, in response to what their child lived through. One parent referred to this process as taking the chemotherapy herself to free her child from the cancer of self-blame. Some caregivers or even clinicians will ask: Why does an eating disorder have to be anybody's fault when it is nobody's? And the answer is that deep down most children will feel to blame and most parents will blame themselves. The relationship repair is, thus, a process through which both the child and her parents can release themselves from maladaptive self-blame and attendant shame and, thus, be able to move forward together.

Parent Blocks

There is a growing awareness and recognition that the emotions of parents of individuals with EDs interfere with caregiving efforts (Goddard et al., 2011; Kyriacou, Treasure, & Schmidt, 2008; Lafrance Robinson, Dolhanty, & Greenberg, 2013; Schmidt & Treasure, 2006; Treasure, Smith, & Crane, 2007). In fact, even though the primary aim of EFFT is to support and empower caregivers to adopt a primary role in their loved one's behavioral and emotional recovery, the over-arching target of the therapy is

the attention paid to emotional “blocks” in caregivers. Parent blocks can manifest behaviorally in a variety of ways including refusal to become involved, denial, overcontrol, criticism, and accommodating and enabling behaviors. These behaviors are regarded as efforts to regulate the caregiver’s own strong negative affect, namely fear, shame, helplessness, hopelessness and resentment.

Processing Emotional Blocks

One of the ways that clinicians can help to process caregiver fear, shame, hopelessness, helplessness, and feelings of resentment is to employ the steps of emotion coaching to validate the caregiver’s experience, in the same manner that the clinician will teach the caregiver to validate those of the child. In some cases, we have observed that simply bringing into awareness and validating the impact that the caregiver’s emotional blocks have on their ability to feel compassionate toward their child, to feel confident in themselves, and to be able to engage in the tasks of home-based treatment can free caregivers to follow the treatment protocol. Awareness, too, of their own history of unmet emotional needs and unresolved emotional pain can help to loosen the grip these can have and subsequently allow the caregiver to attend to their child’s emotional needs more effectively. Caregivers can complete self-assessment tools that help them to identify their emotional blocks. They are also presented with the New Maudsley’s Animal Models (Treasure, Schmidt, & Macdonald, 2009). The Animal Models illustrate common (and problematic) emotional and behavioral response patterns that caregivers engage in when caring for someone with an ED. Parents are taught to identify the animal best representing their emotion coping style, be it the transparency and “wobbliness” of the Jellyfish, the head in the sand of the Ostrich, with the aim of moving towards the calm and supportive warmth of the St. Bernard. In terms of caregiving style, they can identify as the Rhino charging in or

the Kangaroo with the loved one protected in their pouch, again with the aim of moving towards the ideal of the playful and nudging Dolphin as companion. These depictions provide a non-threatening way for parents to identify themselves and their partner, and to share their realizations with their loved one, to have a common language to address family dynamics.

Should these interventions fail to engage the caregiver sufficiently and effectively in the tasks, the EFFT clinician can work with the caregiver using an EFFT version of chair work (inspired by self-interruptive split work in traditional EFT) to attend to and process the emotional block driving the therapy-interfering behaviors.[1] Such blocks may occur in parents feeling unable to engage in a behavior to help their loved one, or in feeling unable to stop an unhelpful pattern. The example below illustrates an example of a parent feeling unable to help her daughter with an ED to eat her meals.

Sample Script for Working With a Parent Block[2]

Step 1. The parent begins in the "self" chair. The clinician and parent formulate the block. In this example, the parent feels incapable of helping her young adult daughter eat her meals.

> *Parent:* It's better if I just leave her alone and let her manage it. I just can't do it.

Step 2. Switch the parent to the "other" chair. Have the parent picture herself in the "self" chair and convince her "self" not to help daughter with eating. Have her be specific about how it will be bad for her (the mother) if she does help. Have her tell the "self" what to do instead.

> *Clinician:* Picture yourself in the chair facing you. Be the part of you that convinces you not to help her with her eating, to back off instead.
>
> *Parent:* Okay, um . . . don't do that, because you don't know what you are doing, and you're going to mess it up, and

you're going to make things worse.

Clinician: Really scare yourself by telling yourself how badly it will go for your daughter.

Parent: She'll end up vomiting or worse, cutting, uh, or even worse killing herself.

Clinician: And be specific by telling yourself how it will go badly for you if all of this happens.

Parent: She's going to hate you. And then you'll have really lost her. And if anything happens to her because you pushed her too hard, you will NEVER forgive yourself.

Clinician: Tell her [the imagined self] what to do instead of helping with meals.

Parent: Don't push the agenda of "moms should help with meals." Just avoid it and steer clear of the whole eating thing. Let her handle it. She prefers to eat with no one watching anyway.

Step 3. Switch the parent to the "self" chair. Instruct the parent to picture her daughter in the other chair. Tell the parent to tell the child (who is being pictured in the other chair) that she (the mother) can't help her (the daughter). Instruct the parent to explain that her fear is too strong and that she could never live with herself if she made things worse.

Clinician: Imagine Vanessa in the other chair. Tell her: "It's not a good idea for me to help you. I can't help you. I'm too nervous about screwing up and being to blame if it goes badly."

Parent: Vanessa, I'm really sorry but I just can't help you. I'm too scared to make it worse.

Step 4. Switch the parent to the "other" chair where she will "be" her daughter.

Clinician: Be Vanessa. Tell mom what it's like to hear that.

Parent as daughter: (looks sad) Wow. I say that I don't want you involved because you get on my case but it's devastating to hear that—like, there's no hope. Actually it makes me mad that you can't find a way to support me and be there for me in a better way.

Clinician: As Vanessa, tell mom what is underneath the anger.

Parent as daughter: I'm scared. I can't do this alone. And I do want you involved on some level. I just can't say that out loud. It's scary. I need you to be able to help me. I feel like you're the only one who really can. You're my mom. I need you. I need for one of us to not be scared.

Step 5. Switch the parent to the "self" chair and ask her to reflect on what it is like to hear that from her daughter—and what she now wants to do for her daughter instead.

Clinician: What's that like for you to hear? What do you want to do for Vanessa?

Parent (to clinician): Oh . . . I never think of it like that. I forget that she is my little girl and that she needs me. She puts up such a tough front. Vanessa—I am so sorry. I know that you need your mom. I am going to do this. I will get better at helping you. I won't let my fears get in the way.

Clinician: Like—"I'll figure it out?"

Parent: Yeah—I won't give up. I'll keep working with the team until we find the way.

Step 6. Switch the parent to the "other" chair where she responds as daughter.

Clinician: How does Vanessa respond?

Parent as daughter: It feels good. (she lets out a sigh) Nervous but good. I feel grateful. I really want things to be better and

I need your help. Please believe in me. I need you to believe in me.

Step 7. Switch the parent to the "self" chair. Ask the parent to tell the clinician what it's like to hear this.

Clinician: What's it like to hear her say that?

Parent: It's touching. It's so easy to forget. Since she's had this illness she just appears not to care about me at all and not to want me in her life. And I believed her! That must have been so scary for her. It's hard to hear this but it does feel good to remember that she needs me.

Clinician: Can you tell her that? I forget . . .

Parent: Yeah—I'm sorry that I forget that. I've been so beside myself and so burned out by this thing. I do know that you need me. Wow—it feels good to find that part of me again. A bit scary too but good.

Clinician Blocks

Treatment is an emotional experience for the ED clinicians as well. In 2012, Thompson-Brenner, Satir, Franko, and Herzog conducted a literature review of clinician reactions to individuals with EDs and found that negative reactions in regard to patients typically reflected frustration, hopelessness, lack of competence, and worry. Treatment resistance, ego-syntonicity, high relapse rates, worry about patient survival, emotional drain, lack of appropriate financial reimbursement, and extra hours spent working, also contributed significantly to feelings of burnout reported by clinicians working with ED (Warren, Schafer, Crowley, & Olivardia, 2013).

Two theoretical models identify clinician factors related to emotion that can interfere with treatment delivery. The iatrogenic maintenance model for ED (Treasure, Crane, McKnight, Buchanan, & Wolfe, 2011) and the clinician drift model (Waller, 2009) describe various ways that clinician

emotion can interfere with treatment delivery. Clinician anxiety has been found to be related to lower levels of adherence to evidence-based practices in the treatment of both child and adolescent, and adult ED (Waller, Stringer, & Meyer, 2012). Lafrance Robinson and Kosmerly (2015) conducted a survey among child and adolescent ED clinicians to explore clinicians' perceptions of the negative influence of their own emotions on clinical decisions and practices in treatment. Whether they responded about themselves or their colleagues, decisions regarding the involvement of the family were perceived to be the most emotionally charged, in particular the involvement of a critical or dismissive parent.

In the context of EFFT, when faced with an emotionally charged session or decision, or when treatment is stuck, clinicians engage in "emotion-focused" supervision in order to identify and work through the emotional "blocks" that surface in the therapy. For example, a clinician working with this approach may hesitate to enlist caregivers as recovery allies if the parent appears to be excessively hostile or in denial of the severity of the symptoms, both of which can be common reactions to the challenge that the ED presents to the family. Similarly when a parent also has an active ED themselves, the clinician may rationalize that this parent is not capable of being part of their loved one's recovery. Every clinician, in fact, will present with the case of "What about the parent who . . .?" "What about the parent who has their own ED or addiction?" "What about the parent who has borderline personality disorder?" Valid as all of these concerns are, the clinician can work productively with their own feelings about the situation to restore their empathy for the family's struggle and open new pathways to working with caregivers as allies in some way.

There are several modalities through which EFFT clinicians can engage in supervision around clinician blocks. They can engage in regular "talk" supervision to explore the emotions evoked in response to the work with a family. They can complete an emotion-focused self-assessment tool

to help identify potential emotional blocks in administering the therapy. In addition, and similar to the structured chair tasks for the resolution of parent blocks, emotion-focused supervision can involve using EFFT chair work to process the clinician blocks. This could entail having the clinician begin with the self-interruption: “Don’t involve this mom in the therapy.”

Sample Script for Supervisors Working With a Clinician Block

Step 1. The supervisee begins in the “self” chair. The supervisor and supervisee formulate the block. In this example, the supervisee hesitates to invite the adult client’s mother to therapy.

> *Supervisee:* Julia’s mother is very critical. She makes critical comments about her weight and accuses her of not working hard enough.

Step 2. Switch the supervisee to the “other” chair. Instruct her to picture her “self” in the empty chair. Instruct her to be the part of her that stops her from bringing the client’s mother into session. Have her tell her “self” specifically how it would be bad for the client if she invited the parent to engage in her child’s recovery. Have her tell her “self” specifically how it would also be bad for her, the clinician.

> *Supervisor:* Picture yourself in the chair facing you. Be the part of you that stops you from bringing in mom. Encourage “her” (imagined self) to protect the child from the parent’s involvement in treatment. Tell “her” how it will go poorly for her (the clinician) as well.
>
> *Supervisee:* Don’t let Julia’s mother into the treatment. She is too critical. She will hurt her daughter and she will stop the therapy from moving forward. Julia does not need this on top of everything else she is working through. She’s working way too hard. And you don’t need to deal with the extra resistance. You’re already drowning with this case.

Supervisor: Tell her (the imagined self) what to do instead of bringing in the mom.

Supervisee: Don't push the agenda of mom's involvement. If mom calls, let her know that it may not be the best time for her to join the therapy.

Step 3. Switch supervisee into the "self" chair: The supervisor instructs the supervisee to picture the child in the "other" chair. Have the supervisee tell the child that her parent can't help her—that in fact, the parent may be damaging to her progress.

Supervisor: Imagine Julia in the other chair. Tell her: I just don't believe that it's a good idea for your mom to be involved. She is too critical. I don't think she can be helpful to you. I don't think you can handle her critical style and I don't want to deal with it either.

Supervisee: Julia, I'm really sorry but I just don't think your mom can help you. Uh, I really don't like saying that.

Step 4. Switch the supervisee to the "other" chair where the supervisee will respond as the client.

Supervisor: Be Julia. Tell her (the supervisee) what it's like to hear that.

Supervisee as client: Wow. I say that I don't want her to be involved because she does criticize me and she gets on my case but it's devastating to hear that there is no hope. Actually it makes me mad that you won't find a way to support her to be there for me in a better way.

Supervisor: As Julia, what do you want her (the supervisee) to know?

Supervisee: That I can't do this alone. And I do want my mom involved on some level. I just can't say that out loud. It's scary. And I understand why she gets so critical, she has

been dealing with this for as long as I have and I know she is tired and I know she is scared.

Step 5. Switch supervisee to the “self” chair. Have the supervisee reflect on what it’s like to hear this and respond to the child client who is imagined in the “other” chair.

Supervisor: What’s that like for you to hear? What do you want to do for Julia? For her mom? Tell her.

Supervisee: Julia—I am so sorry. I know that you need your mom. I will help her to be able to help you better.

Step 6. Switch supervisee to the “other” chair where she responds as the child client.

Supervisor: How does the child respond?

Supervisee as client: It feels good. (lets out a sigh) Nervous but good. I feel grateful. I really want things to be better and I need your help. Please believe in us. I need you to believe in us.

Supervisor: Do you have a sense as to what is needed at this point in time?

Supervisee: (laughing) I’ve got to call that mom . . . Show her the compassion she deserves. Show her the compassion that she needs so that she can get unstuck too.

Supervisor: And how do you feel about that?

Supervisee: To be honest, a bit embarrassed. And really nervous (laughter). But I know it’s the right thing to do.

EFFT RESEARCH

EFFT for ED has been researched in different formats with parents of children with ED of various ages and clinical presentations. For example, a

2-day intervention was developed on the basis of EFFT principles and delivered to parents of adolescent and adult children with ED (Lafrance Robinson, Dolhanty, Stillar, Henderson, & Mayman, 2016). As in the 8-week format, parents were taught strategies for meal support and symptom interruption as well as emotion coaching. Parents were also supported to identify and work through their own emotional blocks. There was a significant increase in parental self-efficacy, a positive shift in parents' attitudes regarding their role as emotion coach and a reduction in the fears associated with their involvement in treatment, including a decrease in self-blame. Parents also reported intentions to implement strategies to support their loved one's recovery that were consistent with the targeted treatment domains.

Process research has begun to explore the relationships and interactions among self-efficacy, fear and self-blame. Among a sample of parents and caregivers, including partners, fear and self-blame predicted feelings of self-efficacy and accommodating and enabling behaviors. As noted earlier, the more fear and self-blame caregivers experienced, the lower their self-efficacy and the more likely they were to engage in behaviors that accommodated and enabled ED symptoms (Stillar et al., 2016). Building on this research, Strahan and colleagues (2017) developed an EFFT process model showing that targeting and reducing parental blocks of fear and self-blame through EFFT leads to an increase in self-efficacy which in turn leads to an increase in parents' intentions to engage in tasks associated with recovery.

INTEGRATING EFT AND EFFT: USING EFT TECHNIQUES WITHIN EFFT

In this model, EFT and EFFT can work together fluidly. For example, parent blocks can be resolved by helping the parent to increase their

awareness of them or by processing these blocks through the use of the very structured EFFT chair work. Having these options that can both be effective speaks on the one hand to the goal of EFFT to make this emotion work accessible for caregivers to learn and for many more clinicians to be able to teach to caregivers without necessarily becoming "experts" in EFT. However, should the clinician feel that a deeper processing of the block is warranted, more traditional EFT chair work can be integrated into the therapy. This flexibility speaks to a tradition in EFT of a lifetime learning model whereby clinicians who so desire can enhance their skill set in implementing EFFT by learning to deepen their EFT skills and techniques.

The following is a clinical vignette illustrating EFT chair work in the context of EFFT to support a mother whose resentment made her unable to attend to her daughter due to her own childhood wounds. Specifically, the clinician offered support and very brief (part of one session) EFT chair work to identify, validate and process the grief of losing her mother at a young age, as well as the anger, until then out of awareness and unexpressed, that her mother had left her with no one to care for her. Processing and resolving this block freed this mother from the resentment and allowed her to be present for her struggling teenaged daughter as illustrated next.

The clinician begins with the mother in the "self" chair.

Mother: I can't help my daughter.

Clinician: Picture your daughter there (in the "other" chair) and tell her: "I can't help you."

Mother: (begins crying softly) I can't risk getting in there and getting close with the possibility of losing you. Because you are the age I was when my mother died.

Clinician: It sounds like you miss your mother a lot.

Mother: I do.

Clinician: Can we do some work on that? Can you picture your mother there and tell her how much you miss her? [Note the fluid transition from picturing her child in the other chair to picturing her mother.]

Mother: I've worked on this a lot in therapies. They're always telling me to get angry with her.

Clinician: You don't sound angry with her. You sound like you miss her. Can you tell her: "I miss you so much"? [The clinician is aware that there is likely underlying anger as is common in grief. The key in EFT is to follow the presenting emotion, then proceed to process it or have it transform to a more primary emotion.]

Mother: (crying) I miss you so much. I miss having you in my life. I missed you being there when I got married and when I had my daughter.

Switch client to the "other" chair.

Clinician: Come over here (to the "other" chair). What does she (your mother) say when she hears this?

Mother in chair as her mother: I'm so sorry I wasn't there. I see what a wonderful mother you are and what a wonderful girl my granddaughter is. You have done so well. I love you very much. And I'm sorry that I didn't leave you better looked after—that there was no one there to care for you.

Switch client to the "self" chair

Clinician: What happens when she says all of that?

Mother: It feels nice. And (with a wry smile) I feel a little bit angry!

Clinician: Can you tell her that?

Mother: Yeah—I am angry with you. You left and I had no one. I had to manage completely on my own. It was awful. And

it's affected my parenting of my own daughter.

Switch the client to the "other" chair.

Clinician: What does she say to this?

Mother as her mother: I am truly sorry. That wasn't okay. You should not have had to go through that.

Switch the client to the "self" chair.

Clinician: Can you picture your daughter there again? What do you want to say to her?

Mother: I'm sorry I haven't been there for you. That's going to change.

Clinician: It sounds like you're saying to her: "I won't let losing my mother affect our relationship anymore."

Mother: Yeah—that is how I feel.

Clinician: Can you tell her: "I won't let that stop me from being there for you."

Mother: Yeah—I won't let that stop me from being there for you.

Switch the client to the "other" chair.

Clinician: How does that feel for her to hear?

Mother as her daughter: It feels good.

CONCLUSION

There has been a call in the treatment of ED to include families as "critical partners in care" and to address "sources of intrafamilial strain and the need for other forms of therapeutic dialogue to reduce it" (Strober & Johnson, 2012, p. 170). We propose a treatment that privileges the role of caregivers as active, primary agents in their loved one's recovery. EFFT is

an emotion-processing skills-based approach that focuses on the development of self-efficacy in the experiencing and processing of previously avoided emotional experience, a deficit ubiquitous among these individuals and their families. A simple 2-day workshop offering parents a set of tools in the four domains of recovery coaching, emotion coaching, relationship repair, and processing emotional blocks, has proved effective in reducing caregiver fear and self-blame, and increasing self-efficacy, known to be highly predictive of loved one's outcome. The rapid growth and adoption of EFFT is testimony to the need to fill in "missing pieces" in ED treatment. This new approach attempts to fill this gap by affording caregivers a significant role in their loved one's recovery and by facilitating the development of emotional self-efficacy in caregivers and their loved ones. Developed first as a treatment for ED, the application of EFFT has expanded to general mental health and research shows promising results for individuals and their caregivers.

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[1]It is important to note that, although caregivers can benefit greatly from a course of individual therapy themselves, this is not the point of the intervention, nor is it necessary or prescribed by the model, even when it may appear indicated. Rather, the work is specifically related to and singularly focused on the resolution of the block in order to support the caregivers to support their child in the different domains.

[2]The authors verify that they have concealed client identity by disguising details of the case or by combining details from multiple cases

19
INTEGRATING FEMINIST-MULTICULTURAL PERSPECTIVES INTO EMOTION-FOCUSED THERAPY

HEIDI M. LEVITT, WILLIAM J. WHELTON, AND SHIGERU IWAKABE

We are now said to live in a “global village.” It is worth meditating on the implications of this striking image. The ease of modern travel, sophisticated communication technologies, and the economic process of globalization, along with vast migrations of peoples looking for work and safety, have greatly altered our social ecologies. One effect of this is that, increasingly, societies are composed of people from multiple cultural backgrounds, bringing into contact groups with distinctive beliefs, values, religions, and social practices. Over the past few decades, feminist and multiculturalist movements have prompted a number of prominent psychologists and psychotherapists to consider this diversity in light of the constricted and parochial assumptions underlying traditional approaches to psychotherapy (e.g., Brown, 1995; Fish, 1996; Sue & Sue, 2012). In this chapter, we situate emotion-focused therapy (EFT) within the purview of

these concerns and issues, and we offer a few considerations and suggestions for adapting EFT for effective use with multicultural and diverse populations.

THE CONTEXT OF EFT

Some of the roots of EFT, and several of its central principles, are found in a range of humanistic and experiential therapies which themselves owe a great deal to the philosophical and literary movements that swept through Europe over the past century and half. Existentialism and phenomenology, for example, were complex philosophical movements emanating from Europe that emphasized honest awareness of the contents of conscious experience and an attitude of openness to the reality and limitations of one's concrete circumstances (Elliott, Watson, Goldman, & Greenberg, 2004). One of the original hallmarks of these philosophies is a hesitation about privileging reason, and an acceptance that cognition is embodied and that human experience arises from a unified blend of the sensory, bodily, emotional and rational—therefore, all forms of experience must be given their place and their due (Barrett, 1990). The originators of humanistic and experiential therapies mostly viewed their therapies, rooted in these ideas, as having a universal application (e.g., Perls, Hefferline, & Goodman, 1951; Rogers, 1959). But the beliefs, values, and attitudes of Europe are not universal.

In response to this assumption from across psychotherapy approaches, a long overdue sensitivity has emerged within psychology and, more specifically, within psychotherapists to the need for a more expansive understanding of the impact of culture on functioning (Sue & Sue, 2012). One of the effects of a psychological perspective can be an exaggerated emphasis on the individual, which can fail to correctly identify the roles of poverty, racism, misogyny, and other systematic forms of oppression in the

creation of misery, hopelessness and a range of mental health difficulties (Smail, 2001). Feminist and multicultural traditions have brought to light the enormous variety in the beliefs, traditions, values, practices, and fundamental assumptions of disparate human groups. Cultures can vary with ethnicity, geography, nationality, religion, gender, ability, age, and sexuality among other features. Concerns about multiculturalism and diversity inevitably entail considering these forms of cultural variability in light of larger social issues of justice and inequality.

In the first part of this chapter, we provide a brief summary of some of the theory and research of recent years on feminist-multiculturalism and counseling. Then we lay out some basic guidelines and principles for adapting EFT to situations involving a range of diverse clients. In doing so, we highlight some multicultural developments within the whole family of humanistic therapies. It is very important as well to emphasize that humanistic and experiential therapies have values and principles embedded in their interventions, such as an empathic stance that requires entering into what Rogers (1959) called the client's "internal frame of reference," that lend these approaches an exceptional facility for being adapted for use with very diverse clients. EFT has strengths that can make it ideal for feminist-multicultural counseling. Finally, we will give two case examples with clients from different cultural identities to exemplify the integration of EFT and feminist-multicultural approaches.

FEMINIST-MULTICULTURALISM AND PSYCHOTHERAPY

The term *feminist-multiculturalism* as we are using it encompasses a number of values. It recognizes that we live in social contexts in which there are many signals and stereotypes that identify sets of people as either belonging to or outside of dominant social groups. In Canadian and U.S. contexts, privileged groups tend to be White, middle-class, moderately

educated, heterosexual, able-bodied, and male. Within the discourse on psychotherapy, concerns about marginalization based upon gender, racism, ethnic identity, sexual orientation, and poverty developed more or less contemporaneously as the field became concerned about the potential for therapists to echo oppressive societal stereotypes and attitudes (Brown, 1995).

Psychotherapy is a structured, confidential contract (usually) between two people, therefore, it is commonly viewed as almost hermetically sealed from the political, cultural, and economic forces at work in larger society. This is not the case. One of the core underlying assumptions of multiculturalism is that the practice of psychotherapy is a social construction that inescapably has sociopolitical overtones (e.g., Sue & Sue, 2012). People are products of their cultures to an enormous degree. The lives and identities of clients and therapists are fully at play in the process of therapy, and they are shot through with meanings and conflicts arising from their cultural and political circumstances. When a therapist and a client meet, the possibility of genuine encounter and dialogue can be impacted by race, language, poverty, sexuality, gender identity, immigration status, and a host of other issues that can hinder or facilitate the meeting. The encounter is in part mediated by whether the therapist has the capacity and training to really understand the client in their cultural context. It is a myth to imagine that individuals in therapy can be disembedded from the social and historical contexts that give their lives meaning.

The foundational competence in multicultural counseling is self-awareness (Sue & Sue, 2012). Members of the dominant culture are privileged in that their culture, and its values and attitudes, tend to be presented as “reality”—quite simply the way things are. As a result, White people in North America, for example, might view the values and beliefs from other cultures to be relative and constructed, but not understand that their own perspectives are also the product of similar processes. In a

powerful turn of phrase, Sue (2011) has frequently remarked that "Whiteness" in our society has become invisible. A first step towards multicultural competence on the part of the therapist is to develop an awareness of their ethnic identity and culture and insight into the biases, assumptions, values, and beliefs that generally accompany that culture. We are all the products of a particular culture and must, as therapists from any cultural background, recognize the ways in which our culture orients and constrains us.

Not grasping the fundamental differences between Western assumptions and those of other cultural perspectives can lead to many unnecessary barriers to effective therapy. For instance, one of the most central of these potential barriers is the emphasis placed on individualism and autonomy in industrialized societies such as the United States. Models of growth and development in these countries tend to stress the need for high levels of individuation and autonomy. Many cultures, such as those of Japan, China, India, and most of Latin America for example, focus much less on autonomy and much more on the ties and duties that bind the individual to the family and society in a collectivistic framework (Markus & Kitayama, 1991). Western models also tend to highlight the importance of emotional self-disclosure, insight, expressiveness, and transparency (Sue & Sue, 2012), whereas many other cultures favor varying degrees of self-control, community mindedness, and interpersonal responsibility.

Psychotherapy is essentially a process of communication, and cultures vary enormously in the rules and practices that govern these acts. For example, cultures appear to differ in habitual practices concerning how much eye contact is considered appropriate and whether this contact is made while speaking or listening (Sue & Sue, 2012), which frequently leads to misunderstandings. Likewise, how much physical space a person requires, the meaning of various head and hand gestures, the signals of deference to age and status, the significance to participants of forms of

verbal turn-taking, degrees of comfort with silence, rules in relation to the expression of emotions, and the amount of acceptable contact between persons of different gender: These are all very significant verbal and nonverbal communication practices that must be harmonized in building a culturally-appropriate, trusting human relationship (Fish, 1996; Sue & Sue, 2012). So one of the most basic requirements of effective feminist-multicultural practice is a minimum knowledge of the various cultures within which one is working with clients.

Another practical difficulty faced by people of color in the North American context is the common belief that we are living in a postracial society. Many view racism as an ugly blight from the past that is now largely behind us. Unfortunately, research has not borne out this perception, though it has shown that the forms racism takes are now more covert for many people. Many White people do not espouse any form of explicit bias, but tests of implicit or unconscious attitudes show that some degree of bias still remains (Dovidio, Kawakami, & Gaertner, 2002). This residual bias, often called aversive or implicit racism, tends to be expressed most in nonverbal behavior (Dovidio, 2009). These subtle, implicit types of racism often are expressed in microaggressions, which by definition are usually invisible to their perpetrator. These are small, everyday verbal or behavioral slights to people of color that can take the form of microassaults, microinsults, and microinvalidations, and which have been shown to affect clinical practice in psychology (Sue et al., 2007). Research on unconscious racism has demonstrated that people absorb racist and other prejudicial messages by living in cultures in which stereotypical imagery and biases are presented routinely (see https://implicit.harvard.edu/implicit/selectatest.html). As therapists, research like this urges us to keep in mind that, even despite our best intentions and work on ourselves, it appears to be impossible to rid ourselves of the biases of our cultures. As a result, our work to increase our

self-awareness and understanding of the influence of systematic biases is never complete.

It can be helpful to consider our spheres of privilege and marginalization and how they interact with those of our clients. Because experiences of marginalization may be subtle and also cumulative, it can be hard to have an awareness of its systemic nature and the toll this can take. For instance, a heterosexual therapist might not be aware of how routinely a gay client is asked to write the name of his wife on therapist forms, has his children directed to speak to their mother, reads newspaper stories that echo heterosexist sentiments, or hears debate about his civic rights. Similarly, it is important to consider how experiences of marginalization interact. For instance, if the gay client was rejected by his family and religious community, he might have fewer resources available to deal with a disability he is also facing. Working to understand the often invisible, systemic, cumulative, and intersectional nature of minority stressors can help therapists to better appreciate the experiences of clients, avoid committing microaggressions, and act as allies and supports (e.g., Carter, 2007; Meyer, 2015; Puckett & Levitt, 2015).

EFT METHODS OF DEALING WITH DIVERSITY: A PROFOUND CONTEXTUALISM

Both humanists (D'Andrea & Daniels, 2012; Quinn, 2013) and feminist and multicultural therapists (e.g., Brown, 2007; Comas-Díaz, 2012) have made valuable advances in considering how their methods can be usefully integrated. Although humanistic approaches have not traditionally focused on examinations of spheres of privilege and marginalization and how they impact clients, they have developed other intrinsic ways of responding to many forms of diversity that are unique strengths when seeking to practice with feminist-multicultural competency.

Because humanistic therapists aim to help clients learn to self-reference and learn to develop their own solutions for problems, they tend to work within the clients' frame of reference. In EFT, clients are guided to attend to their internal experience, make differentiations, and notice shifts that result in integrating distinct emotional experiences and new insights that arise from the clients' own observations and growing self-awareness. Because insights come from *within clients* in a safe interpersonal context, clients can bring into awareness previously unrecognized aspects of their experiences. These experiences might have been unrecognized, however, because they did not fit within the dominant familial or cultural narratives in a client's life or because they were experiences that were socially marginalized and so were fragmented and ignored. Linking intimate emotional and oppressive experiences can help people claim agency and empower them in developing choices.

Also, solutions developed *by clients* with these insights in hand are likely to be culturally sensitive to factors within the clients' own contexts. For instance, a client who notices that she has a sadness and longs for closeness with her mother might decide, in a culture that is less egalitarian and more emotionally expressive, to talk with her mother about these needs and her wish for closeness. In a more hierarchical or less emotionally expressive culture, however, this client might decide to invite her mother to engage in new activities with her or might begin sharing more information with her mother so their relationship gradually grows closer. Because EFT supports clients in generating behavioral options that can fulfill their needs, these choices are likely to be naturally more culturally appropriate.

Although empathic attunement and client-centered problem solving are distinct advantages in working with diverse clients, EFT has limitations as well. One is that it has not addressed as clearly how to engage clients in a process by which they can come to recognize societal stigma as such—especially when this stigma has been internalized and might be out of the

client's own awareness. When clients are not aware of their oppression it can be hard for them to develop solutions that might affirm denied aspects of themselves. Also, EFT does not tend to emphasize therapists learning to situate themselves culturally.

As described previously, this process would entail considering, at a deep level, one's own spheres of privilege and marginalization and thinking about how these might interact with a client's spheres. It would engage therapists in learning about their clients' cultural experiences so they know how a client might respond to their identities and ideas that come into the room while also viewing the client as a unique individual within their culture who may not stereotypically represent their cultural attributes. Although therapists would not be looking for their clients to educate them about their culture broadly, the humanistic comfort with self-disclosure can allow therapists to comfortably discuss issues of cultural difference and similarity. For instance, a useful intervention is to ask clients in the first session of treatment how they feel talking with a therapist who has certain similarities or differences in terms of various identities and backgrounds. It indicates to clients that therapists are open to discussing cultural factors and that they recognize that these factors might influence the therapy process. Even if the client does not indicate initial concerns, it opens a door for future discussion.

Working With a Latina American Lesbian Client[1]

The following excerpt is masked and adapted slightly from the real therapy of a beginning therapist in the process of learning a client-centered approach to therapy from a humanistic supervisor. She is a White, heterosexual therapist, and the client, Carla, is a Latina, lesbian undergraduate student in her first serious relationship with a woman who is living in a more progressive region than her own (in a U.S. Southern mid-sized city). The client's self-generated goals at the beginning of therapy

included better communication within her family, developing an improved group of friends, and a more positive outlook on life. First, we provide an excerpt that does not incorporate a multicultural perspective and, next, we present examples of interventions that could have been helpful in these moments. At this point in this session, Carla has been considering whether or not she should relocate to live with her girlfriend.

Client: Like, so it's a huge step to go, you know, to seeing each other all the time. There's a big difference between going there and actually moving in together. [cut]

Therapist: What's the scary part of being closer to her?

Client: I don't think there is a scary part of it . . .

Therapist: Mm, but I sense hesitation. What's the hesitation?

Client: Just like I said before, I'm just ki-, I kinda feel bad for leaving my sister here . . . But, I mean . . .

Therapist: What doesn't feel right?

Client: But I can't (nervous laughter) plan what I'm gonna do around what she wants to do. So.

Therapist: That's more related to your sister I—I somehow get a sense that it's related to taking a step toward an alternative lifestyle that maybe you're not just quite ready for.

Client: It could be.

Therapist: I mean that's okay. But, that's the hesitation. It's a big step.

Client: The problem is I don't feel like there's any hesitation on (girlfriend)'s part.

Therapist: And so you feel like you're the, the member who's holding back a little. (Client: Right.) But that's okay cause you need to do what is right for you.

In this segment of the session, we can see the therapist moving Carla to explore why she is hesitant about moving to live with her girlfriend. Although the therapist is helping the client to introspect, her discomfort with the clients' emerging lesbian identity is apparent. The therapist uses the euphemism "alternative lifestyle," and avoids saying "being lesbian" and uses "member," instead of "partner" or "girlfriend." These cues of discomfort or avoidance can communicate to clients that their therapist has not done the work of undoing culturally-transmitted heterosexism. Even when they seem subtle to a therapist, they can speak volumes to a client who has to fight for legitimacy in a given arena. These cues reexpose them to messages that convey that their relationships cannot be discussed as openly as heterosexual relationships.

It is for reasons like this that practice guidelines to support therapists in treating clients of different sexual orientations, races, ethnicities, and genders all recommend that therapists engage in a focused process of self-reflection and education—about both their own spheres of marginalization and privilege and those of potential clients (for the American Psychological Association practice guidelines, see http://www.apa.org/practice/guidelines/index.aspx). Because cultural groups may have affirmative language, distinct stereotypes, and ways that they are marginalized, it is incumbent upon therapists to learn about the identities of each client. These guidelines can help therapists to maximize their benefit to their clients and to minimize harm.

In the segment presented, the therapist attributes Carla's hesitation to leave her home and move to a new city to doubts about committing to a lesbian relationship. At this point in the session, the client has indicated some concern about leaving her sister, but there is no evidence that Carla's reluctance is due to being in a lesbian relationship. The therapist introduces this possibility and does not appear to notice or explore the client's

hesitation about agreeing with her. This assumption continues to direct the interventions, as can be seen in the second excerpt.

Client: Right. Like, she just got a new job and like came out a month ago, and like everybody she works with knows she's gay. Like, I mean, she tells me these stories and, like, everybody knows. (Therapist: Mmhmm) Umm, so, like, all of my friends at work know. But, there's just, like it doesn't really come up with anybody else. I'm just, like, I don't know if she's taking that as I'm ashamed of the relationship, but it's not.

Therapist: What do you think that is?

Client: I guess I'm just I don't know how people will react to it. (Therapist: Mmhmm) And I just over think it.

Therapist: And maybe it's partially your own reaction, still, to it.

Client: It could be . . . yeah.

Therapist: I mean, that's part of why it's easier not to push the envelope with your sister, and attending some of the gay lesbian activities cause it, it's you're just not ready

Client: Right. It could be. (Pause) I don't know . . . I just, she tends to take everything, she tends to take a lot of things the wrong way.

Therapist: Ya think she'd take it personal? (Client: Yeah) Think it was more meant with her. (Client: To her directly, yeah.) And that doesn't feel like it's the case for you. It doesn't feel like it has anything to do with (girlfriend).

Client: No, I don't think it does.

Therapist: Mmhmm. I don't get that sense from you. I get the sense that it's still your own personal struggle.

Client: Right . . . But, it's definitely something I'm working on. (Therapist: Mm) Like, talking to people about it.

In this session excerpt, Carla is struggling with her own internalized heterosexism and is expressing concerns about being out in relation to how others will react to her sexual orientation. Instead of recognizing the validity of these fears that are related to social stigma and oppression, the therapist repeatedly attributes the clients' concern to her "personal struggle." Learning to recognize forms of social stigma and how to work with it—in this case with internalized heterosexism (e.g., Puckett & Levitt, 2015)—can allow therapists to become more attuned with their client. Because marginalization only influences people selectively, it can be hard for therapists (or for anyone not in a marginalized group) to recognize the privileges they hold and to fully understand the very real barriers that people in another group face that remain invisible to outsiders. It can be easy to attribute consequences of oppression to clients themselves, as is done here—and this process can be particularly dangerous with clients who have internalized stigma themselves, as it can lead to heightened self-blame and further complicate self-determination. Because clients tend to defer to their therapists' expertise (Rennie, 1994), as is evident in this transcript, they may not be overt about their hesitations and may engage in lines of exploration that might be harmful to them. Therapists need to invite the exploration of stigma explicitly.

In this case, her therapists' consideration should extend beyond Carla's lesbian identity to her Latina identity and the intersecting forms of marginalization that someone with dual marginalized statuses may confront. It may be that being completely out about her sexual orientation would limit the supports she has within her Latina/o community. These supports may be all the more important as Carla might be finding that her ethnic identity limits her support within the lesbian, gay, bisexual, transgender, and queer community. A challenge that people with intersecting marginalized identities often confront is that each identity reduces the resources that might have been available to overcome barriers introduced by another

identity. Depending on the type and severity of symptoms that the client has, she might struggle with an identity as someone with a mental illness as well. Exploring with the client what these identities mean to a client and how they intersect within the clients' context can be necessary to develop a full understanding of a client's experience. For instance, Carla's context as someone living within a socially conservative culture might intensify her experiences with ethnocentrism and heterosexism, and also might influence her relationship with her girlfriend who lives in a more progressive city and might not face or understand these obstacles.

The awareness of the multiple spheres of privilege and oppression and how they intersect can increase a therapist's culturally sensitive empathy—a concept distinct from intracultural empathy as it requires intentionality and education to develop (McDougall, 2002). Because emotion-focused therapists tend to be highly skilled in empathic communication, they can recruit these abilities in the service of cultural empathy. As a recent meta-analysis (Tao, Owen, Pace, & Imel, 2015) showed that clients' perceptions of their therapist's multicultural competencies account for significant proportions of the variance in the working alliance (37%), client satisfaction (52%), general counseling competence (38%), and session depth (34%), demonstrating cultural attunement appears quite relevant to experiential therapists' goals.

Specific EFT interventions that could be indicated when working with a client with a multicultural-feminist awareness could include traditional empty-chair exercises—for instance, empty-chair work with Carla's sister to help her deal with the guilt of potentially leaving. EFT interventions can be adapted to work with stigmatized clients, however. Self-critical work could be adapted so that the self-critic is understood explicitly to be embodying introjected societal stigma and could permit the self to strengthen in the face of these messages. Self-interruptive work could examine how internalized stigma holds back clients' self-expression. Two-

chair work can be used to unpack the impact of oppressive messages. The following transcript illustrates a segment of an exercise that could be used with Carla.

Client: I guess I'm just, I don't know how people will react to it. (Therapist: Mhmm) And I just over think it.

Therapist: It sounds like there is a part of you that is worrying that people might have a poor reaction? (Client: Mhm) I wonder, what is this part worried that they might say? Can you come over here and be that part?

Client: I think you will be laughed at. People will look at you differently. You've worked so hard to be respected at your church, to do well at school. Do you really want to throw that all away?

Therapist: Tell her more about how she won't be respected. How will people see her?

Client: People will see you just as a lesbian. They will think that something is wrong with you, that you are immoral, that you are not trustworthy. They will think you are perverted.

Therapist: I can see your face cringe. These are all messages that you've heard about being lesbian. Can you switch chairs? What is it like for you to hear these terrible attacking messages?

Client: (starting to sob quietly) It hurts me so much. It's terrible. I just feel like curling up into a ball and disappearing. (putting up her arms and hands self-protectively) Just stop; please stop.

Therapist: Yes, yes. The pain is awful. You just want them to stop. Can you say that more forcefully.

Client: (with more vigor) Stop!! I want you to stop this. You're wrong! Who I am is OK!!

Therapist: That's right. Say this some more. Tell her that she is wrong!

Client: This is not true. None of what you are saying is right. Lesbians can be just as moral as anyone else. They can be caring and loving. I will not stop being who I am just because I decide to live with my girlfriend. I am still the same person no matter what anyone thinks!

Therapist: OK. What do you need from this worrying and critical part of yourself?

Client: I need you to leave me alone first of all. Stop attacking me.

Therapist: What else do you want from her.

Client: Support me. I need you to encourage me instead of criticizing me.

As the chair work continues, the therapist can continue to label the internalized cultural stigma as such. Once identified, the client can recognize this stigma more easily when it appears in other people as well as in cultural systems. By acknowledging this process, the therapist also gives the client permission to raise issues related to stereotypes and discrimination that might have been threatening to discuss otherwise. It may create an opening to discuss processes that cannot be processed in other contexts and act to enrich the alliance.

The Case of Kenta

Emotional expression and therapeutic interactions are embedded in and influenced by a particular cultural context. Some research has indicated that Asian clients in the United States and Asian countries preferred expert advice giving and formal interactions in the therapeutic relationship (Paniagua, 2014). Because it is a collectivist culture, public displays of

emotion in Japan, as seen in the following case example, are quite restrictive and often determined by a social order and hierarchy (Iwakabe & Enns, 2012). The nature of emotional experience is more reflective of the role relationship and the context than the internal experience of the parties involved (Markus & Kitayama, 1991). Therefore, it is sometimes assumed that emotion-focused tasks as well as the empathic and emotionally charged relationship characteristic of EFT are not the best option for this cultural group. However, it is important to recognize that when these rules are punitive, they not only define behavior but also can create and maintain dysfunctional defenses against emotions such as shame, fear, and even positive emotions. It is indeed for this particular reason that EFT can be particularly effective in East Asian cultures, as will be demonstrated in this case that took place in Japan.

Kenta, a Japanese married man in his mid-30s, was unemployed at the time when he was referred to psychotherapy by his psychiatrist who treated him with medications for panic disorder and depression for over 6 months, with no positive effect. Kenta succeeded as an insurance salesman by using a very aggressive strategy, however, it had become increasingly stressful. He was overcome with a variety of psychosomatic symptoms: fatigue, dizziness, feeling cold, and sweating. He quit his job and sought something less competitive and taxing. When several interview attempts failed, he became depressed.

Kenta was born into a relatively well-to-do family in a lower income area of downtown Tokyo, where his paternal family owned a successful small business. His life changed dramatically after his father died when Kenta was 3 years old. His grandmother who lived with them became very abusive with Kenta and his mother, who had no choice but to move out to a small apartment next to his poor maternal grandparents. This is when Kenta’s behavioral problems, such as shoplifting, started.

Kenta subscribed to a very traditional masculine gender role. He never disclosed or expressed his “soft emotions” to others, including his wife, and considered emotions to be a sign of weakness; however, he got upset easily and reacted with anger. He relied on impulsive outlets such as gambling, drinking, and spending to cope with stressors. Another problem, that his wife recognized but he did not, was his vanity. He needed to have expensive goods that were beyond their means, placing a financial burden on the couple.

A long-term EFT with Kenta that extended over 5 years, with a few breaks, can be divided into three phases. The first phase (1 year in weekly sessions) mainly focused on emotional awareness and regulation skills. The second phase (3 years in maintenance mode with monthly sessions) involved helping him return to work and manage anxiety. The third phase (1 year) was spent working with core emotional issues within a series of evocative tasks. The therapist was a Japanese man similar in age who had expertise in EFT treatments. He had psychotherapy training internationally; therefore, he had a multicultural perspective on emotions and psychotherapy.

In the first phase, the focus was on building therapeutic relationship, enhancing his emotional awareness, and teaching emotion regulation skills. Kenta had never spoken about his feelings or past to other people, and initially he did not feel comfortable receiving empathic comments instead of concrete expert advice and directives. The therapist validated Kenta’s discomfort about being in therapy and gave psychoeducation or experiential teaching about the role and value of experiencing and expressing emotions (see Chapter 8, this volume, for more details about experiential teaching). It was very important for Kenta to learn that emotions are not signs of weakness. Instead, emotions such as fear and shame have the important function of protecting oneself, while sadness and love connect people, and expressing them in words and experiencing them physically without

blocking or constraining them can be therapeutic. Kenta learned to pay attention to and differentiate physical sensations so that he could name his emotions, which was an important initial step towards regulating them. His gradual investment in the therapy relationship helped Kenta appreciate being listened to and emotionally supported. This was a corrective emotional experience for him.

An initial attempt to use chair work came 7 months into the treatment when Kenta was consumed by resentment toward his father. Visualizing his father in the empty chair immediately evoked an intense feeling. Kenta, tensing up his body with clenched fists, spoke to his father with a shaky voice.

Client: You destroyed my life. You don't know how hard it has been for us. My life is ruined because of you.

Therapist: Tell him how hard it has been for you.

Client: I was the only one in my class without a father. On parents' day, we had to draw father's portrait while all parents were watching. I couldn't even remember what you looked like. It was so embarrassing (clenching his fists even tighter).

Therapist: Breathe. Let's breathe. Feel how tight your fists are.

Client: Yeah. They are so tight. My chest is so tight and it's so hard to breathe.

Therapist: Can we do some more?

Client: Sure. Then my uncles closed down your company, my mother decided to leave the house. We moved out to a dirty tiny apartment. I couldn't accept it. I felt so miserable.

Therapist: Repeat "As a child, I couldn't accept it. I was miserable."

Client: "As a child, I couldn't accept it. I was miserable."

Therapist: What did you want from him?

Client: I wanted you to be near us. I am angry for your leaving me.

Therapist: Tell him what you resent.

Client: I resent that I cannot even remember you well. I want to get close to you but even when I look at old photos of us together, it feels so far away. I wished that you were with me.

As Kenta expressed his resentment, his longing for his father surfaced, which led to grieving. Although he felt some relief from unloading his emotions in the session, he felt very "depressed" as he returned home. In the following week, he visited his mother and expressed how miserable his life was. As his mother, in tears, apologized to him for "making him go through such a hard life," he turned to a Buddhist altar that he had erected for his father and expressed his feelings toward him like he did in the chair work. He was able to shed tears for the first time in his adult life. The incident was deeply transformational. Kenta had insight into the source of his shame and also realized how much he missed his father. The therapist affirmed that Kenta was able to shed tears, because it takes a lot of strength and maturity to allow oneself to cry.

The second phase of therapy focused on his returning to work. The therapist helped the client to get ready for a series of job interviews and use his emotion regulation skills in his daily life. A main focus of therapy was shame regulation. Kenta had a tendency to present himself as larger than life, which put him in a shame provoking position later as he could hardly keep up with the image he created. The frequency of sessions was reduced to once a month as the client felt he was able to manage without therapy. This sparse session frequency, however, made it difficult to introduce deeper emotional work in this phase.

The third phase started as Kenta requested that he wanted to work on unresolved emotions with his paternal grandmother whose death triggered a flood of emotions. At this time, he reengaged in weekly therapy. He was ready to delve into this difficult part of his life. Kenta was engaged in a number of empty chair exercises with his grandmother and his father as well as self-soothing tasks with his childhood self. One of the most productive and transformational experiences came from empty-chair work with his grandmother who would belittle, disapprove, and invalidate Kenta's existence. In the following vignette, enacting the harsh critical and unloving grandmother, he reached his core emotional pain.

Client: (enacting the grandmother) Don't come into the living room. It is ours (his family name), and you don't belong. You don't belong to our family.

Therapist: Again.

Client: (louder and harsher) You don't belong to our family.

Therapist: What is he? Tell him.

Client: (silence) You are not from the same class. You are vulgar. So never enter that room. Okay? You are just a punk from a poor shoe repair shop.

Therapist: Change (Kenta changed to sit in the self chair). What happens? (indicating his chest) What do you feel?

Client: Stomach ache. Like it is being squeezed and squashed. Painful.

Therapist: Tell her that.

Client: My stomach is in so much pain when you say that. I want you to stop. I want you to accept me. (After switching chairs, the grandmother refused to recognize him and the verbal attack escalated. Finally, the therapist asked adult Kenta to change back to the self chair and speak back to her.) You are an adult. You should know better than that. He

(child Kenta) is a child and he needs care. He deserves to be treated as a person. He is a wonderful kid who is hurt and lonely.

Therapist: Yes. Yes. Tell her what she needs to do to protect Kenta.

Client: He needs to be valued, cared, and loved (looking at his child self). There is no love in this house. Just anger and resentment. So much sadness. Kenta, we do not need to stay here. Let's leave this house and build a family with love.

Kenta was firm and assertive in confronting his grandmother. The therapist acknowledged his courage. In this chair work, he vividly felt and faced his maladaptive core shame. As painful as it was to articulate his core shame, he felt relieved to identify the source of his problem. Kenta was also surprised to catch himself saying that receiving love had become even more important. He became aware that his attitudes towards his feelings and himself, and something deep and important in his whole value system had changed.

Kenta was engaged in a series of similar exercises over the course of his therapy. Many of them explored shame evoking episodes in which he felt defective and inferior. Others were associated with loneliness and attachment longing: how he wanted to feel protected and cared for by his mother who was busy working to make a living as a single mother. He enacted a scene at the funeral of his father in which everyone told him: "You don't cry because you are a boy." "You are not sad at all because you are so strong." He was so lonely and scared that all the adults were so preoccupied and afforded him little attention. In an empty-chair work, Kenta expressed these emotions to adults around him and repeated: "I am not an adult. I am a boy. I can be sad but still a boy." He later reflected on what he experienced in this chair work and understood the origin of his gender role. In one of the following sessions, he spoke to his child self: "Love is warm. No need to feel lonely. No need to feel shame." The client

later recounted that accepting and articulating his need for affection and love, which he denied for so long, and the therapist's receiving and fully appreciating its significance was among the most important moments in his therapy. He realized how much shame was associated with feeling the need for affection, not to mention expressing it to others.

As this emotion work had progressed, Kenta's warmer reminiscences of his father and his grandmother started to emerge. Some of the chair work was dedicated to uncovering positive emotions that he blocked off: Kenta learned to allow himself to need love and to be cared for, which led to deep grieving of his loss. Kenta reported experiencing deep transformation. He was no longer fearful of shame and he enjoyed affectionate interactions with significant others. His impulsive behaviors decreased dramatically, and he had maintained his new employment for 3 years. Although neither the social status nor salary matched his desires, he enjoyed his job and was happy to live within his means.

Although EFT is often used as a short-term approach, this longer therapy was organized to develop foundational skills and resiliency before engaging in more emotionally challenging work. Initially, didactic teaching on emotions was coupled with experiential learning in which knowledge about emotion was closely aligned to his in-session experience. Later, empirically derived principles of emotional change guided therapist interventions and tasks within empathic and affirming therapeutic relationship. The therapy allowed him to consider cultural hierarchal structures and to reevaluate his sense of self-worth and comfort with emotional intimacy.

In EFT, therapists need to not only be aware of cultural rules around emotional expression and interactions but also attend to how cultural contexts interact with client's past emotional injuries and his or her protective strategies, preventing an optimal adaptive emotional functioning. Because his beliefs were in accordance with commonly held gendered

notions of emotions, Kenta initially was unaware of how his view of emotions and his coping strategies were exacerbating his emotional distress. He was easily overwhelmed by his impulsivity and somatic symptoms, making him feel vulnerable and weak in spite of the very effort that he made to avoid these feelings. The therapy helped him consider the rules that had become introjected through his familial and cultural experiences, make decisions about the types of relationships he desired, and engage in healing past traumas. It allowed him to arrive at solutions that were uniquely his own and so were embedded within his relational contexts and cultural landscape.

CONCLUSION

This chapter has considered the question of how EFT can be practiced with feminist-multicultural competence, with illustrative case examples. It described why an awareness of feminist-multicultural approaches is essential for EFT therapists in the contemporary international context. Feminist-multicultural approaches can guide therapists to develop an understanding of how their own experiences of marginalization and privilege might interact with their clients' experiences and influence therapy, helping therapists to avoid potential microaggressions and alliance ruptures. In addition, it can provide therapists with a better sense of why their clients might face markedly different challenges in the world, and how their experiences with prejudicial treatment aggregate and build upon each other. Engaging in this work of developing cultural self-awareness and becoming comfortable discussing these issues in therapy can remove the taboo of examining cultural experiences in sessions. This work can help clients to honor their own experiences even when they differ from dominant cultural narratives so that they make choices that work in their lives. Although this chapter provides a useful introduction to these themes, further

readings on practice guidelines with specific client populations are recommended.

Currently, the practice of EFT is expanding to many parts of the world where cultural and societal contexts, as well as the health care systems that surround the practice of psychotherapy, are quite different. In the midst of these varied cultures, a number of adjustments will be made to the structures, processes, and parameters of EFT treatments to better serve the clinical population of a particular society. We recommend that this process not be viewed as a matter of adapting the original theory to a different context, but as creative endeavors to further develop EFT and discover how emotional functioning intersects with cultural practice. The development of a discourse that bridges feminist-multiculturalism and EFT approaches will be central to the therapy's continued growth, both internationally and within North America. This bridge can be built upon the shared values of appreciating the holistic experiences of clients and a commitment to empowering them to make decisions that work in their lives. The integration of these approaches will advance the EFT and create a responsive approach to treatment across contexts.

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[1]The authors verify that they have concealed client identity by disguising details of the case or by combining details from multiple cases.

IV
EMOTION-FOCUSED THERAPY FOR COUPLES

20
EMOTION-FOCUSED THERAPY FOR COUPLES

CATALINA WOLDARSKY MENESES AND JACQUELINE M. MCKINNON

Helping partners in intimate relationships access and express their underlying vulnerable emotions to each other is at the heart of emotion-focused therapy for couples (EFT-C). Developed by Leslie Greenberg and Sue Johnson in the mid-1980s, this approach adopts a systemic view of interactions and sees couple dynamics through the lens of affect regulation. Stemming from the humanistic–experiential tradition, EFT-C considers each couple within their relational context and uses empathy to explore couple interactions, particularly as they occur in the moment while exploring the emotional experience of the partners. In keeping with a systemic view, neither partner is seen as at fault for the couple's problems, but instead their difficulties are understood to be maintained by cycles of negative interaction that need to be changed.

A large number of studies have demonstrated the effectiveness of EFT-C in reducing relationship distress (e.g., Dalgleish et al., 2015; Greenberg, Warwar, & Malcolm, 2010; Johnson, Hunsley, Greenberg, & Schindler,

1999). Additional studies have found EFT-C to be effective in promoting forgiveness in couples presenting with unresolved emotional injuries (e.g., Greenberg et al., 2010; Makinen & Johnson, 2006). Moreover, EFT-C has shown success in treatment of couples presenting with a range of specific challenges including childhood sexual abuse (MacIntosh & Johnson, 2008), posttraumatic stress disorder (Greenman & Johnson, 2012), and terminal cancer (McLean, Walton, Rodin, Esplen, & Jones, 2013).

As mentioned above, Greenberg and Johnson developed EFT-C together; however, over time, differences in their theoretical understanding of EFT-C emerged. Whereas Johnson (2004) viewed couples' functioning primarily through the lens of attachment theory, Greenberg, in collaboration with Goldman, viewed affect regulation as the central force that organizes couples' dynamics (Greenberg & Goldman, 2008), governing three primary motivational systems: attachment, identity, and attraction and liking. This chapter focuses primarily on presenting the theoretical and research developments made by Greenberg and colleagues over the past decade (see Wiebe & Johnson, 2016, for coverage of research findings from Johnson and colleagues). Despite their theoretical differences, it should be noted that both Greenberg's and Johnson's versions of EFT-C remain highly similar at the clinical level as they each rely on the same core interventions, which are outlined in the original text (Greenberg & Johnson, 1988).

MOTIVATIONAL SYSTEMS IN COUPLES

The question of why human beings get involved in intimate relationships is a complex one encompassing a series of factors, one of which is the feel-good factor: It feels good to us to be close to another person and to feel as if this person knows and values us. Even if at times intimacy can be frightening, it is also one of the richest experiences a human being can know—to feel safe, to feel valued, is to feel loved. The

motivation to seek out another person or to withdraw from him or her or to engage in a myriad of behaviors is fueled by how we feel. For instance, we like to feel calm, we experience a sense of satisfaction when our partner recognizes our efforts, and we enjoy the thrill of feeling sexually attractive to our partner. In contrast, we dislike feeling criticized, blamed, or worthless in the eyes of our partner. According to Greenberg and Goldman (2008), motivation is seen as deriving from affect. In the context of close relationships, Greenberg and Goldman argued that motivation works through three primary subsystems: attachment, identity, and attraction and liking.

Attachment

Attachment refers to the sense of security and closeness one experiences with a close other, and it includes the needs for availability and responsiveness from one's partner. Research on attachment was originally focused on the infant–caregiver relationship (Ainsworth, 1967; Bowlby, 1988), and over time it has also been conceptualized as an important process in adult romantic relationships (Hazan & Shaver, 1987). We monitor and appraise events for their relevance to attachment-related goals, such as our partner's physical or psychological proximity, availability, and responsiveness, then adjust our attachment behavior accordingly. For example, to regulate attachment-related anxiety, we either seek more closeness from the other or disengage momentarily to attempt to soothe this anxiety alone. Greenberg and Goldman (2008) considered humans to be fundamentally relational beings that need to feel connected to others, and they proposed that affect regulation is a core motive that leads to attachment. That is, without fear at separation, joy at connection, and sadness at loss, there would be no attachment.

Identity

Another dimension important to human relatedness is the need for self-coherence, self-esteem, and mastery, which Greenberg and Goldman (2008) described as the need for *identity*. It is maintained by recognition and validation from others and as such is considered to be a relational need. There is a sense of satisfaction and pleasure that comes with having our thoughts and feelings recognized and validated by our partner. Conversely, feeling unseen, invalidated, or defined in ways that are damaging to one's identity evokes feelings of hurt, disappointment, and shame. Perceptions of threat to one's identity or fears of being dominated and controlled lead us to impose our view of reality over that of our partner. In other words, when we feel the discomfort of shame that arises when we feel diminished or the fear of loss of control, we attempt to exert our influence or control over our partner (Greenberg & Goldman, 2008).

Attraction and Liking

According to Greenberg and Goldman (2008), satisfaction in relationships is governed by *attraction and liking*—the positive feelings that are generated when people are interested in, like, and feel attracted to their partner. Gottman (2011) referred to this aspect of relationships as the *fondness and admiration system* and considered it central to the maintenance of relationships over time. Without positive feelings, a relationship may function, but it lacks excitement, joy, and expansion, and therefore its longevity is questionable.

DYSFUNCTION IN COUPLE DYNAMICS

Harmony in an intimate relationship can reign when partners have the ability to be aware of their emotions, know how to express these emotions and their corresponding needs adaptively to their partners, and have the

skills to soothe their emotions when their partner is unable to respond in the way they would hope or wish for. When there is a breakdown in any of these areas, frustration builds and is either expressed as secondary anger or not expressed at all, interfering with the spontaneous flow of emotions in the relationship and blocking closeness.

Partners engage in all sorts of behaviors in attempts to have their emotions attended to and corresponding needs met, not all of which are effective. Because one partner's behaviors typically elicit a complementary response from the other partner, over time ineffective attempts at getting these core needs met can result in the couple relating in a rigid, cyclical style that causes distress. For example, a wife begins to feel sad and abandoned after weeks of her husband returning home late in the evening. Seeing that her initial attempts to seek closeness by making a special dinner go unnoticed, she then moves to criticizing him, which propels him to become more distant. He attempts to make gestures of appreciation by buying flowers, which she criticizes as she prefers spending more time with him. He feels inadequate and withdraws in an effort to soothe the sense of shame that becomes activated, which she perceives as abandonment, leading her to criticize him more forcefully although she is actually feeling sad and alone. In this example, we see that each partner's attempted solution inadvertently serves to elicit from the other the very behavior that he or she had hoped to change.

Distinguishing Different Types of Emotions in Couples' Conflict

The aim of EFT-C is to help partners disengage from their negative interactional cycle by having them express the primary vulnerable emotions and unmet needs that underlie their blaming, controlling, distancing, and other hurtful patterns of behavior. This typically invites empathy and validation from the other partner, which gives way to a new way of relating and serves as an antidote to conflict.

Consistent with the emotion-focused therapy model for individual therapy, in EFT-C emotions are considered to fall into one of four categories: primary adaptive, secondary, primary maladaptive, and instrumental (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, Rice, & Elliott, 1993; Greenberg & Safran, 1987). *Primary emotions* can be understood as one's initial gut reaction in response to a situation, whereas *secondary emotions* are often reactions to a primary emotion (e.g., anger at feeling sad). A primary emotion is considered adaptive when it is congruent with the situation and promotes healthy behaviors and coping strategies (e.g., fear in response to an abusive parent). *Primary maladaptive emotions* are instances in which one's gut reaction is incongruent with the situation (e.g., fear in response to a loving partner). Primary maladaptive emotions are often the result of past trauma or unresolved wounds. *Instrumental emotions* are emotions that are expressed to achieve an aim (e.g., crying in order to pull for compassion and comfort). A partner may or may not be aware that he or she is instrumentally displaying an emotion with the purpose of eliciting a desired response from others (Greenberg, 2002).

The EFT-C therapist aims to assess which types of emotions are being expressed and intervene accordingly. Partners are helped to access and express primary emotions and to communicate the needs associated with instrumental emotions overtly (rather than through emotional expression). Secondary emotions are acknowledged but contained with the goal of redirecting partners toward exploration and expression of underlying primary emotions.

Negative Interactional Cycles

In EFT-C, the focus is on understanding how each partner's emotional experience contributes to the negative interpersonal dynamics in the couple. Greenberg and Goldman (2008) conceptualized couple interactions as taking place along two dimensions, which they labelled *affiliation* and

influence. Examples of behaviors occurring across the affiliation dimension range from expressions of love, warmth, and nurturance at one end of the continuum to hostile, indifferent, or withdrawn behaviors at the other end. With respect to the influence dimension, behaviors range from attempts to control, override, or dominate the other on one end of the continuum to submissive, deferential, and yielding behaviors at the other end. Negative behaviors from the affiliative dimension can be understood as counterproductive attempts to manage or shift the dynamics of closeness in the relationship. Likewise, negative behaviors from the influence dimension can be understood as counterproductive attempts to manage or shift the dynamics of power and influence in the relationship.

Negative interactional cycles develop when each partner's efforts to manage or shift the other's behavior inadvertently serve to reinforce the very behavior he or she is hoping will change. For example, the more one partner pursues for closeness, the more the other withdraws in order to protect himself or herself, and the more this partner withdraws, the more the other pursues. As another example, the more controlling one partner behaves, the more the other partner resists his or her influence, and in turn the more resistance this partner shows, the more extreme the first partner becomes in his or her attempts at gaining control.

When working with a couple to identify their negative interactional cycle, the EFT-C therapist frames each partner's problematic behaviors not as personal failings but rather as attempted solutions, which have now become the problem. This framework helps to externalize the blame onto the interaction rather than the individuals, so that rather than attempting to change one another, the couple's focus shifts toward changing their problematic interactional patterns. Greenberg and Goldman (2008) identified attachment- and identity-related needs as being the two fundamental concerns driving negative interactional cycles.

Attachment Cycles

Negative interactional cycles falling into the attachment category are typically characterized by critical, demanding, blaming, or clinging behavior by one partner and defensive, withdrawing, or rejecting behavior by the other partner. Variations of attachment-related cycles include pursue–distance, demand–withdraw, and cling–pull away. Each partner's negative interactional stances may be understood as secondary or defensive reactions used to regulate underlying affect. Beneath the pursuing partner's anger, there is typically primary fear or sadness. Beneath the distancing partner's defensiveness and withdrawal is typically fear or shame.

In this type of cycle, the pursuing partner's behavior is typically driven by a need for greater closeness, security, availability, or responsiveness from his or her partner. When feeling insecure about the extent of the partner's love and devotion to him or her, the pursuing partner may attempt to obtain reassurance through requests or demands that the other partner show greater interest in spending time together, behave more thoughtfully or lovingly, and so forth. Rather than experiencing closeness as soothing or comforting, the distancer may experience closeness as dangerous, potentially leading to boundary intrusion, engulfment, or increased pain in the event of future abandonment. Keeping his or her distance is thus an attempted solution to regulate anxiety and prevent heartache. This may manifest itself as shutting down, responding in an indifferent and detached manner, withdrawing to another room, and avoiding spending time together. This type of behavior is then likely to evoke further anxiety or anger in the pursuing partner, whose attempt to regulate his or her own negative affect may then escalate into angry, condemning, blaming, and attacking behaviors. Although the intention behind the pursuing partner's behavior is to draw out increased levels of engagement and responsiveness in the distancing partner, frequently it results in pushing him or her further away.

Identity Cycles

The most typical negative interactional cycle in the identity category involves dominating or controlling behavior by one partner and deferential and submissive behavior by the other. Those in the dominant position typically make the decisions, define reality, and generally view themselves as knowing what is best or right. Those in the submitting position typically follow, defer, and look to the other for direction. Negative interactional positions in identity cycles can be understood as efforts to regulate self-esteem and identity concerns by attempting to get the other partner to provide things such as validation, respect, and appreciation. Primary emotions commonly underlying the dominant partner's interactional stance are shame and fear. Primary emotions commonly underlying the submissive partner's interactional stance are fear, shame, and anger.

Early on in the relationship, submitting partners typically seek to please their partner and to avoid their disapproval. They may lack confidence in themselves and therefore look to the dominant partner for direction. This type of cycle can go on for years without becoming overtly conflictual. Problems typically arise when the submitter eventually grows resentful of the unequal dynamic in the relationship and begins to resist or stand up to the dominant partner. When challenged, dominant partners may experience their status or sense of self as under threat. They may also experience fear relating to the potential loss of control over their partner. It is difficult for dominant partners to admit to having been wrong or apologize, as for them being wrong is often experienced as akin to being stupid or worthless. Rather than face the sense of humiliation that comes with admitting defeat or acknowledging that they were wrong, they regulate their negative affect by exerting their powers of persuasion or coercion, maintaining their one-up position and their sense of being right or superior. Dominant partners often use intellect and rationality to convince the other that their views or actions are the correct ones. When intellectual arguments

fail to sway their partner, they may then escalate into anger and contempt in order to achieve acquiescence.

Another variation of this cycle involves an overfunctioning–underfunctioning dynamic. Typically, the overfunctioning partner takes on the lion's share of the work, responsibility, and decision making in the relationship as a way of regulating his or her underlying feelings of anxiety. When paired with a partner with underlying feelings of inadequacy and fear of failure, this can lead to a cycle wherein the overfunctioning partner takes on increasingly more, leaving the underfunctioning partner with fewer and fewer opportunities to contribute, which intensifies his or her feelings of inadequacy or incompetency and is likely to lead him or her to rely on and defer to the overfunctioner even more.

For both attachment and identity cycles, helping partners access and express vulnerable underlying emotions such as shame and fear is viewed as key to initiating a more positive cycle of interaction, as these types of emotional expressions tend to beget more empathic and compassionate responses from the other. For some partners in the distancing and submissive positions, accessing and expressing underlying anger in an assertive manner is also important to producing change in the negative interactional cycle.

INTERVENTION STRATEGIES AND STAGES OF TREATMENT

Change in EFT-C is understood to occur not from insight, catharsis, or improved skills but from awareness and expression of primary emotions and corresponding needs. This is considered to be the key to transforming the couple's rigid cycle of relating and bringing partners closer together. The EFT-C therapist aims to help both partners realize that what they typically express to each other are secondary or instrumental emotions, which serve to keep them trapped in their negative interactional cycle.

Helping partners become aware of and express the primary underlying attachment- and identity-oriented emotions (e.g., the fear underneath anger or hostility or the shame or inadequacy underneath contempt) is at the heart of this approach. Much of the work is spent on understanding each partner's underlying vulnerabilities and sensitivities in the relationship and focusing on how these may predate the couple's union (e.g., feeling sensitive to abandonment or to criticism).

The original model developed by Greenberg and Johnson (1988) has been reorganized by both authors. Johnson (1996, 2004) organized the 1988 model into three stages: cycle de-escalation, restructuring of interactions, and integration and consolidation. Greenberg and Goldman (2008) proposed a five-stage treatment model, outlined below. These stages do not proceed in a linear fashion, as some stages are revisited, sometimes there is overlap between stages, and some remain relevant throughout the treatment (e.g., validation and alliance formation stage).

Five-Stage Treatment Model

Validation and Alliance Formation Stage

During the validation and alliance formation stage, a collaborative alliance between the couple and the therapist is established. The therapist validates each partner's emotional pain and creates an emotional bond with each partner (Greenberg & Goldman, 2008). This fosters the safety that is needed for partners to reveal themselves emotionally and process their experiences freely in therapy (Greenberg & Goldman, 2008). In this stage, the therapist also attempts to understand the couple's core issues and how they relate to problems with attachment and identity.

Negative Cycle De-Escalation

The main objective at the negative cycle de-escalation stage is to reduce the emotional reactivity between the partners (Greenberg & Goldman, 2008). Externalizing the couple's difficulties by framing their functioning in terms of a cycle aids with de-escalation as it serves to create distance between the partners and their problematic style of relating. The therapist observes how partners relate to each other, tracking their emotional reactions in the unfolding of the interactions. The therapist also explores each partner's sensitivities and vulnerabilities to understand how these contribute to the couple's interactional cycle. Each partner's position in the cycle is identified and then linked to its likely psychogenetic origins, which often are found in trauma experiences or in the unmet needs of early childhood or past relationships (Greenberg & Goldman, 2008). This allows the couple to reframe their problems in terms of vulnerabilities, sensitivities, and unmet needs rather than character flaws or defects, which helps to decrease emotional reactivity.

Accessing Underlying Vulnerable Feelings

The stage of accessing underlying vulnerable feelings emphasizes the revealing, experiencing, and owning of the unacknowledged feelings that contribute to each partner's position in the interactional cycle. In this way, the attachment- and identity-related needs associated with each partner's underlying emotions are accessed. Generally, blamers need to express fear, sadness, or loneliness, whereas distancers need to express anxiety or anger. Likewise, dominant partners need to express underlying shame, fear, or anger, whereas submissive partners need to express anger, shame, or fear. The interactional pattern in the couple changes as partners disclose their unacknowledged emotions to each other. This usually results in a more empathic, accepting space in which each partner can then ask the other for help getting his or her needs met.

An important skill that an EFT-C therapist must learn in order to help partners access underlying emotions is how to identify blocks to and interruptions of underlying feelings and how to help partners overcome these blocks. If the couple is ever to move beyond talking about their feelings to true revealing, they have to feel safe enough with both the partner and the therapist to overcome their usual avoidance of core feelings and fear of revealing them.

One of the main methods for dealing with interruptions and avoidances is to understand and voice their protective function. Therapist operations that are helpful in overcoming blocks to revealing, especially when an injury or betrayal has occurred or when there is a lot of distrust and vulnerability in one partner, are *reaching in and speaking for* and *focusing on the fear of opening.* Here the therapist needs to make explicit what is being protected and what is not being said and to say it for the partner. It is important to identify the nature of the fear that is organizing the protection. The therapist therefore needs to focus on the fear of reaching out or of letting the other in. The fear may be either of what the other may say or do (e.g., reject, criticize) or of feeling worthless, ashamed, or afraid. Whatever the fear is, the therapist may need to formulate the partner's unformulated experience and say this for the partner. If one partner is having particular difficulty opening up and revealing vulnerability, the therapist may even have that partner say this to the other partner. For example, the therapist might say, "Can you tell him this now? 'I feel vulnerable and I need to protect myself. I just can't let you in right now. I am too afraid.'" Partners' interruptions of emotion, their avoidances or defenses, thus are validated as protective, and the need for them is empathized with and explored until such time as the readiness for change emerges.

Once emotions and needs have been accessed in the session, the therapist promotes the reowning of the previously disowned needs and aspects of self, integrating these into relationship interactions. This is often

done with the use of homework, in which the partners are asked (a) to be aware during the week when these feelings and needs arise and what they typically do when they feel this way and (b) to try instead to reveal their underlying feelings and associated needs to the partner in nondemanding ways as they had in the session.

Restructuring the Negative Interaction and the Self

Responding to the revealed emotions with acceptance and validation is important to restructuring the couple's negative interactional cycle (Greenberg & Goldman, 2008). If there are any maladaptive emotional blocks to the acceptance of emotion based on the receiving partner's sense of mistrust or protection, these blocks need to be accessed, explored, and transformed. Once each partner is able to hear what the other is saying and needs, the restructuring process can progress at a deeper level as the emotional and behavioral patterns have changed (Greenberg & Goldman, 2008). This stage emphasizes the enactment of new ways of being with each other in which partners are asked to turn to each other and express their feelings and needs.

In restructuring the interaction, it is the partners' acceptance of the expressed vulnerable underlying feelings and needs that is paramount, and it is this that sets up a new interaction. When one partner has nonblamingly revealed a primary feeling about an identity vulnerability or an attachment insecurity and the listening partner is unable to respond with validation or caring, attention needs to be turned to what is blocking more bonding and validating responses from the listening partner. This is usually a two-step process. Working with the blocked partner, the therapist helps the client identify and acknowledge that there is a block, which in turn allows the therapist to "hold" and contain the vulnerable partner while exploring what may be blocking the listening partner from responding more acceptingly and compassionately to a revealed vulnerability.

Once acceptance has been achieved, the expression of and response to heartfelt needs are promoted. This is often expressed in an enactment in which the partners turn toward each other and express and respond to each other's feelings and needs. These expressions result in a change in interaction. For example, a blaming partner no longer expresses anger and attacks the other, but instead he or she expresses anxiety and fear of the partner's absence and is able to ask for comfort. The other partner is then able to respond in a different manner, no longer needing to protect himself or herself or withdraw.

Once partners are more accessible and responsive and interactions have been altered, to ensure enduring change individuals may also need to develop their own capacities to self-soothe and transform their own maladaptive emotional responses, often stemming from unmet childhood needs or past traumas (Goldman & Greenberg, 2013). The capacity to self-soothe is also important when the partner cannot be emotionally available or responsive. With less dysregulated couples, restructuring the interaction typically involves first developing more responsiveness to each other. With couples that become highly dysregulated in response to the other's nonresponsiveness or unavailability, the work of restructuring often requires helping partners with self-soothing at an earlier stage of the treatment. (Self-soothing work in the context of EFT-C is outlined in the next section.)

Integration and Consolidation

The aim of the final phase of therapy is to have partners integrate and consolidate their new interactional patterns in daily life. The changes and gains made in therapy are captured in the couple's narrative. Typically, this includes a comparison between the negative cycle that previously characterized their interactions and the new pattern of validating cycles. It may also involve reference to improvements in one's ability to regulate emotion for oneself and to attend to the other partner's emotion, awareness

of one's self's and one's partner's vulnerabilities, and a sense of knowing how to deal with difficulties should they arise (Greenberg & Goldman, 2008).

The therapist encourages the articulation of a new relational narrative as well as self narratives of each partner by eliciting examples of their personal and relational growth. This is a point in therapy in which positive feelings are focused on and their expression is encouraged. The partners are also invited to practice new behaviors involved in their positive cycles. Furthermore, they are asked to identify what they could each choose to do to precipitate the negative cycle if they wanted to return to a more dysfunctional way of relating. This gives them a sense of their own role and responsibility in, and control of, their negative interactions. Finally, the new ability to take a self focus rather than an other focus is emphasized and practiced.

Incorporation of Individual Self-Soothing Work Into Emotion-Focused Therapy for Couples

Recent developments in EFT-C involving further discriminations between attachment- and identity-related concerns have led to the incorporation of individual self-soothing work into EFT-C. Self-soothing is seen as complementing other soothing and a necessary capacity associated with overall healthy emotion regulation (Goldman, 2012; Goldman & Fox, 2010). In couple therapy, the capacity for self-soothing becomes especially important when the partner is unavailable (Greenberg & Goldman, 2008). In addition, in our observations of psychotherapeutic work with couples, we have found that problems or difficulties that can be traced to core identity concerns such as needs for validation or a sense of worth are often best healed through therapeutic methods directed toward the self rather than to the interactions. For example, if a person's core emotion is one of shame and they feel "rotten at the core" or simply fundamentally flawed, soothing

or reassurance by the partner, although perhaps helpful, will not ultimately solve the problem, lead to structural emotional change, or alter the view of the self. In other words, hearing that one's partner will not leave if one chooses to reveal shame about the self may feel comforting but will not lead to healing of the shame itself. However, emotional changes made within the self, such as transforming the shame by accessing a sense of pride and self-confidence that are then witnessed and supported by a partner, can lead to a sustained change in one's view of oneself. This type of change, in turn, feeds back into the relationship as the individual has a more positive view of self and is seen in a new way by his or her partner.

The self-soothing task itself is initiated in therapy when there is a verbal indication that one partner is struggling with issues of self-worth and when reassurance by the partner does not result in change in his or her negative self-perceptions. At this time the therapist may intervene by putting out a hand to represent an "other" aspect of self and ask the person to direct expression toward it (a similar process to what would be done in individual emotion-focused therapy using an empty-chair dialogue). The "other" part of self is best represented as a small, often vulnerable, child. The therapist asks the person to assume the role of an adult caregiver version of themselves and to express compassion toward the small child. The therapist then asks the person to assume, in imagination, the position of the small child and express the experience of being soothed. Finally, the therapist validates and underscores the importance of the needs (previously unmet) of the small child and reflects and validates whatever positive, internalized feelings have resulted from the intervention.

SELECTED RESEARCH EXAMINING MECHANISMS OF CHANGE PROCESSES IN EMOTION-FOCUSED THERAPY FOR COUPLES

Since the development of EFT-C, there has been a strong research focus aimed at understanding how in-session processes are related to outcome. The first intensive task analyses of couples' conflict resolution in EFT-C revealed that *accessing underlying self experience* and *softening of the critic* were central to conflict resolution (Greenberg & Johnson, 1986; Plysiuk, 1985). Johnson and Greenberg (1988) subsequently found that good sessions were characterized by (a) deeper levels of experiencing, as measured on the Experiencing Scale (Klein, Mathieu, Gendlin, & Keisler, 1969) and (b) interactions characterized as affiliative (e.g., disclosing, supporting, understanding), as coded by the Structural Analysis of Social Behavior system (Benjamin, 1974). Moreover, these in-session processes predicted outcome. The sections below detail findings of recent research studies conducted by Greenberg and colleagues, which have focused on furthering our understanding of the role of emotional vulnerability in promoting change in couples receiving EFT-C, as well as of the process of the resolution of emotional injuries via forgiveness.

Vulnerability

Research examining the relationships between vulnerability and session outcome in the context of EFT-C suggests that couples are likely to view sessions in which vulnerable emotion was expressed as being particularly helpful (McKinnon & Greenberg, 2013). Specifically, when partners' ratings of sessions containing vulnerable emotional expression were compared to their ratings of control sessions, the sessions containing vulnerable emotional expression were rated significantly more positively by both partners on a global measure of session outcome. Moreover, those partners in the listening position rated these sessions significantly more positively than control sessions on a measure of unfinished business and a measure assessing how understanding one feels toward one's partner (McKinnon & Greenberg, 2013).

Vulnerable emotional expression in the context of EFT-C has also been linked to greater levels of improvement at final outcome among couples seeking to heal from emotional injuries. McKinnon and Greenberg (2017) examined the proportion of variance in outcome predicted by two hierarchical regression models. The first model consisted of the injured partner's level of observer-rated vulnerability combined with the offending partner's level of observer-rated supportiveness immediately following this vulnerability; the second model consisted of the offending partner's level of observer-rated vulnerability combined with the injured partner's level of observer-rated supportiveness immediately following this vulnerability. Both models were found to predict a significant proportion of the outcome variance on several measures of forgiveness and a measure of unfinished business. Of the four predictors examined, the offending partner's level of vulnerability and the offending partner's level of supportiveness emerged as the most influential. Overall the pattern of findings suggests that the resolution of an emotional injury is most likely to occur when (a) the offending partner shows a high level of supportiveness at those times when the injured partner expresses vulnerable emotion and (b) the offending partner expresses a high level of vulnerable emotion himself or herself.

The following excerpt provides an example of how one of the therapists in this study helped to facilitate vulnerable emotional expression in Susan (the injured partner) and supportive responses from Dave (the offending partner; McKinnon & Greenberg, 2017).[1] In the initial phase of therapy, Dave appeared uncomfortable and would begin using humor and other deflective behaviors at times when Susan began to express vulnerable affect. In the example below, from Session 3, Dave briefly responds directly to Susan's vulnerable emotional expression, but then quickly moves to speaking about how he feels awkward and unsure of what to do or say when Susan is like this. The therapist encourages him to try and stay present with

Susan in these vulnerable moments even though it's difficult, providing him with some guidance and coaching about how he can do this.

Therapist: Uh-hmm. What are you trying to tell him?

Susan: I don't know.

Therapist: I think you know. I mean, not that you know, but your tears know; I mean, they come from someplace very—right, is it that, I think, "I am so hurt by this," right?

Susan (crying)*:* I don't know; I think it's how I'm feeling about myself. (sighs)

Therapist: Right, you just . . .

Susan: You know, not really angry, so much as I'm just hurt that . . . (sighs)

Therapist: Right, "I'm hurt that . . ."—

Susan: (sighs) That I don't matter.

Therapist: Uh-huh, right. Right.

Susan: And I guess it's, it's just the choices that just prove something, I suppose, that . . .

Therapist: Some old place of yours then, right? Like that "I don't matter, and then this made me feel like that was true, and this was a place where I thought that this wasn't true," right? "This is my marriage, and I thought I counted."

Susan: Or maybe I never did think that and (*Therapist:* Uh-huh) . . . and it was just having to, having to face that again.

Therapist: Right, because that was an old wound of yours, right. So like, his betrayal, it isn't really just "you did this, you did that," but it's like "you opened up a deep place of mine that is so deeply painful, where I don't matter."

Therapist (to Dave)*:* So I just want you to take a breath as you hear it because this is different, right? This isn't just telling

you what you did wrong; this is telling you her deep, dark place from her old life.

Dave: Um-hmm. (sighs)

Therapist: Mm-hmm, yeah, follow the sigh, Dave, because that's where a lot of your strength is, in your ability to tolerate this, right? To not have to let the discomfort pull you away. And I think just finding a way to speak into these tears of Susan's, right? Not the ones that criticize you, but the ones that tell you, this very vulnerable place, right? And inside, I mean, I think it looks on your face like it reaches you.

Dave: It's a, it's a very, uhh, you know . . . When she says those things, I feel, I feel very sad. My, uhh, just physically, I just feel really bad. (*Therapist:* Uh-hmm) I just feel, you know, I feel bad for Susan.

Therapist: Can you tell her?

Dave: I, I, no, I do feel bad for you, and I don't know how to, uhh, I feel very awkward in that situation, (*Therapist:* I see) you know, (*Therapist:* . . . that you're doing . . .) because I don't really know, you know, how does one—We've had a couple of situations where we've tried to help each other like this, and it's been very awkward, and I don't know how to do that.

Therapist: Stay in it, though, because . . .

Dave: I don't know how to do that.

Therapist: You're starting; you're trying.

Dave: I try. I don't know how to, though, because I never had that when I was (*Therapist:* OK) growing up, and it always was a very awkward situation.

Therapist: So let me try to help you now, because as you look at her and your own tears come, it's a start, right? (*Dave:* Um-

hmm) It's a start of saying, "I see your pain, and I, and I see, and a part of it, it pains me to have pained you."

Dave: See, this right now is what I was talking about earlier when I said that, you know, I had these opportunities to work with Susan, but I chose not to, probably because it was a fearful place to go, it was an uncomfortable place (*Therapist:* Right) to go; it was, you know, I didn't work these things. I could've.

Therapist: But now, "but it's very hard, and I'm . . ."

Dave: I know it's hard; that doesn't mean you have to avoid it, though.

Therapist: And I'm sort of trying, I'm trying to hold you there now, because when I see her look like this, I see you—that you can attend to her, just by your presence, just by hearing it, and I see that it's awkward, but it's an opportunity to reach, you know, that part that is, I mean, part of it is triggered by you, partly it's an old, hurt place, right? And I see that it's hard to stay there, but for a minute, you kind of get there. (*Dave:* Yeah) It's like, "I wanna stay there, but I get uncomfortable, so I kind of, distract a bit."

Dave: And you know, maybe I have that place, too, perhaps, deep down inside, you know.

Therapist: You do, but I want you to hang on for a sec, and go to hers, so that eventually she can come back to yours.

With continued guidance and coaching from the therapist, Dave was eventually able to listen to Susan's pain without becoming uncomfortable or defensive and moving the conversation in another direction. In an interview with Susan conducted after completion of the therapy, she discussed how helpful it was to have their therapist mediate Dave's usual defensive reactions so that she was able to speak about her unresolved emotions and feel that he was truly hearing her:

Interviewer: So basically I just want to know what your experiences have been like in your own words, whether things have changed for you, what's changed for you, if anything.

Susan: I feel like the therapy came at a good time for us. I think we were ready to reach some kind of an understanding about what happened that certain amount of time has already passed. We have been working on it, in our own level, but having an unbiased therapist to help us through some of the unresolved parts was very helpful. In particular, being able to bring it all out again and having, like, for me, anyway, in particular being heard was important because so much time had passed from the original incident that some things tend to get swept out of the rug, and, it's, like, it's not really proper to always bring it up in conversation or whatever, so there—I guess there was unresolved emotions, so therapy was helpful to resolve some of those emotions for me to be heard by my husband and, you know, in a way, kind of like having my date at court, that I could say what I needed to say and be heard with somebody there to mediate so that there would be no unnecessary reactions or defensive reaction, or if there was, there was, somebody was there to mediate the process, and that was helpful.

Forgiveness

To better understand the subtleties of how forgiveness unfolds in session, Woldarsky Meneses and Greenberg (2011, 2014) used a task analytic methodology. On the basis of their observations of videotaped therapy sessions of six couples (four couples who forgave and two who did not), they developed a model of interpersonal forgiveness, along with a rating system of the observed steps leading to forgiveness (referred to as *components* of the model).

The general sequence that was unique to couples who resolved their injury at the end of therapy began with the offending partner first "assuming responsibility for the emotional injury," then either expressing "shame or empathic distress" or "offering an apology" (these were interchangeable) and, finally, "accepting forgiveness." The injured partner revealed a "shift in the view of the other," which sometimes followed the offender's "acceptance of responsibility" and in other cases followed the offender's "expression of shame" or "apology."

Going Beyond "I'm Sorry"

A central part of the forgiveness process is the apology. In the initial phase of the task analysis of forgiveness, the primary author observed that apologies included expressions of guilt ("I feel bad for what I did"), remorse and regret ("I wish I had done things differently"), empathic distress ("I understand your pain, and it hurts me"), and shame ("I'm suffering because of what I did"). Rather than investigating all of the elements of the apology, Woldarsky Meneses and Greenberg (2014) focused their follow-up research (the validation phase of the task analysis) on the role of shame and its impact on the outcome of therapy. This decision was based on the preference for a well-differentiated and vividly expressed emotional state rather than a microprocess that is content based. This is congruent with the emotion-focused therapy spirit of prizing emotional expression over verbal content, and it was also done for the practical reason that it facilitated measurement (i.e., differentiating remorse from regret from guilt proved to be challenging, as they are closely related concepts).

Working from 205 videotaped segments from 33 couples therapies, and using hierarchical regression models, Woldarsky Meneses and Greenberg (2014) examined the impact of three core components on outcome: the "offender's expression of shame," the injured partner's "accepting response to the shame," followed by an "in-session expression

of forgiveness." They found that the offending partner's "expression of shame" was the strongest predictor of forgiveness posttherapy (accounting for 33% of the variance on the Enright Forgiveness Inventory; Enright, Rique, & Coyle, 2000). This is an important finding suggesting that shame has an adaptive function in the reparation process for couples as it facilitates forgiveness. Whereas much of the emphasis in the literature is on guilt, Woldarsky Meneses and Greenberg (2011, 2014) argued that shame is transformative for couples attempting to resolve an emotional injury.

Facilitating Shame in Session

Therapists working with couples wanting to resolve an emotional injury should aim to have the offending partner express nondefensive responsibility for the injury, tolerate the injured partner's anger, and respond to his or her pain before attempting to facilitate an expression of shame. This is a delicate process that requires the therapist to be highly attuned to the offending partner's vulnerability in expressing shame and to be mindful to not judge or shame the offending partner. Rather than imposing an agenda on the session, the therapist is advised to be fully present to both partners and to the process that unfolds, listening attentively for the offending partner to express remorse or guilt in a self-focused manner, which is the entry into shame. Ideally, the offending partner will disclose how his or her behavior (the injury) has resulted in a profound sense of having let himself or herself down by failing to live up to his or her standards or values. (It is essential that the shame be about the behavior, not the person, because the latter [maladaptive core shame] can derail the process of interpersonal forgiveness as it pulls for reassurance from the injured partner). Slowing down the process is recommended so that the offending partner is in contact with the shame and expresses his or her suffering in a focused vocal quality (see the Client Vocal Quality measure; Rice & Kerr, 1986), such that the offending partner is speaking from his or

her core with a sense of searching and newness (rather than a rehearsed quality). There is a clear sense that the offender feels distressed by and empathizes with the pain caused to his or her partner and that rather than simply making amends, he or she is genuinely suffering by having been the source of this pain. Lastly, the expression of shame is not instrumental (i.e., it cannot be used as an expression of self-flagellation or as an attempt to pull for comfort or to shift attention away from the injured partner's pain).

Below is an excerpt from a therapy with Oscar and Isabel, who participated in the York Emotional Injury Project (Greenberg et al., 2010) wanting to address the difficulties that emerged following Oscar's extramarital affair 4 years earlier.

Therapist: So I know you said that he's apologized many times over this, but I wonder if we can just take a few moments and come back to that. I mean, when you hear Isabel talk about the pain of having felt discarded, what happens for you?

Oscar: It's hard, you know—it's really hard to know that I hurt her so much. (*Therapist:* Mm-hm) I'd rather just move on (*Therapist:* Yeah, yeah, yeah, mm-hm), wish it hadn't happened. I don't know what else to say, but I'm so sorry. I do feel bad, but I've already apologized many times that I'm at a loss for what else to say.

Therapist: It sounds like you're saying it's not easy to find a way or the words to take her pain away. (*Oscar:* Exactly) But can you try; I mean, I know it's—I guess—exasperating to have to revisit this, the apology, but can you try to tell her what it feels like for you inside? Actually, try to look at her; see how she's sitting attentively and looking sad about what happened. What happens when you see her like that?

Oscar: (pause) I don't know. (quiet voice) Um, I—it hurts me to see her so sad. It makes me say, "How could I have been so selfish! to have been so reckless and not realized how it

would hurt her and damage what we worked so hard to build?" (*Therapist:* Mm-hm) and, uh—I'm not proud of those things, I'm actually very ashamed of those things. It's like this dark thing I have to carry with me now.

Therapist: Right, I think the shame is very important; you know, it's not an easy feeling (*Oscar:* Not at all.), but you know, in a way, it's like you're saying what you did then is not what you would do now, or could even imagine.

Oscar: Well, I still can't believe I did it, because (sigh) I had, you know, I swore I would never be like my father, um, and that's a really difficult thing to accept. (voice breaks) Um, I behaved like a bastard. I walked around thinking I would not destroy my family, and now when I see what it's done to us, uh (crying) I just feel so ashamed. (pause) I held these values so firmly, but I betrayed them. I betrayed myself (crying) when I betrayed Isabel, and I'm so very truly sorry. (crying)

Isabel: (inhale) I know you are. It's both comforting and hard to see you like this.

Therapist: Mm-hm, so it touches you to see how he's hurting, too.

Isabel: Yeah, because for so long (voice cracks) it just felt like (crying) he was angry. Like he has apologized, but in his "I'm sorry" and his sadness, there was also, like, resentment that I couldn't just get over it, and this is the first time I'm seeing how it's affected him. (crying) So thank you.

Therapist: Right; it's like you're saying that seeing his suffering is healing. Mm-hm—Oscar, can you tell her what was going on that led you to betray your values?

Oscar: I don't think I was happy. I was very sexually frustrated; I think that was the primary thing that drove me into the affair—something was missing, and I should have spoken to

her about it. I'm now seeing how cowardly I was to have done what I did.

CONCLUSION

Couples in distress can benefit immensely from EFT-C, an empirically supported approach that views affect regulation as the primary force organizing interpersonal interactions. This approach focuses on understanding how each partner's emotional experience contributes to the negative dynamics in the couple, and it aims to transform these negative interactional dynamics by helping couples to access and express their underlying vulnerable primary emotions and needs.

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[1]The authors verify that they have concealed client identity by disguising details of the case or by combining details from multiple cases.

21
INTEGRATING INDIVIDUAL TASKS INTO EMOTION-FOCUSED THERAPY FOR COUPLES

CHARLES EDWARDS AND JAMIE LEVIN-EDWARDS

Earlier therapy models for using emotion-focused therapy with couples (EFT-C) did not attempt to integrate the extensive research on emotion-focused therapy (EFT) with individuals into a comprehensive model (Greenberg & Johnson, 1988; Johnson, 2004). Greenberg and Goldman's (2008; Goldman & Greenberg, 2013) significant update of the EFT-C model presented a theoretical rationale for the importance of integrating individual work into ongoing couple therapy. Our clinical experience, based on using EFT models in long-term therapy, is consistent with this position. Understanding individual EFT tasks and integrating them into EFT-C provides therapists with both a wider repertoire of interventions for deepening the therapy process and critical options for resolving some common impasses in EFT-C.

Although Greenberg and Goldman (2008; Goldman & Greenberg, 2013) emphasized the importance of integrating individual work into couple

therapy, they did not explicate how to achieve this integration or provide a comprehensive list of potential individual therapy tasks. In addition, many therapists who use EFT with couples, particularly those who are trained in the step-based, attachment-focused approach advocated by Johnson (1996, 2004), are not familiar with the individual EFT literature that has evolved over the past several decades. This literature contains both descriptions of individual tasks and research on the emotional change process that underlies both individual and couple EFT. Understanding this evolving and increasingly sophisticated emotional change model facilitates effectively combining individual and couple EFT interventions.

An approach that provides a foundation for integrating the use of individual tasks into couple therapy is needed. The purpose of this chapter is to present a conceptual foundation for integrating individual and couple EFT models that facilitates the use of individual tasks in ongoing couple therapy. This approach evolved from an integration of the individual and couple EFT literature, clinical experience with using individual and couple EFT models in long-term therapy, and experience with teaching this integrated approach to therapists.

This aim will be met in several ways. First, the emotional change process that underlies both individual and couple EFT models is explored, with an emphasis on the importance of understanding and tracking this underlying change process, whether using individual tasks or couple therapy tasks (steps). Second, the fundamental tasks common to both individual and couple EFT, and their importance in long-term therapy, are discussed. Third, we present a comprehensive list of individual tasks that can be used in couple therapy. Finally, we review a range of alternative techniques for using individual tasks that can facilitate brief individual interventions in couple therapy.

INDIVIDUAL AND COUPLE EMOTION-FOCUSED THERAPY: THE UNDERLYING CHANGE PROCESS

EFT-C has evolved into two approaches that both provide research-validated models for working with couples (Lebow, Chambers, Christensen, & Johnson, 2012). Susan Johnson's approach (1996, 2004) uses the original nine-step model (Greenberg & Johnson, 1988), which she later organized into three stages (Johnson, 2004), and focuses on establishing secure attachment as the goal of therapy. Leslie Greenberg and Rhonda Goldman's approach (2008) uses an updated five-stage model, broken down into 14 steps, that focuses on the underlying affect-regulation issues and maladaptive emotion schemes that mediate attachment experiences. Although there are significant differences, both of these approaches evolved from Greenberg's integration, in the early 1980s, of systems theory and relational model perspectives with his earlier work (Greenberg, 2001; Rice & Greenberg, 1984), and they overlap considerably in both theory and practice.

However, differences in language and presentation of critical concepts have obscured the fact that both approaches can be situated within the contemporary relational paradigm, that both use the same model to conceptualize the structure of core conflicts, and that both use the same emotional change model. These differences have also obscured the fact that the same principles underlie both individual and couple EFT. Effectively integrating individual tasks into couple therapy requires understanding these fundamental principles and tracking the underlying change process.

Structure of Core Conflicts

In the 1980s, psychoanalytic theory was revolutionized by the emergence of the relational model, which evolved from earlier work by Fairbairn, Bowlby, Sullivan, and others (J. Greenberg & Mitchell, 1983). As

this paradigm became more prominent, it influenced a wide variety of psychotherapy approaches. All psychotherapies that use these contemporary relational concepts to understand core conflicts, including relational psychoanalytic approaches, third- and fourth-generation brief dynamic therapies (Levenson, 2010), attachment-focused EFT approaches, and modern emotion-focused therapy, maintain that emotional problems stem from conflicts created by internalized patterns evolving from early relationships.

All of these approaches imply that in early development, adaptive emotions and associated needs were met with emotionally misattuned responses. Over time, this interpersonal pattern, with its expectation of misattuned responses from others, becomes internalized. The structure of these internalized schemes involves dyadic patterns in which one aspect of the self is in conflict with another part of the self. One part encodes the original adaptive needs and the painful emotion resulting from misattuned responses, while the other part represents the unresponsive caretaker. In addition, other secondary dyadic internal conflicts, such as self-interruption or self-criticism, arise from attempts to cope with the pain of the original maladaptive pattern. These internalized dyadic maladaptive patterns are described by a variety of terms: transference, internalized object relations, cyclical maladaptive pattern, core conflictual relationship theme, internal working model, insecure attachment, internal cycle, or core maladaptive emotion scheme. In all of these approaches, these internalized patterns are seen as unconsciously influencing moment-by-moment perceptions, emotions, narratives, and behavior. These patterns are also seen as the central mechanism that precipitates and maintains both individual and interpersonal emotional problems.

To clarify a potential misunderstanding, we maintain that the dyadic *structure* of core conflicts is the same in both Johnson's and Greenberg's schools, and the same in individual and couple EFT. However, the specific

relational needs involved in the *content* of core conflicts in the two schools are different. Both schools recognize the importance of secure attachment—that is, the adaptive, internalized expectation that significant others will respond with attuned responses to core relational needs. Johnson's (1996, 2004) monomotivational model focuses on only one core relational need, termed attachment, that involves needs for comfort, connection, and emotional closeness. Greenberg and Goldman (2008) agreed that attachment needs for connection are important but contended that there are equally important core relational needs for the validation of identity. Identity involves needs for control, respect, validation of opinions and experience, appreciation of competence, and support of preferences and choices. Core conflicts involving identity needs have different dynamics and require different interventions.

When using EFT with either couples or individuals, the internalized patterns described in this section, whether termed insecure attachment or core maladaptive emotion schemes, are the primary target of the therapist's efforts to change the client's emotional conflicts and relationship problems.

Emotional Change Process

The underlying model for changing these internalized patterns is the same for both couple and individual EFT. Whether focusing on the higher level concept of "creating secure bonding events" (Johnson, 1996, 2004) or on changing the underlying core maladaptive emotion schemes (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg & Goldman, 2008; Greenberg, Rice, & Elliott, 1993), both approaches are based on the same emotional change model. This change process, first presented by Greenberg and Safran (1987), was elaborated by Greenberg and Paivio (1997) and was further validated by Pascual-Leone and Greenberg (2007). Recent work has continued to elaborate this change model and explore the clinical implications of these refinements (Angus, 2012; Angus et al., 2017; Angus

& Greenberg, 2011; Auszra & Greenberg, 2007; Auszra, Greenberg, & Herrmann, 2013; Goldman & Greenberg, 2015; Greenberg, Auszra, & Herrmann, 2007; Paivio & Angus, 2017; Pascual-Leone, 2009, 2018; Timulak, 2015; Timulak & Pascual-Leone, 2015). Given the importance of understanding this change model, which is the foundation of all approaches to EFT, we present a brief overview of its evolution before summarizing the basic model.

Greenberg and Safran (1987) reviewed the psychological theories of emotion and emotional change used in psychoanalytic, cognitive–behavioral, and experiential approaches. On the basis of this review, they identified particular affective processes and events in therapy that warranted intensive study. They then "[began] the heart of task analysis by generating models of possible change performances . . . and comparing these rational models of change with actual performances in order to construct rational–empirical . . . models of change" (p. 169). Two critical findings emerged from their work.

First, they emphasized the importance of differentially assessing emotion and understanding that focusing on secondary, reactive emotion does not lead to successful task outcomes:

> We are distinguishing three types of emotional expression, because each plays a different role in psychotherapy and change. . . . *It is only primary emotions that aid adaptive problem solving and integrated functioning.* Effective therapeutic intervention depends on accurate assessment. (Greenberg & Safran, 1987, p. 172)

Effective psychotherapy requires using different interventions with secondary and primary emotions. Secondary emotions are reactive, defensive patterns that evolve from attempts to cope with and avoid the pain associated with the original, primary maladaptive emotion schemes. Primary maladaptive emotion schemes encode the original misattuned

responses to core relational needs and the painful experience that ensues. Primary adaptive emotion schemes encode the original adaptive emotions and relational needs with the expectation of an attuned response.

Second, Greenberg and Safran (1987) highlighted the importance of identifying the underlying model of emotional change that produces optimal outcomes in EFT. The most important sequence they identified was a multistep process of allowing and accepting painful (maladaptive) experience that required accessing secondary and maladaptive emotion before then shifting to adaptive states.

Building on Greenberg and Safran's (1987) seminal work, Greenberg and Paivio (1997) elaborated this model of emotional processing that provides a map for the transformation of core conflicts. Conflicts involving defensive, secondary emotion and primary maladaptive emotion schemes are resolved by a three-step process: (a) secondary emotions are explored to (b) access primary maladaptive emotions, which are then (c) transformed by accessing primary adaptive emotions. This model was further validated by Pascual-Leone and Greenberg (2007). This fundamental, three-step model of emotional change underlies all approaches to emotion-focused therapy.

In EFT for couples, this change model unfolds in the following sequence. First, secondary defensive emotion is explored to clarify the generating sequences for interpersonal conflicts (often by focusing on interpersonal negative cycles) and to increase awareness of the underlying primary maladaptive emotions (for Johnson, attachment fears; for Greenberg, core maladaptive emotion schemes of fear or shame). Then, primary maladaptive schemes involving core relational needs about attachment security or identity issues are accessed and aroused. Finally, these activated core maladaptive schemes are transformed by accessing and then expressing primary adaptive emotions and core relational needs to the partner. The partner's attuned responses disconfirm the maladaptive expectations.

In EFT for individuals, dialogues or role plays between parts of the self in conflict are used to explore the internal sequence that generates the secondary emotion embedded in presenting symptoms and to increase awareness of the underlying primary maladaptive emotions. After the primary maladaptive emotion schemes are clarified and aroused, they are transformed by expression of primary adaptive emotions and core needs. The client then accesses new internal resources in a part of the self that can validate assertion of core needs and provide comfort for grief about past unmet needs.

Viewed through the lens of the three-step emotional change process, it is clear that arousal and direct expression of primary adaptive emotion are used to transform activated core maladaptive emotion schemes, whether one is doing individual or couple EFT. In both therapy models, the internalized parts involved in a dyadic conflict are activated and transformed by the use of enactments. In individual EFT tasks, the critical enactment involves a role play or dialogue between parts of the self in conflict; in couple EFT tasks, the critical enactment occurs between the partners. In both instances, the same underlying emotional change process is used to transform the relational dyadic conflicts embedded in core maladaptive emotion schemes. Individual EFT tasks (e.g., for working with self-interruptions, self-critical splits, unfinished business, or self-soothing) or couple EFT tasks (e.g., Step 7 in the nine-step model or Step 11 in the 14-step model) are just different interventions to achieve the goal of transforming internalized maladaptive schemes.

Understanding this concept, that all of these tasks lead the client through the three-step change process to transform core conflicts, is key to integrating individual tasks into couple therapy. This understanding facilitates flexibly shifting between individual tasks and couple tasks (steps) to promote optimal movement through the change model without any conceptual confusion. Using this approach, the therapist tracks both the

client's moment-by-moment experience and progression through the underlying change model; then, based on the markers that emerge, the therapist chooses the next optimal intervention from an expanded repertoire of individual and couple tasks.

BASIC TASKS OF EMOTION-FOCUSED THERAPY

Effectively integrating individual and couple therapy also requires understanding the role of the basic tasks or interventions that are the foundation of both individual and couple EFT, and their relationship to the steps of the couple therapy model. Johnson (1996) grouped three sets of interventions together and named them basic tasks. These three sets of interventions are (a) the alliance and therapeutic relationship, (b) empathic exploration for increasing emotional awareness and depth of experiencing, and (c) restructuring interactions for changing interpersonal patterns. The first two basic tasks, alliance and empathic exploration (which Johnson named accessing and reformulating emotion), are used in both individual and couple therapy; the third task, restructuring interactions, is specific to couple therapy.

Relationship Between Basic Tasks and Steps

The overall map of couple therapy presented in Johnson's (1996, 2004) approach is easy to understand; she used the nine steps from Greenberg and Johnson's (1988) original EFT-C model to provide a clear-cut way to proceed through the therapy process. As noted, her model also includes three basic tasks that are the "tools" used to complete the steps. Greenberg and Goldman (2008) expanded the original EFT-C model into a 14-step model and provided some discussion of basic interventions. However, these authors did not fully clarify the relationship between basic tasks and steps.

In our opinion, this has led to a tendency for many couple therapists to focus on completing the sequence of steps (a step-based model) and not realize the importance of consistently tracking and using the basic tasks independently when they are the optimal intervention.

These three basic tasks (alliance, empathic exploration, and restructuring interactions) are not just a set of tools that are used to complete the steps; they are key aspects of the therapy process and are used independently for significant amounts of time without doing any couple therapy steps. The three basic tasks are the foundation of EFT-C. These basic tasks are the starting point of all therapeutic work; are tracked and used continuously within more complex, higher level tasks (couple therapy steps and individual therapy tasks); and are the baseline that the therapist returns to when other tasks are complete.

Using these basic tasks for extended periods of time is emphasized more clearly in the individual EFT literature. For example, one individual EFT treatment manual noted that when working with depressed clients, “The baseline task of empathic exploration . . . typically takes up about half of the therapy” (Elliott et al., 2004, p. 294). In their book focusing on case conceptualization, Goldman and Greenberg (2015) noted that with fragile clients, it may be optimal to wait 6 to 12 months before initiating more evocative chair work.

Using Basic Tasks

When the optimal intervention requires spending a significant amount of time using basic tasks without focusing on a couple therapy step, this understanding facilitates using these interventions without any theoretical confusion or loss of focus. For example, many couples in long-term therapy need extended work using basic tasks to incrementally increase emotional processing capacities such as emotional awareness and affect regulation,

before being able to move through the initial steps of the couple therapy model and achieve de-escalation.

Repeatedly attempting to complete a couple therapy step when the requisite emotional processing capacity is not present can lead to escalating dysregulation and alliance ruptures. By frequently dropping back to basic tasks to enhance the alliance and further develop critical processing capacities, the therapist can better support these more vulnerable clients in long-term therapy.

Understanding that these basic tasks are the foundation of EFT facilitates using individual EFT tasks in couple therapy. The therapist is no longer trying to awkwardly slot an individual task into a step-based couple therapy model. Instead, the therapist uses basic tasks as the foundation of couple therapy and then, on the basis of the markers that emerge, selects the optimal task to move the therapy process forward. The optimal task can be either a couple therapy task (a step) or an individual task.

INDIVIDUAL TASKS: EXPANDING THE RANGE OF INTERVENTIONS IN EMOTION-FOCUSED THERAPY FOR COUPLES

This section provides an overview of the individual tasks that can be integrated into EFT for couples. Detailed models of these tasks and transcripts demonstrating their use are available in the individual EFT treatment manuals (Angus & Greenberg, 2011; Elliott et al., 2004; Goldman & Greenberg, 2015; Greenberg et al., 1993; Greenberg & Watson, 2006; Paivio & Angus, 2017; Paivio & Pascual-Leone, 2010; Watson & Greenberg, 2017).

Promoting Emotional Awareness and Acceptance

As the therapist works with the initial steps of the EFT-C model to build awareness and acceptance of emotion, a significant amount of this work involves using basic tasks. Three other individual tasks, focusing, empathic affirmation of vulnerability, and systematic evocative unfolding, provide additional options for promoting emotional awareness and supporting the client's acceptance of previously avoided, vulnerable emotional states in this early phase of therapy.

Focusing

Many clients, in response to the use of the empathic exploration task, rapidly achieve increases in emotional awareness and depth of experiencing, which supports their progress through the steps of the couple therapy model. However, some clients who have significant difficulty with symbolizing emotion (i.e., are "out of touch" with their feelings) do not respond readily to empathic exploration. Attempting to continue exploration and deepening of experience when it is not linked to the client's ongoing internal process creates a common therapeutic impasse. Focusing is an individual task that addresses this potential impasse.

Focusing is an important task for clients who have difficulty in forming low-level, evocative symbols (words or images) that link to their internal experience (emotion schemes). The goal of this task is increased capacity to symbolize the preverbal, implicit, somatic component of emotion schemes. The client is asked to focus on his or her unclear or absent felt sense and guided to find possible descriptors or symbols for it. Through interaction with the symbols, the felt sense becomes more precise, and the client is helped to explore what the felt sense is about. The therapist then facilitates consolidation of any shifts in feeling that have occurred as a result of bringing it into awareness and clarifies any meaning linked to the experience. Focusing can be done as a full task early in treatment, and for some clients, it may be an important, ongoing part of therapy. For clients

with some capacity to symbolize, it is more often used briefly within other tasks when the client becomes blocked or stuck.

Empathic Affirmation of Vulnerability

As clients explore their emotions and their internal world more deeply, they may encounter moments of intense vulnerability about facing and sharing experiences that feel deeply shameful. These emotional states present along with a strong reluctance to share associated with anxiety and fear about anticipated judgment. The self is often experienced as deeply flawed and defective or as not deserving empathy and nurturance. The empathic affirmation of vulnerability task provides a map for helping clients stay with, regulate, and accept these painful experiences.

The essence of this task is communicating “what you feel makes sense, and I’m here with you to break the isolation” (Greenberg, 2013). This task involves revealing rather than exploring. Confirming and validating interventions are used, not exploratory interventions. The focus stays on the intense vulnerability and fears related to facing and sharing the newly exposed experience. The goal of this task is to have an experience with the therapist of feeling connected, being accepted, and sharing when vulnerable to counter the fears of judgment and shameful isolation. This connection with the therapist implicitly promotes regulation of painful, previously avoided, overwhelming emotion. The client can then accept the previously avoided experience and tolerate the painful emotions. The task resolves with a strengthened sense of a self that can face, tolerate, and share previously overwhelming experience.

Systematic Evocative Unfolding

As clients become more emotionally regulated and more able to reflect on their contributions to negative interactions, they can start to explore their problematic reactions in more detail. Systematic evocative unfolding (SEU)

is a task for exploring reactions that maintain negative interpersonal cycles and for increasing awareness of the underlying maladaptive schemes that trigger these reactions (Greenberg et al., 1993; Rice & Greenberg, 1984). All therapists trained in EFT implicitly explore these reactions, but many EFT couple therapists are not aware of the SEU task. The description of SEU in the individual EFT treatment manuals and Greenberg and Goldman's (2008) detailed discussion of the use of this task within couple therapy provide a precise, clear-cut task model for doing this critical exploratory work.

Systematic evocative unfolding is used to build awareness of core maladaptive schemes that trigger dysregulated reactions. It involves a detailed, step-by-step exploration of an incident to find the trigger for the emotional reaction and the meaning associated with this trigger. SEU starts with a vivid evocation of a problematic situation to bring it alive in the session. The client's processing is then slowed to facilitate differentiation of his or her emotional reaction to the stimulus or event. In the process of linking the reaction with the details of the experience, the client gains awareness of the previously implicit meaning of the problematic reaction and situates it within a coherent narrative. In the early stage of therapy, this awareness is then shared with the partner and often contributes to understanding the couple's negative cycle. In the later stages of therapy, SEU is often a gateway task that leads into work on transforming core maladaptive schemes.

Transforming Core Maladaptive Schemes

In the later stages of therapy, after sufficient emotional processing capacities have been developed, individual tasks can provide more options for evoking and transforming core maladaptive emotion schemes. As discussed previously, core conflicts are internalized in core maladaptive schemes that manifest in both internal conflicts between two aspects of the

self and interpersonal conflicts between the two partners. Both couple therapy models have a specific step focused on evoking and transforming these core maladaptive schemes. The maladaptive schemes are evoked, the client then accesses adaptive relational needs, these are expressed to the partner, and the partner disconfirms the maladaptive expectations with attuned, accepting responses. In this task, the client's maladaptive schemes are evoked and transformed in enactments with the partner.

If repeated use of this couple therapy task does not sufficiently transform core maladaptive schemes, there are no other options available in the original nine-step couple therapy model. A common impasse occurs here when some individuals in long-term EFT-C continue to struggle with strong maladaptive reactions, even after their partners are responding with attuned responses that disconfirm core relational fears. In the later stages of therapy, these individuals report feeling that their partners are much more responsive to core relational needs and that this helps significantly. However, they still experience strong problematic reactions, indicating that their core conflicts have not been fully transformed. Interpersonal enactments with the partner that focus on other-soothing, which is the only intervention available in Johnson's (1996, 2004) nine-step attachment-focused EFT-C approach, are not always sufficient to transform core conflicts.

Greenberg and Goldman's (2008) 14-step model includes an additional step focusing on individual work. Individual EFT tasks for transforming the individual's core relational conflicts and self-soothing issues can often help resolve these impasses. These individual EFT tasks use enactments or dialogues between two different self-organizations or parts of the individual's personality. There are four individual tasks for transforming core maladaptive schemes. These tasks address issues with self-interruption conflicts, self–self conflicts, self–other conflicts, and self-soothing deficits.

Self-Interruption Conflicts

Self-interruption of emotional experiencing or expression is a critical emotional processing issue that is targeted in EFT. Self-interruption occurs when one part of the self interrupts or blocks emerging emotion or experience that threatens the stability of the self. Self-interruption can emerge from negative beliefs about experiencing and expressing emotion, from the need to ward off the pain associated with core maladaptive schemes, or from specific fears embedded in core maladaptive emotion schemes. Markers for this task can occur early in therapy as the EFT therapist overtly focuses on emotional experience or at any point when new experience, previously avoided emotion, or maladaptive schemes emerge. Also, this task can be a major focus in therapy involving emotional trauma, when schemes involving avoidance and emotional overcontrol originally protected against overwhelming, shattering experience but now interrupt productive emotional exploration.

The two-chair task for self-interruption splits provides a map for helping the client become aware of and overcome maladaptive interruptions. The therapist first directs awareness to the self-interruption and highlights the two parts of the self in conflict—an interrupting part and a part whose experience is blocked. The two parts are differentiated and heightened; enactments are then used to bring the two parts into contact. As this dialogue evolves, there is a gradual shift from secondary, reactive fears and the need to interrupt, to allowing the blocked emotion to emerge. The initial goals of this task are increased awareness of how the interruptive process blocks emotion, increased agency (the interruptive process is owned), and awareness of the specific fears that trigger the block. Over time, the maladaptive self-interruption scheme is reorganized, and the task resolves when the blocked experience is allowed, accepted, and expressed.

Self–Self Conflicts

Conflict between two self-organizations is another issue associated with core maladaptive emotion schemes that is targeted in EFT. Markers for self–self conflicts emerge when one part of the personality manifests negative emotions and narratives involving judging, criticizing, or threatening another part. In depression, this conflict often involves a harsh, negative, contemptuous, judgmental critic. In anxiety, it often involves a critic who scares the other part by emphasizing inadequacy and predicting catastrophic outcomes.

The therapist first directs awareness to the conflict and highlights the two parts in opposition. After the two parts are heightened and differentiated, they are brought into contact with a two-chair dialogue. As they interact, the sequence in which the critical part generates secondary, defensive emotion is explored. As the critic and experiencer become more differentiated, the therapist tracks, heightens, and leads the client into the underlying primary maladaptive emotion scheme. These schemes often involve fear and anxiety about attachment security or shame about identity issues.

After heightening and exploring the core maladaptive emotion scheme, the therapist then leads the client into primary adaptive emotion. As adaptive emotion emerges, the focus shifts to expression of core relational needs to the critic. Expression of specific needs further activates and consolidates the emerging adaptive emotion scheme. Finally, the therapist facilitates reflection and the creation of new narratives to further consolidate the new experience. The task resolves with a softening of the critic and integration between the two self-organizations or in boundary setting and limits by the experiencer if the internalized critic remains harsh.

Self–Other Conflicts

Conflict between two internal organizations, one experienced as self and one experienced as a significant other, is a third emotional processing

issue associated with core maladaptive emotion schemes. In this task, the client is able to experience, express, and resolve unfinished emotional business with significant others. The task may focus on issues with current others or may directly focus on issues with early caretakers.

First, the other person is imagined to be sitting in a chair across from the client. The experience of the imagined other is heightened until the client makes emotional contact with the other. The client starts the dialogue by expressing the unresolved feelings. When the other first responds, it is usually a reenactment of the original, hurtful, unattuned behaviors and attitudes. Initially, secondary and primary emotions in both the self and the other part are often experienced and expressed in a global, jumbled, fused manner. Over time, as the dialogue unfolds, the experience of both self and other is differentiated into more detailed, specific, primary emotions. After the parts are differentiated and the core maladaptive scheme is activated, the therapist leads the client into primary adaptive emotion and tracks emerging core relational needs. The therapist heightens, validates, and facilitates expression of these unmet needs and limits to the other.

At each step of growth and partial resolution in this task, reflection and the creation of new narratives are facilitated to consolidate new ways of being in the world and a new, more adaptive identity. Over time, the task resolves with one of two different sequences. In integration, the part that represents the other person softens. The other becomes responsive to the self’s expression of adaptive, protective anger and validates unmet needs, expectations, and limits. The self can then safely express adaptive sadness about losses and unmet needs and receive attuned responses from the other. If the other does not soften or past actions have been too abusive, the task resolves with boundary setting and limits. The self accesses adaptive, protective anger, and a shift in power from the other to the self occurs. The other is confronted and held accountable for inappropriate behavior.

Self-Soothing Deficits

As the importance of self-compassion and internalized self-soothing for affect regulation becomes increasingly clear, EFT has developed a task to address deficits in this capacity. It is used when critical parts in self–self or self–other dialogues are so harsh that the experiencing part cannot access adaptive emotion and becomes overwhelmed. It is also used to develop a nurturing, compassionate internal part for clients with a history of abuse or emotional neglect, who have little or no internalized compassion or self-nurturing. This task, in combination with affective attunement provided by the therapist, facilitates the internalization of self-soothing and self-compassion capacities that may have been absent in the client's developmental history.

The task starts by having the client imagine someone in the other chair who deserves empathy. This may be a generic child or a close friend who is imagined to be struggling with issues similar to the client. The therapist evocatively heightens the pain this vulnerable individual is experiencing, incorporating poignant aspects of the client's own history. The client is then guided into an empathic, compassionate response to this suffering. Following this, the client is asked what the child needs and what he or she can give the child that would help. After the client has been able to offer soothing and compassion to the generic child or friend, the therapist transitions to having the client imagine his or her self as a child in the other chair, and then respond to that child in the same compassionate, protective way. The client then shifts and explores the new experience of receiving compassion, protection, and soothing. Finally, the therapist facilitates the creation of new narratives to consolidate a new identity (vulnerable parts deserve and need compassion and protection) and a new experience of being in the world (others and parts of self can meet these valid needs). The task resolves over time as the newly generated self-soothing emotion scheme (part) is internalized and consolidated.

In summary, individual EFT tasks offer additional options for accessing emotion and facilitating productive emotional processing in the early stages of couple therapy. These tasks also offer a wider range of options for transforming core conflicts in the later stages of couple therapy.

ALTERNATIVE INTERVENTIONS

Two-chair enactments are the primary interventions in individual EFT for transforming core maladaptive schemes. However, a number of alternative interventions for enactments have evolved in modern EFT practice that provide a wider range of options when using individual tasks. These options can facilitate flexible, brief individual interventions in couple therapy when using the underlying change model to guide interventions.

These alternative interventions combine varying amounts of guided imagery, verbal enactments, and reflection. Although the interventions are discussed in different treatment manuals and articles, there is no organized, detailed presentation regarding their use in the literature. There is also no established terminology for these interventions in the EFT literature.

Greenberg referred to the use of imagery for alternative interventions in several treatment manuals. Guided imagery, in which the whole process unfolds in the client's imagination, can be used to reduce arousal in a task if the client has affect regulation issues—for example, using imagery for the self-soothing task (Greenberg & Watson, 2006). Paivio and Pascual-Leone (2010) described another alternative technique for working with clients with trauma. This intervention guides the client through the unfinished business task using interventions ranging from imagining expression and reactions to having the client express emotions to the therapist when it is too threatening to express them directly to the imagined other.

Research by Paivio, Jarry, Chagigiorgis, Hall, and Ralston (2010) suggests that alternative interventions can be as effective as two-chair work

if the therapist keeps a sustained focus on the task and uses the underlying change model to guide interventions. The ability to track the emotional change model while doing individual tasks, combined with the use of alternative interventions, promotes a more flexible therapy style. The therapist can adjust interventions on a moment-by-moment basis to help clients move into productive emotional processing and productive emotional states without exceeding their affect regulation capacity.

In contrast to the traditional two-chair dialogue, which always involves physically shifting between two chairs, these alternative interventions can vary across the following dimensions:

- evocation of the imagined other:
  - If arousal is lower, some time may be required to create an image that evokes emotion.
  - If arousal is high, the other can be evoked with a gesture and a brief intervention—for example, “Can you imagine your mother sitting over here and say that directly to her?”
- location of the imagined other:
  - The imagined other is in a chair in the room.
  - The other is in an imagined scene that is modified to provide more boundaries or protection for the self.
- mode of expression:
  - Experiences are expressed verbally to an imagined other in a chair.
  - Experiences are expressed only in imagination—for example, “Can you imagine saying ___ to him? . . . Say it to him. . . . What happens inside as you say that?”
- target of expression:
  - Experiences are expressed directly to the imagined critic or other.

        - Experiences are expressed to the therapist—for example, “I’m with you. It’s too scary to say that to him; can you say that to me?”
- number of roles in a chair:
    - One role occupies a chair throughout the dialogue.
    - Multiple roles occupy a chair as the therapist shifts tasks and moves through the steps in the change model.
- exploration of the critic or other role:
    - The dialogue shifts between the self and other.
    - Experience is expressed and explored only from the experiencing or self role.
- length of sequence:
    - An ongoing dialogue is maintained for an extended period of time.
    - One expression is directed to the imagined other, and then the internal reaction to that expression is explored.
- therapist interaction with the enactment or dialogue:
    - The therapist allows spontaneous or multiple exchanges before intervening.
    - The therapist is involved in leading or reframing almost every exchange.

Traditional two-chair work, in which the client physically changes chairs, can be done within couple therapy, but the therapist does not always have to use an extra chair for individual tasks to be effective. Understanding these alternatives to traditional two-chair work provides the therapist with a more flexible repertoire of options to evoke emotion, facilitate expression, and lead the client into the next, optimal emotion state. These options permit brief intervention sequences, don’t require setting the stage, are easier to introduce early in therapy, and facilitate the integration of individual tasks into ongoing couple therapy.

CLINICAL APPLICATIONS

The brief examples that follow suggest some possibilities that emerge from the approach presented in this chapter. As noted previously, the self-soothing task can be done in imagination rather than using chairs to reduce arousal if the client is struggling with affect regulation issues or feeling overwhelmed by a severe negative cycle. Protective responses that emerge from the self-soothing task will often clarify core relational needs and can segue into couple therapy enactments. Self-soothing interventions can also be used very briefly without switching chairs to increase compassion for a vulnerable part or entitlement to adaptive emotions, before shifting to confronting an internal critic or expressing adaptive needs to a partner. If, in an enactment with a partner or a part of self, direct expression becomes too threatening, the client can be directed to express the experience to the therapist to decrease arousal and increase safety. Finally, the unfinished business task can be done without switching chairs. The vulnerabilities and relational needs that are clarified in this task can often lead to more differentiated, nuanced enactments with the partner that help resolve the client's conflicts.

The following paragraphs describe a more complex intervention sequence with some prototypical interventions that demonstrate the approach presented in this chapter. A series of individual tasks were used, but the client never changed chairs. The work proceeded smoothly because the therapist tracked the steps in the change model and strongly evoked each role that was imagined.

A client in the later stage of couple therapy was struggling with why she kept "spinning and shutting down," even though she experienced her partner as becoming more responsive and supportive. When exploring a specific incident using systematic evocative unfolding, it became clear that the secondary, obsessive worrying was generated by an intense self-critical process.

Because several interpersonal enactments using the couple therapy task to transform this conflict had already been done, the therapist opted to use the individual task for working on self-critical conflicts. As the client's internalized critical statements were heightened and became more overt, the therapist gestured to a chair across from the client and said, "Can you put yourself in that chair and say those harsh criticisms directly to her?" After the critic expressed this hostile, judgmental position, the client was asked to shift roles: "Can you imagine yourself over there now? What happens inside when this critical part talks to you this way?" After working with the client for several exchanges, it became clear that she was collapsing back into secondary emotion and could not access any primary adaptive emotion to assert herself with the critical part. Because the goal at this point in the emotional change model was to access primary adaptive emotion, the therapist shifted tasks to continue pursuing this goal.

Knowing that this client was very loyal to her close friends, the therapist switched to the self-soothing task by saying, "If your best friend was sitting in this chair, struggling with these painful feelings, and someone was saying these critical things to her, how do you think she would feel?" The client easily empathized with her friend's feelings, so the therapist shifted to the next step: "And what would you say to your friend now? How would you protect her?" The client accessed a burst of protective anger and spontaneously shifted to talking directly to the critic, confronting the lack of caring and the emotional impact of the harsh comments. The therapist kept the roles in the enactment clear and heightened the current emotion: "The critic's over in this chair right now. Can you say more to that critic about how this treatment hurts your friend?"

Once primary adaptive emotion had been accessed, the therapist transitioned back to the task for the self-critical conflict: "This critical part over here treats you the same way. Can you tell your critic how it makes you feel?" The client was now able to adaptively express both limits (the

criticism was hurtful and not appropriate) and the painful impact of the critic's attacks (it shut her down, and she couldn't assert herself or reach for support). After several exchanges, the critic started to soften, and the client became more empowered and lively. The therapist ended the individual work by exploring and consolidating the change: "What happens inside as you push back on your critic?" and "How do you feel about yourself now?" Finally, the therapist returned to couple work by structuring an enactment in which the client shared these new, more nuanced and differentiated experiences with her partner and facilitated their mutual exploration of the new emotions and new narratives generated by this work.

CONCLUSION

This chapter has outlined an approach for integrating individual tasks into couple therapy that emphasizes the importance of understanding two fundamental concepts in emotion-focused therapy. One concept involves the emotional change model used in EFT and the nature of the core conflicts that this model targets. We emphasized that this change process underlies both individual and couple EFT, whether the approach focuses on establishing secure attachment or on transforming the underlying core maladaptive emotion schemes. The second concept involves the basic tasks common to both individual and couple EFT. These interventions are the foundation of all therapeutic work in EFT. Therapists who understand these two concepts and use this approach with couples have access to a much larger repertoire of interventions to help their clients access critical emotions and resolve their most painful conflicts.

This approach also emphasizes constantly tracking the emotional change model and using it to inform the choice of specific tasks or steps. Recent research in individual EFT has elaborated this change model into a more detailed process that describes 10 critical emotion states that can be

reliably identified (Pascual-Leone, 2005; Pascual-Leone & Greenberg, 2005) and delineates how these states unfold in a specific sequence associated with optimal outcomes in therapy (Pascual-Leone, 2009, 2018; Pascual-Leone & Greenberg, 2007). Another complementary change model that describes the sequence of narratives associated with optimal outcomes (Angus, 2012; Angus & Greenberg, 2011) has been recently refined by further research (Angus et al., 2017). This new model identifies optimal sequences of 10 specific narrative-emotion states. The extrapolation of the clinical refinements emerging from these new change models (e.g., Paivio & Angus, 2017; Timulak, 2015; Timulak & Pascual-Leone, 2015) into work with couples will be an important contribution to the future evolution of emotion-focused therapy for couples.

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22
MASTERING THE INTERVENTIONS OF EMOTION-FOCUSED THERAPY FOR COUPLES

BRENT BRADLEY

Leslie Greenberg and Susan Johnson (1988) are the coauthors of emotion-focused therapy for couples (EFT-C). For years they collaborated to establish, research, and publish the new couples approach. Since the late 1990s, however, they have largely written and developed the approach separately, as noted in Chapters 20 and 21 of this volume. This chapter integrates both Greenberg's and Johnson's intervention contributions through the years into one larger whole. It is impossible to list and explain all of them, so the focus in this chapter is on key interventions—the ones most often used in EFT-C.

AN EMOTION FOCUS

EFT-C revolves around entering into primary emotion and forging new experiences between couples in session (Greenberg & Goldman, 2008;

Greenberg & Johnson, 1988; Johnson, 1996). That's the power of the approach. It's the up-and-running, live emotion in session that generates powerful change.

The very first process study on EFT-C (Johnson & Greenberg, 1988) found that the presence of partners experiencing primary emotion and sharing these with each other via in-session enactments did in fact mediate success in the approach. Greenberg, Ford, Alden, and Johnson (1993), in a study of in-session change, found that peak-session conflict interaction was deeper in level of experience and more affiliative than the interaction in poor-session conflict episodes. In addition, events beginning with intimate, affective self-disclosure by one partner were found to involve greater affiliation in spouses' responses to the self-disclosure than in a control event not involving self-disclosure. In addition, Johnson and Talitman (1997) found that couple participation in experiential tasks predicted success. More recently, Bradley and Furrow (2004, 2007) examined the moment-by-moment process of change in blamer softening events. These authors found high levels of experiencing in successful events versus markedly lower levels of emotional experiencing in an unsuccessful softening event.

Change in this approach is not in *talking about* emotion. It's about *being inside of* the emotion, so to speak. It's not talking about the negative arguing cycle, attachment, or identity. It's not really about steps and stages of the model. Sometimes these peripheral items can get in the way of the bull's-eye: eliciting and processing emotion. For effective and powerful change in EFT-C, it is, and always will be, centered in following the yellow brick road of emotion (Furrow, Johnson, & Bradley, 2011).

FROM LEARNING TO INTUITION

Salvador Minuchin and Charles Fishman (1981), pioneers in family therapy, believed that interventions within an approach need to be learned in depth, and then forgotten. By *forgotten,* they really meant *internalized*. This is the result of mastering interventions.

EFT-C interventions are vehicles into emotion. They aid in learning how to get to and how to process emotion. But they must be learned and implemented to the point of becoming akin to muscle memory. Once in muscle memory, they are used naturally without thinking specifically about them, just as the basketball player, for example, doesn't have to consciously think "take two steps, jump with the left leg, shoot off the backboard with the right hand" when running to shoot a layup. Once in muscle memory, it becomes about feel.

As in most approaches, there are times when the therapist educates, normalizes, and gives insight. But the majority of time spent in EFT-C is centered on experiencing or feeling emotion—for both the clients and the therapist. The emphasis has mainly been on the couple feeling primary adaptive attachment- and identity-related emotions. Less has been written about the therapist feeling emotion in session as compared with client experiencing, but the therapist's feeling emotion and then using that to help guide the process are also important (Furrow, Johnson, & Bradley, 2011).

Furrow, Edwards, Choi, and Bradley (2012) demonstrated that an EFT-C therapist's emotional presence and corresponding evocative vocal quality were more likely to predict heightened levels of client emotional experience in successful softening attempts. Empathic conjecture, for example, is a staple of this approach (Greenberg & Elliott, 1997). Empathic conjecture demands that the therapist use personal hunches or ideas—ones anchored in current in-session emotional experiencing of the therapist—to help clients take a step forward into their own emotional experience. Research has shown that EFT-C therapists rely on empathic conjecture to successfully

navigate through the vital blamer softening event (Bradley & Furrow, 2004).

To master this approach, the EFT-C therapist must work and practice to the point at which interventions are committed to muscle memory. Before this is possible, however, the specifics must be learned by conceptualizing, studying, practicing, and repeating. The rest of this chapter aids in this process of making the implicit explicit.

INTERVENTIONS THEN AND NOW

Interventions in EFT-C have been described slightly differently through the years, but the key interventions remain similar. In her initial stand-alone book on EFT-C, Johnson (1996) brought forth a heavier emphasis on adult attachment. This emphasis found its way into how reframing and other interventions were described compared with the original EFT text (Greenberg & Johnson, 1988).

In 2008 the approach went through another developmental leap. Greenberg and Goldman (2008) published a volume on EFT-C that proposed a five-stage, 14-step model. The book emphasized the important conceptualization of maladaptive primary emotion work in couple therapy, which is not recognized in Johnson's writings to date. The authors also added the importance of identity and the underlying emotion of shame in their updated EFT-C text. In part a reflection of their work in the EFT for individuals model, the couples model increased its focus on each partner's individual self, rather than relying solely on attachment when viewing roots of distress in intimate relationships. To this end, Goldman and Greenberg (2013) developed the intervention of self-soothing that can be used in addition to partner soothing and is particularly helpful when working with shame in the context of couples therapy.

Maladaptive primary emotions are those old, familiar, bad feelings that occur repeatedly but have outlived their usefulness and now keep people stuck. These often arise from past traumatic learning and attachment- and identity-related injuries that include fears around

- abandonment,
- engulfment,
- criticism,
- shame at feeling worthless,
- feelings of not being good enough, and
- explosive anger that destroys relationships.

When a client was young, for example, and treated poorly by his father, in his fear he would duck his head and attempt to appear smaller and protect himself. Now that he is older, however, such behavior is out of context in communications with his partner. His partner does not understand how he can get afraid when she just wants to engage in an important conversation with him. Unfortunately, he doesn't understand why he gets afraid, either. He knows in his head that his wife is not threatening him, nor is she someone to fear, but too often his fear surfaces in certain situations. It makes little sense to either of them, and it derails some of their serious discussions.

His primary emotion in the current context is maladaptive fear, cemented in from his past. The key is to loosen that cement by finding other primary emotions that have always been there but have been shut down from his awareness by the consuming nature of the original fear. Once that cement is loosened, other primary emotion is allowed to surface that frees him to function out of healthy and current primary emotion in the context of his adult interactions.

THE PROCESS THEN AND NOW

The original framework of EFT (Greenberg & Johnson, 1988) was broken into nine steps. Johnson (1996) later organized the steps into three stages: negative cycle de-escalation, restriction of the negative interaction, and consolidation and integration. More recently, Greenberg and Goldman (2008) expanded this into a five-stage framework with 14 steps. The additional steps were added to integrate a deeper psychological understanding of individual self-change and process with the existing relational, cycle-change emphasis. The five stages of EFT-C are now validation and alliance formation, negative cycle de-escalation, accessing of underlying emotions, restructuring of negative interactions, and consolidation and integration.

The overarching goal of interventions in EFT-C is to show empathy, identify and deepen primary emotion, and process primary attachment- and identity-related emotional experience between partners to restructure the relational bond. The therapist is always thinking relationally, which is outwardly evident by the “inside and then in-between” intentional flow of interventions.

Bradley and Furrow (2001) created the EFT Coding Scheme for use in research and training. This coding scheme was designed to identify the use of EFT interventions following criteria from existing descriptions of EFT interventions and tasks (Greenberg & Johnson, 1988; Johnson, 1996). These and the newer intervention writing of Greenberg and Goldman (2008) are included in the list and descriptions below.

Three Primary Tasks

The following tasks provide the overall structure from which all EFT interventions stem. The therapist is consistently operating from these three tasks throughout the process of therapy. The specific interventions are tools that help carry out these primary tasks.

Creating and Sustaining the Therapeutic Alliance

A caring, accepting stance is a vital component of EFT-C. The therapist carefully listens and reflects content and emotion in a genuine manner. From the first session onward, clients feel heard and understood. The client feels free to correct the therapist when necessary to make sure both clients and therapist are understanding each other. It is a constant give-and-take and mutual back-and-forth flow. With experience, the therapist grows increasingly competent at working with improving relationships and working deeply with emotion to facilitate this change. Thus, although the therapist directs the process, and often seeks to take the emotional processing one step forward with conjecture, it is always the clients who are the experts in their own emotional experiencing.

Typical creating and sustaining alliance reflections include the following:

- "My hope is to provide an environment where you feel free to share with me whatever is on your mind, whatever is on your heart."
- "It's OK. We cry in here. That's why I have tissues. It's OK to be sad. Let it happen. Especially in here."
- "Sometimes I will say things that seem on target to me, but I am counting on you to correct me if I am off, OK?"
- "Sometimes I get a feeling that what you mean is 'this,' and I will put that out there in a tentative manner, fully expecting you to guide me from there. Can I count on you for that? I need to."
- "When I said that, I noticed you kind of withdrew some. Did I say something that bothered you? Can we talk about that for a second?"

Accessing and Processing Emotion

The therapist first identifies secondary and primary emotion. This is followed by slowly moving into processing the primary, or vulnerable, emotion. The therapist helps clients "sit" in their primary emotions by doing the following:

- locating the emotions in their body—where they feel them;
- asking what they usually do when they feel this in their body;
- learning how they often push these emotions away from their awareness;
- asking what their body might be trying to tell them;
- having them just slow down, focus, and feel their emerging emotion in the session;
- helping them describe and put words to the emotion in the moment;
- normalizing how people often don't pay attention to these bodily feelings and associated emotions;
- aiding them in gaining new meaning from primary emotional experiencing—that is, what the emotion is trying to tell them; and
- identifying clients' internal emotion processing cycle. It's not just the "in-between" partner cycle—it's also each individual's internal emotion processing cycle that is important. They work in tandem. It's impossible to separate them. The self and relationship cycles are intricately tied.

Restructuring Key Interactions

Enactments are vital in EFT-C. It's simply not enough for the therapist to deepen primary emotion with a client alone. Clients must turn toward their partner and risk sharing their primary emotion directly in session. Greenberg and Johnson (1988) noted that newer therapists often struggle with initiating enactments, perhaps because of the emotionally heightened nature involved. Bradley and Furrow (2004) indeed found unsuccessful

softening event attempts were characterized, in part, by therapists' failure to have the softening partner turn and share directly with the partner via enactment. Rather, therapists deepened primary emotion between themselves and each partner individually, but failed to initiate enactments between partners.

Johnson (1996) stressed the importance of partners sharing attachment-related emotion during enactments. More recently, Greenberg and Goldman (2008) stressed the added necessity of partners sharing identity-related primary emotion directly with their partners. Once again, the relationship-related primary emotion (i.e., attachment-related emotion) and the emotion related to each partner's own unique person or self (i.e., identity-related emotion) combine in EFT-C.

Key Interventions, Descriptions, and Examples

There are key EFT-C interventions taken from the individual model of EFT. These are covered in other areas of this book (see Chapter 21). These are important, especially in Step 8, when the therapist identifies and works through blocks to accessing primary emotion. Below are the key EFT-C interventions, followed by brief descriptions and examples.

Validation

In validation, the therapist offers support and normalizes current experiencing, thoughts, and behavior. To do this, the therapist might say the following:

- "It makes sense that you would be wary of sharing this with him, of showing this part to him. It's not something that you guys have often done in the past."
- "I appreciate you sharing that with me. I know you said you usually push your vulnerable emotion away."

- “It’s nice that you are so honest and up front in here.”
- “I can see why you would be angry. I understand. It makes sense.”
- “It’s too hard to tell her that now? That’s OK. Maybe it’s a little too much for now.”
- “You guys are working really hard. It’s really good to see. I know it’s not easy, but it’s inspiring to me.”

Reflecting

In reflecting, partners’ positions and statements are summarized. Reflecting is vital to the flow of the approach. Clients quickly learn to expect the therapist to respond with a reflection to make sure the content and emotion are being attended to and heard correctly. Clients are free to amend the reflections in order to clarify and keep the therapist on immediate track. Some examples of reflecting include the following:

- “When he withdraws from you, it feels like, as you say, ‘He doesn’t care.’ That’s the message you get.”
- “When you see his sadness, it affects you, too. You feel sad for him. It works both ways for you two.”

Reframing

A systemic perspective is especially important when reframing. The therapist is constantly aware that both partners are listening. They are aware of how what they say affects each partner simultaneously. Couple conflict emerges when one or more of their needs remain unmet. Individual and couple behaviors are stated in terms of

- negative interactional cycle,
- attachment- and relationship-related primary emotions,
- self-identity-related emotions (shame and self-esteem), and

- affection (intimacy and joy).

Negative Interactional Cycle. The therapist describes the negative interactional cycle itself, including roles, behaviors, and emotions. This cycle is reframed over time as something that the couple fall prey to, get sucked in by—as if it is an entity in and of itself, with power to do damage. Over time, the couple begin to unify in fighting back against this negative pattern.

Describing the cycle might sound something like this:

> You come home, and she greets you with barely a glance. You've been out of town and really hoping for a nice greeting, but it doesn't happen. You are disappointed. (Therapist looks to the other partner.) But you are busy with the kids, with the laundry, not to mention your own job. You had hoped to have more completed by the time he arrived, but here he is, and you are disappointed with yourself. What he sees is disappointment. He thinks it's disappointment that he is home. But what he doesn't see is that it's disappointment in yourself. So he marches to the bedroom and isolates in anger. And you keep busy, trying to push away your own disappointment in yourself. This way of interacting happens a lot, and it leaves you both feeling pretty isolated.

Attachment- and Relationship-Related Primary Emotions. The therapist describes the cycle with an added element—the couple's underlying desire to be close to each other—and spotlights the relational emotional connection that is one part of couples' relational needs.

Core attachment and relationship issues include the following:

- When I am really down and out, can I count on you to support me?
- Can I depend on you to be available when I really need you?
- Can I believe that you will be open and accessible to me when I am hurting and alone?

To highlight these issues, the therapist might say the following:

> When he gets angry, you shut down, go to your bedroom or to the porch. When she goes there, you feel shut out, like she doesn't really care. So that's when you just stew in your emotions. But underneath your anger is a sense of disappointment with yourself. You said it's a sense of "I did it again. I can't even talk with her correctly." And that's when that familiar loneliness [primary emotion] sets in. You hate that loneliness. What you want is to have it be OK with her—for you two to be welcomed by her [relationship and attachment]. But what she sees is your anger.

Self-Identity-Related Emotions (Shame and Self-Esteem). Emotions of fear and shame are activated when self-esteem or perceived status in the relationship is threatened. Emotions are particularly sensitive to how others see us and what others can do (or have done) to us (e.g., criticism, control). If a person's sense of worth, self-esteem, or position in the relationship is challenged, identity is threatened.

Challenges to identity are a key concern in couples and can lead to power and control struggles. The key for the EFT-C therapist is recognizing this cycle, reframing it in terms of self-identity–related emotions to become clear to both partners, and getting into the primary assertive emotion underlying the partner's submission of his or her identity.

Core self-identity–related issues include the following:

- Do you see, recognize, and validate me?
- Can you understand and accept me as I am?
- Do you support my aspirations?
- Do you respect and value me and my role in this relationship?
- Do we "get" each other?

Here is an example of reframing a conflict in terms of identity:

Partner 1: It's just gotten to whatever I do is not enough for her to still respect me. I mean, I carry a lot of responsibility in my job. I've moved up the ladder more than I ever dreamed. You know, I am really, really proud of that. And yet when she gets upset, I feel like a 7-year-old, like I have achieved nothing and that part of me just doesn't matter.

Therapist: (to Partner 1) When she gets upset, you hear her throwing aside all of your accomplishments, how smart you are and how you are respected and "seen" at work. That's a big part of you. And sometimes when you come home, (to Partner 2) and you sense he isn't available and you need him, you are in pursue mode, (to Partner 1) and you hear her anxious words that say to you, "you are inadequate," "you are not able to provide for this family," "we can't even take a vacation because of you," "you're not measuring up." (to Partner 2) I understand you don't say these exact words, OK? (to Partner 1) But this is important because this is how you interpret whatever she is saying—to you, this is what she really means.

Partner 1: You better believe it. That's exactly what happens. It's awful.

Affection (Intimacy and Joy). Warmth, liking, and appreciation of the other seem to be another important but distinct aspect of the bonding system that, like identity, is different from the attachment system. An analysis of the positive emotions involved in intimate relationships is important here. Although partners may be secure in knowing that the other is there for them and can be counted on, couples also seek the other for excitement, interest, and joy in who they are. Couples need to enjoy each other in positive emotions such as being happy, excited, cherished, and playful.

Core intimacy-related issues, which are often anchored in sadness and fear, include the following:

- Do you like being with me?
- Do we enjoy things together?
- Do you miss me and feel sad or lonely when I am gone?
- Do you communicate?
- Do you desire me?

When the therapist hears the following phrases, it may be time to focus on the affection–intimacy–joy category:

- just friends,
- no spark,
- no excitement,
- doesn't initiate time together,
- doesn't enjoy spending time with me,
- don't have fun together,
- don't feel special,
- never touches me,
- don't feel attractive, and
- not excited to see me.

To focus the conversation on affection, a therapist might say, for example,

> When you don't seem very happy to be around each other, or rarely feel necessarily excited to see each other, it sounds kind of sad. You feel closer now. You trust each other much more. But still you want more. You want to feel more of the playfulness that you used to have. You want that part again.

Tracking the Cycle

Client behaviors, thoughts, and emotions are reflected back in session as a recurring pattern while noting the general sequence and positions partners take. Partners begin to see the cycle as something they get caught up in, that has a life of its own. For example, the therapist might say,

> Let me see if I am hearing this correctly. It often starts when you, Sheila, are frustrated with something about Russell. You start telling him about your frustration, which involves complaining about something that he has done or said. As you tell him about it, Russell, you say you just stay quiet, stare at the wall. Sometimes you will defend for a few sentences, but mostly you just go quiet. And it seems you guys do this cycle a lot—around a lot of different issues, too.

Evocative Responding

Evocative responding involves focusing on client emerging experience in an effort to differentiate emotions and elicit an in-the-moment felt sense. The aim is to evoke a feeling using evocative language, connotative language, image, and metaphor (Greenberg, Rice, & Elliott, 1993). The therapist often lowers or softens his or her voice or talks slowly to help evoke feelings. Evocative responding is often used to deepen emotion and help clients locate feelings in their bodies. It's helpful to repeat the emotional essence of what has been said back to the client along with an evocative question. For example,

- What's it like to hear her say that right now? That for so long she's missed you, but feared that you didn't much care? What happens inside of you now as you hear that?
- What happens inside as you say that? "I have been so sad for so long." Do you feel it somewhere in your body right now?
- I see that you get sad as you are saying this. What's it like for you to hear that?

Empathic Conjecture

The empathic conjecture technique prompts the client to examine the leading edge of immediate emotional experience in order to connect emotions and behavior. For example, a therapist might conjecture, "When

the conflict heats up, you check out, looking disinterested, but I wonder if a part of you gives up, like saying, ‘It’s no use. I’ll never please her; it’s no use trying.’”

PUTTING IT ALL TOGETHER

Important elements of learning these interventions include role playing, watching video, and reading transcripts to see how they are artfully implemented in the real work of actual therapy. The key interventions are listed below within the five stages of EFT-C. Although the same interventions are used in different stages, the way they are used, and for what, can differ. Some of this variety is captured in the extended transcripts that follow.

Stages 1 and 2

Common interventions in Stages 1 and 2 are validation, reflecting, tracking the cycle, evocative responding, empathic conjecture, and reframing. The goals of each stage are as follows:

- Stage 1: Validation and alliance formation
    1. Empathize and validate each partner’s position and underlying pain.
    2. Delineate and assess core problems in areas of connectedness and self-identity.
- Stage 2: Negative cycle de-escalation
    3. Identify the negative interactional cycle and each partner’s position in the cycle, and begin externalizing the cycle as the problem.
    4. Identify attachment- and self-identity-related primary emotions underlying the negative cycle.

5. Identify historical origins of each partner's sensitivities to underlying emotions in the couple's current negative interactional cycle.
6. Reframe problems in terms of primary emotion related to attachment and self-identity needs.

Below we share an example of how Stage 2 can play out in a session. This illustration was taken from the first session with a couple.

F: We are so busy with life. He works long hours. I work part time, and a lot of the daytime kid duty falls on me.

Therapist: (to F) There's not a lot of time for the two of you. You miss that?

F: I do. Well, if we wouldn't argue, I would really miss time alone together. He gets home around 7:30 to 8:00 p.m. during the week, so there's not a lot of time for us to spend together. With my work and the kids, I am usually tired by 8:30.

M: (shuffles his feet, shakes his head, and looks agitated) That's not true!

Therapist: (to M) What's going on for you now? Something she said, or the way she said it, disturbs you? What's happening for you now? [evocative responding]

M: When she talks about what time I get home from work, it's just not true. I usually get home at 7:15, 7:30 at the very latest!

Therapist: Mmmm. Tell me if I am off here . . . You know, as we work together, I am going to really listen and try to tune in to you as best I can, and I am going to talk to you about what I think I am hearing and feeling as I listen to you, and I need you to guide me when I share this with you—tell me if I am off track or hearing correctly.

F and M: OK. No problem.

Therapist: (to M) But when she said that, it hit you pretty fast. You got frustrated pretty fast. [reflecting secondary emotion]

M: Yeah, well, I work so hard. I do it for my family, and . . . (slows down, tears up, looks down) [touching emotions related to his identity]

Therapist: Your work situation, how that keeps you there late, that really bothers you. [validation]

M: It's hard.

Therapist: Yeah. Does it eat at you sometimes? [heightening]

M: Yes, it does. I try to distract myself and move on.

Therapist: It's painful, huh? [reflecting primary emotions]

M: Whew. Yes.

Therapist: I wonder if sometimes you really question yourself, like, "I am not even able to make enough money for my family to pay all the bills." I wonder if you ever get down on yourself like this. [empathic conjecture]

F: (nods head "yes")

M: I do. But I try to move on and not think about it.

Therapist: (to F) If he were able to share with you when he gets down on himself, could you hear it and help reassure him? [reframing in context of self-identity]

F: I would love to. I am afraid that we might get in another argument somehow, though.

Therapist: Yeah. Right now, you guys get in that arguing habit so quickly, that even sharing when you are down doesn't seem to be an option. It's just too risky, right? (both nod) [tracking cycle]

Therapist: This arguing gets you in trouble so fast. It takes away your emotional connection—as you say (to F)—it takes away even attempts at emotional connection. You (to F)

walk on eggshells. You (to M) rarely try to talk to her anymore because you think it will lead to a big fight. And this happens over and over and over. (both nod in agreement) [tracking the cycle]

Stages 3 and 4

Common interventions in Stage 3 are validation, reflecting, tracking the cycle, evocative responding, empathic conjecture, and reframing. In Stage 4, common interventions are evocative responding, empathic conjecture, heightening, reframing, and restructuring interactions. The goals of each stage are as follows:

- Stage 3: Accessing primary emotions
    7. Access unacknowledged feelings and needs underlying interactional positions and express them.
    8. Identify and overcome possible intrapsychic blocks to accessing primary emotions.
    9. Identify attachment- and self-identity–related needs and integrating these into interactions.
- Stage 4: Restructuring the negative interaction
    10. Promote acceptance by the other of partners' experience and aspects of self.
    11. Facilitate the expression of needs and wants to restructure the interaction and create emotional engagement.
    12. Promote self-soothing and emotion transformation in each partner.

Here is an example of what Stage 4 can look like in a therapy session:

Therapist: (to M) It's really important to you that she recognize how hard you work for the family, how much you sacrifice,

and how much that means to you as a husband and father. [reframing in the context of self-identity]

M: It means a lot to me, yes.

Therapist: And mainly you keep this to yourself. It's something that hasn't been safe to share with her. You guys used to argue and be like each other's enemies, that you kept this powerful stuff to yourself. [tracking the cycle]

M: I didn't realize quite how powerful it was before counseling. But it was always there. It's just really personal, you know? It's just something that I've kept to myself. I never even thought about sharing it. I just always thought that she couldn't fix it anyway.

Therapist: Right, but by keeping it to yourself, you created your own loneliness. You effectively kept her away from a very important part of yourself. Now we know that she cares about this part of you; she wants to recognize and reassure this part of you. [reframing in the context of self-identity]

M: I believe her. It's still hard, though.

Therapist: Yes. It's hard. But you can do it. I want you to share with her now how strong this part is, and how it would be great if she could hear that and understand that in you. [restructuring interactions]

M: (turns toward F) I need you to hear how me sacrificing time and so much else to provide for us, our home, our bills—how important this is to me. And when I get laid off from work, or don't like my work, it's miserable for me.

F: Yeah. I am getting it.

M: I don't want you to try and fix it, or try to give me advice. I guess I just need you to get it emotionally. That's a new idea to me, and I don't know exactly how to say it, but I want you to respect that it's important to me, and feel that somehow. Keep it in mind.

F: I understand, honey. I do. As best as I can, I mean. I feel sad for you when you feel down on yourself. I don't feel that way about you. And I do recognize how much you sacrifice and how much you do for us. I need to tell you that more. I realize that now. I am sorry. And it feels great that you are sharing this with me.

Therapist: Now, this is really good. You guys are both opening up, risking and letting each other in. [validation] (to M) Can you let her in right now?

M: Yes. I am.

Therapist: What's happening inside of you, in your chest or shoulders, as she says this right now? That's where you usually feel—what's happening now? [evocative responding]

M: It feels a little scary, weird. But more than that, it's good.

Therapist: It's kind of new?

M: Yes, it's new. But I like it.

Therapist: Tell her about that. [restructuring interactions]

M: (to F) It's kind of scary to let you in around this, but it feels good to hear that you do understand and can respect it, or me. Thank you.

Therapist: That's very good. Very good. Both of you. [validation]

Stage 5

Common interventions in Stage 5 are validation, evocative responding, reframing, and restructuring interactions. The goals of this stage are as follows:

- Stage 5: Consolidation and integration

13. Facilitate the emergence of new interactions and solutions to problematic interactions and issues.
14. Enact new positions and consolidate new narratives.

CONCLUSION

Since the late 1990s, the interventions of Leslie Greenberg and Susan Johnson have largely been written and presented separately. This is unfortunate because each offers unique perspectives that, when taken together, strengthen the approach. This chapter integrated key interventions put forth by Greenberg and Johnson through the years. By studying and practicing with these interventions, therapists can grow to where using them in-session becomes intuitive and free flowing. This takes discipline, practice, and repetition, however, much like learning a skill in athletics. In time, these interventions are implemented artfully, like strokes of a brush creating a painting.

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V
CONCLUSIONS

23
ENDURING THEMES AND FUTURE DEVELOPMENTS IN EMOTION-FOCUSED THERAPY

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Emotion-focused therapy (EFT) has evolved in the past decade to have a significant impact on the field of psychotherapy. Its increasing popularity and the growing support for its efficacy with a wide variety of problems have meant that EFT is increasingly practiced and integrated into the clinical literature.

As the field of psychotherapy changed over the past 25 years, calling for increased specificity, empirical validation, and greater attention to diversity, EFT theory and research developed in sync with these conditions. A number of randomized clinical trials and evaluation studies, plus meta-analyses by Elliott and colleagues (Elliott & Greenberg, 2016; Elliott, Greenberg, Watson, Timulak, & Freire, 2013), have demonstrated the effectiveness of EFT. EFT treatments have now been developed for different emotional styles and populations and for application to specific disorders.

One of the defining features of EFT's development has been the iterative way in which research has informed practice and practice has informed research. At its inception, EFT emerged from what had become an increasingly marginalized humanistic framework into what had become a world dominated by psychodynamic and cognitive–behavioral therapies. Rice and Greenberg (1984) initially felt convinced that the most meaningful contribution would be derived from an events-based, process–outcome research paradigm that studied from the bottom up how people change in therapy by a study of in-session change performances. They were compelled, however, by the National Institute of Mental Health and the political zeitgeist of psychotherapy research to focus on outcome for a specific disorder to validate the approach. This led to a productive research program that allowed not only for the validation of the approach but also for its further specification and development (Greenberg, Rice, & Elliott, 1993).

EVOLVING PERSPECTIVES OF DISORDER AND TREATMENT IN EMOTION-FOCUSED THERAPY

EFT has moved toward a differentiated and unified perspective of the treatment of various clinical presentations. Emerging out of a humanistic framework that was never disorder focused, and adopting an emotion-centered, dialectical constructivist framework for understanding human functioning, EFT theory is evolving a conceptualization that emotional processing difficulties are the source of many of the different disorders that we encounter (Goldman & Greenberg, 2015; Greenberg, 2015; Timulak, 2015). Whether in depression, anxiety, trauma, eating disorder, or addiction, painful bodily felt emotions such as core fear, shame, or sadness are the source of major difficulties. This unified view of disorder means, first, that treatments of most disorders must involve the activation of the painful

primary maladaptive emotions of fear, shame, and sadness of lonely abandonment underlying the secondary symptomatic presentations and, second, that these deeply rooted painful feelings need to be transformed through the activation of bodily experienced adaptive anger, sadness, and compassion and their attendant action tendencies. These goals are attained when clients feel deserving of the unmet needs embedded in their painful emotions.

Over the years, practicing therapy while engaging in research of EFT at the same time has allowed EFT proponents to refine methods for working with various types of problems. As the therapy has developed, new tasks have been added designed to work on specific types of problems that different types of clients and different disorders have presented. For example, self-soothing has been found to be particularly helpful with certain types of anxiety and dysregulation. In addition, study of the therapy has helped us understand how to refine and adapt the tasks in application to certain disorders.

EFT practitioners use many of the same treatment processes with all disorders. All involve the relational processes as well as experiential focusing, and all require moment-by-moment processing of emotion. Some of the process-guiding chair dialogues for splits, unfinished business, self-interruption, and self-soothing appear in almost all treatments, regardless of presenting problems and attendant disorders. Differentiation becomes necessary in that each disorder calls for different degrees of different interventions.

In fact, sometimes different sequences of chair dialogues are most helpful depending on the client’s core painful emotions. For example, depression work emphasizes self-critical work first and then moves on to unfinished business. Shame and sadness may be the core emotions. Anxiety disorders, in contrast, seem to pull for catastrophizing or worry splits first to deal with the anxiety symptoms, followed only later by self-critical or self-

interruption and unfinished business chair dialogues, possibly followed by self-soothing. Generalized anxiety emphasizes work with fear related to basic insecurity, whereas social anxiety emphasizes shame. Trauma-based treatments, which are fear based, use empty chair dialogues for unfinished business to reprocess painful emotions and work with self-interruption when emotions are blocked. When self-blame or guilt are particularly strong, self-critical dialogues and possibly self-soothing are useful. In work with eating disorders, we now have an increased understanding of the particular annihilating character of the anorexic critic within the context of the two-chair dialogue for negative self-evaluation and how to work with this. We also have a greater understanding of how to adapt two-chair work to work with personality disorders, and this can in fact lead rapidly to strong emotional depth for more dysregulated populations and help people productively process emotions.

CULTURE AND DIVERSITY

We have also expanded research, practice, and training to be able to apply EFT with people from diverse cultural backgrounds. Extensive international training has shown us that regardless of culture, nationality, or ethnicity, all humans have emotions, experience them in similar ways, and have similar difficulties with them. Although there are different cultural rules of expression, when people’s core emotions are approached in therapy, we find similar emotional experience that can be worked on in similar ways across cultures, taking into account cultural context.

Each cultural population, and even subgroups within a population, has particular types of emotional processing styles and problems that may vary according to disorders. Emotional competence, the ability to be aware of one’s feelings and name them, and emotional expressiveness do appear to vary across cultures and disorders. In communal cultures, respect for

parents, shame, and the need to not shame the other are paramount, and these need to be tended to prior to encouraging expression, assertion, and autonomy. In individualistic cultures, assertion and autonomy are prized over harmony. Ease of expression of emotion tends to differ in northern and southern parts of Europe and the Americas.

Cultural context requires tailoring different types or sequences of intervention to the specific population. Within the particular context, however, similar underlying psychological difficulties emerge that have at their source core painful emotion schematic processing. Different populations manifest different markers and require different sequences of treatment priorities. At the moment-by-moment level, all populations require the same type and sequence of optimal emotion processing, but each may present different entry points, and one may encounter culturally specific processing difficulties. As we learn more, we move toward a unified and yet differentiated approach to disorder and treatment.

INCREASED DIFFERENTIATION IN WORKING WITH EMOTION

With developments in the neurobiology of emotion, EFT theory has been expanded and differentiated to help us understand how to do different things with different emotions at different times. This has led to an expanded framework of principles of emotion work. So at times we attempt to activate emotions, at times we need to access and transform emotions, and at times we work to regulate emotions. In addition, we have come to understand the significance of sequencing in emotional processing and of the value of moving from secondary through primary maladaptive to adaptive emotion. How to recognize and classify different emotions and process emotions productively has also been specified. All this research has highlighted that it is not just having emotions, but which ones and in what sequence they are experienced, that is important.

Therapist processes and interventions have developed to facilitate emotion change work. We now have a clear idea of how empathic responding, attunement, and presence help clients regulate affect and feel safe to be able to access core painful emotions. Significant developments in task models have helped articulate how to facilitate change in much more precise and specific ways, allowing us to tailor intervention to clients' emotional styles and ways of being. We have delineated how we help clients build narrative frameworks that, in part, form scaffolds for emotional change work to help clients move forward after therapy. Additionally, we have clarified how we specifically coach and teach clients within an experiential mode, and how this helps both within sessions and in carrying change forward outside of sessions and beyond therapy.

TASK ANALYSIS AND QUALITATIVE RESEARCH

Intensive analysis of client performance and subjective experience using qualitative methods and task analytic model building has continued slowly but surely to build a better and fuller understanding of how people change and of some of the important therapeutic processes, including the importance of experiences such as empowerment, emotional relief, and connecting vulnerability. What is particularly worthwhile is the demonstration that clients, after a course of therapy, report not only changes in symptoms but also a newfound appreciation and valuing of experiences such as vulnerability, a sense of belonging, and grieving. The emphasis on describing the sequential nature of therapeutic processes also has highlighted that therapists, while remaining present to the moment, need to have different process goals in mind at different times during the session, during different stages of the task, and at different phases of therapy.

CASE FORMULATION

Case formulation has been an important development as it has given us an overarching framework that ties the many pieces of the therapy together. This framework helps describe how to conceptualize a case and how to tie together the emotional and narrative strands to create a focus across therapy. Through the introduction of case formulation, we have moved from a pure focus on markers and tasks and their resolutions to seeing these tasks as aiding access to core emotion schemes and facilitating the transformation of emotion with emotion.

PSYCHOEDUCATION AND EMOTION-FOCUSED SKILL TRAINING

Another development is a greater focus on the use of psychoeducation and coaching and the application of emotion-focused principles and skills. This has been done with such groups as executives and parents. Experiential training of skills for working with emotion can be used preventively and as treatment and seems like an area that will develop drawing on the basic processes that have proved helpful in therapy. This effort will aid a general expansion of EFT to apply to different types of populations and problems as well as to children and families. Work has been done with intergenerational groups that focuses on common problems such as eating disorders, mental health disorders in childhood, and autism.

EMOTION-FOCUSED COUPLES THERAPY

Another area of growth and development is in EFT for couples (EFT-C). Much of its development has been impacted by updates to the individual model. With developments in neurobiology, we have come to see affect regulation as a key process in couple bonding, and we have added to the focus on other soothing, a focus on self-soothing. Self-soothing has been developed as an important process that helps partners within relationships

to both take care of self and be available to their partner. EFT-C has incorporated a circumplex model that conceptualizes both attachment and identity as core processes in intimate relationships. Furthermore, the core maladaptive emotions of fear and sadness are associated with attachment, and shame with identity, and these become the target of intervention that is designed to facilitate transformation. The model has also been expanded to allow for further work with individual processes such as the historical origins of maladaptive emotions, individual blocks to accessing emotion, and self-soothing.

EMOTION-FOCUSED TRAINING AND THE INTERNATIONAL SOCIETY

As EFT has developed, training has become a major focus. At the time of this writing, 15 to 18 international training centers were operating (refer to http://www.iseft.org/page-18209 for an updated list). The initial training curriculum started with emphasizing skills of emotional deepening, recognition of markers, and facilitation of tasks in an empathic relational context. As both EFT practice and training have evolved, new training methods have emerged that include a specific training in empathic attunement to affect, use of new procedures including exercises in presence, and use of films to help people identify emotions. Although experiential work has always been seen as a key aspect of training, we recognize that what is needed is further models of how to integrate experiential work and personal therapy more directly to enhance training. As early humanistic therapists and trainers understood, the best way to learn is through self-experience, and yet it is a challenge to provide this experience and contend with the different modes and roles that such training requires of the trainer.

Developments in and proliferation of emotion-focused therapy have led to the establishment of the International Society for Emotion Focused

Therapy (https://iseft.wildapricot.org). This has helped to build an EFT community and led to further growth in EFT. The opening of different training centers and programs across different continents has allowed new voices to emerge. The application of EFT in different cultural contexts has helped create new dimensions in the approach. The International Society has also meant creation of training standards and an EFT certification. Standards and certification have become a greater priority and have helped with growth. Certification, however, has both benefits and drawbacks. In our experience, learning to practice EFT to proficiency is a long process that is difficult to delimit. One is always learning. To quantify this process according to training standards that culminate with an official stamp of approval does not represent the process-oriented nature of EFT. We recognize, however, that the creation of standards and the supervision and mentorship structure that certification processes promote has led to the development of more EFT therapists!

THE FUTURE

As we move into the future, what seems important for us is to define and explicate what is being termed the *interpersonal modes* in which we work. These interpersonal modes of working go beyond empathic exploration and the provision of tasks. They include how we build alliances and what we do when they break down, how we connect and use ourselves to help clients change emotion, and how we deal with interpersonal difficulties.

There have been a number of attempts to integrate EFT into cognitive–behavioral, psychodynamic, and person-centered approaches. Although we applaud these efforts, often they are watered-down versions of EFT or merely technical integrations of chair dialogues rather than meaningful or well-thought-out integrations. The way to integrate emotion meaningfully

into other approaches is an important topic. A real integration involves not just use of techniques from EFT like chair work but the adoption of a view of emotion and its function that is compatible with EFT's theoretical propositions.

EFT proposes that emotions themselves have an innately adaptive potential that if activated can help clients change problematic emotional states or unwanted self-experiences. In this view, emotions also are connected to essential needs. They rapidly alert people to situations important to their well-being. They also prepare and guide people to take action toward meeting their needs. In addition, people are continuously making sense of their emotions and constructing meanings, and these act to guide their lives. Therapy then involves the development of a safe relationship with a therapist who is empathically attuned to affect and who guides clients to engage in productive emotional processing by identifying, experiencing, exploring, making sense of, transforming, and flexibly managing their emotions. As a result, clients become stronger and more skillful in accessing the important information and meanings about themselves and their world that emotions contain. They then can use this information to live more vitally and adaptively. In couple therapy, dysfunctional interactions are seen as best changed by partners being able to express to each other their underlying vulnerable emotions that arise from threats to their feelings of attachment security and their sense of identity. Saying what they really feel and need helps partners change the pursue–distance and dominate–submit cycles that they become stuck in when they feel threatened. Approaches that adopt these views and have truly integrated an emotion-focused perspective will hopefully move toward the creation of a truly integrative emotion-focused, motivational, cognitive–behavioral approach of the future.

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