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Emotion-Focused Therapy

Revised Edition

Leslie S. Greenberg

Emotion-Focused Therapy

Revised Edition

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Series Preface

Some might argue that in the contemporary clinical practice of psychotherapy, evidence-based intervention and effective outcome have overshadowed theory in importance. Maybe. But, as the editors of this series, we don't propose to take up that controversy here. We do know that psychotherapists adopt and practice according to one theory or another because their experience, and decades of good evidence, suggests that having a sound theory of psychotherapy leads to greater therapeutic success. Still, the role of theory in the helping process can be hard to explain. This narrative about solving problems helps convey theory's importance:

> Aesop tells the fable of the sun and wind having a contest to decide who was the most powerful. From above the earth, they spotted a man walking down the street, and the wind said that he bet he could get his coat off. The sun agreed to the contest. The wind blew, and the man held on tightly to his coat. The more the wind blew, the tighter he held. The sun said it was his turn. He put all of his energy into creating warm sunshine, and soon the man took off his coat.

What does a competition between the sun and the wind to remove a man's coat have to do with theories of psychotherapy? We think this deceptively simple story highlights the importance of theory as the precursor to any effective intervention—and hence to a favorable outcome. Without a guiding theory we might treat the symptom without understanding the role of the individual. Or we might create power conflicts with our clients and not understand that, at times, indirect means of helping (sunshine) are often as effective—if not more so—than direct means (wind). In the absence of theory, we might lose track of the treatment rationale and instead get caught up in, for example, social correctness and not wanting to do something that looks too simple.

What exactly is *theory*? The *APA Dictionary of Psychology* defines theory as "a principle or body of interrelated principles that purports to explain or predict a number of interrelated phenomena." In psychotherapy, a theory is a set of principles used to explain human thought and behavior, including what causes people to change. In practice, a theory creates the goals of therapy and specifies how to pursue them. Haley (1997) noted that a theory of psychotherapy ought to be simple enough for the average therapist to understand, but comprehensive enough to account for a wide range of eventualities. Furthermore, a theory guides action toward successful outcomes while generating hope in both the therapist and client that recovery is possible.

Theory is the compass that allows psychotherapists to navigate the vast territory of clinical practice. In the same ways that navigational tools have been modified to adapt to advances in thinking and ever-expanding territories to explore, theories of psychotherapy have changed over time. The different schools of theories are commonly referred to as waves, the first wave being psychodynamic theories (e.g., Adlerian, psychoanalytic), the second wave being learning theories (e.g., behavioral, cognitive-behavioral), the third wave being humanistic theories (e.g., person-centered, Gestalt, existential), the fourth wave being feminist and multicultural theories, and the fifth wave being postmodern and constructivist theories (e.g., narrative, solution-focused). In many ways, these waves represent how psychotherapy has adapted and responded to changes in psychology, society, and

epistemology as well as to changes in the nature of psychotherapy itself. Psychotherapy and the theories that guide it are dynamic and responsive. The wide variety of theories is also testament to the different ways in which the same human behavior can be conceptualized (Frew & Spiegler, 2012).

It is with these two concepts in mind—the central importance of theory and the natural evolution of theoretical thinking—that we developed the American Psychological Association Theories of Psychotherapy Series. Both of us are thoroughly fascinated by theory and the range of complex ideas that drive each model. As university faculty members who teach courses on the theories of psychotherapy, we wanted to create learning materials that not only highlight the essence of the major theories for professionals and professionals-in-training but also clearly bring the reader up-to-date on the current status of the models. Often in books on theory, the biography of the original theorist overshadows the evolution of the model. In contrast, our intent is to highlight the contemporary uses of the theories as well as their history and context. Further, we wanted each theory to be reflected through the process of working with clients that reflect the full range of human diversity.

As this project began, we faced two immediate decisions: which theories to address and who best to present them. We looked at graduate-level theories of psychotherapy courses to see which theories are being taught, and we explored popular scholarly books, articles, and conferences to determine which theories draw the most interest. We then developed a dream list of authors from among the best minds in contemporary theoretical practice. Each author is one of the leading proponents of that approach, as well as a knowledgeable practitioner. We asked each author to review the core constructs of the theory, bring the theory into the modern sphere of clinical practice by looking at it through a context of evidence-based practice, and clearly illustrate how the theory looks in action.

There are 24 titles planned for the series. Each title can stand alone or can be put together with a few other titles to create materials for a course in psychotherapy theories. This option allows instructors to create a course featuring the approaches they believe are the most salient today. To support this end, the American Psychological Association has

also developed a DVD for most of the approaches that demonstrate the theory in practice with a real client. Many of the DVDs show therapy over six sessions. A complete list of available DVD programs is available at http://www.apa.org/pubs/videos.

We are pleased to present this revised version of *Emotion-Focused Therapy.* Emotion-focused therapy (EFT) advocates that emotional change is necessary for permanent or enduring change in clients' growth and well-being. Grounded in humanistic theories of psychotherapy, EFT draws on knowledge about the effect of emotional expression and identifies the adaptive potential of emotions as critical in creating meaningful psychological change. In this book, Leslie S. Greenberg, cofounder of EFT, traces the development of the model and illustrates how the expression of emotions, as well as the development of positive emotions, leads to healing. Many strategies are highlighted to help clients accept, express, regulate, make sense of, and transform emotions in this empirically based approach. Over the past decade the interest in learning and understanding the EFT approach has been immense. *Emotion-Focused Therapy* is an important addition to the series as it represents an approach at the forefront of clinical innovation and research.

This revised edition includes important new research findings on constructs such as emotional needs and describes key developments in the use of EFT in treating anxiety disorders.

—Jon Carlson and Matt Englar-Carlson

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How to Use This Book With APA Psychotherapy Videos

Each book in the *Theories of Psychotherapy Series* is specifically paired with a DVD that demonstrates the theory applied in actual therapy with a real client. Many DVDs feature the author of the book as the guest therapist, allowing students to see an eminent scholar and practitioner putting the theory they write about into action.

The DVDs have a number of features that make them excellent tools for learning more about theoretical concepts:

- Many DVDs contain six full sessions of psychotherapy over time, giving viewers a chance to see how clients respond to the application of the theory over the course of several sessions.
- Each DVD has a brief introductory discussion recapping the basic features of the theory behind the approach demonstrated. This allows viewers to review the key aspects of the approach about which they have just read.
- DVDs feature actual clients in unedited psychotherapy sessions. This provides a unique opportunity to get a sense of the look and feel of real psychotherapy, something that written case examples and transcripts sometimes cannot convey.

- There is a therapist commentary track that viewers may choose to play during the psychotherapy sessions. This track gives unique insight into why therapists do what they do in a session. Further it provides an in vivo opportunity to see how the therapist uses the model to conceptualize the client.

The books and DVDs together make a powerful teaching tool for showing how theoretical principles affect practice. In the case of this book, the DVD *Emotion-Focused Therapy Over Time*, which features the author as the guest expert, provides a vivid example of how this approach looks in practice.

Emotion-Focused Therapy

Revised Edition

1

Introduction

There can be no knowledge without emotion. We may be aware of a truth, yet until we have felt its force, it is not ours. To the cognition of the brain must be added the experience of the soul.

—Arnold Bennett

Emotion-focused therapy (EFT) can be defined as the practice of therapy informed by an understanding of the role of emotion in psychotherapeutic change. EFT is founded on a close and careful analysis of the meanings and contributions of emotion to human experience and change in psychotherapy. This focus leads therapist and client toward strategies that promotes the awareness, acceptance, expression, utilization, regulation, and transformation of emotion as well as corrective emotional experience with the therapist. The goals of EFT are strengthening the self, regulating affect, and creating new meaning.

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Emotion-Focused Therapy, Revised Edition, by L. S. Greenberg

CORE CONCEPTS

EFT is a neohumanistic, experiential approach to therapy reformulated in terms of modern emotion theory and affective neuroscience. It is informed by humanistic–phenomenological theories of therapy (Perls, Hefferline, & Goodman, 1951; Rogers, 1957), emotion and cognition theory, affective neuroscience, and dynamic and family systems theory (Damasio, 1999; Frijda, 1986; J. Pascual-Leone, 1987, 1988; Thelen & Smith, 1994; Weakland & Watzlawick, 1979). It views fundamental emotions—like anger, sadness, fear, and disgust—as foundational to the construction of complex frameworks that orient us to our environment. In addition, the emotional system is seen as the primary motivational system throughout life, essential to our survival and adaptation. Emotions are seen as purposive and playing a key role in goal directed behavior. They have unique motivational and phenomenological properties and influence perception, cognition, and behavior (Izard, 1977).

Since its inception decades ago as an approach to how people change in different episodes in psychotherapy (Rice & Greenberg, 1984), EFT has evolved into a full-blown theory of functioning and practice that proposes that emotional change is central to enduring change. EFT is premised on the belief that traditional psychotherapy has overemphasized conscious understanding and cognitive and behavioral change to the neglect of the central and foundational role of emotional change in these processes. Although it does not deny the importance of the creation of meaning and behavioral change, EFT emphasizes the importance of awareness, acceptance, and understanding of emotion; the visceral experience of emotion in therapy; and the importance of changing emotion in promoting psychotherapeutic change.

EFT posits that emotions themselves have an innately adaptive potential that if activated, can help clients reclaim unwanted self-experience and change problematic emotional states and interactions. This view that emotion, at its core, is an innate adaptive system that has evolved to help people survive and thrive has garnered extensive empirical support. Emotions are connected to our most essential needs (Frijda, 1986). They rapidly alert us to situations important to our well-being, by giving us

information about what is good and bad for us by evaluating whether our needs are being met. They also prepare and guide us in these important situations to take action toward meeting our needs. EFT views the individual as fundamentally affective in nature. Emotion sets a basic mode of processing in action (Greenberg, 2015; LeDoux, 1996). Fear sets in motion a fear processing mechanism that searches for danger, sadness informs us of loss, and anger informs us of violation. Emotions are also our primary system of communication, rapidly signaling our intentions and affecting others when expressed. As our primary meaning, communication, and action orientation systems, emotions determine much of who we are. Rather than "I think, therefore I am," EFT is based on the idea that "I feel, therefore I am" and proposes that first we feel, and then we think, and we often think only inasmuch as we feel. Thus, emotional change is seen as the key to enduring cognitive and behavioral change.

Clients are helped in EFT to better identify, experience, accept, explore, make sense of, transform, and flexibly manage their emotions. As a result, they become more skillful in accessing the important information and meanings about themselves and their world that emotions provide, as well as become more skillful in using that information to live vitally and adaptively. Clients in therapy are also encouraged to face dreaded emotions to process and transform them. A major premise guiding intervention in EFT is that transformation is possible only when individuals accept themselves as they are. EFT is an approach designed to help clients become aware and make productive use of their emotions.

EFT grew out of, and was a response to, the overemphasis on cognition and behavior in Western psychotherapy. It is easier to focus on cognitions than implicit emotions because they are more easily accessible to consciousness, and it is easier to try to change behaviors than automatic emotional responses because behaviors are more accessible to deliberate control. Emotion, however, exerts a key influence on cognition and behavior. EFT attempts to shift the focus by emphasizing the crucial role of the experience of adaptive and maladaptive emotion in therapeutic change.

A core feature of EFT practice is that it makes a distinction between conceptual and experiential knowledge and it posits that people are wiser than their intellects alone. In an experiencing organism, consciousness is

seen as being at the peak of a pyramid of otherwise nonconscious organismic functioning. Experiments in directed awareness are used to help concentrate attention on as yet unformulated emotional experience, to intensify its vividness, and to symbolize it in awareness. In therapy, emotion is focused on as visceral experience and is accepted, as well as worked with directly, to promote emotional change. The articulation of emotion in *narratives* of being with self and others provides the story of our lives (Angus & Greenberg, 2011).

At the center of the approach is helping clients discern when they need to use adaptive emotion as a guide and be changed by its urgings, when they need to change maladaptive emotions, and when they need to regulate emotions that overwhelm them. A key tenet of therapy is that clients must experience emotion to be informed and moved by it and to make it accessible to change. Clients do not change their emotions simply by talking about them, by understanding their origins, or by changing beliefs; rather, emotions are changed after they are accepted and experienced, opposed with different emotions to transform them, and reflected on to create new narrative meaning (Greenberg, 2015).

Changing emotions is seen as central to the origins and treatment of human problems, but this does not mean that working with emotions is the sole focus in EFT. Most problems have biological, emotional, cognitive, motivational, behavioral, physiological, social, and cultural sources, and many of these need attention. EFT adopts an integrative focus on motivation, cognition, behavior, and interaction; the focus is on people's emotions as a primary pathway to change. EFT therapists help clients understand the complexities of their lifelong relationships and their psychogenetic origins and manage their thoughts, behaviors, and interactions in a healthy manner. An emotion-focused therapist adds the following key elements as a focus of therapeutic work: (a) the provision of an empathic relationship to facilitate healing, (b) a nuanced exploration of a client's emotional experience and the origin and dynamics of these emotions, (c) encouragement to allow and accept emotions for the information they provide rather than cathartic repetition of emotional expression to get rid of an emotion, (d) a focus on interruptive processes that interfere with the client's efforts to

access emotion, (e) access to new emotions to change old emotions, and (f) the symbolization of and reflection on emotion to create new narratives.

Whether a therapist practices individual, couples, or family therapy, an understanding of emotion and emotion system dynamics can be crucial for success because emotions are involved in all clients' efforts to change. The issues and methods discussed in this book are thus applicable and useful to all forms of therapy. EFT is being used increasingly by couples and individual therapists, work with emotion is being integrated into psychodynamic and cognitive approaches, and many integrative therapists integrate EFT into their approaches.

Although methods for focusing on emotion can be used in all treatment approaches, EFT itself is not a simple, prescriptive therapy. Instead, it is a complex approach, theoretically and in practice, and mastering its empathic and emotion stimulating methods requires years of experience. This book attempts to provide a flavor of the approach, but it is only a beginning. I hope it excites you and motivates you to learn more.

CONCEPTUAL FRAMEWORK

EFT (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2015; Greenberg & Johnson, 1988; Greenberg & Paivio, 1997; Greenberg, Rice, & Elliott, 1993; Greenberg & Watson, 2006; S. M. Johnson, 2004) is an empirically supported, integrative, experiential approach to treatment (Greenberg, Watson, & Lietaer, 1998). It is integrative in that it synthesizes elements of person-centered therapy (Rogers, 1959), Gestalt therapy (Perls et al., 1951), experiential therapy (Gendlin, 1996), and existential therapy (Frankl, 1959; Yalom, 1980) with modern emotion, cognitive, attachment, interpersonal, psychodynamic, and narrative theory in a dialectical constructivist metatheory. The individual approach was originally termed *process experiential psychotherapy* (Greenberg, Rice, & Elliott, 1993), reflecting its roots in, and embodying principles of, a neohumanistic and experiential approach. Over time, developments in the understanding of the central role of emotion in human functioning and in therapy led to a change in name from process experiential therapy to EFT. The term *emotionally*

focused therapy, however, was used initially to describe the EFT couples therapy approach, where expression of underlying vulnerable emotions was seen as central in changing interaction and in reestablishing the couple's emotional bond (Greenberg & Johnson, 1988). EFT has been adopted as an overarching term to encompass the individual and couple applications of this approach; Greenberg (2015) proposed its use as an integrative term to refer to all treatments that see emotion as the main focus of intervention.

A fundamental tenet underlying EFT is that the organism possesses an innate tendency toward maintenance, growth, and mastery. The growth tendency is seen as being embedded in the adaptive emotion system (Greenberg, Rice, & Elliott, 1993; Perls et al., 1951; Rogers, 1959). Emotions are seen as governing the most important aspects of our lives. They are signals of events that affect our deepest concerns and our most important relationships. They keep us connected, energized, loving, and interested. Sometimes, however, they lead us to do things we do not understand or that we regret. Emotions also can be vague and unformed, with meanings that only become clear as we symbolize them and express them to others. At the same time, however, our emotions are guides to our most authentic selves. Clients thus are viewed as experts on their own experience in that they have closest access to their emotions and are agents who construct the meanings by which they live.

Emotions are seen as crucial in motivating behavior. People generally do what they feel like doing rather than what reason or logic dictates. It follows that to achieve behavioral change, people need to change the emotions motivating their behavior. Emotion also influences thought. When people feel angry, they think angry thoughts; when they are sad, they recall sad memories. To help people change what they think, therapists must help them change what they feel. For example, even cognitive changes such as the reappraisal of the self as worthy rather than unworthy are not simply cognitive changes on the basis of evidence or logic, but rather they are attitudinal changes that are highly affectively based. Seeing oneself as worthy involves a change in one's fundamental affective orientation toward the self and a change in one's basic mode of processing (Whelton

& Greenberg, 2005). Change in the view of self, world, and other thus fundamentally depends on emotional change. Emotion not only governs our views of self and others but also strongly influences interactions between people. Emotional expression governs, and changes, interaction. Anger, for example, produces distance, whereas vulnerability disarms. Thus, interpersonal conflict can be resolved by changing what people express (Greenberg & Johnson, 1988).

In the therapy, the therapist therefore encourages the client to attend to momentary experiencing and nurtures the development of more adaptive functioning by continuously focusing clients on their felt sense and emotions. The paradox of emotion work is that change initially involves acceptance rather than efforts to change. Emotional pain must be allowed and accepted to be fully felt and heard. Only then will it change. At the center of this approach is an I–Thou therapy relationship based on principles of presence, empathy, acceptance, and congruence (Buber, 1958; Geller & Greenberg, 2012; Greenberg & Watson, 2006; Rogers, 1959). This type of relationship is a fully accepting one that facilitates a focus on adaptive needs and validates the client's growth toward optimal complexity and adaptive flexibility.

As well as having biologically based emotions that act as a guide to adaptive action, people are viewed as living in a constant process of making sense of their emotions. Clients are consistently encouraged to identify and symbolize internal experience and bodily felt referents to create new meaning that promotes narrative change. Therapy is seen as facilitating conscious choice and reasoned action on the basis of increased access to and awareness of inner experience and feeling. Thus, when clients are able to symbolize their experience in words such as "I feel sad" or "I felt so redundant in my family, like an extra," they create the meanings that guide their lives.

Psychological health is seen as the ability to creatively adjust to situations and to be able to produce novel responses, experiences, and narratives. The goal of treatment is to transform maladaptive emotional responses and gain access to adaptive ones to guide a *process of becoming.* Dysfunction is seen as arising through a variety of different emotional

mechanisms, such as lack of emotional awareness, avoidance, or disclaiming of emotional experience; learned maladaptive emotion schematic memories; the creation of narratives that are overly rigid or dysfunctional (meaning creation); conflict between two emotionally based parts of the self; and unresolved feelings between self and other (Greenberg & Watson, 2006).

EFT aims to help clients develop their emotional literacy and emotional intelligence (Greenberg, 2015). Emotional competence is seen as involving (a) access to emotional experience, (b) the ability to regulate and transform maladaptive emotion, and (c) the development of positive identity narratives. Ultimately, emotional competence is seen as enhancing a person's ability to deal with problems in living and as promoting harmony within and among people.

CONCLUSION

The basic idea in EFT is that although emotions are basically adaptive, they can become problematic for a variety of reasons: past traumas, skill deficits (e.g., never having learned to symbolize emotions in awareness or having been taught to ignore or dismiss them), or emotion avoidance (for fear of their impact on self or others). Emotion avoidance, however, robs people of part of their intelligence because emotions reveal what is important to them in a situation and guide them in the actions that are required to get what they need or want. Knowing that one feels angry or sad informs one that one's needs have not been met. Becoming aware of what one feels, therefore, is a first step in helping one to identify the nature of the problem. Then one can figure out what actions are most appropriate in specific situations. Over time, awareness of emotions and the ability to reown, regulate, use and transform them, when necessary, gives people a sense of mastery and helps them to function more effectively. A key tenet of EFT is that one has to *feel* a feeling in order to change it.

In EFT, clients are helped to better identify, experience, accept, regulate, explore, make narrative sense of, transform, use, and flexibly manage their emotions. As a result, they become more able to tolerate previously

avoided emotions and more skillful in accessing the important information that emotions contain about their central needs, goals, and concerns. Awareness of emotion also gives access to the action tendencies in emotion, which help move people toward their goals. EFT thus helps people become more skillful in using emotional information and action tendencies to live more vitally and adaptively.

This approach is growing in popularity and acceptance. Given that it is now an evidence-based approach, it is being taught in graduate schools and internship programs. Cognitive–behavioral approaches are focusing on emotion and are rapidly assimilating many aspects of EFT. Psychodynamic therapy, which has always theorized about emotion, and systemic theory, which has not, are now also both paying a lot more attention to the experience of emotion in the therapy session and in relationships.

2

History

Emotion-focused therapy (EFT) theory grew out of person-centered, Gestalt, experiential, and existential therapies, viewed through the lens of modern cognitive and emotion theory. These humanistic and experiential approaches to psychotherapy had together formed the "third force" that swept North America in the 1960s and 1970s as an alternative to behaviorism and psychoanalysis. Humanists offered a more positive orientation toward human nature than the deterministic views implicit in the behaviorist and dynamic approaches. Humanists maintained that individuals have resources and are capable of awareness and choice. Subjective experience was seen as influencing behavior, and individuals were seen as having the potential for agency and creativity.

EFT has developed beyond its origins by drawing on advances in emotion, cognition, and neuroscience, and on psychotherapy change process

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research (Greenberg, 1986) to propose a treatment that is neohumanistic, process oriented, and emotion focused. EFT began from a study of moderately distressed people with interpersonal problems but has been expanded to apply to, and been shown to be effective with, a number of different populations and diagnostic groups (e.g., depression, trauma, couples in distress, eating disorders, borderline personality disorder, anxiety disorders; Dolhanty & Greenberg, 2007; Greenberg & Watson, 2006; Warwar, Links, Greenberg, & Bergmans, 2008; Wnuk, Greenberg, & Dolhanty, 2015). The development of EFT is outlined in this chapter; a summary of its originating theories is followed by the additional concepts that influenced its emergence as a distinct approach.

PERSON-CENTERED THEORY

The origin of EFT can be traced to the person-centered approach (Rogers, 1959). In this approach, dysfunction is seen as being caused by incongruence between self-concept and experience. When a discrepancy between self-concept ("I am strong") and experience (feeling weak) threatens to enter awareness, the person responds by becoming anxious. Rogers (1959) postulated that *organismic experience* provided the basic datum of existence, where experience included everything going on within the organism that was potentially available to awareness. In Rogers's view of motivation, the primary drive in all human behavior is the *actualization* of the person's potentialities. Rogers also believed that when people are guided by this tendency, they are trustworthy, reliable, and constructive. As did Rogers, EFT theory posits a growth and development tendency; but rather than adopting the view that people are oriented toward actualizing all their capacities, which implies a type of drive toward being the best they can be, EFT sees people as oriented toward the development of complexity and viability in adapting to the environment in which they find themselves (Greenberg, Rice, & Elliott, 1993).

Although Rogers proposed one major motivation, he needed two further motivational constructs for his theory to make sense. The first was the notion of an organismic valuing process, which was the actual agent

that evaluated whether something was good or bad for the organism, and it was this that guided the actualizing tendency. The second was in essence a second major motivation: a need for the positive regard of others, which gives rise to the *conditions of worth* that influence people's self-concept to become what they "should be" in the eyes of others. The self-concept was seen as being maintained by a self-actualizing tendency, which was a derivative of the actualizing tendency.

When a conflict arises between the actualizing tendency and the need to maintain the self-concept and the positive regard of others, one solution is for the individual to deny or distort awareness of his or her organismic experience. However, when life situations arise that make it difficult to maintain the distortion or denial, the person becomes anxious or behaves defensively, and generally exhibits some degree of psychological disturbance. Other options for maintaining consistency, not spelled out by Rogers but articulated by EFT, are to attack the self, to attack others for being conditional, or to deny the need for the regard of others (i.e., radical independence).

In Rogers's (1959) view, person-centered therapy is effective because the therapeutic relationship provides an antidote to the introjected conditions of worth as clients have the corrective experience of being seen as they are (empathic) and being genuinely (congruence) accepted in an unconditional manner (unconditional positive regard) for who they are. As EFT therapists, we adopt these core conditions as our basis and also propose that the reduction in interpersonal anxiety produced by the conditions, as well as being curative in and of itself, also allows clients to tolerate more intrapersonal anxiety and this helps them to focus on, and explore, previously denied or distorted anxiety-generating internal experiences (Greenberg, Rice, & Elliott, 1993; Rice, 1974).

Process research gradually began to influence Rogers's (1959) theory and demonstrated that clients' *immediate experiencing* in therapy was related to outcome (Gendlin, Jenney, & Shlien, 1960; Kiesler, Mathieu, & Klein, 1967). Rogers thus developed a concept of seven stages of client process, which were operationalized into a Process Scale, and Gendlin and colleagues (Klein, Mathieu, Gendlin, & Kiesler, 1969) developed a related

Experiencing Scale that measured the extent to which the individual was remote from, or engaged with, his or her experiencing.

EXPERIENTIAL FOCUSING

Gendlin (1962) presented his own account of psychotherapy in which experiencing, the process of concrete bodily feeling, constituted the basic datum of psychological phenomena. Awareness of this basic datum was seen as essential to healthy living. Gendlin argued that optimal self-process involves an ever-increasing use of experiencing as a process in which felt meanings interact with verbal symbols to produce an explicit meaning and in so doing moved away from more structural, denial-incongruence models to a process view of functioning. EFT adopts this process view.

Blocking of the experiencing process was seen as the cause of dysfunction. In Gendlin's (1962) view, it was not so much the content of the perception but the manner of experiencing that was the problem. In dysfunction, it was the experiencing of structure and patterns, rather than the immediacy of the present event, that was the problem. Effective process in therapy then involved directing clients' attention to their present experience, and this was shown to affect physiology and meaning creation. Gendlin (1996) termed this process *focusing*.

Central to Gendlin's (1996) thought was the idea that human experiencing has a rich intricacy that can be articulated conceptually and linguistically only to a limited degree. There always is far more to a person's experiencing than can be put into words or concepts, but if people attend to their experiencing, words and symbols may be found to describe their experience. Focusing involves checking words against experience and finding a fit that generates the feeling of certainty ("Yes, that captures it"). Gendlin used the term *felt sense* to refer to the "it" that is captured. An important tenet is that the felt sense can be articulated in a variety of ways, but the expression cannot be random. The felt sense is vague in that there are as yet no words for it, but quite precise in that only certain words will "fit." Making the implicit explicit becomes the process goal of treatment.

It is the interaction between the continuing feeling process and the attention that is brought to it that generates a specifiable feeling, a "this."

The feeling is then recognized as of a particular sort. Gendlin labeled that to which one can directly refer in this way a *direct referent*; symbolizing it, in Gendlin's term, carries it forward. As Campbell (2004) noted, it is thus impossible to draw a sharp line between finding and making, discovering and creating. When we hold a ball in our hand, the form of the grasp is a function of hand and ball. Experiencing that which is implicit in the referent implies what may come next if it is grasped with attention. "Implying" is not like logical implication; something more is required to complete it. Automatic emotional responding and tacit meaning making thus may cause a bodily felt sense, but because it is not in the center of awareness, it is ignored. The felt sense implies what is felt, but unless the client attends to the felt sense, it is never organized sufficiently into a form that can be recognized as a feeling, and thus cannot be processed.

In this view, language, then, is seen as creating meanings rather than as acquiring its meanings through corresponding to, reflecting or being congruent with a nonlinguistic reality. Symbolization thus is no longer seen as involving congruence between symbols and experience. This reformulates Rogers's notion of congruence and introduces a complex constructivist element to a phenomenological perspective. EFT adopts this type of constructivist perspective; it regards interaction between emotion and symbol as central to the creation of meaning.

The felt sense differs from emotional reactions, such as crying or yelling, which involve actions that are very specific forms of behavior in which we are likely to lose track of the intricacies of the situation. What is involved in having a felt sense is that there is an implicit sensing of what the situation requires, which would be impossible to put fully into words. When Gendlin referred to the felt sense, he did not mean an explicit emotion (e.g., fear, anger, sadness), nor did he mean body sensations (e.g., soreness, tightness). The felt sense of the whole situation of the sadness of loss contains more than sadness. It includes a sense of the missing of a loved one, the feeling of the irreplaceable and unique importance of that person in one's life, and the feeling of not knowing how one will carry on without the other. The felt sense differs from emotions; according to Gendlin, emotions are more specific reactions to particular kinds of situations and less uniquely intricate about something than is a felt sense.

When Gendlin referred to emotion, however, he often was referring only to experiences in which individuals are overcome by their emotions, and he referred to these as *sheer emotions.* In EFT, distinctions are made between different types of emotion, and Gendlin's view of sheer emotion is regarded as a reference to a particular class of emotions (*secondary emotions*). EFT therapists agree with his arguments against the value of venting and against the cathartic view of the value of emotional expression, but we propose that *primary emotions*, rather than being sheer emotions, are fundamental aspects of what constitutes experiencing and that it is important to access and express these emotions for their information action, tendencies, and need.

Thus, whereas Gendlin and Rogers regarded experiencing as the basic datum of existence, EFT takes emotion as the fundamental given and sees experiencing as a higher order, complex derivative of blends of affective responses and meaning that results from a tacit synthesis of many levels and types of processing (Greenberg & Pascual-Leone, 1995, 2001). Sadness in response to a loss is the fundamental response, whereas the felt sense of the irreplaceable nature of the loss and the sense of not knowing how to carry on is a complex derivative. EFT incorporates the importance of Gendlin's felt sense and adds the recognition of the importance of basic emotions and emotional arousal. EFT therapists believe that the felt sense must be attended to and symbolized to create meaning but that the categorical emotions such as fear, anger, and sadness also must be aroused and regulated to provide access to implicit appraisals, action tendencies, and needs that inform us of what is good for us and move us to adaptive action.

In terms of practice, Gendlin (1996) developed an approach he termed *focusing.* The first phase of focusing involves attending to the bodily felt sense. As one does this, the felt sense of the situation becomes clearer. He called the second phase *unfolding.* Through giving attention to the felt sense one finds that it begins to "open up," and new meanings emerge. The third phase of the focusing process is *global application.* Here one experiences a flood of associations with other situations, circumstances, and memories. The fourth phase of focusing is *referent movement.* This involves a shift in "how it all feels," a shift in the whole felt sense of the issue.

Whereas Rogers initially proposed a single therapeutic intention (i.e., checking one's understanding), Gendlin's view introduced a dual intention model: to provide an understanding environment and also to deepen experience. Attending to the immediately felt data of experience became a new process goal of therapy, in addition to empathic understanding, and this view gave birth to experiential psychotherapy in which the key process and the goal was seen as the deepening of experience. EFT builds on these two major intentions and expands the approach by proposing further intentions. EFT proposes a marker guided, process directive approach that sees therapy as involving empathic understanding, deepening of experiencing plus a variety of context-specific intentions such as promoting, attending, expressing, regulating, and symbolizing that depend on recognizing different in-session situations and client states. EFT thus offers a multi-intentional model of therapy in which, in addition to conveying empathy and deepening experiencing, different methods are used at different times to promote specific emotional processes.

This adoption of multiple intentions and specific interventions has created controversy as to whether EFT is true, in turn, to person-centered, Gestalt, or humanistic–existential principles. Classical person-centered therapists who view nondirectiveness and the therapeutic attitudes as the key ingredients of therapy tend to see the use of therapeutic techniques and therapist intentions as being too directive or nonrelational. Gestalt therapists regard any form of goal directed or prescribed intervention and change process as contrary to open experimentation and see the use of specific methods as too prescriptive and not sufficiently authentic or relational. EFT proposes that it is *process directive* rather than *content directive*, and that so long as the therapist's understanding of the client's experience is not imposed on the client, the use of specific procedures do not necessarily conflict with being relational or viewing clients as experts on their own experience. In EFT, the therapist is not an expert on what the client is experiencing or should experience, but rather is an expert on how to help the client to experience. The use of techniques is not seen as making clients experience but as enabling experiencing to occur. The addition of marker-guided intervention to the core relational conditions and its

emphasis on method are EFT's unique contributions. These additions were never intended to diminish the significance of the curative aspect of the person-centered relationship and I–Thou relating, in which therapist and client are open and genuinely present and responsive to one another. EFT intervention methods have always been seen as being particular ways of relating, rather than as technical treatments that view the client as an object.

The use of methods thus does not violate the I–Thou dialogue or conflict with treating the client as an agent.

GESTALT THERAPY

Gestalt therapy (Perls, 1947; Perls, Hefferline, & Goodman, 1951) forms an intrinsic part of EFT. Like Rogers, Perls (1969) held that many difficulties were the outcome of a conflict between an image (self-concept) that the person is trying to actualize and what in Gestalt was called the *self-actualizing tendency* (Rogers's organismic experiencing). In Gestalt theory, introjects (conditions of worth) are seen as interfering with self-actualization by having people behave and experience according to their "shoulds" rather than their feelings and needs. Some form of agency in the personality ("I") was seen as either identifying with, or alienating itself from, aspects of spontaneous, preverbal level of experiencing to form a "me" (James, 1890). Awareness of the process of identification and alienation of experience was seen as the road to health. Awareness of functioning provided people with the option to choose, if and when, to own experience and act on it (Perls et al., 1951). Therapy, then, offered clients experiments of deliberate awareness to promote the experience of being an active agent in the creation of their experience; this allowed the person to begin to experience that "I am the one who is thinking, feeling or doing this" (Perls et al., 1951).

Perls was committed to the idea of an inherent organizing tendency and emphasized self-regulation as a natural or organismic tendency. Effective self-regulation was seen as depending on discriminating feelings and needs by means of sensory awareness. A core assumption was that the healthy organism "knows" what is good and should be assimilated and what is bad and should be rejected. Gestalt therapy adopted a dynamic,

field theory view of motivation in which the most dominant need was seen as emerging in the situation and as organizing the field. For example, people at a party are organized by whether one is interested in finding a date, needs a ride home, or is looking for a job. Organismic wisdom works by a spontaneous emergence of needs to guide action. Life is the process of a need arising and being satisfied and the next most urgent need emerging and being satisfied. Needs appear to be the most basic process in this theory. How needs arise, however, remained a mystery. In EFT, need emergence is explained in terms of scheme activation.

According to Gestalt theory (Perls et al., 1951), health involves the owning of emerging experience, whereas dysfunction involves the automatic *disowning* or *alienation* of this experience. Pathology or dysfunction occurs when the need-satisfaction process is interrupted. This occurs because of lack of awareness. A variety of interruptive mechanisms, including introjections, projections, and retroflections, block awareness and prevent contact with the environment and need satisfaction. Other phenomena such as conflict between polarities, habits, unfinished business, avoidance, and catastrophizing are also seen as important processes that block awareness and need satisfaction and produce dysfunction. In addition, the person is viewed as being constituted by parts and as functioning by the integration of polarities. In essence, a modular theory of self is postulated in which there existed different parts of the person that needed to be integrated and dysfunction arose because of a lack of integration. These ideas have all been incorporated into EFT.

Gestalt theorists also proposed a self-as-process model (Perls et al., 1951). According to this model, the self comes into existence in the experience of contact (i.e., I "am" my experience). The self is therefore removed from "inside" the person and becomes a field process (Perls et al., 1951; Wheeler, 1991; Yontef, 1995). In process terms, self is the meeting point of internal and external, achieved by a process of what EFT and dynamic system theory refer to as a *dynamic synthesis* of all elements of the field. The self is formed on the surface, not somewhere deep inside, and it forms continually, at the ever-changing boundary between the organism and the environment, to fulfill needs, solve problems, and deal with obstacles. In this view, there is no true self, and the field (environment) is given an

important role in understanding experience. EFT's dialectical constructivist theory of self-formation draws on these views of self-function by seeing the self as a dynamic self-organizing system that is agent and the coming into being at the moment influenced by interaction with the environment.

In Gestalt therapy, the core process is to increase awareness by attending to feelings, sensations, and motoric processes. The client's awareness is followed in a disciplined manner as it makes contact with or withdraws from the environment. Awareness is followed as a continual process that changes moment by moment, as a need is recognized, acted on, and satisfied; as a goal is met; or as an interest is followed. Gestalt therapy thereby offers clients a means of becoming aware of their manner of constructing reality in the moment that this is occurring. This is aimed at helping people experience their agency in constructing reality and identify and rework unfinished business that impedes contact with present reality. EFT incorporates these aspects of Gestalt practice.

Gestalt therapy is process directive in style; the therapist makes process suggestions and observations. Initially, Gestalt therapists did not engage in empathic responding; rather, the graded experiment was used as the major form of intervention. This experimental method involved setting up tasks in the session, not so much to be completed as to discover something new. Essentially, the experiment involved "try this" followed by "what do you experience now?" EFT has adopted a number of key experiments from Gestalt practice and specified more clearly when they are best used and what processes they facilitate that lead to change. EFT has incorporated Gestalt therapy's emphasis on accessing and heightening emotional experience and awareness and added this to the person-centered emphasis on provision of safety and to experiential therapy's emphasis on the deepening of experience. Making experience vivid in awareness and searching the edges of awareness are both emphasized in EFT.

EXISTENTIAL THERAPY

Existential therapy has influenced EFT's broader view of human nature and life's ultimate concerns. The existentialists tend to be more future oriented, seeing the person as striving toward and being motivated by goals

and ideals. They believe in possibility, in the sense of potential, ability, or capacity. The person exists as a bundle of possibilities for relating to the world, and at any time, a particular possibility is carried out. In addition, human beings have the capacity for understanding that they have possibilities and, therefore, are also aware if they do not carry them out. Each individual has to choose which possibilities will be carried out and which will not, and the person is viewed as responsible for this choice. In this way, therapy is focused on helping people choose which potentialities to carry out.

In an existential view, no innate "essence" precedes existence; rather, people determine themselves. People are born morally neutral, with a penchant for health and sickness and for good and evil. However, people are seen as having innate worth in the sense that they have the ability to know the difference between good and evil and the capacity to choose. Frankl (1959) proposed a *will to meaning* as a fundamental human drive. EFT adopts this view that meaning creation is central in human functioning.

In existential theory, dysfunction has been seen as resulting from lack of authenticity, alienation from experience, and the resultant lack of meaning, isolation, and ontological anxiety. There is an inevitable anxiety about the "givens" of existence, the ultimate concerns such as finiteness, freedom, isolation, and meaninglessness (May, 1977; Yalom, 1980). The anxiety generated by a person's awareness of these ultimate concerns is considered to lead to defense mechanisms, which block the person's capacity for making authentic choices. For the existentialist, the awareness of the ultimate concerns leads to anxiety and defenses (May & Yalom, 1989; Yalom, 1980). EFT adopts existential therapy's focus on dealing with the ultimate concerns and choice as one of the possible foci of treatment.

TRACING THE DEVELOPMENT OF EFT AS A UNIQUE APPROACH

EFT grew out of a research-based approach to understanding change processes in psychotherapy (Greenberg, 1979, 1986; Rice & Greenberg, 1984) coupled with an interest in the role of emotion in human functioning (Greenberg & Safran, 1984, 1987). At York University in the early 1970s,

Laura Rice and I began to view therapeutic change as the result of a helping relationship constituted by the client-centered relational conditions, plus the impact of significant events in therapy, which led to specific types of change processes and different types of changes. Over time we came to see that certain significant change events could be characterized as cognitive-affective problems marked by the client entering certain states (markers) amenable to particular types of intervention. Clients were construed as active agents trying to resolve problems, whose efforts therapists could facilitate by specific interventions. We referred to the clients' and therapists' efforts to promote change on the problem as *therapeutic tasks.* This led to the marker-guided, process diagnostic approach to differential intervention, which is the hallmark of EFT. The first two tasks we studied were the resolution of problematic reactions by systematic evocative unfolding taken from person-centered therapy and the resolution of splits by two-chair dialogue taken from Gestalt therapy (Greenberg, 1979; Rice & Greenberg, 1984).

In tandem with my clinical training in person-centered and Gestalt therapies and the Satir approach to systems, I immersed myself in J. Pascual-Leone's (1987) neo-Piagetian constructivist model of mind in which experience was seen as being determined by the automatic activation of schemes plus the action of deliberate processes such as attention and reasoning. In this model of mind, situations might act as cues that pull for a certain response, but people as agents also can focus or disattend to cues and thereby amplify or interrupt their automatic responses and influence their responses (J. Pascual-Leone & Johnson, 1999). Affect was given some role in this model as boosting scheme activation but was not a focus in modeling cognitive problem solving.

After my therapy training and through studying the process of change (Greenberg & Pinsof, 1986; Rice & Greenberg, 1984), I became convinced that emotion was central in therapeutic change and that affect boosted scheme activation and guided our processing in resolving problems in living. I saw too that emotion had been ignored, or not clearly conceptualized, in most theories of functioning and of therapy. Initially, my clinical views and the development of my ideas were influenced by working with

clients in outpatient settings, private practice, and university and school counseling centers. Trust and acceptance in the relationship appeared to be a crucial element of therapeutic effectiveness. This form of relating promoted the safety needed to disclose underlying feelings and provided the type of corrective emotional experience that occurs through the empathic attunement to affect. This promoted the dyadic regulation of affect. These populations often were emotionally overregulated, and helping them become more aware of emotions and to experience, rather than talk about, their emotional experience seemed crucial.

The origins of EFT were presented in two books, *Patterns of Change* (Rice & Greenberg, 1984) and *Emotion in Psychotherapy* (Greenberg & Safran, 1987), which laid the groundwork for marker-guided intervention and for understanding emotion in therapeutic change. From the start, my goal was to study the process of change and articulate the role of emotion in individual and couples therapy rather than to develop a brand name therapy (Greenberg & Johnson, 1986; Greenberg & Safran, 1984, 1987). The development of the brand name, EFT, came later, in connection with naming the couples approach. The development of a brand name approach was dictated by the questionable move, in my view, in the field toward testing the effects of manualized treatment. Although I believe in the importance of the empirical investigation of psychotherapy, the emphasis on clinical trials as the gold standard has led away from understanding the processes of change. In the context of the evidence-based treatment movement, however, treatments had to be manualized and their effects tested to have validity and gain legitimacy. We thus manualized an approach to couples and individual therapy, and although this has been productive, my ultimate commitment is toward a scientifically investigated, integrative approach to treatment rather than to brand name therapies. Schools of therapy are often more political, economical, and power based than knowledge focused.

Along with my growing understanding of the role of emotion in change, an important parallel development in my thinking was taking place in conceptualizing the role of the therapeutic alliance in change. In 1974, I was present at the first presentation of Bordin's concept of the

working alliance as a core ingredient of change. According to Bordin (1979), the working alliance was constituted by the type of relational bond formed by an agreement on goals and by the perceived relevance of tasks engaged in therapy. The latter two aspects were an operationalization of the idea of collaboration in the work of therapy. I encouraged one of my doctoral students to work on developing the Working Alliance Inventory in his dissertation, which we did, and there we found that the alliance, and especially the collaboration components, was more effective in predicting outcome than either perceived empathy or the bond component of the alliance (Horvath & Greenberg, 1989). I thus came to see perceived task relevance and task collaboration as more predictive of outcome than empathy. Over time I came to understand that collaboration involved an enactment of empathic understanding that led to offering appropriate interventions that fit clients' needs and that this enactment was even more helpful than only the verbal communication of an understanding of the client's inner world. Collaboration on task, in addition to communication of empathy, thus became an important foundational principle of an EFT approach and a core ingredient of our theory of relationship.

During my first sabbatical, in 1981, I completed an externship, in systemic approaches at the Mental Research Institute in Palo Alto, under Carlos Sluzki. There I began integrating the emotion-focused perspective that I had been developing in individual therapy with a systemic interactional perspective, to develop and study an integrative emotionally focused approach to couples therapy. I then developed a research program at the University of British Columbia to see whether couples resolved interpersonal conflict in a similar fashion to intrapsychic conflict resolution, which I had studied in individual therapy (Greenberg, 1979; Greenberg & Clarke, 1979; Greenberg & Webster, 1982). To do this I developed the Emotion-Focused Couple Therapy (EFT-C) manual in which systemic perspectives were assimilated into an experiential approach (Greenberg & Johnson, 1986, 1988).

The unique contribution of EFT-C to a systemic view was the focus on the role of emotion in maintaining negative cycles and the use of emotion to break negative interactional cycles and to create new patterns

of interaction (Greenberg & Johnson, 1986, 1988). Negative cycles were reframed in terms of more vulnerable underlying feelings and needs. The emphasis was on the importance of emotional disclosure of vulnerability in bringing about connection and on promoting empathic responsiveness to disclosed vulnerability. EFT-C thus added experiential work with feeling to systemic work with interaction; by focusing on emotion, it put the self back into the system.

After working extensively with couples and families in 1986, I refocused on studying the experiential change processes in individual therapy, now in the context of the resolution of interpersonal emotional injuries (Greenberg & Malcolm, 2002; Paivio & Greenberg, 1995) and the treatment of depression (Greenberg, Rice, & Elliott, 1993; Greenberg & Watson, 2006; Greenberg, Watson, & Goldman, 1998). I had by this time fully developed a style that combined following the client empathically, which came from person-centered therapy, with process guiding, which came from a Gestalt experimental style and from working with couples in directing interactions and promoting enactments. Collaboratively, Laura Rice, Robert Elliott, and I laid out the basic principles of a process experiential approach, on the basis of a marker-guided, process directive approach to treatment that focused on emotion scheme change (Greenberg, Rice, & Elliott, 1993).

EVOLUTION TO THE PRESENT

After the effectiveness of an emotion-focused, process experiential approach to treatment had been demonstrated in the treatment of depression, couple distress, the resolution of interpersonal problems, and trauma (Goldman, Greenberg, & Angus, 2006; Greenberg, Watson, & Goldman, 1998; S. M. Johnson & Greenberg, 1985a; Paivio & Greenberg, 1995; Paivio & Nieuwenhuis, 2001; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003) and we had completed a variety of studies (see Chapter 5, this handbook) relating process to outcome, it was time to articulate the basic principles of an overarching emotion-focused approach to functioning. These were set out in the book *Emotion-Focused Therapy: Coaching Clients to Work*

Through Their Feelings (Greenberg, 2015). In this book, the term *emotion-focused therapy* was coined for the overall individual and couples approach to adhere to the more general American usage in psychology of the term *emotion-focused coping* (Greenberg, 2015). The idea of therapists acting as emotion coaches was introduced. This completed the effort started in *Emotion in Psychotherapy* (Greenberg & Safran, 1987) and continued in *Working With Emotions in Psychotherapy* (Greenberg & Paivio, 1997) to understand the role of emotion in therapy. In addition, the emotion-focused approach began to be taught and practiced in a variety of multicultural contexts and was found to be applicable with some modifications. We found that more trust and more explicit rationales for working with emotion often were needed to adapt to more communal cultural contexts in which emotion expression was more restricted out of concern for its impact on the other.

By this time, the theoretical importance of an individual's core maladaptive emotion schemes in psychological distress became more clearly articulated. People's core fears and sadness related to abandonment, and their shame and anxiety related to invalidation and diminishment became a focus of treatment. The overall importance of affect regulation in human functioning also became clearer. A key principle of emotional change, changing emotion with emotion, was also articulated (Greenberg, 2015; Greenberg & Watson, 2006).

I also have been involved with the constructivist psychotherapy movement since the 1990s (Guidano, 1995; Neimeyer & Mahoney, 1995) and found this view, and subsequently narrative views (Angus & McLeod, 2004), helpful in articulating the meaning-making aspect of EFT. The constructivist view can be understood best in contrast with the realist perspective that is typically aligned with cognitive therapy and error analysis, and that assumes there is an objective, consensual reality. Constructivism, on the other hand, posits that everything is a construction of the mind and so meaning making, rather than correcting errors, was of central importance in constructivist psychotherapy. A dialectical constructivist perspective on functioning emphasized the interaction of emotion schemes and narrative, seeing emotion as a principal organizing factor in the evolution

of consciousness and as crucial to higher order levels of complexity. EFT has since incorporated influences from Piagetian and therapeutic views of constructivism (Greenberg & Pascual-Leone, 1995, 1997, 2001). Our dialectical perspective integrates the bottom-up, essentialist idea that discrete emotions do exist and are quantifiable, alongside the top-down constructivist notion that it is what we make of our emotions that determines how they function.

The arrival of the new millennium saw a number of new developments. Jeanne Watson compared EFT with cognitive–behavioral treatment, helping to establish EFT as an evidence-based treatment (Watson et al., 2003). In addition, Elliott, Watson, Goldman, and Greenberg (2004) further specified aspects of the treatment to aid in learning the skills of EFT. Sue Johnson and her colleagues popularized the original approach to couples (Greenberg & Johnson, 1988) making it into a more attachment-based approach (S. M. Johnson, 2004), which vastly expanded the recognition of EFT. (Although I do believe that attachment is important, I remain fundamentally an emotion theorist and see attachment as well as identity needs as deriving from emotion, rather than as basic motivations in their own right.) Sandra Paivio developed EFT for complex trauma (Paivio & Pascual-Leone, 2010). In addition, a number of investigators began to study EFT for anxiety disorders. Elliott (2013; Elliott, Rodgers, & Stephen, 2014), and Shahar (2014) developed and studied treatments of social anxiety, whereas Timulak (2015) and Watson and Greenberg (2017) have done so for generalized anxiety disorder (GAD). More recently, Dolhanty and Lafrance Robinson (Lafrance Robinson, Dolhanty, & Greenberg, 2015) developed emotion-focused family therapy (EFFT), a promising model of therapy for families who require a more intense treatment than best practice family-based treatment, to bring about improved recovery from an eating disorder.

The previous developments all led to a fleshing out of a full-blown approach to the use of EFT in treating different disorders in *Emotion-Focused Therapy of Depression* (Greenberg & Watson, 2006), *Emotion-Focused Therapy for Generalized Anxiety* (Watson & Greenberg, 2017), and *Emotion-Focused Couples Therapy: The Dynamics of Emotion, Love,*

and Power (Greenberg & Goldman, 2008). In addition, *Case Formulation in Emotion-Focused Therapy* (Goldman & Greenberg, 2014) and *Supervision Essentials for Emotion-Focused Therapy* (Greenberg & Tomescu, 2017) spelled out different aspects of the approach. Each of these books presents the development of the approach, the course of treatment, case formulation, supervision, and a theory of functioning on the basis of the role of emotion and affect regulation in maintaining attachment and identity, as well as achieving intimacy. Finally, books fleshing out an EFT approach to working with narrative (Angus & Greenberg, 2011) and therapeutic presence (Geller & Greenberg, 2012) have focused on the meaning-making and relational aspects of EFT.

3

Theory

GENERAL THEORETICAL DEVELOPMENTS

Contemporary *emotion theory* (Frijda, 1986; Greenberg, 2015; Greenberg & Paivio, 1997; Greenberg & Safran, 1987) holds that emotion is fundamentally adaptive in nature, and in emotion-focused therapy (EFT) this provides the scientific basis for the growth tendency. In this view, emotion helps the organism to process complex situational information rapidly and automatically, to produce action appropriate for meeting important basic needs (e.g., attachment, identity). Emotions provide rapid, automatic appraisals of the significance of situations to people's well-being and therefore guide adaptive action. Emotion in combination with a dynamic self-organizing systems view provides a more adequate explanation of Rogers's organismic valuing process and Perls's organismic wisdom.

In EFT, humanistic perspectives on subjectivity and perception have been connected to *constructivist* epistemology and views of functioning.

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People are seen as dynamic self-organizing systems in which various elements continuously interact to produce experience and action (Greenberg & Pascual-Leone, 1995, 1997; Greenberg & Van Balen, 1998). In this view, the "I" is an agentic self-aspect or self-narrating voice that constructs a coherent story of the self by integrating different aspects of experience in a given situation. This voice, however, has no special status as an "executive self"; rather, people are seen as constantly synthesizing conscious experience out of many levels of processing, constantly configuring experience and reality into meaningful wholes (Greenberg & Pascual-Leone, 1995, 1997; Greenberg, Rice, & Elliott, 1993). Three major levels of emotional processing—innate sensorimotor, emotional schematic memory, and conceptual level processing—have been identified (Greenberg & Safran, 1987), and emotion-based schemes are seen as playing a central role in functioning.

In classical humanistic approaches, *experiencing* was treated as the given *datum*—it just happens. According to EFT, however, experiencing can be understood as the synthesized product of a variety of innate sensorimotor responses and acquired emotion schemes (as is described in the section that follows), tinged with conceptual memories, all activated in a situation (Greenberg, Rice, & Elliott, 1993). In this view, multiple patterns of neural activation (schemes) are evoked by the same releasers and function together to produce a complex, coordinated internal field (Greenberg & Pascual-Leone, 1995, 1997, 2001). The internal field, constructed from its component schemes, provides the person with a sense of internal complexity to which to refer and in which much more is contained at any one moment than any one explicit representation can capture.

In EFT, congruence between self-concept and experiencing is no longer viewed as the main mechanism of dysfunction. Instead, problems are seen in part as arising from the way experience is constructed. In addition, rather than viewing problems as arising only from the nonacceptance of experience, as do classical humanistic and current acceptance-based cognitive therapy approaches, EFT is concerned with emotion utilization and people's relationships with their own emotions in therapy. Problems are seen as arising from maladaptive responding on the basis of feelings such as fear, sadness, and shame stemming from past painful experiences

as well as from dysregulated emotions (being overwhelmed by them). People are seen not as possessing a self-concept but as actively narrating their experience, constructing views of who they and others are as well as how and why things happened (Greenberg & Angus, 2004; Greenberg & Pascual-Leone, 1995). People also have many views of themselves, and they are constantly revising these while engaged in an ongoing process of creating coherence and unity. In each moment, people are the expression of one of many possible selves.

In an EFT view, the principle of *coherence* replaces the traditional principle of congruence as the final arbiter in explaining healthy functioning. Thus, it is not simply that the client becomes aware of his/her "feelings," that his/her self-concept and experience are consistent with one another; it is not that dysfunction is caused by disowning fully formed experience. Rather, the client forms a coherent sense of self (e.g., angry, sad, confident, unsure), which successfully organizes previously unformulated aspects of experience, integrating them into a coherent whole that is viable in a given situation. Adaptive functioning involves discovery of experience and coordination of different aspects of experience. Synthesizing different levels of processing generates a coherent whole that makes conscious sense and is identified as integral with one's self. This view helps overcome the problem, in language and thought, of presuming the operation of any fully formed preexisting hidden content or meaning that comes into awareness and is accepted into a self-concept. Rather, there is an ongoing process of attending to and organizing different levels of processing and different modules of experience, which themselves have been synthesized, out of awareness, to form a complex internal field that can be symbolized in awareness.

In this view, discovery of experience and creation of meaning operate in tandem, neither process being privileged over the other (Greenberg, Rice, & Elliott, 1993; Greenberg & Safran, 1987). The person is an agent who acts to become aware of needs and creatively resolves problems that arise from interactions with the environment. Consistent with Gestalt field theory, need emergence is seen as a field event rather than as an inner drive and occurs as internal and external elements are synthesized into coherent forms.

In addition, emerging internal experience and interpersonal support are seen as active ingredients in the process of change. Meaning is created by human activity, in dialogue with others, and people are seen as creators of the self. In integrating a relational and a growth model, change is seen as emerging through the self-organization of some type of biologically based, emotionally guided growth tendency and also from genuine dialogue between two people. Change thus occurs by the coconstruction of new meaning in a dialogue between client and therapist. In this dialogue, the therapist plays an active role in confirming and validating clients' emotional experiencing and thereby helping them synthesize an identity. Therapeutic presence (Geller & Greenberg, 2002, 2012) in an I–Thou dialogue (Buber, 1958, 1965) in which each person is made present to, and by, the other is seen as important. The therapist contacts and confirms the client by focusing on the client's internal experience and validating that it makes sense.

The growth tendency is thus seen as being dialectically guided from within and without. The internal aspect is guided by the emotion system, which evaluates situations in relation to well-being (Frijda, 1986; Greenberg, Rice, & Elliott, 1993; Greenberg & Safran, 1987). Support of the growth process comes from the therapist, who sees the client's coping efforts, confirms and validates them, and focuses on possibilities and strengths. This influences what is activated in the person's internal experience. In other words, growth occurs in an interpersonal field. It is strengthened by being focused on, symbolized, and confirmed in dialogue. Growth thus truly emerges from the "in-between," from two people working together in a collaborative alliance toward the client's survival, enhancement, and affirmation of life. The therapist's ability to help the client explicate experience and to focus on implicit growth-oriented possibilities is an important element of promoting the client's directional tendency.

VIEW OF HUMAN NATURE AND MOTIVATION

EFT offers a positive orientation toward human nature. Human beings are seen as being determined by more than biologically reinforced contingencies, innate drives, or the past; they are seen as having the potential

for creativity and agency and as capable of awareness and choice. People are understood to be oriented toward survival and growth and are best understood as striving for adaptive viability in the environments in which they find themselves.

EFT adopts an integrative view of motivation and posits that multiple forces guide experience and behavior. Motivation is viewed as involving elements of *push*, in the form of desire and need, as well as *pull*, in being driven by stimulus and consequence or reward. Individuals are agents with intentions and goals in interaction in a social field; awareness, choice, and context are the final determiners of action. Because individuals exist in a social field, experience and behavior emerge as a function of what is occurring in the organism and in the environment. There are strong cultural and subcultural views of emotion and rules of emotional expression and emotional experience, and expression is thus influenced by biology and culture.

People are dynamic self-organizing systems in constant interchange with the environment, forming and being formed in mutually regulating ways. Regulation can be broken into *self-regulation*, involving satisfying one's desires and calming one's fears, as well as *other regulation*, which involves having desires satisfied and fears soothed by the other. These two forces of self and other in mutual regulation exist right from birth, at which time the infant feels hunger and self-organizes to suck, whereas the mother's breast produces milk to regulate the infant's need.

Affect Regulation and Meaning Creation

Affect regulation is seen as a core aspect of motivation: People are seen as being motivated to experience the emotions they want and avoid the emotions they don't want, and they have evolved this way because it aids survival and growth. Much action and interaction thus is driven by felt satisfaction—by the excitement and joy we experience when relationships are meeting our needs or when we attain our goals, and by the shame, anxiety, and loneliness when relationships fail or we do not reach our goals. In EFT, emotion guides us as to what is good and bad for us, and

we maintain our identities and pursue connection because of how these actions make us feel (Greenberg & Goldman, 2008). If touch was not experienced as soothing, we would not attach value to it, and if overcoming obstacles did not produce a feeling of joy or excitement, we would not strive to do so. It is important to note that although people primarily seek to feel "positive" and not "negative" emotions, all emotions are highly functional, and people self-regulate them with the aim of achieving their goals and not of simply seeking pleasure. Thus, a surgeon or soldier will sweat and strain for hours, not to achieve pleasure, but rather to feel the pride of satisfaction or the contentment of a job well done. Seeking pleasure and avoiding pain are not proposed as the primary motivations; rather, people are motivated to regulate their emotion because having emotions of particular kinds promotes adaptive, survival-related action.

EFT posits that people are motivated to seek meaning as well as to regulate affect. People are born into and strive constantly for meaning. Our main motivation for living is our will to find meaning in life. Meaning is not given and must be achieved. Meaning creation is central in dealing with suffering. Meaning also brings positive feelings, including pleasure (Greenberg & Goldman, 2008). People's goals therefore consist of more than just "feeling good"; at times, and under certain circumstances, they will seek negative emotions—tolerate pain, embrace anger, or sacrifice themselves—in the service of higher order feelings (e.g., virtue, love) or values (e.g., freedom, justice). In addition, culture influences what meanings are formed and how emotions are expressed.

What Are Needs?

What are *needs*, and where do they come from? Are we born with certain intrinsic needs, or do our emotions provide us with a template for the development of our needs? Assumptions that basic drives or motivations are a fundamental part of our nature are so deeply embedded in our theoretical preconceptions that it often takes a great deal of thought to recognize that life might not necessarily be governed by predetermined motivational systems. In my view, needs (unlike instincts or reflexes)

are emergent phenomena that are constructed via a complex process of development. Psychological needs are not simply innate, unlike biologically based drives (e.g., hunger, thirst, the fundamental motivation to survive and thrive). Rather, our human needs for safety, security, belonging, closeness, self-esteem, and what Maslow called *being needs*—seeking personal growth, peak experiences, creativity, and fulfilling one's potential—emerge and are coconstructed in our relationships with others. From an emotion-focused perspective, emotions, rather than needs, are the basic mental units that nudge the self in one direction or another. It is emotions that provide our fundamental preferences and biases. Needs, in this view, emerge out of a nonlinear, dynamic, self-organizing process derived from interactions among basic preferences and biases and lived experience in the environment. And so rather than postulate a set of basic motivations such as attachment, competence, autonomy, or control, we see needs as coconstructed from the basic affective values with which the infant is born, along with their interactional experience. The only major motivation we postulate is the tendency to survive and thrive, and this involves two subprocesses: affect regulation and meaning creation. These are not content-specific needs but general process motivations. All other needs of a specific nature, like needs for connection or power, emerge from what is more basic, emotional preferences plus experience from interaction. Thus, the infant is prewired through the affect system, for example, to favor warmth, familiar smells, softness, smiling faces, high pitched voices, and shared gazes. These all produce pleasant affect and therefore are sought after. Needs therefore do not derive from drives but from affect. They are constructed and influenced by biology, experience, and culture.

We have many needs, and they emerge continually as responses to what is going on around us. They emerge somewhat automatically, just like feelings. Identifying the basic human needs is probably impossible, because they are not fully predetermined, but from work with people in therapy, we have learned that needs related to attachment and identity usually appear to be of the greatest psychological concern to most people (Greenberg & Goldman, 2008). The need to be connected and protected, and the need to be effective and valued, appear to be related to people's

basic interpersonal nature (Bowlby, 1969; White, 1959); therefore, needs for safety and security as well as for novelty and mastery seem of critical importance. Our ancestors probably were more likely to survive if they remained connected to a group and if they were curious, because curiosity pushes people to learn about things ahead of time, before the necessities of survival demand it. Curiosity in humans, in conjunction with reason, promoted by a group that can support its inventors, has been the most powerful source of progress in civilization. Without attachment, interest, and curiosity, we would still be in the Stone Age—or perhaps not here at all.

EMOTION THEORY

In EFT, emotion is viewed as fundamentally adaptive and as providing 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. With the aid of emotions, people react automatically to their apprehension of patterns of sounds, sights, and smells and to other nonverbal signs of people's intentions in a way that has served us well as a species for centuries and as individuals for years. Fear-induced flight produces safety, disgust expels a noxious intrusion, and sadness creates a longing for the lost other. People respond emotionally, in an automatic fashion, to patterns of cues in their environment that signal novelty, comfort, loss, or humiliation.

Client emotions thus act as a kind of therapeutic compass, guiding the client and therapist as to what is important to the client and what needs are being met (or not met). A key principle of EFT is that emotions provide access to needs, wishes, or goals and the action tendencies associated with them. Thus, every feeling has a need, and every emotion scheme activation provides a direction for action, one that will indicate what need is not being met. When a client acknowledges feeling sad, this statement conveys that their tacit processing has evaluated that they have lost something important to them, are in need of comfort, and probably want to cry out for the connection. In individual therapy it often is maladaptive emotion schemes of past painful experiences that are evoked to make them amenable to change. By contrast, in couples therapy the

expression of underlying adaptive emotions and needs to the partner is seen as crucial in changing the partner's view of the self and emotion, and its expression thereby changes negative interactions (Greenberg & Goldman, 2008).

Emotion is a brain phenomenon that is vastly different from thought. It has its own neurochemical and physiological basis and is a unique language in which the brain speaks. The limbic system, a part of the brain possessed by all mammals, is responsible for basic emotional responses. It governs many of the body's physiological processes and thereby influences physical health, the immune system, and most major body organs. LeDoux (1996) identified two different paths for producing emotion: the shorter and faster amygdala pathway, which sends automatic emergency signals to the brain and body and produces gut responses; and the longer and slower neocortex pathway, which produces emotion mediated by thought. Clearly, it was adaptive to respond quickly in some situations, but at other times better functioning resulted from the integration of cognition into an emotional response (by reflecting on emotion).

The developing cortex added to the emotion brain's adaptive wisdom a new form of emotional response. This new emotional response system not only used inherited emotional responses, like fear of the dark, but also learned signs of what had evoked emotion in a person's own life experience, such as fear of one's father's impatient voice. Those *emotional memories* and organizations of lived emotional experience were formed into *emotion schemes* (Greenberg & Paivio, 1997; Greenberg, Rice, & Elliott, 1993; Oatley, 1992). Through these internal organizations or neural programs, people react automatically from their emotion systems, not only to inherited cues, such as looming shadows or comforting touch, but also to cues that they had learned were dangerous or life enhancing. These reactions are rapid and automatic.

Emotion Schemes

Emotion schemes are at the base of the adult emotional response system. They are 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. Schemes are elicited by cues that match the input features of the scheme and produce experience and action as their output. Important life experiences, significant by virtue of having activated emotional responses, become coded into *emotion schematic memory.* The emotion scheme represents the situation as construed and its emotional effect on the individual, and this is done in a predominantly wordless or imagistic script in the form of narrative. Thus, emotional memories of cuddling in one's mother's arms or being physically abused are coded as procedural memories of what happened and how this felt. The scheme represents an unfolding of an experience from the initial cue (e.g., a touch) to a sequence of moments of experience, with a beginning, middle, and end. The innate capacity for emotional response and experience thus evolve into core emotion schematic autobiographical memories with an internal narrative structure (Angus & Greenberg, 2011).

Emotion schematic learning makes emotions a flexible, adaptive processing system but also opens them to the possibility of becoming maladaptive. People 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 important issue is that the emotionally motivated, basic mode of processing that is set in motion by scheme activation occurs out of awareness and influences conscious processing. Only after this basic mode of processing has been activated does the person begin to process more consciously for sources of danger and ultimately symbolizes in words the appraised danger and generates ways of coping with it. Thus, the activation of a fear scheme sets a basic mode of processing for threat in motion, and this conscious processing works in the service of the affective goal activated by the scheme (e.g., safety in the case of fear). Emotion schematic processes can include linguistic components but often consist largely or entirely of preverbal elements (including bodily sensations, visual images, and even smells); emotion schemes are also oriented toward action to satisfy needs, goals, and concerns.

The development of schemes is best understood as the development of neural networks that represent the basic story of a lived experience. A network is shown in Figure 3.1. Here a scheme of fear of failing, formed

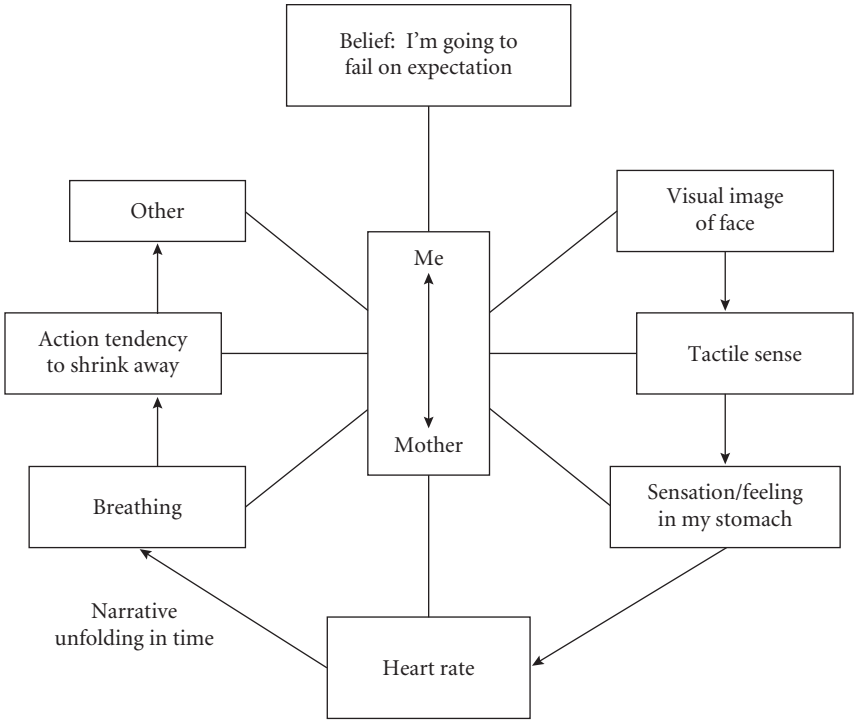

Figure 3.1

Emotion scheme.

from the experience of having failed a mother's expectation, contains components of a visual image of the mother's face, a variety of nonverbal physiological and sensory aspects of those experiences, as well as the action tendency to withdraw, and possibly, but not necessarily, a belief stated in language that the self is going to fail an expectation. The whole representation is an unfolding sequence, as shown by the arrows leading from one node to the next. The most obvious therapeutic implication is that optimal emotional processing involves activating the whole scheme and focusing on all of the narrative schematic elements. Particular difficulties occur when the person excludes all the elements from awareness or neglects one or more types of elements, so that his/her experiencing is not processed fully or coherently.

Putting emotions into words is an important element of healthy emotion utilization. Problems arise, however, when emotions are unconnected to cognition. Language gives conscious meaning to experience, and when emotions are connected to linguistically based cognitive affective organizing structures, they allow for more differentiated behavior. Moreover, when emotions are linked to cognitions and behaviors that do not fit the current context, they lead to maladaptive emotional responding on the basis of painful feelings (e.g., fear, shame) stemming from past experience. Past experience that remains uncognized and unaddressed leads to the development of maladaptive emotion schemes (Izard, 2009). Emotions also may become maladaptive when they overwhelm one's ability to make meaning. Thus, maladaptive functioning can also arise from the dysregulation of emotion (i.e., being overwhelmed by emotions).

Improved emotion regulation helps people cope, but enduring change occurs only through a developmental process involving the synthesis of two or more existing schemes and the formation of higher level schemes (Piaget & Inhelder, 1973). In development, when opposing schemes are coactivated, compatible elements from the coactivated schemes synthesize to form new higher level schemes. For example, in a 1-year-old child, schemes of standing and falling can be dynamically synthesized into a higher level scheme for walking, by a process of dialectical synthesis (Greenberg & Pascual-Leone, 1995; J. Pascual-Leone, 1991); similarly, schemes of different emotional states can be synthesized to form new integrations. Thus, a schematic emotional memory of fear and withdrawal from prior abuse can be synthesized with current empowering anger against violation, which motivates approach rather than withdrawal, to form a new sense of confidence or assertion.

Emotion Generation

The flow diagram in Figure 3.2 depicts the process of emotion generation; it can be used to think linearly about what is in reality a complex nonlinear and dynamic process. (A more representative form of a more complex dynamic process can be found in Greenberg & Pascual-Leone, 2001.) In

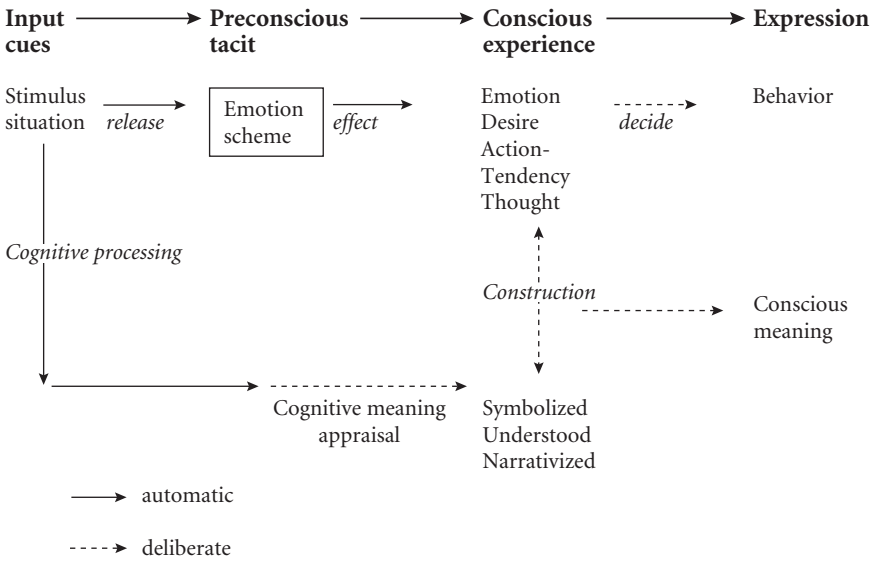

Figure 3.2

The dialectical construction of the self.

this diagram, attention to a stimulus preconsciously activates an emotion scheme (or more accurately, a number of schemes) by the cues matching the releasers of a scheme. For example, a frown or a raised voice activates a fear scheme. In addition, certain automatic cognitive processing takes place along a separate and ultimately slower path that helps generate conscious appraisals in language. Each scheme includes its basic components of affect, action tendency, need, and cognition structured in a wordless narrative; the person experiences the other as a threat, the body tenses and prepares for escape, and negative beliefs about self become primed. With attention, the activated scheme or schemes in turn may be symbolized in language, giving rise to conscious emotion, the concern or desire, an action tendency, and thought, and these combine, in the case of fear activation, to influence behavioral avoidance.

Note that in this model it is not cognitive appraisal in language that produces emotion; rather, it is a type of automatic pattern matching that releases the scheme that produces emotion. In this view, meaning appraisal

occurs at two levels. The first level is the rapid evaluation of patterns *matching* internal features of the emotion scheme where the evaluation is one of fit (e.g., a frowning face). The second level is a more conscious cognitive appraisal of explicit meaning (e.g., this person is angry at me and I am in danger). The latter is generated by more automatic and deliberate cognitive processes. The cognitive level of meaning in language is influenced by and interacts with the experiential output of the emotion scheme. However, emotion scheme activation provides our basic mode of processing information and sets specific emotion-based scripts (e.g., seeking, safety, closeness, boundary protection) into motion, plus certain anticipatory expectations that guide ways of thinking. Emotion schemes themselves are not directly available to awareness but can only be accessed indirectly through the experiences they produce. EFT works to activate schemes, articulate their output in language, and then explore and reflect on this experience to create new meaning (Greenberg, 2015; Greenberg & Safran, 1987). Emotion schemes thus provide implicit higher order organizations of experience on the basis of biologically given emotional responses influenced by the person's history of lived emotional experience. The emotion schematic memory system is the central catalyst of self-organization. It is the generator of not only healthy states (e.g., confidence, calm, security) but also of disordered self-organizations (e.g., anxious insecurity, shame-based worthlessness, lonely abandonment). Emotion schemes and their activation are the final targets of intervention.

Types of Emotion

Not all emotion serves the same function. It is theoretically and clinically crucial to distinguish between different types of emotional experience and expression to guide intervention. Four types of emotional experience are outlined in the following section.

The normal function of emotion is to rapidly process complex situational information, in order to provide feedback to the person about his/her reaction and to prepare the person to take effective action. Such uncomplicated responses are referred to as *primary adaptive* emotion

responses because the emotion is a direct reaction consistent with the immediate situation, and it helps the person take appropriate action. For example, if someone is threatening to harm a mother's children, anger is an adaptive emotional response because it helps her take assertive (or if necessary, aggressive) action to end the threat. Fear is the adaptive emotional response to danger and prepares us to take action to avoid or reduce the danger, by freezing and monitoring or, if necessary, by fleeing. Shame, on the other hand, signals that we have been exposed as having acted inappropriately and are at risk of being judged or rejected by others; it therefore motivates us to correct or hide to protect our social standing and relationships. Rapid, automatic responding of this kind helped our ancestors survive. Such responses are to be accessed and promoted. Not all emotions, however, are functional or fit the situation. The three types described in the following paragraphs generally are dysfunctional.

Maladaptive primary emotions are also direct reactions to situations, but they no longer help the person cope constructively with the situations that elicit them; rather, they interfere with effective functioning. These emotion responses generally involve overlearned responses, on the basis of previous, often traumatic, experiences. For example, a fragile client may have learned when she was growing up that closeness was generally followed by physical or sexual abuse. Therefore, she will automatically respond to caring or closeness with anger and rejection as a potential violation. (These are further discussed in the following section on dysfunction.)

Secondary reactive emotions follow some more primary response (i.e., they come second). Often people have emotional reactions to their initial primary adaptive emotion, so that it is replaced with a secondary emotion. This "reaction to the reaction" obscures or transforms the original emotion and leads to actions that are, again, not entirely appropriate to the current situation. For example, a man who encounters rejection and begins to feel sad or afraid may become either angry at the rejection (externally focused) or angry with himself for being afraid (self-focused), even when the anger is not functional or adaptive. Many secondary emotions obscure or defend against a painful primary emotion; others are emotional reactions to primary emotions. If the man feels ashamed of his

fear, he experiences *secondary shame.* People can feel afraid of, or guilty about, their anger, ashamed of their sadness, or sad about their anxiety. Secondary emotions can also be responses to interceding thoughts—in other words, an emotion that is secondary to a thought (e.g., feeling anxious because of an expectation of rejection). Some emotions can be secondary to thought, but it is important to notice that this is symptomatic emotion and that the thought itself stems from a more primary mode of processing set in motion by a maladaptive emotion scheme, probably the fear of rejection. Although thought can produce emotion, not all emotion is produced by thought.

Instrumental emotions are emotions expressed to influence or control others. For example, crocodile tears may be expressed to elicit support, anger may be expressed to dominate, and shame often is expressed deliberately to indicate that one's behavior is socially appropriate. A person may respond deliberately or out of habit, automatically or without full awareness. In either case, the display of emotion is independent of the person's original emotional response to the situation, although the expression may induce some form of internal emotional experience. These emotions are referred to as *manipulative* or *racket feelings.*

A DIALECTICAL CONSTRUCTIVIST MODEL OF SELF-FUNCTIONING: INTEGRATING BIOLOGY AND CULTURE

Human brain anatomy is seen as resulting in two important processes: the ability to have emotion and the ability to reflect on it, and because of this, life involves two major evaluations. The first evaluation is made automatically by our emotion system, out of awareness, without language. This evaluation tells us whether things are good or bad for us on the basis of fundamental appraisals such as relevance, novelty, threat, violation, loss, noxious intrusion, and goal attainment. This appraisal serves as the basis for the wisdom of the organism and for Roger's (1959) organismic valuing process that guides the growth process. Then we have a second order evaluation in which we consciously reflect, most often in language, on the output of our

first evaluation. Essentially we evaluate whether we can, and should, follow the directions suggested by the first evaluation. We assess whether we can trust our basic feelings and rely on them to guide us and whether we want to want what we want. It is this second level evaluation for which we are responsible and where agency and choice reside (Taylor, 1990).

The elements involved in the dialectical construction of the self are depicted in Figure 3.3. In this diagram, two main streams feed conscious experience: one coming from within, which is biologically based and affective in nature; and the other from without, which is linguistically based and cultural in nature. Both streams themselves are in constant interaction with others and the environment in a dialogical process of meaning construction. The internal affective stream provides the building blocks for a person's basic self-organization. Over time, this level is influenced by

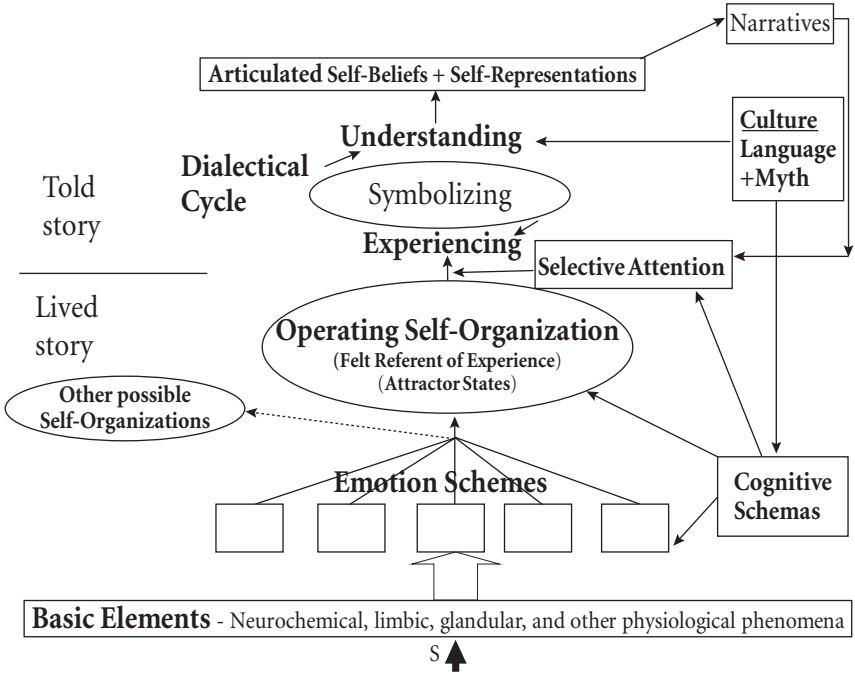

Figure 3.3

Emotion generation process.

cultural practices (e.g., culturally determined child-rearing practices) and by learning and experience and is organized into schemes on the basis of emotion experienced in situations. These emotion schemes become the primary generators of experience. They synthesize into *self-organizations*, which when attended to result in conscious experience. When experience is symbolized in words, this conscious dialectical process creates understanding, which is formed into beliefs, self-representation, and narratives, which in turn guide attention. The whole process forms a told story from the lived story of our 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, as shown in Figure 3.3, they are generated by a 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 direction in which the majority of schemes vote determines how the person is organized. Thus, feelings generated by one's quality of sleep, the pleasantness of one's interaction with one's family in the morning, and the ease or difficulty of one's drive to work all influence the vote on how one will organize (e.g., irritably, calmly) in response to a difficulty that arises at work. 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 and executive processes, which can either boost or interrupt the application of certain schemes (Greenberg & Pascual-Leone, 1995, 2001; J. Pascual-Leone, 1991). Attention to how one feels when one is reacting to a difficulty at work and understanding the reason for and consequences of one's reaction will all influence one's final experience, constructions, and response.

At any one time, a person is organized by a tacit, dialectical synthesis of a number of coactivated emotion schemes into one of many possible self-organizations (e.g., feeling confident, insecure, worthless, angry, sad, ashamed), which can change from one moment to the next. This tacit organization provides "the feeling of what happens": a bodily felt sense of oneself in the situation. This is one's *gut feeling.* Conscious experience results when this implicit feeling is attended to and symbolized explicitly

and one is able to sense the whole way something feels and create a coherent meaning that feels right. In EFT, the self is seen as a dynamic system, a multiprocess, multilevel organization that emerges from the dialectical interaction of many component elements. In this dialectical constructivist view, it is the synthesis of different levels and aspects of mental processing to create coherence that best explains human knowing.

EFT psychotherapists then work with the dialectic between ongoing, moment-by-moment implicit experience and the higher level explicit, reflexive processes that interpret, order, and make sense of elementary experiential processes. Articulating, organizing, and ordering experience into a coherent narrative is a set of major processes involved in integrating reason and emotion, head and heart (Greenberg & Pascual-Leone, 1995, 2001). Ultimately, it is the two-way communication between the implicit and explicit systems that constitutes who we are. Emotions move us, whereas meaning is what we live by.

The constructivist aspect of this perspective holds that we live by our constructions, and knowing always involves organization of and successive approximations toward reality rather than being able to know it directly. Whereas the constructivist aspect speaks to the nature of what we know, the dialectical aspect of dialectical constructivism refers to the process of the systematic weighing of contradictory information by the brain to resolve contradictions and construct coherent wholes.

Dialectical constructivism also argues that reality constraints limit our constructions and influence the meaning we create but that how we organize these reality constraints into a coherent meaning influences what we come to know. Dialectical constructivism steers a course between relativism ("anything goes") and realism ("nothing but the facts") by proposing that not all constructions fit the data equally well, although several different accounts might end up being plausible or valid. We simultaneously create, as well as discover, the world in which we live, who we are, and what we feel in the moment, and our self-understanding is changed by knowing what we feel.

In therapy, we work with a combination of discovering and creating experience to generate new meaning. A client who is jet-lagged after a flight and has low energy may symbolize this state as jet-lagged, tired,

depleted, depressed, despairing, hopeless, or suicidal. All of these symbolizations, to some degree, fit with the embodied, low-energy experience, and all these symbolizations fit the state much better than would labeling the state as happy or angry. How the experience is labeled clearly influences the client's next moment of experience and the narrative that ensues. Embodied experience constrains and influences how it is understood, but what people make of their experience also makes them who they are. This combined process of discovery and creation determines the self one is about to become in the next moment. Verbal symbolization represents and, at the same time, helps make the experience what it is. Moreover, by further reflecting on experiencing, we make narrative sense of what we feel. Thus, if the person labels the experience as depleted, he or she might understand it as being caused by having a bad case of jet lag, by working too hard, or by marital distress, and the explanation will form the basis of a narrative by which the person understands the experience. How we explain our experience to self and other creates narrative meaning.

According to this view, we see a multilevel process of emotion production by which evolutionarily fundamental emotions like fear, anger, and sadness are foundational to the construction of more complex emotion schemes. These schemes represent bottom-up processes that loom large in early stages of life and become more influenced by cognition with development. As one develops greater cognitive competence and more social-cultural experience, this too influences emotion in a top-down fashion, and so the influences are bidirectional. Most psychologists see cognitive development as promoting complex thinking, remarkable imagination and deep feelings, and I am no different. These developments are, however, built on an affective base, and I propose that these bottom-up emotion production processes are the most influential in forming who we are.

The Problem of Nonaware Emotion

Prior to the formulation of a constructivist view, the dilemma of how one can acknowledge a previously unacknowledged feeling was explained as follows. In a situation in which someone says (for example), "I have been angry but I wasn't aware of it," a Freudian psychologist would have said

that the person's anger was repressed but now the barrier to consciousness has been lifted and the person remembers the anger. According to Rogers's (1959) incongruence theory, the person's organismic experiencing had been one of anger, but it had not been admissible to the self-concept as such. However, Rogers was inconsistent on this point because his latter theory (1959) also posited an ever-changing self rather than a true self to be discovered and maintained that the therapist could not assume that the client has feelings that are not being experienced. Early Gestalt theory, coming out of psychoanalysis, also assumed emotion was disowned, which implied that anger was there to be discovered. Later Gestalt theory, which was more guided by field theory, saw the emotion as coming into being in the moment but did not explain the process. Gendlin's (1996) view contributed to a change in denial and congruence views by offering that the person has been blocked in a state of incipient anger, which is being experienced and expressed in the present. 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. In this view, the present state of an organism "implies" future states, but these future states are not yet realized. The person is thus in a state that implies angry behavior, but it may not be safe to feel angry and so no anger is felt; the anger is blocked and not yet completed. The person is stuck, and experiencing does not (as Gendlin would put it) "carry forward." If an implicitly angry man took some time to stay with the whole felt sense of a problem with his wife, for example, he might notice a tightening in his stomach. His body is responding to the situation in a quite definite way, he physically senses something, and he can begin trying to grasp this and carry it forward into realizing he is angry.

An EFT approach would not explain anger as having been blocked and as only now being realized, nor would it maintain that only certain words will "fit" as though an "it" preexisted its articulation in language. Rather, EFT theory endorses a more fully agentic, constructivist view in which anger as constructed in the present from constituents that were there, but not yet organized or configured into a coherent form. Rather than blocked anger being realized, EFT would posit that constituent elements of experience are being organized into a coherent whole.

In the EFT view, bodily reactions to support anger experience and expression were activated, but they did not imply anger, nor were they blocked; rather, they were never organized sufficiently into a coherent form to constitute experienced anger. To give an example, a woman in therapy is talking about having been left by her partner. She symbolizes her bodily felt sense as "feeling discarded, like I've been thrown on the dump heap." This feeling is created by her symbolization and was not blocked. The bodily feeling could have been symbolized in many ways; the way she does so is an active organization and one of many ways she could have created meaning, ranging from "I don't care" to "I'm desperately alone." All these meanings would form a more or less coherent sense of self in situation in a way which "I'm happy" or "I'm amused" would not. EFT argues that the person is more active as an organizing agent than does Gendlin. Just as the shape of a cloud can be formed into a fish or a face, so too is the bodily feeling shaped into what it becomes. An EFT therapist would maintain that the fish or face is not implied by the cloud. There is a bodily felt sense there, but the feeling becomes what it is organized into, and some symbolization fits what is there, more or less.

In a dialectical view, people live in a constant process of making sense of their emotions. We are biologically hardwired with innate affective responses, yet we also build on and develop our innate affective repertoire in cultural contexts and through our lived histories. As a result, we respond emotionally with adaptive innate responses but also with complex socially constructed emotion that is personally and historically tinged. In addition, although biology and culture may occasionally conflict, we do not see them as inherently antagonistic to one another. Conflict between experience and social control thus is not seen as a major course of dysfunction. Rather, biology and culture are seen as necessary streams of a dialectical synthesis, and people live most viably by managing to integrate inner and outer, biological and social, and emotional and rational.

People are seen as dynamic systems attempting to maintain the coherence of their organizing processes by continuous synthesis. The person grows toward greater complexity and coherence by constantly assimilating experience and integrating incongruities. Growth is inherently dialectical and dialogical. This view emphasizes that internal focusing is needed

because it often is what is most lacking, but it does not intend to privilege an internal process of feeling and attending over meaning-creating processes of symbolization, reflection, and narrative formation in the construction of reality. Nor does it privilege internal experience over contact with others or field influence in the construction process. Rather, it sees a dialectical synthesis of all elements, neurochemical and physiological, emotion and cognition, internal and external, and biological and social, as a crucial process in the creation of meaning. Culture, experience, and biology are given equally important roles. What this view does do, however, is reclaim the long-neglected internal emotional process as a crucial aspect of human functioning.

Characteristics of Self-Process

In this section, different aspects of self-process are described. The self is seen as an emergent phenomenon and is a process, not a structure (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2015; Greenberg & Pascual-Leone, 1995). Change, then, is the given, and the self emerges in the moment as a synthesis of inside and outside influences. In addition, there is no permanent, hierarchical organization, topped by an executive self or single ruling "I." Instead, at different times, different voices or aspects functioning heterarchically act to construct a sense of coherence or unity by integrating different aspects of emotional experiencing in a given situation and across time (through memory).

In a process view of functioning, stability is seen as arising from repeated constructions of the same state from multiple constituent elements. People are viewed as stabilizing around characteristic self-organizations that are unique constellations of emotion and cognition that are constructed afresh each time. These attractor states are characteristic organizations that impart character to the person and are responsible for the more enduring aspects of personality. Self-organizations or inner states are continually constructed and reconstructed (Greenberg & Pascual-Leone, 1995, 1997, 2001; Whelton & Greenberg, 2001). Stable self-structures and trait-like characteristics (e.g., being an anxiously organized person) 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. The self thus is a temporal phenomenon not a structural or spatial one; it is formed in each moment in contact with the environment (Perls, Hefferline, & Goodman, 1951).

Although there is no such thing as a true self from a dialectical constructivist perspective, there is such a thing as "true self experience." There are moments when, subjectively, the client feels in some fundamental way that what is being experienced is real and deep and true. The person then signifies this as an experience of his/her true self, even if this experience is occurring for the first time. Clients say such things as "I'm able to be myself" or "I'm discovering who I truly am."

In addition, a multilevel synthesizing system of the type described here makes it always possible to perceive more than we currently experience and to experience more than we currently attend to. New sets of tacit experience are always available to be explicated in consciousness. Experiencing is thus 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. 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. Thus, we cannot ascribe a single, simple linear cause to human experience. We smoke a cigar for many reasons—pleasure, aroma, image, social etiquette, physiological effect, and any possible phallic associations. Remove any of these motivators and we still may smoke the cigar, because behavior is overdetermined as well as multidetermined.

The person is viewed as a complex, ever-changing, organized collection of various part-aspects of self. These self-aspects or "voices" interact to produce experience and action (Greenberg & Pascual-Leone, 1995, 1997, 2001; Whelton & Greenberg, 2001). At any one time a person may be singularly organized, as "vulnerable" or "mellow," or more complicatedly, as multiply organized with more than one voice, as when a child loves

and is afraid of an abusive father, or one who loves and hates one's spouse. The adoption of a view of a multivocal self points to how important it is in practice to work with the relationship a person has between parts of the self and between an "I part" and different aspects of self-experience. There is a difference experientially in saying "I am angry" or "I am afraid" versus saying "Part of me is angry" or "Part of me is afraid." Adopting a stance toward any external experience as partial rather than total allows the feeling to more easily be accepted. Thus, recognizing my shame as part of me allows me to tolerate it far better than if I am all shame. Allowing the hating of a parent comes easier when there also is a loving part. Getting to know each part, like a critical part, or a blocked or blocking part, is facilitated by seeing it as an aspect of the self that one can get to know and have a relationship with, rather than being totally identified with it. Seeing aspects of experience as part of oneself becomes a crucial aspect of change in EFT: It implies possibilities of alternatives because one's fear or sense of worthlessness or unlovableness is only a part of the self.

VIEW OF DYSFUNCTION

In EFT theory, dysfunction is not viewed as stemming from any one mechanism alone. Rather, dysfunction is thought to arise via many possible routes, including lack of awareness or avoidance of internal states, failure in emotion regulation, maladaptive responding on the basis of traumatic learning or developmental deficits, protection against injury to one's self-esteem (shame), internal conflict, and blocks to the development of meaning. EFT has incorporated the earlier theories of dysfunction, such as Rogers's incongruence theory, Gendlin's view of blocked process, Gestalt's notions of disclaimed experience, existential theories of loss of meaning, learning theories of traumatic learning, and psychodynamic views of developmental deficits, but has reinterpreted them in strongly constructivist terms.

An EFT approach favors a phenomenologically based view of dysfunction in which the therapist attempts to work with a person's current experience to identify underlying determinants and maintainers of each person's problem. EFT clinicians privilege process diagnosis of in-session

states over person diagnoses or diagnoses of disorders. We have found a number of types of emotional difficulties contribute to many forms of dysfunction. One or more of these often become the focus of treatment because all of them are emotion based. Four major types of processing difficulties are: lack of emotion awareness, maladaptive emotional schemes, emotion dysregulation, and problems in narrative construction and existential meaning.

Lack of Awareness

The first general source of dysfunction is the inability to symbolize bodily felt experience in awareness. Nonacceptance of emotion, because of a skill deficit, denial, or avoidance, deprives people of valuable adaptive information and is a common difficulty seen in clients. A client may, for example, not be aware of or not be able to make sense of the increasing tension in his/her body and therefore be unable to symbolize it as resentment. *Alexithymia*, the inability to name emotions, is the most extreme form of the inability to label one's feeling, but this lack appears in various forms and occurs in people with difficulties ranging from women with borderline personality disorder to men with difficulties in identifying their feelings. Avoidance of or inability to label emotion and internal experience can be a major cause of anxiety and depression. Inability to access empowering anger or blocked grief can underlie many depressions, whereas worry in generalized anxiety can protect against more primary emotions, such as shame or fear. Another common difficulty is that people's most adaptive emotional responses can be obscured by other emotional responses, as when anger conceals fear.

A central EFT assumption is that dysfunction results from the avoidance or disclaiming of primary experience and the resulting inability to integrate certain experiences into existing self-organizations. What is unacceptable to the self, however, is not necessarily seen as being dealt with by expelling it from consciousness (repression) but rather by failing to experience it as belonging to one's self. Rather than experience being repressed or forgotten, the experience is not symbolized in awareness and is thereby disowned or disclaimed. What leads to dysfunction is not having

an embodied experience of one's anger, sadness, shame, or fear, as opposed to not knowing that this is what one feels. So people need to reown their primary adaptive emotional responses and reprocess disclaimed or painful emotions.

In EFT, what is disclaimed is not always pathogenic. What is not experienced could be either adaptive anger or healthy sadness, or it could be maladaptive fear or shame. Healthy needs for connection or boundary protection may be as likely to be disowned as unhealthy shame or traumatic fear. Dysfunction arises from the disowning of healthy growth-oriented resources and needs, the suppression of unacceptable aspects of experience, and the avoidance of painful emotions. The key process aim in therapy is not to make repressed contents conscious, but rather to reown disclaimed experiences so that they are owned as being felt. Reowning promotes assimilation of experience into existing meaning structures and the creation of increased self-coherence and integration.

A growing body of research has revealed that labeling an emotion (i.e., putting one's feelings into words) helps to regulate affect downwards (Lieberman, Eisenberger, Crockett, Tom, Pfeifer, & Way, 2007). Thus, when one sees an angry face and attaches to it the word *angry*, there is a decreased response in the amygdala. The benefits of affect labeling thus go beyond whatever actual insights are gained by knowing what one feels, because the act of labeling itself actually decreases arousal. Research has shown, for instance, that spider-fearful individuals who were repeatedly exposed to a live spider and labeled their affect during the exposure, exhibited reduced skin conductance and marginally greater approach behavior than comparison groups who did not label affect. Additionally, greater use of anxiety and fear words during exposure was associated with greater reductions in fear responding (Kircanski, Lieberman, & Craske, 2012; Lieberman et al., 2007).

Maladaptive Emotion Schemes

Maladaptive emotional reactions develop for a variety of reasons. In addition to biological causes, they most often are learned in interpersonal situations that evoke an innate emotional reaction, such as anger or shame

at violation, fear at threat, or sadness at loss. A child who is abused may learn to associate connection with people as fearful and withdraw from contact. If early experience of emotion is repeatedly met with less optimal, or problematic, responses from caregivers, this results in the development of core maladaptive emotion schemes in contrast to healthy and resilient ones. The developing self organizes to cope with the difficult emotion itself and with the inadequacy of the caregiver.

In childhood abuse, the primary source of safety and comfort is, at the same time, a source of danger, fear, and humiliation, and so the inability to be protected or soothed by the caregiver results in unbearable states of anxiety and aloneness. Pathogenic fear, sadness, shame, and possibly rage are the result. An empty sense of the self as unlovable, bad, defective, worthless, and powerless is formed; the person experiences secondary despair, helplessness, and hopelessness and sometimes a sense of fragmentation, a feeling of falling apart, and an inability to regulate one's own affect. Emotions such as primary adaptive fear, once useful in coping with a maladaptive situation in the past, no longer are the source of adaptive coping in the present, and a person abused as a child may feel maladaptive fear of potentially nurturing closeness.

In other circumstances, a family rule that one must not show anger may result in development of a core maladaptive emotion scheme of powerlessness. Shaming in response to tears or to reaching out for affection may result in core maladaptive shame and the formation of a maladaptive emotion scheme of shame-based withdrawal and feelings of isolation. The self thus organizes around emotional experience to form core maladaptive emotion schemes that function to manage the difficult feelings. Over time, however, the core maladaptive emotion scheme results in increasing difficulties as the individual attempts to navigate life's emotionally evocative events and developmental challenges, such as reaching adolescence, changing schools, moving, rejection, loss of a loved one, or trauma.

If the present triggers past responses, the newness, richness, and detail of the present moment are lost. Then present functioning is ruled by the past and imposes the past on the present. This is maladaptive or contributive to dysfunction. Dysfunction occurs when a person's weak or bad self-

organization is triggered or becomes dominant. These self-organizations involve the evocation of shame-, fear-, and sadness-based experience and the dysfunctional ways of coping with these emotions. Fear and sadness over abandonment are at the center of the "weak me" organization, and shame is at the center of the "bad me" organization. Intense shame, on the basis of a fundamental evaluation of defectiveness or diminishment, is evoked by perceived failure, whereas ruptures in relationship lead to the fear and sadness of abandonment or isolation and the anxiety of basic insecurity. The person's dysfunctional way of coping with these feelings by means of avoidance and withdrawal further exacerbates the problem. Symptoms such as depression or anxiety set in when an emotional sense of some combination of feeling insecure and unloved or humiliated, trapped, and powerless dominates, and the person is unable to mobilize alternative responses.

The degree to which emotional responses become subsequently disorganizing and resistant to change by alternate life experience depends in part on how early they were experienced, how intensely, and how frequently they and the situations activating them occurred. In addition, other temperamental and organic factors also influence people's moods, and these influence activation thresholds of different emotions. Physiological factors also influence activation. When people are tired or irritable, anger is more likely to be activated, and if one has a learning history of maltreatment, he/she is more likely to overreact angrily when tired or irritable. In addition, the frequency and intensity of prior feelings of neglect, anger, or sadness will lead to these feelings being more easily activated by current situations with similar themes or story lines. Thus, inattentiveness from a spouse can activate intense feelings of neglect that stem from a loveless childhood. These feelings then become maladaptive responses to the present situation.

Emotion schematic memory structures most likely are changed through the recently investigated process of memory reconsolidation (Nadel & Moscovitch, 1997). An emotionally distressing event, such as a betrayal or abandonment, initially results in an emotional reaction. This emotional reaction to the situation fades unless it is "burned" into memory by being formed into an emotion schematic memory. The more highly aroused the

emotion, the more the evoking situation is remembered (McGaugh, 2000), and the emotional response can be recreated again and again long after the event. Thus, a memory of an abandonment or betrayal stimulates an emotional response of sadness or anger and hurt.

Change in emotion schematic memory structures most likely occurs through the process of memory reconsolidation. The classic view of memory suggests that immediately after learning, there is a period of time during which the memory is fragile and labile, but after sufficient time has passed, the memory has become more or less permanent. During this consolidation period, it is possible to disrupt the formation of the memory; once this time window has passed, the memory may be modified or inhibited but not eliminated. Recently, however, there has been renewed interest in an alternative view of memory suggesting that every time a memory is retrieved, the underlying memory trace is once again fragile and labile—and requires another consolidation period. This reconsolidation period allows another opportunity to disrupt the memory. Given that maladaptive emotion schematic memories can at times be maladaptive, resulting in such emotions as fear in anxiety disorders and posttraumatic stress disorder and shame and sadness in depression, the possibility of disrupting a previously acquired emotion schematic memory by blocking reconsolidation may have important clinical implications.

This renewed interest in reconsolidation and its role in the control of fear was stimulated by a study by Nader, Schafe, and LeDoux (2000) that demonstrated that conditioned fear can be eliminated by blocking reconsolidation. Furthermore, Hupbach, Hardt, Gomez, and Nadel (2008) showed that at times of reconsolidation new input can alter the original memory, which is then reconsolidated incorporating new material into the old memory. This suggests that emotion schematic memory can be changed by new emotional experience.

Emotion Regulation and Dysregulation

In EFT theory, the inability to regulate one's emotions is another general form of dysfunction. Human problems involve having too much or too little emotion. Problems in emotion regulation can result in people

being overwhelmed by strong, painful emotions or, alternatively, becoming numb to and distant from their emotions. Clients who come to therapy are frequently experiencing acute and chronic conditions related to underregulation in their emotion systems. In addition, many symptoms such as depression and anxiety and disorders such as substance abuse and anorexia are often dysfunctional attempts by clients to regulate underlying emotional states. The development of skills of healthy emotion regulation is an important part of emotional development. Part of emotional intelligence is the ability to regulate emotionality so that one is guided but not compelled by it. Being able to defer emotional responses, know what they are, and reflect on them is quintessentially human. Affect regulation is a major developmental therapeutic task.

The ability to regulate emotions derives in part from early attachment experiences with responsible parents and other caregivers (Schore, 1994; Sroufe, 1996). If parents are good "emotion coaches," they recognize emotions as opportunities for intimacy, validate and empathize with the emotions, and help guide children toward socially effective expression and goal attainment (Gottman, Katz, & Hooven, 1996; Greenberg, 2015). Schore (1994, 2003) documented that the experience of how caregivers treat infants actually affects how the infant brain matures and affects the ability to self-soothe. The secure self is formed primarily through the dyadic regulation of affect, and failure in this leads to an insecure sense of self (cf. Fosha, 2000; Schore, 1994; Stern, 1985, 1995; Trevarthen, 2001).

From infancy on, people learn behaviors for self-soothing, such as sucking their thumbs or whistling in the dark. An important aspect of emotion regulation involves soothing one's own anxiety and adjusting one's general level of emotional arousal to function adaptively. As an adult, one can learn relaxation and meditation to regulate anxiety. People can learn to regulate anger, for example, by breathing, slowing down, and counting to 10. They even can learn to regulate joy, to express it appropriately depending on the situation. Emotion regulation involves the ability of the person to tolerate, be aware of, put into words, and use emotions adaptively to regulate distress and to promote needs and goals.

Evidence from affective neuroscience indicates the possibility that there is implicit, more affective, right hemispheric regulation and explicit,

more cognitive, left hemispheric affect regulation in the brain (Schore, 2003). Unconscious quick processing is mediated more by the brain's right hemisphere and conscious, slower, and serial processing more by the left hemisphere (Davidson, 2000a; Markowitsch, 1998). Functions such as emotional, social self-regulation appear to require an enhanced activation of the right hemisphere of the brain (Tucker, 1981). According to a dynamic system view of emotion regulation, much affect regulation occurs implicitly through right hemispheric processes and is not verbally mediated. This processing is highly relational and is most directly affected by processes such as the automatic generation of self-soothing and relational regulation through touch, facial expression, vocal quality, and eye contact.

Rather than subscribing to the predominant self-control view of emotion regulation (Beck, 1976; Gross, 2015) in which one system is seen as generating emotion and another as subsequently regulating emotion, emotion regulation in EFT is best seen as being intrinsic to the experience of generating emotion. Emotion regulation is seen as an integral aspect of the generation of emotion and coterminous with it (Campos, Frankel, & Camras, 2004). In this view, affective and cognitive processes act as a dynamic system to mutually regulate each other, and the majority of this process occurs automatically and out of awareness. Emotion is inherently, as well as deliberately, regulated.

These differing views of emotion regulation have implications for treatment. Strategies to regulate emotion suggested by a self-control view involve higher levels of cognitive executive involvement, and people are seen as being able to change the way they feel by consciously changing the way they think or practicing skills of distraction or relaxation. In addition, when emotion regulation is viewed as the control of too much disruptive emotion or too much of the wrong type of emotion, the role of therapy is to control these emotions. Clinical work then views dysfunction as resulting from faulty learning and skill deficit, and focuses on teaching skills to control emotion and on changing the cognitive system to modify undesirable emotion (Beck, 1976). This has led to approaches like anger management to control and constrain emotions, and skill training.

In an EFT self-maintenance view of emotion regulation, the cognitive system receives information from the emotion system as well as influences

it, and emotion guides cognition and action. The emotion system is seen as being able to be transformed or regulated by processes other than cognition, such as by other emotions and by relational attachment (Greenberg, 2015). Self-maintenance and enhancement, rather than self-control, is the goal, and the affective processes involved occur largely below conscious awareness. When emotion regulation is seen as an aspect of emotion generation, much dysfunction is viewed as a result of avoidance, suppression, or motivated lack of awareness of emotion, and clinical work focuses on emotion approach coping, emotion tolerance, and clarification. Emotion regulation is viewed as having desired emotions at adaptive levels at the right time, and the first step of therapy is based on the acceptance or facilitation of particular emotions. EFT emphasizes approaching and accessing previously avoided emotion and being able to tolerate, accept, validate, and understand them as the optimal method of emotion regulation.

People often experience emotional flooding as dangerous and traumatic, which leads them to try to avoid feelings altogether. At times emotional avoidance or numbing may be the delayed result of trauma, and this is one of the key forms of posttrauma difficulty. Emotional overarousal also often leads to the opposite problem, maladaptive attempts to contain emotion. Trying to suppress or avoid emotions entirely or to reduce one's level of emotional arousal to very low levels may lead to emotional dysregulation in the form of emotional rebound effects, including emotional flooding. In addition, excessive control of emotion may lead a person to engage in impulsive actions, in which they break out of overly strict self-control and engage in activities (e.g., eating, drinking alcohol, spending money, having sex) more than they generally want to engage.

Narrative Construction and Existential Meaning Making

A general source of dysfunction stems from people's ways of making sense of their experience and their narrative accounts of self, other, and world. Meaning that is not grounded in bodily experience is empty meaning. The capacity to construct narratives, understand, and integrate our most important life stories is key to adaptive identity development and the establishment of a differentiated, coherent view of self. Trauma

narratives perpetuate distress. Narrative incoherence is a sign of the chaotic nature of self-organization, where people are unable to construct a stable sense of self. Problematic narratives of violation or loss, for example, can be altered by the creation of new meaning in which people find purpose or reconstruct their understandings of their role or of others intentions in past events. The articulation of more coherent, emotionally differentiated accounts of self and others that facilitates heightened self-reflection, agency, and new interpersonal outcomes is a corrective emotional experience. The accounts people give of their experience influence their experience and change these from stories of disempowerment and victimization, often incoherent, to more coherent stories of agency with positive outcomes, which promotes health.

Clients come to therapy with problems of meaning and existence, and dysfunction develops as a result of the anxiety that arises from defensive unawareness of the possibility of nonbeing. Dysfunction thus comes from lack of authenticity and alienation from experience and the resultant lack of meaning that emanates from the anxiety of being (ontological anxiety). Making a personal life meaning is a key aspect of healthy living, and meaning provides a way of coping with the existential issues of death, loss, freedom, and isolation.

CONCLUSION

Emotion identifies what is significant for well-being and prepares people to take adaptive action. Emotion also coordinates experience, provides it with direction, and tells us what is important; knowing what is important tells us what we need to do and who we are. In addition, realizing that emotion is a basic biologically adaptive system solves the problem of the scientific basis of the organismic valuing process (the "wisdom of the body"). This system operates by evaluating situations in relation to our well-being, thus serving as an organizing function for experience. The growth tendency works by means of a dynamic system process involving the dialectical coordination of many different elements to form inclusive, coherent syntheses of activated elements. This dialectical process works through the

medium of a basic biologically adaptive emotion system and through the human symbolic capacity and drive to make sense of things, in the service of goals to survive, maintain, and enhance the self. The organism is always producing a directional tendency informed by all its learning, experience, and interaction.

This dynamic view supports a form of practice in which emotion plays a more important role in the construction of reality than in earlier theories. Emotional experience, although seen as a basically healthy resource, is viewed as capable of either providing healthy adaptive information on the basis of its biologically adaptive origins or, in certain instances, as having become maladaptive through learning and experience. The most basic process for the client is thus one of developing awareness of emotion and discriminating which emotional responses are healthy and can be used as a guide, and which are maladaptive and need to be changed.

4

The Therapy Process

Let's not forget that the little emotions are the great captains of our lives and we obey them without realizing it.

—Vincent Van Gogh

Emotion-focused therapy (EFT) is based on two major treatment principles: the provision of a therapeutic relationship and the facilitation of therapeutic work (Greenberg, Rice, & Elliott, 1993). The relationship principles come first and ultimately receive priority over the task facilitation principles. The overall therapeutic style combines following with guiding. A person-centered approach (Rogers, 1957), which involves entering the client's internal frame of reference and responding to it empathically, is combined with a more guiding, process directive experiential and Gestalt therapy style (Gendlin, 1996; Perls, Hefferline, & Goodman, 1951) to deepen experience. In this approach, following and

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leading combine synergistically into a sense of flow. Therapy is seen as involving a coconstructive process in which client and therapist influence each other in nonimposing ways to deepen client experiencing and exploration and promote emotional processing.

In this chapter, the principles of EFT are discussed, followed by a discussion of the perceptual and intervention skills for working with emotion and a summary of the principles of emotional change. This is followed by a consideration of the phases of treatment, the main markers and tasks, case formulation, and a case presentation. The chapter ends with a description of the application of the treatment to various disorders.

RELATIONSHIP AND TASK PRINCIPLES

The three relationship principles that guide EFT are presence and empathic attunement, communication of the Rogerian core conditions, and the creation of a working alliance. 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. 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 promote breaking of the isolation, validation, strengthening of the self, and self-acceptance. 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, and painful emotions. Over time, the interpersonal regulation of affect becomes internalized into self-soothing and the capacity to regulate inner states (Stern, 1985). When an empathic connection is made with the therapist, affect processing centers in the brain are affected and new possibilities open up for the client. This type of relationship creates an optimal therapeutic environment, which contributes to affect regulation and helps the client feel safe enough to fully engage in the process of self-exploration and new learning. In addition to

being curative, the therapeutic relationship 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 therapist and client 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 him or her, and thereby it is an enactment of empathy. Goal agreement in EFT is often 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 three task principles of promoting differential processing, task completion, and agency and choice are 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. These principles guide therapists in helping clients resolve internal, emotion-related problems through work on personal goals and within-session tasks.

The task principles guide the pursuit of work on therapeutic tasks and facilitate different types of processes at different times, depending on client states. In this process, different client in-session problem states are seen as markers of opportunities for differential interventions best suited to help facilitate productive work on that problem state. Therapeutic work involves therapist suggestions to try a specific behavior followed by solicitation of the client's 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 and accepting. 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 the

application of EFT to different populations, it has become clear that the degree of guiding and of structure provision must 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 more fragile clients or those with greater internal locus of control or more reactant styles benefit from more responsive following and less guiding. Clients from different cultural backgrounds often have different expectations of the degree of therapist directiveness, and this can be varied to match clients' expectations, especially early in therapy.

PERCEPTUAL SKILLS

Treatment is guided by perceptual skills, to guide identification of different types of emotion, and problem markers, and executive or intervention skills, which guide intervention. Some of the general perceptual and intervention skills are outlined first. More specific problem markers and specific interventions for each marker are discussed in a later section.

Accurate assessment of different types of emotion is important because each type of emotion must be worked with differently (Greenberg, 2015; Greenberg & Paivio, 1997). Assessment of different emotion types is a perceptual skill that, once developed, often takes place implicitly as a natural part of the therapist's empathic attunement. The very first emotion assessment therapists probably make is whether clients have too much or too little emotion, and they intervene accordingly, either to access emotion or to regulate it. It is important, however, to note that in therapy all emotion emerges in a relational context, and what an emotion becomes is influenced by the relational context and by the client's cultural rules about emotion expression. A client's inability to regulate or tendency to overregulate emotion is thus a constructive interpersonal and cultural process and not just a function of the client's personality. Whether emotion emerges and how it is regulated are functions of the therapeutic relationship and of the client's cultural and familial norms.

How, then, do therapists assess emotion and discriminate among them? For example, how does a therapist discriminate whether a person is weeping in secondary depressive hopelessness or in the primary sadness of loss? How does the therapist assess whether the sadness is a sign of working through of distress, as in grieving, or is a symptom of distress, as in depression, or whether a client's tears are tears of protest that express underlying primary anger or are instrumental "crocodile tears" designed to get comfort?

Therapists use different sets of skills and information to help them discriminate what emotion type is being expressed (Greenberg, 2015; Greenberg & Paivio, 1997). First of all, EFT therapists never simply assess from their own frame of reference; rather, they collaborate with their client to codetermine how the emotion is functioning at that time for the client. Empathic attunement is essential to sensing what another's emotion is about. Nonverbal cues especially voice, face, and gesture are all crucial sources of information regarding the nature of the emotion being expressed. The voice or face often reveals whether the emotion is primary and sincere or secondary and obscuring other feelings. The therapist's own knowledge and experience of general human emotion responses and sequences of emotion and awareness of their own typical emotional responses to situations tells him or her what is probably primary. For example, if the therapist knows what it feels like to spill a glass of wine at a formal dinner with all eyes watching, this helps him or her understand that a client's primary experience in this situation might be embarrassment. Congruence between feeling, action tendency, and need, such as feeling sad at a loss or reaching out for comfort to be close, suggests a primary emotion, whereas being angry and pushing away when hurt and wanting comfort suggests a secondary emotion.

In addition, awareness of one's own emotional responses to the client is important in emotion assessment because people are wired to react emotionally to emotional cues from others, and this provides us with important information. Thus, we automatically feel compassion for others' primary pain and suffering but are irritated by their secondary whining, and we feel fear or caution at maladaptive, attacking anger but

are supportive of adaptive, empowering anger. Our emotional reactions inform us of what type of emotion the other is feeling. Knowledge of a specific client's typical ways of responding and the kinds of emotional responses often found in specific types of clients or clients from different cultures also is helpful in guiding emotion assessment. Knowledge of the context of the emotional expression is most helpful in understanding the emotion in context. A first-time expression of a new emotion is very different from the same old emotion being expressed for the 20th time, and if the expression of the emotion leads toward more productive processing or adaptive action, or, on the other hand, to more dysregulation, this informs the therapist's decision as to whether the emotion is primary or adaptive.

INTERVENTION SKILLS

Intervention is guided by principles of emotion intervention, an understanding of emotion process, and descriptions of specific interventions for different problem markers. The general strategies are described first, followed by principles of emotional change, phases of treatment, and a discussion of markers and tasks.

General Emotion-Focused Therapy Strategies for Working With Emotion

The two major tasks in EFT are helping people (a) with too little emotion access more emotion and (b) with too much emotion to contain emotions. There are many possible ways of helping clients access feelings, including encouraging attention to bodily sensations that cue emotions; helping recall previous emotion episodes or situations that bring up particular feelings; and using vivid emotion cues, such as poignant words or images, in communicating with clients. In addition, therapists can suggest that clients act as if they feel a certain way, or exaggerate and repeat phrases or gestures (e.g., speaking in a loud, angry voice, shaking one's fist). It also is important to help clients monitor their level of arousal to maintain the safety that allows emotion to arise. This latter strategy is very

important because most people cut off access to their feelings if they sense that they are losing control.

Therapists often ask me what they should do to access emotion in constricted clients or to help regulate dysregulated clients. These questions are better posed as follows: In what kind of relationship will a therapist be able to help the client access or regulate emotion? The relationship always plays a key role in accessing and influencing the type of emotion experienced and how it is processed. The assumption in EFT is that the therapist is a potential agent in accessing emotion through affect attunement, in regulating emotion through interpersonal soothing, and in providing new emotional experiences through the relationship.

Types of empathy that help clients access and symbolize their emotions range from purely understanding empathic responses, through validating and evocative responses, to exploratory and conjectural responses as well as empathic refocusing (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg & Elliott, 1997). Empathic exploration is the fundamental mode of intervention in EFT and is a response that is focused on the leading edge of the client's experience—that which is most alive or poignant or implicit—to help it unfold. When a therapist's response is structured in such a way that it ends with a focus on what seems most alive in a client's statement, the client's attention is in turn focused on this aspect of his/her experience and more likely to differentiate this leading edge of that experience. By sensitively attending, moment by moment, to what is most poignant in clients' spoken and nonspoken narrative, a therapist's verbal empathic exploration can help capture clients' experiences even more richly than the clients' descriptions. This helps clients symbolize previously implicit experience consciously in awareness.

Clients usually begin therapy by telling the story of their problem. EFT therapists start with empathy and encourage clients to focus inward and deepen their experience. If this does not deepen client experience, they move to focusing, guiding attention to the bodily felt sense. This often is followed later by more stimulating interventions such as chair dialogues and imagery work in which affect is heightened to bring it vividly into focal awareness.

The therapist encourages clients to bring their attention to their experiencing as it is bodily felt and to ask themselves, "What's problematic for me?" The therapist then helps the client verbalize the feeling, focus on the experiential effect this has, sense a problem as a whole, and let what is important come up from that bodily sensing. This is the focusing process and represents the basic style of engagement with internal experience that is being encouraged.

EFT therapists also help clients who feel overwhelmed or emotionally flooded develop adaptive strategies for containing emotion by using a range of possibilities, including observing and symbolizing the overwhelming feelings (e.g., meditatively creating a safe distance by adopting an observer's stance and describing one's fear as a black ball located in one's stomach). Offering support and understanding and encouraging clients to seek others' support and understanding are also helpful in regulating emotions, as is encouraging clients to organize their distressing emotions (e.g., by making a list of problems). Helping clients to engage in self-soothing is a crucial strategy. Here the therapist encourages relaxation, self-comfort, and self-care (e.g., "Try telling this other part of you that it's OK to feel sad"). Helping clients in distress distract themselves (e.g., by counting backward or going to a safe place in their imagination) is another useful intervention for promoting regulation. If clients become overwhelmed in the session, the therapist can regulate their distress by suggesting that they breathe, put their feet on the ground, feel themselves in their chair, look at the therapist, and describe what they see.

Paradoxically, one of the most effective ways of helping clients contain emotion may actually be helping them to become aware of it, express it, and decide what to do about it as soon as it arises. This is because suppressing an emotion and doing nothing about it tend to generate more unwanted emotional intrusions, making it more overwhelming or frightening. One of the dilemmas for clients and therapists alike is knowing when to facilitate awareness and experience of emotion and when to regulate it. A helpful practical guideline, especially for people who experience overwhelming destructive emotions, is to be aware of how intense the feeling is and to use this as a guide to coping. Emotional approach and awareness should be

used when the emotions are below some manageable level of arousal, say 70%, but distraction and regulation should be applied when they exceed this level and the emotions become unmanageable.

In addition to these general strategies for working with emotion, the different types of emotion described in Chapter 3 of this volume must be worked with in different ways. Primary adaptive emotions must be accessed and more fully allowed to provide information and action tendency. To help clients sort out if what they are feeling is a primary adaptive emotion, therapists respond empathically and act as surrogate information processors, offering symbols to describe feelings that clients can check against their experiences for fit. Therapists can help to assess whether an emotion is primary by asking, "Is this what your core feeling is at rock bottom?" or prompting them, "Check inside; see if this is your most basic feeling." Maladaptive emotions are best handled by helping the client to approach, allow, tolerate, symbolize, regulate, and explore these emotions. After they have been accessed and accepted rather than avoided, these emotions become amenable to change by accessing different underlying emotions (e.g., undoing maladaptive shame with anger, self-compassion, or pride) and by reflecting on them to make sense of them. Therapists help clients access these emotions by means of empathic exploration of, and empathic conjectures into, the client's deeper experience. To access maladaptive emotions, therapists might ask, "What is your most vulnerable feeling, one you have had from early on, ever since you can remember?" or "Does this feeling feel like a response to things that have happened in the past, or does it feel mainly like a response to what's happening now?" Other questions that are helpful are, "Does this feel like a familiar stuck feeling?" and "Will this feeling help you deal with the situation?"

Secondary reactive emotions are best responded to with empathic exploration to discover the underlying primary emotions from which they are derived (e.g., primary fear under reactive anger). To get beneath the secondary emotions, therapists also might ask, "When you feel that, do you feel anything in addition to what you're most aware of feeling?" or "Take a minute and see if it feels like there is something else underneath that feeling."

Instrumental emotions are best explored for their interpersonal function or intended impact on others. After conveying an understanding that the person feels sad or angry, the therapist might say, "I wonder if maybe you are trying make a point or tell this person something with this feeling?" People may recognize the intention in their emotional experience, be it their desire for self-protection or comfort or their attempt to dominate the other.

Principles of Emotional Change

From the EFT perspective, change occurs by helping people make sense of their emotions through awareness, expression, regulation, reflection, transformation, and corrective experience of emotion in the context of an empathically attuned relationship that facilitates these processes. These empirically supported principles of emotional change (Greenberg, 2015) are discussed in the following sections in relation to working with emotion in therapy and not with reference to managing emotion in life. For example, in therapy, often it is helpful to promote awareness, arousal, and expression of traumatic fear or unexpressed resentment to a significant other, whereas in life one might want to promote coping behaviors and regulation of affect.

Awareness

Increasing awareness of emotion is the most fundamental overall goal of treatment. When people know what they feel, they reconnect to their needs and are motivated to meet them. Increased emotional awareness is therapeutic in a variety of ways. Becoming aware of and symbolizing core emotional experience in words provide access to the adaptive information and the action tendency in the emotion. It is important to note that emotional awareness is not thinking about feeling; it involves feeling the feeling in awareness. What is disowned or split off cannot change. When that which is disclaimed is felt, it changes. Only when emotion is felt does its articulation in language become an important component of its awareness. The goal is acceptance of emotion. Self-acceptance and self-

awareness are interconnected. To truly know something about oneself, one must accept it.

Three important stages of awareness of problematic emotions can be delineated. The first stage of change is awareness of emotion after the event, when a person is reflecting on what was felt in the past, which can serve as a basis for learning how to respond better in the future. This also may include awareness of the trigger of the emotional response. Much of insight-oriented therapy stops at step one, in which people understand why they acted in a particular way they regretted, but this does not help them to stop behaving that way or stop being triggered again by similar situations. The second stage is reduction in the length of time it takes an emotion to determine one's feelings. The third stage is recognizing the emergence of the emotion as it is arising and being able to head it off before it arises (e.g., one recognizes the impulse to anger or disappointment and can transform it before it emerges fully). Here one can see the impulse before the action. Finally, in the last stage of change, the emotion is not triggered in the first place.

Expression

Expressing emotion in therapy does not involve venting secondary emotion but rather overcoming avoidance of experience and being able to express previously constricted primary emotions (Greenberg & Safran, 1987). Expressive coping also may help one attend to and clarify central concerns and may serve to promote pursuit of goals. There can be no universal rule about the effectiveness of emotional expression, and the distinction between the role of expression in therapy, to reexperience and rework past problematic experience and the role of expression in life must be maintained. The role of arousal and expression and the degree to which they could be useful in therapy (and in life) depend on what emotion is expressed, about what issue, how it is expressed, by whom, to whom, when and under what conditions, and in what way the emotional expression is followed by other experiences of affect and meaning. In daily life, expression of problematic emotions is often not helpful. In therapy, arousal and expression are necessary but not always sufficient for therapeutic progress.

Because of the strong human tendency to avoid experiencing and expressing painful emotions, clients must be encouraged to overcome avoidance and approach painful emotion in sessions by attending to their bodily experience, often in small steps. This may involve changing explicit beliefs (e.g., anger is dangerous, men don't cry) governing their avoidance or helping them face their fear of dissolution (Greenberg & Bolger, 2001). Then clients must allow and tolerate being in live contact with their emotions. These two steps, approaching emotion and tolerating often uncomfortable emotion, are consistent with notions of exposure. Extensive research supports the effectiveness of exposure to previously avoided feelings for a sufficient length of time in reducing its negative effect (Foa & Jaycox, 1999). From the emotion-focused perspective, however, the emotional processing steps of approach, arousal, and tolerance of emotional experience are necessary but not sufficient for change of primary maladaptive emotions. Optimal emotional processing involves the integration of cognition and affect (Greenberg, 2015; Greenberg & Pascual-Leone, 1995; Greenberg & Safran, 1987) and the transformation of affect, not only its tolerance (Greenberg, 2015). After contact with primary maladaptive emotional experience, such as core shame or basic insecurity, is achieved and the emotion is expressed, clients must also cognitively orient to that experience as information; symbolize it in awareness and explore, reflect on, and make sense of it; and finally transform it.

Regulation

The third principle of emotional processing involves the regulation of emotion. For some individuals with psychological disorders, and in some situations, emotions are under- or dysregulated (Linehan, 1993). An important issue in any treatment is what emotions are to be regulated; how they are to be regulated then becomes a central aspect of treatment. Emotions that require down-regulation generally are either secondary emotions, such as despair and hopelessness, or anxiety about anxiety or primary maladaptive emotions, such as the shame of being worthless, the anxiety of basic insecurity, and panic.

The first step in helping emotion regulation is the provision of a safe, calming, validating, and empathic environment. This helps soothe

automatically generated underregulated distress (Bohart & Greenberg, 1997) and helps strengthen the self. This is followed by the teaching of emotion regulation and distress tolerance skills (Linehan, 1993) involving such things as identifying triggers, avoiding triggers, identifying and labeling emotions, allowing and tolerating emotions, establishing a working distance, increasing positive emotions, self-soothing, breathing, and seeking distraction. Forms of meditative practice and self-acceptance often are most 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 important processes to help regulate emotional distress.

Another important aspect of regulation is developing clients' abilities to self-soothe and develop self-compassion. Emotion can be down-regulated by soothing 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. Promoting clients' abilities to receive and be compassionate to their emerging painful emotional experience is an important step toward tolerating emotion and self-soothing. Being able to soothe the self develops initially by internalization of the soothing functions of the protective other (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.

Reflection

In addition to recognizing emotions and symbolizing them in words, 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). Pennebaker (1995) showed the positive effects of writing about emotional experience on autonomic nervous system activity, immune functioning, and physical and emotional health and

concluded that through language, individuals are able to organize, structure, and ultimately assimilate their emotional experiences and the events that may have provoked the emotions.

Exploration of emotional experience and reflection on what is discovered to form coherent narratives are other important processes in change. 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 where the meaning of individual life events and actions is determined by a particular plot or theme. The story renders the experiences and memories of the client into a meaningful coherent story, orders our experience, and provides a sense of identity. Human beings long to experience their own sense of personal meaning and need to create meaning to overcome an existential vacuum.

Transformation

Probably the most important way of dealing with maladaptive emotion in therapy involves not mere exposure to the maladaptive emotion, nor its regulation, but its transformation by other emotions. This applies most specifically to transforming primary maladaptive emotions, such as fear and shame and the sadness of lonely abandonment, with other adaptive emotions (Greenberg, 2015). I suggest that maladaptive emotional states are best transformed by undoing them by activating other more adaptive emotional states. In EFT, an important goal is to arrive at maladaptive emotion, not for its good information and motivation but to make it accessible to transformation. In time, the coactivation of the more adaptive emotion, along with or in response to the maladaptive emotion, helps transform the maladaptive emotion. The paradox of the path to emotional change is that it needs to start not with trying to change emotion but with fully accepting the painful emotion. Emotions must be fully felt and their message heard before they are open to change by other emotions. 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. One cannot leave a place until one has arrived at it; for emotion, one has to feel it to heal it. Even those aspects of oneself one truly wants to change

must first be accepted, even embraced. Self-transformation thus is always preceded by self-acceptance.

The process of changing emotion with emotion goes beyond ideas of catharsis, completion and letting go, exposure, extinction, or habituation, in that the maladaptive feeling is not purged, nor does it simply attenuate by the person feeling it; rather, another feeling is used to transform or undo it. Although dysregulated secondary emotions such as the fear and anxiety in phobias, obsessive compulsiveness, and panic and fear-laden intrusive images may be overcome by mere exposure, in many situations primary maladaptive emotions (e.g., the shame of feeling worthless, the anxiety of basic insecurity, the sadness of abandonment) are best transformed by contact with other emotions. For example, change in primary maladaptive emotions such as core shame or fear of abandonment is brought about by the coactivation of an incompatible, more adaptive experience such as empowering anger and pride or compassion for the self to the same situations. The new emotion undoes the old response rather than attenuating it (Fredrickson, 2001). This involves more than simply feeling or facing the feeling, which leads to its diminishment; rather, the withdrawal of tendencies (e.g., primary maladaptive fear or shame) is transformed into staying in contact by activating the approach tendencies (e.g., anger or comfort-seeking sadness).

In therapy, maladaptive fear of abandonment or annihilation from past childhood maltreatment, once aroused in the present, can be transformed into security by the activation of more empowering, boundary-establishing emotions of adaptive anger or disgust at the maltreatment that were felt in the past but not expressed, or by evoking the previously inaccessible softer soothing feelings of sadness and need for comfort or compassion toward the self. Similarly, maladaptive anger can be undone by adaptive sadness. Maladaptive shame, which was internalized from the contempt of others, can be transformed by accessing anger at violation at the abuse one suffered, by self-compassion, and by accessing pride and self-worth; anger at being unfairly treated or thwarted is an antidote to hopelessness and helplessness. The tendency to shrink into the ground in shame or collapse in helplessness can be transformed by the thrusting

forward tendency in presently accessed anger at violation. Withdrawal emotions from one side of the brain are replaced with approach emotions from another part of the brain or vice versa (Davidson, 2000a, 2000b). After the alternate emotion has been accessed, it transforms or undoes the original state and a new state is forged. Often a period of regulation or calming of the maladaptive emotion in need of change, and making sense of it, is needed before the activation of an opposing transforming emotion.

How does the therapist help the client access new emotions to change emotions? A number of ways have been outlined (Greenberg, 2015). Therapists can help the client access new subdominant emotions occurring in the present by a variety of means, including 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 (Greenberg, 2015). The newly accessed, alternate feelings are resources in the personality that help change the maladaptive state. These new feelings either were felt in the original situation but not expressed or are felt now as an adaptive response to the old situation. Bringing out implicit adaptive anger at a perpetrator can help change maladaptive fear in a trauma victim. When the tendency to run away in fear is combined with the tendency of angry individuals to thrust forward, this leads to a new relational position of holding the abuser accountable for wrongdoing while seeing oneself as having deserved protection, rather than feeling guilty and unsafe. It also is essential to symbolize, explore, and differentiate the primary maladaptive emotion (in this case fear), and regulate it by breathing and calming, before cultivating access to the new more adaptive emotion (in this case anger).

Other methods of accessing new emotion involve using enactment and imagery to evoke emotion, remembering a time an emotion was felt, changing how the client views things, and expressing an emotion for the client (Greenberg, 2015). Once accessed, these new emotional resources begin to undo the psychoaffective motor program previously determining the person's mode of processing. New emotional states enable people to challenge the validity of perceptions of self and other connected to maladaptive emotion, weakening its hold on them. Accessing adaptive

needs acts automatically as disconfirmation of maladaptive feelings and beliefs.

Enduring emotional change of maladaptive emotional responses thus occurs by generating a new emotional response, not through a process of insight or understanding but by generating new responses to old situations and incorporating these into memory. EFT works on the basic principle that people must first arrive at a place before they can leave it. Maladaptive emotion schematic memories of past childhood losses and traumas are activated in the therapy session so that they can be changed by memory reconstruction. Introducing new present experience into currently activated memories of past events has been shown to lead to memory transformation by the assimilation of new material into past memories (Nadel & Bohbot, 2001). By being activated in the present, the old memories are restructured by the new experience of being in the context of a safe relationship and by the coactivation of more adaptive emotional responses and new adult resources and understanding to cope with the old situation. The memories are reconsolidated in a new way by incorporating these new elements. The past can in fact be changed—at least the memories of it can be changed.

Corrective Emotional Experience

New lived experiences with another person (often the therapist) are especially important in providing an interpersonal corrective emotional experience. Experiences that provide interpersonal soothing, disconfirm pathogenic beliefs, or offer a new success experience can correct previously established interpersonal patterns. An experience in which a client faces shame in a therapeutic context and experiences acceptance, rather than the expected contempt or denigration, has the power to change the feeling of shame. Having one's anger accepted by the therapist rather than rejected leads to new ways of being. Now the client can express vulnerability or anger with the therapist without being punished and can assert without being censured. The undeniable reality of this new emotional experience allows clients to experience that they are no longer powerless children facing powerful adults. Corrective emotional experiences in EFT

occur predominantly in the therapeutic relationship, although successful experience in the world is also encouraged.

The goal in EFT is for clients, with the help of more favorable circumstances in therapy, to experience mastery in reexperiencing emotions they could not handle in the past. The client then undergoes a corrective emotional experience that repairs the damaging influence of previous relational experiences. Corrective interpersonal emotional experiences also occur generally throughout the therapeutic process, whenever the client experiences the therapist as attuning to and validating the client's inner world. Overall, the genuine relationship between the client and the therapist, as well as its constancy, is a corrective emotional experience.

Phases of Treatment

EFT treatment has been broken into three major phases, each with a set of steps to describe its course over time (Greenberg & Watson, 2006). The first phase of bonding and awareness is followed by the middle phase of evoking and exploring. Therapy concludes with a transformation phase that involves constructing alternatives through generating new emotions and reflecting to create new narrative meaning. The first phase, bonding and awareness, involves four steps: (a) attending to, empathizing with, and validating the client's feelings and current sense of self; (b) providing a rationale for working with emotion; (c) promoting awareness of internal experience; and (d) establishing a collaborative focus. The second phase, evoking and exploring, also involves four steps: (a) establishing support for emotional experience, (b) evoking and arousing problematic feelings, (c) undoing interruptions of emotion, and (d) helping the client access primary emotions or core maladaptive schemes. The final phase, generating new emotions and creating new narrative meaning, involves three steps: (a) generating new emotional responses to transform core maladaptive schemes, (b) promoting reflection to make sense to experience, and (c) validating new feelings and support an emerging sense of self.

Through the shift into primary emotion and its use as a resource, 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, 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 and provides an alternative way of responding. Action replaces resignation, and motivated desire replaces hopelessness.

In many instances, however, when 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 sense of powerlessness, or feeling invisible, or a deep sense of woundedness, shame, insecurity, worthlessness, or feeling unloved or unlovable. These feelings often underlie 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 worthlessness or insecurity until one has arrived at them. What is curative is first 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 his or her own symbolized distress that is adaptive and must be accessed and used as a life-giving resource.

Basic Emotional Processing Steps in Transformation

A model for evoking, exploring, and transforming "bad feelings" has been proposed and tested; it is based on clinical theory and practice and involves moving from secondary emotions through primary maladaptive emotions to primary adaptive emotions (Greenberg & Paivio, 1997; Herrmann, Greenberg, & Auszra, 2016; A. Pascual-Leone & Greenberg, 2007). Transformation of distressed feelings begins with attending to the

aroused feelings (e.g., "I feel bad") followed by exploring the cognitive–affective sequences that generate the bad feelings (e.g., "I feel hopeless," "What's the use of trying?"). Eventually, this leads to the activation of some core maladaptive emotion schematic self-organizations based on fear or shame (e.g., "I'm worthless," "I can't survive on my own"). At this point in the transformation process a new adaptive experience is accessed.

When clients in states of global distress begin to elaborate and differentiate their thoughts and feelings, they subsequently move in one of two directions: into a core maladaptive self-organization based on maladaptive emotion schemes of fear and shame or the sadness of lonely abandonment; or into some form of secondary expression, often of hopelessness or a type of rejecting anger (A. Pascual-Leone & Greenberg, 2007). The path to resolution invariably leads to the expression of adaptive grief or hurt and to empowering anger or self-soothing, and these facilitate a sense of self-acceptance and agency. More resourceful clients often move directly from secondary emotions directly to assertive anger or healthy sadness, but many of the more wounded clients need to work through their core maladaptive attachment-related fear and sadness or identity-related shame (Greenberg, 2015; Greenberg & Paivio, 1997; Greenberg & Watson, 2006).

Clients who begin in states of distress and who resolve their distress do so mainly by entering into feelings of maladaptive fear, abandonment, sadness, or shame. In these states they experience themselves as inadequate, empty, lonely, and unable. Transformation occurs when these maladaptive states are differentiated into adaptive needs, which act to refute the core negative evaluations about the self embedded in their core maladaptive schemes. The essence of this process is that core adaptive attachment and identity needs (i.e., to be connected and to be validated) embedded in maladaptive feelings of fear, shame, and sadness, when mobilized and validated, act to access more adaptive emotions and to refute negative self-messages of being unworthy of love, respect, and connection. The inherent opposition of these two experiences ("I am not worthy or lovable" and "I deserve to be loved or respected") supported by adaptive anger or sadness, in response to the same evoking situation, overcomes the maladaptive state. This is done by accessing new self-experience and creating new

meaning, which leads to the emergence of a new more positive evaluation of the self.

Within the context of a validating therapeutic relationship, the client then moves on to grieve, to acknowledge the loss or injury suffered (recognizing, "I don't have what I need, and I miss what I deserved"), and to assert empowering anger or self-soothing. Depending on whether the newly owned need involves boundary setting or comfort, clients direct their adaptive emotion expression outwards to protect boundaries (i.e., in anger) or inward toward the self (as compassion or caring). This then often transforms into grieving for what was lost. This grief state is characterized by either sadness over a loss or recognizing one's hurt or woundedness (or both), but without blame, self-pity, or resignation, which characterized the initial states of global distress. Resolution then involves integrating the sense of loss with the sense of possibility in the newfound ability to assert and self-soothe.

The movement depicted in this process, from secondary emotions through primary maladaptive emotion to primary adaptive emotion, represents a core change process in EFT. Throughout the process of transformation, moderate to high emotional arousal is necessary but always at a level that remains facilitative of the healing process. Therapists must facilitate optimal emotional arousal, enough that it is felt and can be oriented to as information, but not so much that it is dysregulating or disorienting.

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* not only indicate 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 intensively and extensively (see Chapter 5, this volume), and the key components of a path to resolution and the specific form that resolution takes have been specified. Models of the actual process of change act as maps to guide the therapist intervention. The following main markers and their accompanying interventions have been identified (Greenberg, Rice, & Elliott, 1993):

- *Problematic reactions* expressed through puzzlement about emotional or behavioral responses to particular situations (e.g., a client saying, "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. Resolution involves a new view of self-functioning.
- An *unclear felt sense* in which the person is on the surface of his/her experience or is feeling confused and unable to get a clear sense of it (e.g., "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. A resolution involves a bodily felt shift and the creation of new meaning.
- *Conflict splits* are caused when one aspect of the self is in opposition to another aspect. Often this takes the form of one part being critical or coercive. For example, a woman who judges herself to be a failure in the eyes of her sisters quickly becomes hopeless and defeated but also angry in the face of these criticisms and says, "I feel inferior to them, it's as though I've failed and I'm not as good as them." Self-critical splits like this offer an opportunity for two-chair work. In this work, 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. Resolution involves an integration between sides.

- *Self-interruptive splits* arise when one part of the self interrupts or constricts emotional experience and expression (e.g., "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 two-chair enactment, 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. Resolution involves expression of the previously blocked experience.
- *Unfinished business* involves the statement of a lingering unresolved feeling toward a significant other. An example is the following statement by a client in a highly involved manner in the first session: "My father, he was just never there for me. I have never forgiven him." 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. Access to unmet needs and shifts in views of the other and self occur. Resolution involves holding the other accountable or understanding or forgiving the other.
- *Vulnerability* is a state in which the self feels fragile, deeply ashamed, or insecure (e.g., "I just feel like I've got nothing left. I'm finished. It's too much to ask of myself to carry on"). Vulnerability calls for affirming empathic validation. When a person feels deeply ashamed or insecure about some aspect of his/her experience, above all else, clients need empathic attunement from the therapist, who must not only capture the content of what the client is feeling but also note the vitality affects of the client, mirroring the tempo rhythm and tone of the experience. In addition, the therapist must validate and normalize the experience. This mirroring of the self-experience leads to a strengthened sense of self.

A number of additional markers and interventions, such as trauma and narrative retelling, alliance rupture and repair, self-contempt and compassion, emotional suffering and self-soothing, and confusion and clearing a space, have been added to these original six markers and tasks (see Elliott, Watson, et al., 2004; Greenberg, 2015; Greenberg & Watson, 2006). In addition, a new set of narrative markers and interventions combining working with emotion and narrative has been specified (Angus & Greenberg, 2011). These somewhat self-explanatory markers include markers of the same old story—a repetitive description of difficulties in which the person is stuck, which is best dealt with by promoting reexperiencing specific event memories; the marker of an untold story in which the emerging story is accessed by empathic exploration; the marker of an empty story, one devoid of emotion, which is best enriched by means of empathic conjectures about the implicit feelings; and the marker of a broken story, in which unforeseen outcomes challenge one's security and are best dealt with by promoting coherence.

CASE FORMULATION

EFT has developed a process-oriented approach to case formulation to help promote the development of a focus that is especially helpful for brief treatments (Goldman & Greenberg, 2014; Greenberg & Goldman, 2008). Case formulation relies on process diagnosis, development of a focus and theme development rather than person or syndrome diagnosis. In a process-oriented approach to treatment, case formulation is an ongoing process, as sensitive to the moment and the in-session context as it is to an understanding of the person as a case. 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. The therapist's main concern is one of following the client's process and identifying core pain and markers of current emotional concerns, rather than developing a picture of the persons enduring personality, character dynamics, or a core relational pattern.

In formulating a focus, the therapist follows a pain compass, which acts as an emotional tracking device for following clients' painful experience

and attends to a variety of different, emerging, markers. The client's pain and markers guide intervention more than does a diagnosis or even an explicit case formulation.

EFT formulations are made by therapists following what is most painful or most poignant in their clients' narratives, rather than listening to content and forming a conceptual model of underlying causes to understand their clients. Formulation in EFT, first and foremost, involves following the client's "pain compass" to guide client and therapist to the core problem. Following clients' pain guides the process to clients' central concerns, with process being privileged over content. The steps of formulation have been outlined in detail in Goldman and Greenberg (2014) and are described briefly as follows.

The first phase of case formulation involves unfolding the narrative and observing clients' emotional processing styles. This first phase consists of the following steps:

1. listening to clients' presenting problems;
2. identifying poignant and painful experiences;
3. attending to and observing clients' emotional processing styles; and
4. allowing the emotion-based narrative to unfold.

As clients tell their stories, the therapist observes their emotional processing style. The therapist pays particular attention to the emotional tone and various elements of their emotional processing style. He listens for, among other things, whether his clients' emotions are over- or under-regulated, and whether they have an internal or external processing style. To make these assessments therapists observe, among other things, their clients' facial expressions, tones of voice and vocal quality, emotional arousal, and depth of experiencing.

Case formulation then moves in the second phase to a focus on the core painful emotion schemes in clients' narratives. There are six major aspects to identifying the core emotion schemes in the case formulation process (Goldman & Greenberg, 2014), represented by the acronym MENSIT: markers, emotion schemes, needs, secondary emotions, interruptions, and themes. Therapists listen for markers of clients' in-session emotional problem states, such as anxiety splits, unfinished business, and

self-interruption processes. Marker-guided interventions help therapists access underlying feelings and reveal the core painful emotion schemes (E) usually involving fear and shame. Core needs (N) for connection and recognition and the secondary emotions (S) that obscure clients' core emotion schemes, are identified as they arise. Any interruptive processes (I), such as self-silencing or self-neglect, which block access to core painful states and clients' sense of deserving to have their needs met, also are identified. Over time, coevolved themes emerge (T), such as sadness at loss, fear of abandonment, or shame of inadequacy. Using MENSIT as a guide, therapists and clients can coconstruct a narrative that ties presenting problems, triggering stimuli, behavioral avoidances, and the consequences of clients' ways of coping, with their core painful emotion schemes.

Having formulated their clients' painful emotions, therapists continue in the third phase to make process formulations over time. They focus on moment-by-moment formulations, identifying current client states, and ongoing markers related to clients' core issues and micromarkers within tasks. As new meanings emerge therapists assess how clients' new emerging narratives connect back to their presenting problems to assess the degree of change and their clients' readiness for termination (Goldman & Greenberg, 2014).

CASE PRESENTATION: ANGER UNDOES HOPELESSNESS

At the assessment interview, the client, a 39-year-old Caucasian woman of Polish descent, tearfully reports feeling down and depressed. She reports that she probably has been depressed most of her life but that the past year has been particularly bad, that she has not been working, and that she has fallen into a pattern of rarely leaving the house and not answering the phone or the door. Her relationships with members of her family of origin are difficult and often painful. Her mother has been convicted of shoplifting, and she and her brother and two sisters no longer have contact with their mother. Her father is a concentration camp survivor. He has always been emotionally removed from the family and is often perceived as critical and

judgmental. There is a history of physical punishment throughout her childhood. Her family situation was so difficult that all the children left the family as soon as they could. She considers her sisters the most important part of her family and has often viewed them in more of a parental role, getting more affection and support from them than from her parents.

In the first few sessions, the therapist listens, using empathic understanding responses, explorations, and conjectures to communicate his understanding to the client. The client begins therapy by explaining her presenting problem.

Client: I've been feeling quite depressed I think most of my life, but this has been a particularly bad year. I lost a few people that were close to me and helped me in my personal life and I just felt that even though I had crisis in the past with depression, I've always seemed to be able to bounce back you know and I'm having a hard time this year and . . .

She goes on to say that her husband of 9 years also suffers from anxiety and was hospitalized earlier in the year, and her sisters have suggested she get a divorce. However, she stands by her husband and supports him through his difficult time, thereby feeling alienated from her family.

She expresses her view of her depression in her first session.

Client: Most of my depression, I think, centers around my family dynamics. I don't feel close to my family, even like with [my] brother and sisters. They all got married very young, they all had children, their children have children. I'm sort of like the nomad in the family. I didn't get married until I was 36. I moved around a lot and went back, took all kinds of different paths—you know it's just not the same—[it is] a different type of life than what they had.

Therapist: You felt outside. (empathic understanding)

Client: Yes, they ostracized me.

Therapist: So it's not only feeling outside but also criticized by them. (empathic exploration)

Client: Yes, yes, my older sister didn't do it, but I felt my [other] sister did it. My brother and I used to be very close and [now] we're not close anymore and I don't understand that. I don't know, maybe he's tired of being around a depressed person. You know?

Therapist: And you're saying it was hard for you that they were sort of disapproving. They were saying, yes, you should be married, you should be . . . (empathic refocusing)

Client: Settled down.

Therapist: And you felt kind of dumped on. And that would lead you to feeling very bad. (empathic conjecture)

Client: Depressed. Sometimes I feel depressed, I don't know why.

From the exploration of the first session, the therapist had a sense that throughout her childhood and into her adult life, she has often experienced herself as alone and unsupported and that her core emotion schemes are ones of the sadness of lonely abandonment and shame. She has internalized the critical voice of her parents and often judged herself to be a failure, and within the context of a physically and emotionally abusive past, she had often felt emotionally unsafe and abandoned. In terms of her emotional processing style, the therapist observed that she was able to focus on her internal experience, particularly in response to the therapist's empathic responses. As she reported, she tended to avoid her painful and difficult emotions. There appeared to be an identifiable emotional pattern wherein she moved into states of secondary helplessness and hopelessness whenever she started to feel her primary emotions of sadness or anger and experienced her unmet needs for closeness and acceptance. In the first occurrence of this pattern, from early in the first session, the client is describing how she can no longer cope with her family.

Client: My sister called me and left a message saying "I'd like to take you out for your birthday." And for some reason it really upset me all day yesterday and I cried, I was very emotional, and I thought I won't go to dinner with you because I might say something and you'll criticize me. She's very

critical. She has, I guess, an ideal life, and she looks at my life and she's the one that called me and told me to get a lawyer and then I never heard from her for months when [my husband] came out of the hospital. And she wonders why I don't come around. How do you think we feel? They told me to go, to leave him because he's mentally ill. So you're supposed to go over there and feel like everything's OK?

Therapist: So actually it's like you're feeling quite resentful toward them. (empathic exploration)

Client: I am very resentful.

Therapist: It's hard to sort of put on a happy face and go for a birthday lunch or whatever. It's pretend. But it also ends up somehow in you crying. (empathic exploration)

Client: It makes me depressed. Yes.

Therapist: Because in a way it's like you're mad at her for how she's treated you. (empathic conjecture)

Client: Yes, I am.

Therapist: And also it gets into a kind of vulnerability too, that she's going to criticize you or something. (empathic conjecture)

Client: I feel that I'm too sensitive. I mean sometimes when I have gotten angry in the past I just told her to—but I'm at the point now where I don't want to argue. It's hopeless. Basically I want them to leave me alone. That's how I feel. And I know that's not good. Christmas is coming and I dread it.

In the first session, the client continued to talk about her troubles with her parents.

Client: And [my mother] does things, like in the middle of the night [she will] call [me] up and call [me] names and once I was married, I guess I just decided I had enough. I can't take this anymore so I just cut my ties with her. And my father is just, he's just not there. Like I've been—I haven't worked for a year, my husband's had a breakdown, even my best

friend died. He's never called once to touch base. Not just this year, any year. He just doesn't, he's just not there.

The therapist, hearing her voice taking on the qualities of a focused voice (Rice & Kerr, 1986) when she talks about her father being "just not there," which implies a type of searching, eyeballs-turned-inward stance toward her experience, guides her internally by selectively reflecting the loneliness implicit in her current state.

Therapist: You're feeling so alone. There's nobody really there. (empathic conjecture)

In response to this, the client at first moves back to an external, more lecturing type of voice, saying she does have lots of friends. The therapist reflects back that she understands that she has friends but empathically refocuses her on her feeling of being alone and abandoned, and the client begins to cry. The exploration now turns inward toward her lonely, weak, and vulnerable feelings, and she moves into hopelessness. The therapist identifies this as a potential focus of therapy, marking it for later, while also suggesting a beginning rationale for working on emotion.

Client: Oh, I think I should be doing other things rather than sitting around feeling bad for myself.

Therapist: You're saying you hate feeling weak. (empathic exploration)

Client: Oh, yeah, [it is] a waste of time.

Therapist: But somehow your emotion is an important message that you're giving yourself. (rationale)

Client: Well, yeah, I've been doing this all my life.

Therapist: Yes, so it's here you want to . . . somehow, what is this, what do you feel as you begin to cry? Do you feel so alone? Is that what [this is]? (empathic exploration)

Client: I guess that's it. I just feel tired.

Therapist: Tired of the struggle. (empathic affirmation)

Client: Yeah, I'm tired of thinking about it. You know sometimes I'm preoccupied, just like, oh God, like if I could turn a switch. A lot of times I like to sleep because then I don't think.

Therapist: Yeah, yeah, but somehow whatever's going on you do think and it does go around and around.

Client: All the time.

Therapist: It's kind of like there's always unresolved feelings and then they keep coming back. Like it's a lot of emotional baggage you're carrying. We talked about quite the painful history with your family and it's as though it keeps churning, right? I guess some of what we will do is try to work with that to maybe finish it and then pack it away. (rationale)

Here the therapist provides the rationale that emotions provide information and lead to thoughts. In addition, as the therapist listens to the client, he begins to follow the pain compass and help her articulate her chronic enduring pain. When talking about her need to be supported and accepted by her family, she expresses intense emotions, feeling immediately overwhelmed by the sadness that it will never happen and the shame that ultimately she does not deserve such support.

Client: I tell myself a story over and over again to the point I believe it. I believe that it's so and that it can't be fixed. Or I don't care. I don't want it to be fixed. That I'm not loved, that I'm not as good as them you know, my life is chaotic and [my siblings' lives] seem to be going, you know their lives seems so much easier.

The enormity of her aloneness and her sense of worthlessness was girded by a feeling of hopelessness. Not only did she feel she was not loved and a failure but also that there was nothing she could do about it, that it was never going to change.

As the therapist listens to the client, he is attuned to possible markers that indicate openings where tasks may be undertaken. In the very first

session, the therapist hears two markers, one related to unfinished business of feeling being badly treated by her family and another related to a self-critical split between a part of herself that labels her a failure and not entitled to love and another that wants love and be accepted. Because this occurs early in the therapy, these markers are simply noted.

Client: I don't think I'm a bad [person], I believe I'm a bad person but deep down inside I don't think I'm a bad person. And I don't deserve all this. I haven't raped and murdered and robbed banks, and done crazy things, there's no reason for [my family] to treat me this way.

Therapist: So in a way, it's almost like grieving for what you never had from them because you're beginning to say: "I do deserve better, I'm not a bad person, and it's like I feel really sad about what I never got. And I deserve it more." (reflects unfinished business)

Client: Yeah, I guess so.

Therapist: But the sadness is about all that you never got. The anger is [about that]. But some part [of you] says I deserve more and how strong is that?

In Session 3, a marker of self-criticism again arises when the client is talking about possibly returning to school. She quickly becomes hopeless in the face of the further possibility of failure in the eyes of her sisters. At this point, the therapist initiates a two-chair dialogue by putting her sisters in the other chair. Although this is a dialogue with another person rather than a part of the self, it is viewed as a projected self-criticism because her hypersensitivity to her sisters' criticisms suggests that her internalized criticisms are being projected on or attributed to the sisters. The sisters' criticisms are so damaging because they activate the client's internal critic. Her self responds to the criticism by collapsing into secondary hopelessness.

Client: Yeah, [I feel] unsupported, I feel inferior to them, I feel that I have no self-esteem left and it's like I don't want to try anymore with them. It's like OK you win, I'm not as good as you, you win and that's it. Fine. So leave me alone.

In Session 4, she recounts the history of the relationship with her father. She describes not having received any approval from him. In response, the therapist initiates an empty-chair dialogue to work on her unfinished business with her father.

Client: I believe I'm a bad person, but deep down inside I don't think I'm a bad person. Yeah, I'm grieving for what I probably didn't have and know I never will have.

Therapist: Can you imagine [your father] over here (pointing to chair) and tell him how he has made you feel like a bad person? (Setting up an empty-chair dialogue)

Client: You destroyed my feelings. You destroyed my life. Not you completely, but you did nothing to nurture me and help me in life. You did nothing at all. You fed me and you clothed me to a certain point. That's about it.

Therapist: Tell him what it was like to be called a devil and have to go to church. (process guiding)

Client: It was horrible. You made me feel that I was always bad, I guess, when I was a child. I don't believe that now, but when I was a child I felt that I was going to die and I was going to go to hell because I was a bad person.

By the end of this session, the thematic intrapersonal and interpersonal issues have emerged clearly. They are clearly embedded in what the client reports as her most painful experience. First, the client has internalized self-criticism related to issues of failure that emerge in the context of her family relationships. This voice of failure and worthlessness is initially identified as coming from her sisters but clearly has roots in earlier relationships with her parents. This becomes more evident later in therapy. Related to her self-criticism and need for approval is a need for love. Love has been hard to come by in her life. She has learned how to interrupt or avoid acknowledging this need because it has made her feel vulnerable and alone. She has learned how to be self-reliant, but this independence leaves her feeling hopeless, unsupported, and isolated. This need for love is related to her unfinished business stemming from her early relationship

with her father. She harbors a great deal of resentment toward her father over his maltreatment of her as a child, and she has a tendency to minimize it ("being slapped was just normal"). She has internalized this as a feeling of worthlessness and as being unlovable. These underlying concerns lend themselves very clearly to the emotional processing tasks of the two-chair dialogue for internal conflict splits and to the empty-chair dialogue for unresolved injuries with a significant other.

The thematic issues of the therapy continue to be focused on through work on the emotional processing tasks. In a self-critical dialogue in Session 5, she connects her bad feelings to the criticism she heard from her parents.

Client (speaking as internalized critic in the voice of her parents)**:** Well, you're wrong, you're bad, you're . . . you never do anything right. Every time I ask you to do something you don't do it the way I want you to do it and your marks are never good enough, and you're never on time, and you know you just . . . everything you do is wrong.

Therapist: Yeah, now can you come over to this chair (experiencing self chair). It must really hurt to hear that.

Client: When I'm depressed, I believe it. I believe it wholeheartedly. That I'm bad, and I'm wrong and I'm a loser. That's the big word, loser, that goes over and over and then I'm a big loser, and why can't I just have a nice simple normal life? In many ways, this is a feeling that has followed me throughout my life.

Therapist: Tell [your critic] how she makes you feel.

Client: It makes me feel horrible, it makes me feel sad. It makes me feel unloved and not able to give love, you know, it makes me feel like I wish I'd never been born.

Later in the dialogue, the client continues to speak to her critic:

Client: I know I am loved. I've always known that, I never believed it before. So I'm starting to believe that I am loved that it's just. . . . Instead

of being angry because they don't love me, I'm just accepting that they just don't have the capacity to love. It wasn't just me, it was my younger sisters too. If any, it wasn't like they loved them and didn't love me, they didn't love any of us not the way parents are supposed to love.

In this moment the core feeling of being unlovable and the articulated belief that she was not worth loving are being challenged. The critical voice then begins to soften, and her grief over having not been loved and a sense of worth emerge in a dialogue with her critic:

Client: Even though mom and dad didn't love me or didn't show me any love, it wasn't because I was unlovable, it was just because they were incapable of those emotions. They don't know how to [to love], they still don't know how to love.

The client does not experience the hopelessness that had been so predominant in her earlier sessions again.

The client and therapist then go on to identify the way in which needing love makes her vulnerable to hurt and pain and how interrupting these needs have left her vulnerable to isolation and aloneness. In Sessions 7 through 9, the client continues to explore the two different sides to her experience: the critic that attempts to protect her through controlling and shutting off needs and the experiencing self that wants to be loved and accepted. She continues to define and speak from voices and expresses a range of sadness, anger, pain, and hurt. The hopelessness that was so dominant in the early sessions now is virtually nonexistent. The voice that wants love and acceptance becomes stronger, and the critic softens to express acceptance of and compassion toward this part of her. At the same time, she is feeling much better and less depressed than she had been in her initial sessions.

The other main theme of the therapy was her issue with her father, who arouses feelings of hurt, anger, worthlessness, and being unloved. In a key dialogue in Session 3, the client addresses her father:

Client: It hurts me that you don't love me, yeah, I guess, you know, but, I'm angry at you and I needed love and you weren't there to give me any love.

She later tells the image of her father about her fear:

Client: I was lonely. I didn't know my father. My father, all I knew you as was somebody that yelled at me all the time and hit me. That's all. I don't remember you telling me you loved me or that you cared for me or that you thought that I did well in school or anything. All I know you is as somebody that I feared.

Therapist: Tell him how you were afraid of being hit.

Client: Yes, and you humiliated me. I was very angry with you because you were always hitting me, you were so mean and I heard Hitler was mean, so I called you Hitler.

Later in the session, she describes how she interrupts her painful sense of feeling unloved.

Client: The only way I can handle it is by making a joke of it because it helps. It helps because when I'm too serious about it, I become so depressed I can't function. So I learned to laugh about it and you know I have that sarcastic humor and sort of jaded eye, I guess, about things.

Therapist: Because underneath the laugh I guess there's a lot of hurt and a lot of hate.

The client continues expressing her anger in an unfinished business dialogue:

Client: I hate you. I hate you, there's no doubt about that in my mind. I've hated you for years. It angers me when I see you at family functions and I don't feel good being there and you act like nothing ever happened.

Later on in the session, she expresses pain and hurt at her father's inability to make her feel loved:

Client: I guess I keep thinking that you [would] be a parent, that you would pick up the phone and just ask me how I'm doing. It hurts me that you don't love me. I guess, you know.

She ends the session with a recognition that what she needed was acceptable:

Client: I needed to be hugged once in a while as a child or told that I was OK. I think that's normal.

By accessing pride and anger and grieving her loss, her core shame was undone (Greenberg, 2015). The client thereby began to shift her belief that her father's failure to love her was because she was not worth loving. She says to her father in the empty chair:

Client: I'm angry at you because you think you were a good father, you have said that you never hit us and that's the biggest lie on earth. You beat the hell out of us constantly, you never showed [us] any love, you never showed [us] any affection, you never ever acknowledged we were ever there except for us to clean and do things around the house.

Having processed her anger and her sadness and transformed her shame, she takes a more compassionate and understanding position to her father. In an empty-chair dialogue with her father in Session 10, she says:

Client: I understand that you've gone through a lot of pain in your life and because of this pain, and the things you've seen, you've withdrawn. You're afraid to maybe give love the way it should be given and to get too close to anybody because it means you might lose them. You know and I can understand that now, whereas growing up I couldn't understand.

She is also able to continue to hold him accountable for the ways that he disappointed and hurt her while also allowing her compassion to be central in the development of a new understanding of his inner struggles.

Client: You know [being a concentration camp survivor] had a real impact on you. Instead of being a teenager, you were a prisoner of war. It obviously had a lasting impact on you and then as life went on and, you know, [with] your marriage, I'm sure in the beginning it was good. I think at one point, [you and] mom did really love each other, but I think with

my mother's drinking, and maybe with some of the anger that you had about your life, and then you lost your child, your son, that your way of dealing with things was to be cold, to be unfeeling, to not be supportive, not that you didn't want to be. I don't think you know how. I can really understand or I can try to feel your pain and understand that you did the best you could, knowing what you knew.

In talking about these dialogues at the end of the session, the client reported that she felt relief that she didn't have this anger sitting on her chest anymore. She described how she could accept that her father doesn't have more to give. This led to feelings of pride and then joy for having overcome these feelings. Her shame-based core maladaptive belief that she was not worth loving shifted to include the emotional meaning that her father experienced his own pain in his life and that this pain led him to be less available to behave in loving ways toward her or her sisters. Needing to be loved no longer triggered a sense of hopelessness, and giving voice to her strong emotions has validated that she is worth loving and that she can manage with what her father has to offer at this point in her life. A greater ability to communicate her needs, to protect herself from feeling inadequate, and to be close to her sisters has also developed.

OBSTACLES OR PROBLEMS FACED WHEN USING THIS APPROACH

People who are very restricted emotionally or who are highly controlled or self-conscious find it difficult to access their emotions and also to engage in role-plays and enactments. In addition, people who want quick practical solutions to their problems or advice find exploratory processes unpalatable. This can create alliance problems in that agreement on goals and tasks is not easily reached. An EFT relational principle is to meet people where they are and not to impose anything on them, so highly rational people are met at a more rational level before being guided to their emotions. Those clients who clearly need and want rapid symptom-focused relief will be dealt with in more behavioral ways and are provided

with coping strategies as a first-stage entry strategy, but the goal of EFT is to reach deeper levels of change by focusing on underlying painful emotion.

In addition, highly fragile clients, those who are highly dysregulated and are engaging in self-harming behaviors, and those with sense or complex trauma histories may find facing their pain vulnerability, shame, and self-hate too overwhelming. They need to develop a sense of safety and also the ability to regulate their emotions before they can go into them. For these clients, EFT may not be the best entry-level treatment.

HOW DO GENDER AND CULTURE AFFECT EMOTION-FOCUSED THERAPY?

Neither gender nor cultural considerations provide counterindications for work with emotions but rather suggest modifications in approach as to how soon to engage emotions. A fair degree of research has shown that emotions are universal and that there is cultural and gender diversity in the experience and expression of emotions (Fischer, Rodriguez Mosquera, Van Vianen, & Manstead, 2004). For example, men are generally more aggressive than women (Buss, 2003), and women have been shown to be more empathic. In addition, women have been found to report greater intensity of positive and negative affect than men, as well as more intense and more frequent experience of joy and love, but women also experience more embarrassment, guilt, shame, sadness, anger, fear, and distress. Men appear to experience pride more frequently and intensely than do women (Brody, Lovas, & Hay, 1995; Feingold, 1994).

Culture affects gender differences, and culture and gender differences affect the way emotions are expressed. Differences in the expression of emotion may be partly explained by the different social roles men and women have in different cultures and by the status and power men and women hold in different societies, as well as the different cultural values various societies hold (Brody et al., 1995). Cultures that emphasize the maintenance of social order and harmony have been found to suppress emotions, regardless of gender, more than cultures that value autonomy and equality (Matsumoto, Yoo, & Nakagawa, 2008). Compared with Americans,

Japanese report a pervasive tendency toward experiencing engaging emotions (e.g., friendliness, guilt) more strongly than disengaging emotions (e.g., pride, anger; Kitayama, Mesquita, & Karasawa, 2006), whereas Japanese display rules appear to permit people to express powerful emotions (e.g., anger, contempt, disgust) significantly less than Americans, and the rules vary depending on the closeness or distance of the interactional partners (Safdar et al., 2009). Knowledge of gender and cultural differences in emotional experience is helpful in working with emotion with diverse populations; however, adopting an empathic approach should help one arrive at whatever cultural or gender-based differences do exist.

EMOTION-FOCUSED THERAPY THEORY OF DIVERSE DISORDERS

In this section, the general theory of EFT is applied to specific types of disorder—to the affective disorders (depression and anxiety) and to eating disorders. I examine the key role of maladaptive emotion schemes, lack of emotional awareness, and problems with affect regulation in these disorders. Given the cooccurrence of anxiety and depression, it is clear that many processes in these affective disorders overlap. Eating disorders and many other types of addictive disorders often include anxiety and depression. Many disorders stem from the same basic underlying processes of affect avoidance and problems in affect regulation and core maladaptive emotion schemes.

Depression and Anxiety

Within a dialectical constructivist view, depression and anxiety are seen as emotional disorders of the self-organizing process. Depression and anxiety are clearly affectively based. The negative views of self, world, and future and the behavioral withdrawal that one finds in them are reactions to and results of the avoidance of painful core maladaptive emotions often of fear, shame, loneliness, abandonment, or anger as well as the result of maladaptive ways of trying to cope with the events that evoke these painful emotions.

Instead of experiencing themselves as strong, vital, and joyful, people who are depressed experience themselves as vulnerable, damaged, and blameworthy and react to setbacks and disappointments with a significant loss of self-esteem. The self is organized as hopeless, incompetent, and worthless because of the activation of emotion schematic memories of crucial losses, failures, humiliation, or entrapment (Greenberg & Watson, 2006). Anxiety, on the other hand, results when a person is uncertain about his or her capacity to exercise control over a threat. Instead of feeling safe, secure, and confident, anxiety-ridden people experience themselves as afraid, weak, and unable to cope alone, and they react to situations with a lot of anticipatory anxiety, avoidance, and dependence. The self is organized as helpless, unable, dependent, and insecure because of the activation of emotion schematic memories of crucial experiences of abandonment, neglect, and failures in interpersonal soothing.

Stress events related to loss or failure in depression or threat or loss of control in anxiety trigger core maladaptive emotion schemes of the self as deeply inadequate, unable to cope, insecure, or blameworthy, along with related emotion memories including attendant secondary reactions of hopelessness and helplessness emotions. Maladaptive emotion schemes and the self-organizations they generate are seen as the underlying problems in the affective disorders. Fear, sadness, and shame are important maladaptive emotion schematic aspects of the self at the core of the affective disorders. The goal of therapy is to restore the spontaneity of the self's ability to function by helping to access and support the existing resources of the personality to enable these to transform the depressive or anxious self-organization.

Overview of Treatment

Intense feelings of contempt for the damaged self and shame form the core of self-critical depressions. Intense feelings of the core insecurity of being unable to cope with loss or abandonment form the core of dependent depressions (Blatt & Maroudas, 1992). On the other hand, anxiety involving anticipation of future catastrophes, protective fear, and basic insecurity form the maladaptive affective core of anxiety disorders. Adequate processing of sadness at loss and anger at violation often form the adaptive

core of the treatment of depression and anxiety. EFT focuses on helping clients process their emotional experience so that they are able to access primary adaptive emotional responses to situations, such as empowering anger at violation or sadness at loss.

The EFT approach to the affective disorders centers on (a) accessing core emotional experiences and memories to bring them into awareness, label them, and reflect on them; and (b) developing alternative emotional responses to help transform dysfunctional ones (using emotion to change emotion). EFT is appropriate with populations with affective disorders where the severity of disturbance and self-fragmentation are not so high that clients cannot tolerate accessing and experiencing painful emotions in the safety of the therapy environment. The form of EFT that is described in this book is applicable to clients whose level of functioning is sufficient that they are able to function outside of a hospital inpatient setting.

A Case of Anxiety

We have described a sequence of steps that appear effective in working with clients with anxiety in general and general anxiety disorder in particular (Watson & Greenberg, 2017). This sequence involves (a) creating a safe relationship that contributes to the development of a stronger sense of self and the internalization of positive ways of treating the self; (b) strengthening clients' vulnerable selves by developing more confidence in their capacity to trust inner resources, including their perceptions and feelings; (c) working on the process of anxiety generation using two-chair dialogues between a catastrophizing worrier, the anxiety creator, and the experiencing self who feels the anxiety; (d) dealing with the negative ways of treating the self and the self-interruptive self-organizations that prevent access to more adaptive ways of responding and to need satisfaction; (e) working on unfinished business and the underlying attachment and identity related painful emotions that led to the vulnerable self-organization to access protective anger; and (f) working on developing self-acceptance and self-compassion for the vulnerable self, as well as the capacity to self-soothe to consolidate a stronger sense of self and greater confidence in clients' capacities to cope and master themselves and their environments.

The basic process for EFT of anxiety disorders thus is to work first with the anxiety-producing split, which is close to the experience of the symptomatic anxiety. The catastrophizing self occupies one chair and the emotional reaction of anxiety occupies the other. However, to promote enduring change, it is essential to get to the core maladaptive fear-based insecurity scheme, often based on abandonment fears or sometimes the shame of inadequacy. These core schemes are often accessed in unfinished business work, but feelings of having deserved to have unmet needs met are often blocked by the way people treat themselves by silencing the self and suppressing emotions Once the blocks are worked with as something people do to themselves, which helps to undo these interruptive processes, people access assertive anger and self-soothing and this helps transform the underlying maladaptive fear. An example of EFT of generalized anxiety disorder is described as follows.

The client, a 23-year-old African American only child who lives with her parents while working toward her undergraduate degree in business, came for 24 sessions with a short break in the middle over a summer holiday. She presented at a community clinic with problems of "nervousness and worry" (about school and social situations) and resulting physical symptoms. In the first session, she commented, "I'm too anxious for my own good." She described herself as a "control freak" who tends to "overthink things." She described her anxiety as being "all about not knowing what is going to happen. I say 'what if' all the time, like I always have some fantastically disastrous result to everything. I'm like 'well, what if it snows and then I'm stranded?'" As a result, she had spent a lot of time planning and making schedules. The client reported that she has had this problem her whole life and that it had been getting worse. Academically, her grades were OK, but she worried about her productivity and the fact that she made poor use of time. Procrastination was an issue. In addition, her anxiety impeded her relationships, in which she was overly cautious. For example, she had often worried about losing friends by saying or doing the wrong things: "What if I snub that girl? I could lose out on a friend." Her anxiety had an impact on her health. She had an occasional eye twitch as well as frequent gastrointestinal problems, such as stomachaches and

diarrhea. She also had been formally diagnosed with a learning disability (dyslexia) in elementary school. In the first session, she appeared quite anxious and tense but was very talkative as well as eager and cooperative. It was also apparent that she was psychologically minded. She was able to freely describe her emotions and experiences, although she was not always comfortable with certain emotions during the sessions (e.g., sadness, crying). She met the criteria for a diagnosis of generalized anxiety disorder.

In EFT, the goal in treating anxiety is to first establish a safe trusting relationship and then to access and restructure the underlying maladaptive emotion schemes (Greenberg & Paivio, 1997). In working with this client's anxiety in the session, it first had to be determined whether the client was experiencing primary anxiety or secondary anxiety. Primary maladaptive anxiety involves a core vulnerable, insecure self—a sense of basic insecurity, as a result of which the self feels afraid, ineffective, and unprotected. On the other hand, secondary anxiety involves insecurity regarding a specific internal experience that threatens to overwhelm—for example, anxiety about one's anger or sadness, catastrophic expectations, or anticipated fear of failure. Secondary anxiety is marked by future-oriented expectations or imagined dangers and prototypic "what if?" statements, accompanied by a helpless response, such as worrying about being rejected, failing, or being incompetent (Greenberg & Paivio, 1997). The client clearly was experiencing a fair degree of secondary anxiety. She experienced a lot of future-oriented anxiety about possible dangers, she was anxious about failing and about being rejected in relationships, and she felt helpless to cope with these concerns. It appeared that her core emotion scheme might be organized around the fear of rejection, but more work would be needed to confirm this.

Intervention involved first focusing her awareness on her bodily feelings and "heightening" her awareness of what she was doing to herself to create her secondary anxiety—in this case, the client was scaring herself. Her agency in the process and awareness of how she contributed to creating her experience of anxiety was highlighted, along with specifying her catastrophic expectations that generated the anxiety. Specifically, her awareness was heightened through the use of a two-chair dialogue whereby she sat in one chair and expressed the concerns of the "worry

critic"; then she sat in a "self chair" to determine the reaction of herself to these verbalizations. (This is similar to a self-critical split, except that now one side is scaring the other side rather than condemning or being critical.) The long-term aim of this process is to help the client access her core maladaptive emotion scheme or schemes, to which anxiety is the secondary response.

Initially, the client had no idea what her underlying feelings might be, but after two sessions using a two-chair dialogue it became clear that her anxiety was coupled with depressive feelings of failure. Her feelings of hopelessness emerged when her worry critic told her that if she did not do a better job in her academic pursuits, she would fail. For example, in her second session, the worry critic told her that she has many things to do and that she would not be able to manage. In reaction, she noted that she felt anxious, as if there were no hope of finishing and no end in sight. In Session 6, the anxiety-producing voice told her that other people will notice if she fails and that they will reject her. She then began to access her own harsh critical voice that silenced her telling her that she wasn't good enough, and she felt very hopeless, like there was nothing she could do about it. Shame was emerging as part of her core painful experience.

This client had several past experiences of failure and helplessness in elementary school before being diagnosed with a learning disability. In addition, her father did not react in a very supportive manner and often denied or minimized the influence of the learning disability. Instead, he attributed her failure to the fact that she was "not trying hard enough," and when she brought home a low grade on an assignment, he would often ask her if she had tried her hardest. In reaction, the client, who was indeed trying her hardest and still failing, felt very helpless. As these details emerged, the comments of the worry critic were more nuanced during two-chair dialogues. For example, in Session 3 she described how she was "OK" with her learning disability as long as she was doing well in school; however, if she did poorly, she felt she couldn't tell anyone because it would be as though it was "permanent." As a result, she would feel hopeless because there was nothing she could do to change it.

In Session 7, she worked on a conflict-split related to procrastination. Specifically, one part of her felt she "should" be working and using time

more productively ("I could be more productive," "I should exercise"), whereas the other side wanted to relax and take a break from school ("I'll do it tomorrow"; "I work so hard each semester, I should take it off"). Her critical voice told her that she was wasting time and that she should be more efficient and put in more effort. As the critical voice was elaborated, it said, "You are not doing anything special, [just] blending in with the crowd." In reaction, she stepped out of the two-chair dialogue to explain to the therapist that she was uncomfortable being the center of attention. She commented that her aversion to standing out could be a part of the procrastination problem and that it might also contribute to her difficulty losing weight. She said that if she is the center of attention, people "can pick out what your flaws are." The therapist prompted her to "scare" herself about being in the spotlight. The anxiety-producing self said, "People are going to look at you, and they're going to pick out your flaws and your faults, and they're going to laugh because they can see what's wrong with you." Then, in the self chair, she described how scary it is to be the center of attention, and this elicited feelings of vulnerability: "It's just very vulnerable, like I could break into a thousand pieces." After responding empathically, the therapist prompted her to "be those people" in the anxiety-producing chair. When she returned to the self chair, the therapist asked, "How does that feel inside to have that happen to you, the poking [at] you and [them] saying we don't like how you look?" The client reacted with sadness and then hopelessness. She said, "I want you to like me, but there is no hope of you liking me."

On hearing her talk about what was wrong, the therapist redirected the client into split work, where her critic elicited shame. For the rest of the dialogue the critic told her what was wrong with her personality, though it was difficult for her to be specific. She described how she pushed friends away because she holds too many rules for them. The protective function of these rules was identified. Her comment "I've been friends with people who weren't my friends and then I got hurt really bad" suggested that she also has unfinished business from previous friendships, but she did not go into in detail at this point. On the session evaluation form, she rated the session as "excellent" and "very helpful" and reported that she had made "considerable progress." She wrote the following statement in response to

the question whether anything shifted in the session: "I realized that my procrastination issue and my anxiety are all linked to my fear of failure and my weight issues."

Several empty-chair dialogues with her father (i.e., unfinished business) in the middle of therapy helped this client to process her unresolved feelings toward him and led to her core feelings of inadequacy and fears of abandonment. These emerged as her most painful core schemes. While sitting in the "father chair" during one of these dialogues, she said, "You are not trying hard enough. It doesn't matter if you spend 8 hours [on your work] because you will still do poorly." In response to this invalidation of her academic performance, she said, "Why bother? It's hopeless." Another major component of the criticisms had to do with her weight. While growing up, this client was slightly overweight, and her father was concerned for her health. To help "motivate" her to exercise and be healthy, he would often comment on her exercise. For example, he would comment on how much she was eating or point out that she "only spent 20 minutes on the treadmill."

In response to her father's criticisms in the unfinished business dialogue, the client expressed intense anger and sadness toward her father: "I feel like nothing I ever do is going to be enough to be OK" (sadness); and "[There is] no excuse! You are not supporting me emotionally!" (anger). In the following session, this dialogue continued, and the client moved into the expression of her unmet needs (e.g., "I need you to support my efforts and respect my standards") and began to assert herself and hold the father accountable. She at first struggled with feeling undeserving of having her needs met but some further two-chair enactment of the self-interruption helped her overcome this block. On her evaluation form for this session, she noted, "I realized that I am no longer sad and hopeless but am more annoyed and angry. I also realized that I am closer to being able to let go of my issue." By the end of therapy, the client was able to let go of her unmet need for acceptance and approval by her father. When she was able to modify her expectations of his behavior, she was much more peaceful and "free." In fact, during Session 9, she reported strong feelings of happiness. She described feeling more relaxed, less worried, and not bothered by her father. She also noticed intrinsic motivation to exercise and to work. This continued into the following month, so the termination process began. The

therapist and client discussed the client's process of change (in order for her to crystallize and symbolize the process) and how to deal with potential relapse. Session 11 was the last session in the first phase of therapy.

After a break over the summer, the client returned for a second phase of therapy, at which time she noted that she continued to feel confident without worrying unnecessarily and that her relationship with her father was still going well. However, she noted that she had become increasingly dissatisfied with her body image. She wanted to feel confident in her shape regardless of her weight. She related the issue to puberty when she had gained weight and her father told her that "boys don't like fat girls." Even though she said she knew it was irrational, it still "sticks in her head." Although her core maladaptive shame had been touched on in the first phase of treatment as the emotion scheme underlying her anxiety, it had not been clearly transformed. Shame clearly was the emotion underlying her body image concerns, and this scheme became the focus during the second phase of therapy. Feelings of shame had originated with her father's invalidating comments, which she had internalized. As such, the critic's comments included "Boys don't like fat girls" and "You will lose friends and be alone." In addition, the unfinished business with her elementary school friends contributed to her feelings of shame because they made her feel as though she was "not good enough" to be their friend (i.e., when she was enacting these girls, they would say things like "You will never be at our level because it is you as a person that is flawed and you can't change that"). As a result, she also had a secondary reaction of fear of being alone. During the second phase of therapy, the focus was explicitly about resolving her feeling of shame, which was achieved by accessing adaptive pride. Rather than two-chair work to deal with self, it was self-soothing two-chair dialogues and exercises that ultimately helped transform her core shame.

During one of the chair dialogues, the client spontaneously told the scared self that she doesn't need to be something other than herself to avoid being alone because she is good enough the way she is. The therapist immediately prompted her to tell the scared side what she likes about her. She told her that she is generous, kind, and thoughtful. She said that she is good enough the way she is and does not need to be any more than that. She was partially able to "take this in." During another session, when the client's

feeling of fear was strongly activated, she began to look "paralyzed" in the self chair. She agreed that she was feeling somewhat "frozen." The therapist helped her to symbolize and express this part of herself. She said that it was a part of herself deep inside that was frozen and scared to be exposed or vulnerable. This part felt shameful and was scared to come out because it might get exposed or hurt. Then, using the chairs, the therapist asked her to try to soothe this frozen, shameful part. She affirmed that she is "great"—a good person, thoughtful, intelligent, and loyal. The shameful self was "somewhat" able to take in this message and came out to some degree.

In Session 20, the client noted that the shameful part was still present but not as troublesome as it had been; she also reported that she had been feeling much better about herself. In the following session, she noted that she was aware of what she wanted and was able to assert these needs. When asked how she was able to do this, she said that she had become more confident in herself and began to feel "deserving" of the things she wanted (e.g., being treated with respect). She also made the comment that she "is not helpless anymore." She expressed her gratitude and noted that chair work "was like the most helpful thing I have done in my life."

Eating Disorders

Emotion, especially distressing emotion, plays an important role in eating disorders. Emotional disturbances have long been recognized as underlying these disorders, and affect has been implicated in triggering eating disorder symptoms (Bruch, 1973; C. Johnson & Larson, 1982; Wilson & Vitousek, 1999). EFT clinicians understand body image disparagement, or the self-loathing directed toward the body, physical appearance, and weight and shape, as the displacement of negative affect on the body. A fair degree of empirical work has linked bulimia nervosa to affect regulation (Bydlowski et al., 2005; Kearney-Cooke & Striegel-Moore, 1997; Treasure, Schmidt, & Troop, 2000).

Individuals with bulimia, like those who engage in other impulsive and destructive behaviors, are generally impaired in their ability to regulate their responses to strong emotions. Their highly sensitive and overreactive emotional response systems lead them to have little belief in their

ability to cope with the physiological arousal brought about by strong emotion. As a result, a woman with bulimia will become anxious and fearful over the prospect of being overwhelmed by her feelings. As soon as an emotional reaction starts to build, she feels a sense of urgency to put a stop to it and turns to the overlearned, impulsive, and maladaptive mood regulation behaviors of bingeing and purging. Over time, the bingeing and purging pattern leaves her with a decreased sense of self-esteem and competency and feelings of guilt and shame. These set her up for the next cycle of bingeing and purging by further lowering her belief that she can cope with her emotions in healthier ways.

Use of the eating disorder in either bulimia or anorexia nervosa to manage affect regulation difficulties may result in either underregulation or overregulation of affect. Stereotypical clinical presentations of an anorexic client, for example, would include an affect that is highly constricted, impoverished, and overregulated; individuals with bulimia display chaotic and unmodulated affective functioning, and, in addition to bingeing and purging, their symptoms may include other impulsive behaviors such as shoplifting, cutting, or substance abuse.

The affect regulation function of the eating disorder is related to a distinctive and pervasive attitude toward emotion among this population (Dolhanty & Greenberg, 2007, 2009). Feelings are intolerable, dangerous, and to be feared, and they must be "gotten rid of" or avoided altogether. The eating disorder is a highly effective means of accomplishing this. Starving numbs, bingeing soothes, and vomiting provides relief. Attempts at recovery are met with a resurgence of previously avoided feelings that are experienced as being intolerable, with the desire to escape them leading to relapse (Federicci, 2005).

Given that the eating disorder is in the service of avoiding, numbing, or soothing affective dysregulation, EFT for this disorder involves explicitly attending to and accommodating felt emotion to allow its experience and to help clients develop proficiency in accepting, modulating, soothing, and transforming emotion (Dolhanty & Greenberg, 2007, 2009). Individuals experience renewed hope in the possibility that they may alter and improve their eating disorder by means of working to identify and alter emotion schemes and self-organizations, rather than thinking that

their only recourse is to keep trying harder to change intransigent eating patterns in the absence of a substitute for managing their distress.

The overriding goal of EFT with eating disorders is to get beyond secondary emotions such as hopelessness or despair, which obscure or protect against primary emotions, and to gain access to core maladaptive emotions such as fear, the sadness of abandonment, and shame. Transformation of maladaptive emotions plus access to adaptive emotional experience helps to alter dysfunctional behavior patterns and renders the eating disorder unnecessary as a means of coping. This is accomplished by processing the painful and seemingly intractable maladaptive emotions, such as shame, rage, self-loathing, and passive, hopeless despair that diminish the self.

The emotion-friendly stance of EFT is particularly compelling for this population. It deals directly with clients' fears of emotion and with the difficult emotions they fear. EFT challenges clients' inclinations to turn away from emotion and challenges their beliefs that emotion is inherently bad, by its gentle consistent focus on the present experience of emotion. The efforts of clients with eating disorders to reduce affect or distract from it exacerbate their feared view of emotion, whereas experiencing and processing it, to the point of gaining access to the buried healthy emotions, is a corrective experience, giving these clients evidence that they may in fact be able to experience and tolerate their feelings without the eating disorder.

In addition to a continual focus on emotional awareness and experience with bulimic and anorexic clients, work with self-critical splits allows an immediate and effective inroad into the vicious cycle of body image disparagement that is so often resistant to shifting to any more meaningful processing. Two-chair dialogue is highly effective with bulimic clients and is particularly compelling with anorexic clients because many are already aware of an internal critic, which they refer to as their "anorexic voice." This voice sets rules, demands compliance, and berates the self for breaching injunctions. Pursuit of thinness is seen as the only means of feeling better. The individual caught in this cycle becomes fiercely self-critical and denigrates the self for being fat and unable to achieve a goal of sufficient weight loss.

The two-chair dialogue initiates an evocative process in which the emotional impact of the self-criticism comes alive in the session. Putting

the anorexic voice in the chair allows the individual to hear this internal critical voice in a new and emotionally alive way. Split work has an extraordinary effect of rapidly getting to the painful feelings and subsequently to healthier self-assertion. The processing of the emotions evoked can have a powerful effect in softening the harsh critic and altering the internal dialogue of body self-loathing. Markers inevitably occur for moving from the two-chair dialogue with the inner critic to unfinished business with the empty chair. Often clients are very reluctant to speak about their parents, and particularly their mother, feeling like they should take responsibility for their eating disorder and not blame others.

One client with anorexia nervosa, a young woman who was much loved and cherished by both parents yet whose core maladaptive emotion was fear of abandonment, presented as puzzled as to the cause of her severe anorexia. Empty-chair work revealed a mix of anger at her mother but fear of expressing it for fear of losing her. This young woman also became adept at speaking her self-interruptions, which would essentially take the form of "Don't listen to the therapist, because if you recover, your mother will leave." It came out that the onset of the anorexia at the age of 12 coincided with her inadvertently hearing something from an argument between her parents that made her believe that her mother was going to die or leave. She distinctly recalled beginning to do things that she believed would ensure that that would not happen. The empty-chair work involved expressing her anger at her parents for allowing their arguments to affect the whole family and her well-being, and she began to work on finding her capacity to function as a young adult independent of their relationship.

CONCLUSION

EFT, based as it is on process research, offers a variety of empirically based skills ranging from perceptual skills to discriminate different emotional processing styles, different emotions, and different problem markers, to various intervention skills to fit the moment. In addition, principles of emotional change, stages of change, and principles of case formulation have been delineated. These processes were discussed in this chapter in relation to various disorders.

5

Evaluation

There has been extensive research on the effectiveness of emotion-focused therapy (EFT) and its various therapeutic components. More research has probably been conducted on the process of change in EFT than in any other treatment approach (Elliott, Greenberg, & Lietaer, 2004). In this chapter, I discuss the research basis and evaluation of this approach.

EVIDENCE-BASED TREATMENT

EFT has been shown to be effective with individuals and couples in a number of randomized clinical trials (Elliott, Greenberg, & Lietaer, 2004; S. M. Johnson, Hunsley, Greenberg, & Schindler, 1999). In three studies (Goldman, Greenberg, & Angus, 2006; Greenberg & Watson, 1998; Watson,

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Gordon, Stermac, Kalogerakos, & Steckley, 2003), a manualized form of EFT for depression, called process experiential therapy (in which specific emotion activation methods are used within the context of an empathic relationship), was highly effective in treating depression. EFT was found to be equally or more effective than a client-centered empathic treatment and a cognitive–behavioral treatment. Although the latter treatments were found to be highly effective in reducing depression, EFT was found to be more effective in reducing interpersonal problems, it promoted more change in symptoms than the person-centered treatment, and it was highly effective in preventing relapse (77% nonrelapse rate; Ellison, Greenberg, Goldman, & Angus, 2009).

In the York II Depression Study, Goldman and colleagues (2006) found evidence for the superior efficacy at termination of the addition of emotion-focused interventions to the foundation of a client-centered relationship. In addition, and of great importance, the EFT group was doing distinctly better at an 18-month follow-up (Ellison et al., 2009). Survival curves showed that 70% of EFT clients survived to follow-up (i.e., did not relapse), in comparison with a 40% survival rate for those who were in the relationship alone treatment.

Watson et al. (2003) carried out a randomized clinical trial comparing EFT and cognitive–behavioral treatment for 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 who received EFT were significantly more self-assertive and less overly accommodating at the end of treatment than clients who received cognitive–behavioral treatment. At the end of treatment, clients in both groups developed significantly more emotional reflection for solving distressing problems. Several investigators are currently conducting studies on the effectiveness of EFT with generalized anxiety (Timulak, 2015; Watson & Greenberg, 2017) or social anxiety (Elliott, 2013; Elliott, Rodgers, & Stephen, 2014); Elliott and colleagues (2014) reported promising initial results from their study in progress comparing person centered

therapy and EFT to each other and to published cognitive–behavioral treatment benchmarks.

Shahar (2014, in press) evaluated the efficacy of EFT for adults with social anxiety disorder (SAD) using a nonconcurrent multiple-baseline design. Twelve were treated with up to 28 sessions of EFT. EFT was based on an empathic relationship, two-chair work for self-criticism, empty-chair work for unresolved feelings toward a significant other, and focusing. Of the 11 completers, seven did not meet criteria for SAD at the end of treatment. Social anxiety symptoms and self-criticism did not change during baseline, improved significantly during treatment, and remained improved during follow-up. Self-reassurance improved significantly during the follow-up phase. This study provides initial evidence supporting the efficacy of EFT for SAD.

Watson and Greenberg (2017) provided a manual for the treatment of general anxiety disorder (GAD) on the basis of a number of successful cases of treatment, and Timulak and McElvaney (2016) provided an overview of EFT for GAD. In addition, Timulak, McElvaney, Martin, and Greenberg (2014) provided evidence for the effectiveness of EFT for GAD.

There has been an explosion of interest in EFT for eating disorders and for family-based EFT. Wnuk, Greenberg, and Dolhanty (2015) provided preliminary evidence of the effectiveness of an outpatient emotion focused therapy group for women with diagnoses of binge-eating disorder, bulimia nervosa, or eating disorder not otherwise specified. The EFT group involved 16 weekly sessions that targeted problematic emotions connected to eating disorder symptoms. Pre- to posttreatment, changes in binge eating and scores on self-report measures were statistically significant. Participants reported a decrease in the frequency of binge episodes, improvements in mood, and improvements in emotion regulation and self-efficacy.

Lafrance Robinson, Dolhanty, and Greenberg (2015) outlined a promising emotion-focused family therapy (EFFT) treatment for eating disorders in children and adolescents supported by a pilot study of a 2-day transdiagnostic EFFT for parents (Lafrance Robinson, Dolhanty, Stillar,

Henderson, & Mayman, 2016). In addition, parental self-efficacy has been found to predict adolescent outcomes in family-based therapy for eating disorders (Lafrance Robinson, Strahan, Girz, Wilson, & Boachie, 2013). Finally, a study of EFFT (Stillar et al., 2016) examined the relationships among fear, self-blame, self-efficacy, and accommodating and enabling behaviors in 137 caretakers of adolescents and adults with eating disorders. The results revealed that fear and self-blame predicted low caretaker self-efficacy in supporting their loved one's recovery as well as the extent to which caretakers reported engaging in recovery-interfering behaviors. These findings highlight the importance for clinicians to attend to and help process strong emotions in caretakers to improve their supportive efforts and, ultimately, eating disorder outcomes.

EMOTIONAL INJURIES

EFT for emotional injuries by significant others was developed from programmatic research on empty-chair dialogue with abusive and significant others for resolving interpersonal issues from the past (Greenberg & Foerster, 1996; Paivio & Greenberg, 1995; Paivio, Hall, Holowaty, Jellis, & Tran, 2001). In these treatments, confrontations are promoted through enacted dialogues with significant others. EFT that promotes letting go and forgiving as means of overcoming emotional injuries from the past has been found to be superior to psychoeducation in two studies (Greenberg, Warwar, & Malcolm, 2008; Paivio & Greenberg, 1995). Emotion-focused trauma therapy (EFTT; Paivio & Pascual-Leone, 2010) for adult survivors of childhood abuse, which posits the therapeutic relationship and emotional processing of trauma memories as distinct and overlapping change processes, has been found to be effective in treating abuse (Paivio & Nieuwenhuis, 2001). In one study, clients who received 20 weeks of EFTT achieved significant improvements in multiple domains of disturbance. In another study, clients in a delayed treatment condition showed minimal improvements over the wait interval, but after EFTT they showed significant improvements comparable with the immediate therapy group.

On average, these effects were maintained at a 9-month follow-up (Paivio & Nieuwenhuis, 2001; Paivio et al., 2001).

COUPLES THERAPY

Couples-based EFT (Greenberg & Goldman, 2008; Greenberg & Johnson, 1988; Johnson, 2004) can help partners access and express underlying attachment- and identity-oriented emotions, and it has been found to be effective in increasing marital satisfaction (S. M. Johnson & Greenberg, 1985b; S. M. Johnson et al., 1999). This empirically validated approach to couples therapy is recognized as one of the most effective approaches in resolving relationship distress (Alexander, Holtzworth-Munroe, & Jameson, 1994; Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; S. M. Johnson et al., 1999). In a meta-analysis of six studies, EFT demonstrated an effect size of 1.3 with recovery rates between 70% and 73% (S. M. Johnson et al., 1999).

In a recent study (Greenberg, Warwar, & Malcolm, 2010), which was not included in the S. M. Johnson et al. (1999) meta-analysis, an EFT for couples intervention for resolving emotional injuries was found to be effective. Twenty couples acting as their own waiting-list controls were offered a 10- to 12-session treatment to help resolve unresolved anger and hurt from a betrayal, abandonment, or identity insult that they had been unable to resolve for at least 2 years. Treated couples fared significantly better on all outcome measures over the treatment period compared with the waiting-list period. They showed a significant improvement in dyadic satisfaction, trust, and forgiveness, as well as improvement on symptom and target complaint measures. Changes were maintained on all of the measures at a 3-month follow-up except trust (on which the injured partners deteriorated). At the end of treatment, 11 couples were identified as having completely forgiven their partners, and six had made progress toward forgiveness compared with only three having made progress toward forgiveness over the waiting-list period. The results suggested that EFT is effective in alleviating marital distress and promoting forgiveness

in a brief period of time but that additional sessions may be needed to enhance enduring change.

THE PROCESS OF CHANGE

In addition to clinical trials on EFT, empirical research on the independent role of emotion in therapeutic change has consistently demonstrated a relationship between session emotional activation and outcome. Helping people overcome their avoidance of emotion, focus collaboratively on emotions, and explore them in therapy has been shown to be important in therapeutic change regardless of therapeutic orientation (Coombs, Coleman, & Jones, 2002; Jones & Pulos, 1993). Reviews of process-outcome studies show a strong relationship between in-session emotional experiencing, as measured by the Experiencing Scale (Klein, Mathieu, Gendlin, & Kiesler, 1969), and therapeutic gain in dynamic, cognitive, and experiential therapies (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Goldman, Greenberg, & Pos, 2005; Orlinsky & Howard, 1986; Silberschatz, Fretter, & Curtis, 1986). These findings suggest that processing one's bodily felt experience and exploring it more deeply in therapy may well be core ingredients of change in psychotherapy, regardless of approach.

The recipe for emotional processing from the perspective of behavior therapy is arousal plus habituation to the distressing stimulus and exposure to new information—in other words, the experience of old distress in the presence of new information that is accrued experientially in the moment. From an experiential therapy perspective, however, approach, arousal, acceptance, and tolerance of emotional experience are necessary but not sufficient for change. Optimum emotional processing involves progress through a sequence of emotions plus the integration of cognition and affect (Greenberg, 2015; Greenberg & Pascual-Leone, 1995). When contact with emotional experience is achieved, clients must work through a sequence of emotion, from secondary to maladaptive to adaptive emotions, and they must also cognitively orient to that experience as information, explore it, reflect on it, and make sense of it. A focus on accessing needs and making meaning ultimately helps access adaptive

internal emotional resources, and this helps transform the maladaptive states contacted.

Depth of Experiencing, Emotional Arousal, and Productivity in Emotion-Focused Therapy

Supporting the hypothesis on the importance of paying attention to and making sense of emotion, process-outcome research on EFT for depression has shown that higher emotional arousal at midtreatment, coupled with reflection on the aroused emotion (Warwar & Greenberg, 2000) and deeper emotional processing late in therapy (Pos, Greenberg, Goldman, & Korman, 2003), predicted good treatment outcomes. High emotional arousal plus high reflection on aroused emotion distinguished good- and poor-outcome cases, indicating the importance of combining arousal and meaning construction (Missirlian, Toukmanian, Warwar, & Greenberg, 2005; Warwar, 2005). EFT thus appears to work by enhancing the type of emotional processing that involves helping people experience, accept their emotions, and make sense of them.

The York studies (Greenberg, Auszra, & Herrmann, 2007) have shown that depth of experiencing on core themes in the last half of therapy was a significant predictor of a reduction in symptom distress and increases in self-esteem, accounting for 8% to 16% outcome variance over and above that accounted for by early experiencing and the alliance, but it did not predict changes in interpersonal problems. Experiencing, therefore, mediated between any client individual capacity for early experiencing and positive outcome. This suggests that deepening experiencing over therapy is a specific change process, integral to the alleviation of depression through emotion-focused psychotherapies. In addition, Adams and Greenberg (1996) established a path to outcome showing that therapists' depth of experiential focus influenced clients' depth of experiencing, and this in turn was related to outcome. A subsequent study by Pos et al. (2003) suggested that the effect of early emotional processing on outcome was mediated by late emotional processing. Pos, Greenberg, and Warwar (2009), using path analysis, found that working phase emotional processing was the best

direct predictor of reductions in depressive and general symptoms and that it could directly predict gains in self-esteem. In addition, the alliance was found to significantly contribute to emotional processing and indirectly contribute to outcome. Surprisingly, beginning therapy alliance (measured after Session 1) also directly predicted all outcomes. The EFT-proposed theory of change that increase in emotional processing leads to change was supported, but it appears that clients' beginning therapy processes may constrain their success in therapy.

In another line of research on tape-rated emotional arousal, Warwar (2005) examined midtherapy emotional arousal as well as experiencing in the early, middle, and late phases of therapy. Emotional arousal was measured using the Client Emotional Arousal Scale III (Warwar & Greenberg, 1999a). In this study, clients who had higher scores midtherapy were found to have more change at the end of treatment. In addition, midtherapy arousal predicted not only outcome but also a client's ability to use internal experience to make meaning and solve problems as measured by experiencing, particularly in the late phase of treatment, added to the outcome variance over and above middle phase scale scores. This study thus showed that a combination of emotional arousal and experiencing was a better predictor of outcome than either index alone.

Warwar and Greenberg (1999b) found that client reports of in-session experienced emotion were not related to positive therapeutic change. A discrepancy was observed between client reports of in-session experienced emotions and the emotions that were actually expressed on the basis of arousal ratings of videotaped therapy segments. For example, one client reported that she had experienced intense emotional pain in a session. Her level of expressed emotional arousal, however, was judged to be very low on the basis of observer ratings of emotional arousal from videotaped therapy segments.

Carryer and Greenberg (2010) found that a moderate frequency of heightened emotional arousal added significantly to the outcome variance predicted by the working alliance. Up to this point, process research studies had focused on a direct linear relationship between process and outcome. This study, however, showed that a frequency of 25% of moderately to

highly aroused emotional expression was found to predict outcome most accurately. Deviation toward lower frequencies, indicating lack of emotional involvement, related to poor outcome, whereas deviation toward higher frequencies showed that excessive amounts of highly aroused emotion were also 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 undesirable.

Another study discriminated between productive and unproductive arousal. In an intensive examination of four poor-outcome cases and four good-outcome cases, Greenberg, Auszra, and Herrmann (2007) did not find a significant relationship between frequency of higher levels of expressed emotional arousal measured over the whole course of treatment and outcome. They found, however, that productivity of high aroused emotional expression was an excellent predictor of outcome. The measure of productive emotional arousal used in the study was further developed, and its predictive validity was tested on a sample of 74 clients from the York depression studies (Greenberg et al., 2007). *Emotional productivity* was defined as a person's being contactfully aware of a presently activated emotion and was operationalized in terms of the following six features: attending symbolization, congruence, acceptance, agency, regulation, and differentiation. Emotional productivity was found to increase from the beginning phase of treatment to the working and the termination phases of treatment. Working phase emotional productivity was found to predict 66% of treatment outcome, over and above variance accounted for by beginning phase emotional productivity, Session 4 working alliance, and high expressed emotional arousal in the working phase of treatment. These results indicated that the productive processing of emotion was the best predictor of outcome of all variables studied thus far.

In addition to the studies mentioned previously on arousal and experiencing, Greenberg and Pedersen (2001) found that in-session resolution of two core emotion-focused therapeutic tasks predicted outcome at termination and an 18-month follow-up and (most important) the likelihood of nonrelapse over the follow-up period. Both of these core tasks, resolving splits and unfinished business, involve facilitation of the restructuring of people's core emotion schematic memories and responses. These results support the hypothesis that deeper emotional processing and emotion schematic restructuring during therapy lead to more enduring change.

In EFTT studies, good client process, early in trauma therapy, has been found to be particularly important because it sets the course for therapy and allows maximum time to explore and process emotion related to traumatic memories (Paivio et al., 2001). One practical implication of this research is the importance, early in therapy, of facilitating clients' emotional engagement with painful memories. Emotional arousal during imaginal exposure appears to be a partial mechanism of change. Overall, the findings suggest a chain of influence on the degree to which a client processes emotion in trauma: first, the severity of trauma symptoms sets a limiting factor in the facilitation of emotional arousal and processing, followed by early engagement in imaginal exposure tasks, and finally the repetition of exposure tasks over the course of therapy, all have a successively cumulative impact on functioning at outcome (Paivio et al., 2001).

In another study of EFTT, researchers found that a therapist's competence in facilitating imaginal confrontations, by way of an empty-chair dialogue, predicted better client processing. Moreover, adult survivors of child abuse who engaged in an empty-chair dialogue experienced a reduction of interpersonal problems, and this outcome was independent of the therapeutic alliance (Paivio, Holowaty, & Hall, 2004). These important findings are consistent with those found in research on EFT for depression, which showed that deeper levels of emotional experiencing had a curative effect over and above the alliance (Pos et al., 2003). Emotional processes were also examined in two controlled studies on resolving emotional injuries and interpersonal difficulties. Emotional arousal during imagined contact with a significant other was a process factor that distinguished EFT from

a psychoeducational treatment and was related to outcome (Greenberg & Malcolm, 2002; Greenberg et al., 2008; Paivio & Greenberg, 1995).

Research on couples therapy also supports the role of emotional awareness and expression in satisfying relationships and change in therapy. Couples who showed higher levels of emotional experiencing in therapy, together with a softening in the blaming partner's stance, were found to interact more affiliatively and ended therapy more satisfied than couples who showed lower experiencing (Greenberg, Ford, Alden, & Johnson, 1993; S. M. Johnson & Greenberg, 1988; Makinen & Johnson, 2006). A similar effect of the expression of underlying emotion was found in resolving family conflict (Diamond & Liddle, 1996). Revealing of underlying vulnerable emotion has also been related to session and final outcome in the context of EFT for couples. In another study (McKinnon & Greenberg, 2009, in press), couples rated sessions in which underlying vulnerable emotion was revealed significantly more positively than control sessions on a global measure of session outcome. In addition, partners who revealed underlying vulnerable emotion scored significantly higher on measures of problem resolution and understanding than those in sessions in which emotions were not revealed. The revealing of underlying vulnerable emotion was associated with significantly greater improvement in relationship satisfaction at termination.

A developing line of research on narrative and related processes has further illuminated the process of change in EFT. The role of markers of narrative emotion (same old storytelling, empty storytelling, unstoried emotion, abstract storytelling) and change markers (competing plotlines storytelling, inchoate storytelling, unexpected outcome storytelling, discovery storytelling), and treatment and stage of therapy in brief EFT, client-centered therapy, and cognitive therapy for depression were studied. Analyses demonstrated a significant outcome effect for inchoate storytelling and discovery storytelling and a stage-by-outcome effect for abstract storytelling, and a stage-by-outcome-by-treatment effect for competing plotlines storytelling. Within EFT, recovered clients evidenced significantly higher proportions of competing plotlines storytelling at the middle stage of therapy than unchanged clients. There were also significant stage-by-outcome effects for problem

markers and change markers. The results provide preliminary support for the importance of assessing the contribution of narrative emotion processes to efficacious treatment outcomes in EFT in the treatment of depression. Gonçalves and colleagues have also shown that innovative moments, as well as resolution of ambivalence, are important change processes in EFT (Gonçalves, Mendes, Ribeiro, Angus, & Greenberg, 2010; Ribeiro et al., 2014).

Conclusions of Process-Outcome Research

The evidence indicates that certain types of therapeutically facilitated emotional awareness and arousal are important for therapeutic change, when expressed in supportive relational contexts, in conjunction with some sort of conscious cognitive processing of the emotional experience. This has been shown for certain classes of people and problems. Emotion also has been shown to be adaptive and maladaptive. In therapy, emotions, at times, need to be accessed and used as guides; at other times, they should be regulated and modified. The role of the cognitive processing of emotion in therapy has been found to be twofold: either to help make sense of the emotion or to help regulate it.

There can be no universal rule about the effectiveness of arousing emotion or evoking emotional expression. Emotional arousal and expression, although helpful, is not always useful in therapy or in life (Greenberg, Korman, & Paivio, 2001). Its usefulness depends first on factors such as whether the client's emotion is over- or underregulated and whether the emotion is a sign of distress or of working through the distress (Greenberg, 2015; Kennedy-Moore & Watson, 1999). The role of arousal and the degree to which it could be useful in therapy also depend on what emotion is expressed, by whom, about what issue, how it is expressed, to whom, when, and under what conditions, and in what way the emotional expression is followed by other experiences of emotion and meaning making (Greenberg, 2015; Whelton, 2004). It is not arousal alone but the manner of processing the aroused emotion that is most predictive of outcome. Clients who are contactfully aware (i.e., mindful) of their emotions fare best compared with other clients. Evidence suggests that emotional processing

is mediated by arousal. This means that for effective emotional processing to occur, the distressing affective experience must be activated and viscerally experienced by the client. Arousal appears to be essential but not necessarily sufficient for therapeutic progress.

RESEARCH ON AN EMOTIONAL CHANGE PROCESS

Task analysis on the emotional processing steps involved in resolving global distress produced a model of a corrective experience. This involved moving from a starting point of global distress through, fear, shame, and aggressive anger to negative self-evaluations and to the pivotal step of the articulation of needs. Resolution of global distress involved moving to assertive anger, self-soothing, hurt, and grief (A. Pascual-Leone & Greenberg, 2007). A measure identifying model components called the Classification of Affective Meaning States was also developed (A. Pascual-Leone & Greenberg, 2007). Global distress was identified as an unprocessed emotion with high arousal and low meaningfulness. The model was tested using a sample of 34 clients in global distress. Results show that the model of emotional processing predicted in-session outcomes and that the distinct emotions described in the model emerged moment-by-moment in predicted sequential patterns.

Intermediate model components that represent the level of personal evaluation and reevaluation proved to be a point of critical distinction between good and poor in-session outcomes. Statements of negative evaluation about the self and the experience of fear or shame were found to be present in virtually the same number of resolved and unresolved global distress events. However, a heartfelt statement expressing a need to feel valuable, lovable, safe, or alive was predictive of in-session outcome.

This finding is consistent with EFT's model of theoretically articulated change steps (Greenberg & Paivio, 1997) and supports the view held in EFT that the expression of a "heartfelt need"—that is, a wish for attachment, validation, personal agency, or survival—in which the need is embodied and deeply felt is the key to deeper adaptive emotional experiencing (Greenberg, 2015; Greenberg & Paivio, 1997; Greenberg, Rice, &

Elliott, 1993). A further study of this model by A. Pascual-Leone (2009) examined how dynamic emotional shifts accumulated moment-by-moment to produce in-session gains in emotional processing. He showed that effective emotional processing was associated with steady progression along the steps toward resolution characterized by "two steps forward, one step backward." Resolution events were also shown to have increasingly shortened emotional collapses in a backward direction, whereas the opposite was true for poor in-session events.

RESEARCH ON SPECIFIC THERAPEUTIC TASKS

In addition to the general therapeutic processes reviewed in the preceding sections, research has been done on several key EFT tasks, each characterized by a particular client sign of readiness (marker), a sequence of therapist actions and client in-session microprocesses, and definition of successful resolution (Greenberg, Rice, & Elliott, 1993). Research on the major methods is reviewed next.

Two-Chair Dialogue for Conflict Splits

Intensive analyses of the client's change process in the two-chair dialogue led to the development of a model of the essential components of resolution of splits (Greenberg, 1979, 1980). Greenberg and Webster (1982) showed that softening of the harsh critic in two-chair dialogue predicted resolution of decreased conflict. Mackay (1996) provided further empirical support for Greenberg's (1983) three-stage model of successful two-chair work, consisting of opposition (conflict), merging (softening and mutual understanding), and integration (synthesis or negotiation of mutually satisfying compromises). Sicoli and Hallberg (1998) investigated novice client performance using the Gestalt two-chair technique. The presence of "wants and needs" was found to be significantly greater overall for sessions in which the critic softened compared with sessions with no softening, whereas Whelton and Greenberg (2005) found that high contempt and low resilience in response to the critic related to proneness to depression.

Empty-Chair Dialogue for Unfinished Business

In two preliminary studies, empty-chair dialogue was shown to be more effective in resolving unfinished business than empathy on in-session processes and session outcome measures (Greenberg & Foerster, 1996). In a controlled trial of the efficacy of empty-chair dialogue for the resolution of unfinished business, Paivio and Greenberg (1995) found that using an empty-chair intervention in therapy was significantly more effective than a psychoeducational group intervention in reducing symptom and interpersonal distress, reducing discomfort in target complaints, and achieving resolution of unfinished business. Beutler et al. (1991) demonstrated that an expressive form of this dialogue can be effective in working with pain and depression when working with people with overcontrolled anger.

Intensive analyses of the client's change process in the empty-chair dialogue led to the development of a model of the essential components of resolution of unfinished business (Greenberg, 1991; Greenberg & Foerster, 1996). This model specified a number of components of resolution (Greenberg, Rice, & Elliott, 1993). In the process of resolution, the person moves through expressing blame, complaint, and hurt to the arousal and expression of the unresolved emotion, and finally to the mobilization of a previously unmet interpersonal need. In more successful dialogues the view of the other shifts and the other is enacted in a new way. Resolution finally occurs by means of the person adopting a more self-affirming stance and understanding and possibly forgiving the imagined other or by holding the other accountable.

Greenberg and Foerster (1996) found that four performance components of the model—intense expression of feeling, expression of need, shift in representation of other, and self-validation or understanding of the other—discriminated between resolution and nonresolution performances. McMain (1996) found that successful outcome was predicted by change in the representation of the self. Specifically, an increase in self-autonomy, self-affiliation, and positive responses of self in relation to the significant other were each predictive of treatment outcome at post-therapy and a 4-month follow-up, and that assertion of needs was a better predictor of therapy outcome than new view of other, in part because in

abuse cases, resolution can occur without changing the view of the other (McMain, 1996; McMain, Goldman, & Greenberg, 1996). Using the same sample, Paivio and Bahr (1998) found that interpersonal problems at the beginning of treatment predicted alliance.

Greenberg and Malcolm (2002) demonstrated that clients who resolved their unfinished business with a significant other in a manner consistent with the model enjoyed significantly greater improvement in symptom distress, interpersonal problems, affiliation toward self, degree of unfinished business, and change in target complaints. This suggests that the components of resolution capture a clinically important process that relates to outcome. In addition, a significantly greater number of clients in the resolved group were found to express intense emotions. Furthermore, almost all clients in the resolution group experienced the mobilization of an interpersonal need and a shift in their view of the other, whereas no clients in the unresolved group experienced a shift in their view of the other. These results provide evidence of the importance of emotional arousal in this task and indicate that those clients who identified and expressed previously unmet interpersonal needs, and experienced a shift in their view of the other, changed more than those who did not engage in these processes.

Finally, in a study of childhood maltreatment, Paivio and colleagues (2001) found that high and low engagers in imaginal confrontations in empty-chair dialogue differed significantly in their outcomes. High engagers achieved significantly greater resolution of issues with abusive and neglectful others and reduced discomfort on current abuse-related target complaints. The preceding studies, in combination, provide substantial evidence that degree of client engagement in expression of emotions and unmet needs during empty-chair work predicts successful resolution of unfinished issues with significant others.

Evocative Unfolding of Problematic Reactions

Watson and Rennie (1994) used tape-assisted process recall to obtain clients' reports of their subjective experiences during the exploration of problematic reactions and found that clients alternated between two

primary activities: symbolic representation of their experience and reflexive self-examination. In addition, Watson (1996) found that resolution sessions, in contrast to nonresolution sessions, were characterized by high levels of referential activity, which occurred when clients described problematic situations and then immediately differentiated an emotional reaction; in these sessions, clients also reported a change in mood immediately following vivid descriptions of the problematic situation. These two studies highlight the role that vivid description can play in promoting clients' emotional arousal during sessions and the role of self-reflection in the change process. These findings validate the proposition that vividly re-evoking the situation, and clients' subsequent differentiation of their subjective experience, are both necessary but different aspects of productive therapy process; in particular, they are important steps in resolving problematic reactions (Greenberg, Rice, & Elliott, 1993; Rice & Saperia, 1984).

Focusing on an Unclear or Painful Felt Sense

Studies in Japan, North America, and Europe have looked at factors that enhance the effectiveness of focusing. For example, Hendricks (2009) reported that "clearing a space," "finding a right distance," and having a listener referred to their experiencing each helped clients focus. Iberg (1996) found that clients reported increased impact of sessions in which therapists used focusing-type questions. Leijssen (1996) found that 75% of positive client-centered sessions contained focusing steps and only 33% of negative sessions contained focusing. Leijssen also investigated whether long-term clients deemed to be stagnating in their therapy could be taught to focus to increase experiencing levels. Of four clients studied, she found that two deepened their experiencing level, whereas the two clients who returned to their previous levels of experiencing after focusing training expressed unhappiness with their regular therapists and wished to continue with the focusing trainer. Clients with low levels of experiencing apparently do not easily learn the skill; thus, for focusing to take place and be sustained, continued process direction is required (Leijssen, Lietaer, Stevens, & Wels, 2000).

Narrative Processes

Angus and colleagues' (Angus, Levitt, & Hardtke, 1999; Lewin, 2000) studies of narrative sequences in EFT have revealed interesting patterns associated with good outcomes. Angus et al. (1999) found that perceptual process client-centered therapy (Toukmanian, 1992), EFT, and psychodynamic therapy dyads differed significantly from one another in terms of the number and the type of narrative sequences (external, internal, reflexive). More specifically, in the psychodynamic therapy sessions a pattern of reflexive (40%) and external (54%) narrative sequences predominated, with therapist and client engaged in a process of meaning construction (reflexive) linked to the client's descriptions of past and current episodic memories (external). In contrast, the EFT dyad evidenced a pattern of internal (29%) and reflexive (46%) narrative sequences, in which the client and therapist engaged in a process of differentiating emotional experiences (internal) and generating new understandings of those experiences (reflexive) during the therapy hour. As compared with the other two dyads, the proportions of internal narrative sequences were 3 times higher in EFT sessions than in the client-centered sessions and 5 times higher than in the psychodynamic sessions. The primary goal of EFT is to assist clients in developing more differentiated and functional emotion schemes, and the evidence from these analyses indicates that this goal is achieved by an alternating focus on client exploration of experiential states (internal narrative modes), followed by meaning-making inquiries (reflexive narrative modes) in which new feelings, beliefs, and attitudes are understood.

The client-centered therapy dyad revealed a pattern of consecutive reflexive narrative sequences (54%) occurring across topic segments in which clients and therapist engaged in extended reflexive analyses of life events (external, 36%) and to a lesser extent emotional experiences (internal, 19%). The chaining of the reflective narrative sequences with other types of narrative sequences appeared to facilitate an extended client inquiry into core self-related issues in which automatic processing patterns were identified and challenged.

In a further study, good-outcome EFT therapists were found to be twice as likely to shift clients to emotion-focused and reflexive narrative

modes than poor-outcome EFT therapists (Lewin, 2000). Additionally, good-outcome depressed clients initiated more shifts to emotion-focused and reflexive discourse than poor-outcome clients. Depressed clients, who achieved good outcomes in brief experiential therapy, were found to spend significantly more time engaged in reflexive and emotion-focused discourse than were poor-outcome clients. These findings provide empirical support for the importance of emotion and reflexive processes in the treatment of depression.

Honos-Webb, Stiles, Greenberg, and Goldman (1998) used the Assimilation of Problematic Experience Scale (APES) with two EFT clients, one with good outcome and one with relatively poor outcome. The scale measures degree of assimilation of a particular problematic experience (Level 0 = Warded Off; Level 7 = Mastery). Qualitative analysis of the successful client's transcripts suggested that in the good case, assimilation occurred over time in at least three areas of problematic experiences. Analysis of three themes in the less successful therapy suggested that assimilation was blocked. In a further qualitative assimilation analysis of the successful case, the researchers excerpted 43 relevant passages tracking two major themes and rated each passage on the APES (Honos-Webb, Surko, Stiles, & Greenberg, 1999). APES ratings tended to increase across sessions, as expected in successful therapy. In this study, the client's dominant "superwoman" voice was shown to assimilate a voice of need and weakness, whereas her dominant "good girl" voice assimilated a voice of rebellion and assertiveness, yielding a more complex and flexible community of voices within the self. This was interpreted as supporting an emerging formulation of the self as a "community of voices," leading to a reformulation of the goal of therapy as facilitating diversity and tolerance among the different self-aspects or voices.

RELATIONAL FACTORS

The link between outcome and empathy and the alliance is the most highly evidence-based finding in the psychotherapy research literature (Bohart, Elliott, Greenberg, & Watson, 2002; Horvath & Greenberg, 1994). In a

meta-analysis of the general association between therapist empathy and client outcome, Bohart et al. (2002) found that six of the studies involved experiential therapies, and the average association of empathy to outcome in these studies was .25, a value in the same range as the overall sample value. In a study of the relational conditions and alliance in the treatment of depression, Watson and Geller (2005) found that clients' ratings of the relationship conditions and the working alliance were associated with good outcome in EFT and cognitive–behavioral psychotherapy independently of clients' pretreatment scores and initial treatment improvement. The alliance was found to mediate the relationship between the person-centered conditions and outcome. This supports the view that therapists who are empathic, accepting, congruent, and prizing of their clients, irrespective of the specific techniques they use, are able to negotiate agreement about the tasks and goals of therapy and develop a positive therapeutic bond. It is likely that therapists who are more empathic, nonjudgmental, and congruent will be able to implement tasks that fit with their clients' goals, thus increasing the likelihood of good outcome.

Weerasekera, Linder, Greenberg, and Watson (2001) examined the development of the working alliance in EFT and client-centered therapy of depression. Results revealed that the alliance–outcome relation varied with alliance dimension (goal, task, or bond), outcome measure (symptom improvement vs. self-esteem, relational problems), and the point at which in-treatment alliance was measured. Analyses revealed that early alliance scores predicted outcome independently of early mood changes. Although no treatment group differences were found for bond and goal, the EFT group displayed higher task alliance scores in the midphase of therapy.

CONCLUSION

EFT for depression has been extensively researched, to the point where it is recognized as an evidence-based treatment. EFT also has been shown to be an effective treatment for helping clients deal with the sequelae of traumatic and abusive events. In addition, EFT for couples has been shown to be effective for couples' distress (Baucom et al., 1998).

The two central tasks in experiential therapy are the provision of a therapeutic relationship and the deepening of experience. A general therapeutic task associated with but not identical to deepening experiencing that has received empirical support is increasing access to emotions and emotional arousal. Evidence supports the importance of relational factors of empathy and the establishment of an alliance and deeper experiencing and emotional processing as important general processes in experiential therapy. In addition, deeper emotional processing, which involves higher emotional arousal and reflection on the aroused experience, or the type of integration of emotion and reason or right and left brain integration, has been shown to be a better predictor than either process alone. In addition to these generic processes, specific therapeutic microprocesses, such as the softening of a previously harsh critic, a new view of the other, and letting go and forgiving, have been shown to be effective in resolving specific emotional problems.

6

Future Developments

The future of emotion-focused therapy (EFT) is broad and ever expanding. Applications to different populations and diverse cultural groups are underway, as is more research on the process of change. In this chapter, I discuss suggested directions for EFT, including areas for further exploration, training, and EFT as a preventive approach.

AREAS FOR FUTURE RESEARCH

EFT's strength lies in its theory of change. Rather than focusing on a theory of functioning or on diagnosis, it has focused on understanding how people change. A dialectical constructivist, process-oriented macrotheory of functioning has been developed, but the most substantial contribution comes from intermediate and microlevel theories of how change takes place in sessions (Greenberg, Rice, & Elliott, 1993). Change processes for

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Emotion-Focused Therapy, Revised Edition, by L. S. Greenberg

specific interventions applied at specific markers have been developed that lay down a template for future development. Opportunities for the study of further change processes abound, and a method of task analysis and qualitative and quantitative methods has been developed to enable these kinds of studies (Greenberg, 2007; A. Pascual-Leone, Greenberg, & Pascual-Leone, 2009).

A number of new tasks have been defined and merit further study, including trauma and narrative retelling; anxious insecurity and self-soothing, high distress and meaning making; confusion and clearing a space in individual therapy (Elliott, Greenberg, & Lietaer, 2004; Greenberg & Watson, 2006); and attachment injuries, identity injuries and dominance interactions in couple therapy (Greenberg & Goldman, 2008). In the previous edition of this book, I noted the lack of research on these tasks; unfortunately, this lack of research is still a concern, as studies are still needed on many of them. One task that is currently under study is the resolution of anxious insecurity (Sharbanee, Greenberg, & Watson, 2015). Preliminary observation suggests that people need to resolve an intrapersonal conflict related to self-worth from negative self-treatment before they can successfully resolve difficulties in self–other treatment. It appears that clients need to experience a certain degree of pride or self-worth to overcome their negative self-treatment, which helps them to feel deserving and assert the right to have their interpersonal needs met.

New tasks need to be defined and studied by explicating clinicians' implicit knowledge of the process of in-session change. Three markers we have identified, but not yet studied intensively, are markers of projections, disowned parts of self-experience, and closing down or withdrawing into self. In the case of projection, a person has overly intense feelings about another's situation, such as feeling intense despair on seeing a beggar's plight (as opposed to compassion), or feeling very sad for one's child's perceived loneliness when the child is untroubled. Here a person's own despair or loneliness is seen in the other and needs to be reowned. As in classical projection when one projects sexual excitement or aggression on the other and then condemns it in the other, here one projects one's own feeling to the other and then feels pain about it. Reowning of the feelings seen in the other is greatly facilitated by, for example, becoming the beggar or the

child, and speaking as them. Disowning is related to projection, but the disowned feeling is simply not allowed to be felt, for instance, when a client disowns his/her vulnerability, or conversely, when a client feels perennially unable to accomplish anything and thereby disowns his/her own competence. In a closing down marker, the person withdraws behind a "wall" or into a "cave" for self-protection, becomes locked in, and can't come out. Working with this state as a variant of a self-interruptive process is helpful, but here it is not an emotion being suppressed; rather, the self is being protected by walling it off. These are the types of processes that merit further task analyses. Recently, work on narrative and emotion has led to the identification of new narrative-emotion markers, such as *same old story*, *empty story*, *untold* and *broken story*, as well as the different types of empathic narrative interventions most appropriate at each marker (Angus & Greenberg, 2011). More research on the role of these markers in change is also taking place.

EFT's differential process-diagnostic approach (Greenberg, Rice, & Elliott, 1993) may lead to the construction of "mini manuals" describing ways of treating specific problems, such as the wanting of addictions and blocks to action, without losing the essence of EFT of focusing on experience and on what is unique in the whole person. Process research and comprehensive qualitative research, which have contributed to this study of specific events and experiences, will continue to contribute to experience-near process research on EFT. More research on different populations and on cultural adaptations also is needed. Continuing studies of the effectiveness of EFT on anxiety disorders are sorely needed, as are studies on personality disorders and other clusters of difficulties. Although there is good evidence that EFT is effective with Axis 1 disorders and with relational/interpersonal difficulties and complex childhood trauma, there is very little research on EFT treatment for PTSD. Studies are needed to examine non–relationally-focused PTSD, especially PTSD as a result of combat.

On the one hand, we see much disorder as a function of the common mechanisms of maladaptive emotion schemes and problems in affect regulation and the therapeutic relationship as a common factor of all treatments; people need to be treated as unique whole persons with idiosyncratic determinants of their problems and many resources, rather than

as their symptoms. This suggests that diagnostic grouping is not always that relevant to treatment because much distress has the same underlying cause and has unique treatment-relevant manifestations in each individual. On the other hand, we do see that people with common symptoms, such as anxiety or eating disorders, who have certain common characteristics, and grouping them into diagnostic categories does reduce some of the variability in population that affects treatment. We therefore see the relevance of honing a core common treatment to fit different syndromes and specifying particular aspects relevant to different disorders. Future research looking at EFT with a cross-section of the population and looking at contextual factors would enhance generalization to a broader population.

In addition, more research on the EFT theory of emotional change is needed. Most pressing is evidence on the effectiveness of changing emotion with emotion and on the effects of moving from secondary through primary maladaptive emotion to adaptive emotion by way of need mobilization. Studies testing the effect of opposing a maladaptive emotion, such as fear or shame, by focusing on empowering anger or sadness at loss or on changing unresolved anger at a significant other by accessing the underlying abandonment sadness would go a long way toward establishing the scientific basis of principles of emotion transformation Similarly, basic research on corrective emotional experience would allow more refined understanding and intervention with this important process of change.

Further work is needed on such central therapeutic processes as experiencing, emotional arousal and expression, and therapeutic presence and empathy. As for emotional arousal, we see the evidence as suggesting that it is not sheer emotional expression by itself that is therapeutic; rather, what is critical is emotional expression in conjunction with reflective processing and the quantity (25%) and degree of productivity of arousal. In addition, there appear to be complex interactions between people's initial capacity for depth of experience and alliance establishment that set different paths to change (Pos, Greenberg, & Warwar, 2009). Clearer links between process and outcome also must be identified, and the relative contribution of relational connection and emotional process must be

further studied. Research on training of therapists would also be helpful in addressing such questions as the relative merits of personal work and skill training.

TRAINING

A crucial next step is introducing EFT training into graduate programs and internships. The generic relational and emotion approach and regulation skills could benefit all trainees. Training in an EFT approach is needed to the treatment of depression, trauma, and interpersonal problems, and to couples therapy, which all have demonstrated effectiveness, and eventually EFT needs to be applied to other client problems about which evidence is accumulating, such as eating disorders and anxiety disorders. In training programs committed to teaching evidence-based treatments that have emphasized cognitive–behavioral treatment to the exclusion of other approaches, the evidence is now strong enough to recommend that EFT therapies be required as part of a training program and offered as an important addition to more symptom-focused coping-skills acquisition approaches. In fact, students' education as psychologists is incomplete without a greater emphasis on training in working with emotion and emotion attunement.

Although training in EFT with couples has proliferated in marital and family training programs and internship settings, much more is needed in individual therapy training and education. EFT training programs have proliferated since the first edition of this book appeared, but mainly internationally, in Europe and Asia, where psychotherapy training takes place outside of university programs. In North America, where training takes place in universities, EFT is still only slowly being integrated into graduate curricula despite being evidence based. Academic training in these settings tends to be more research oriented and dominated by cognitive–behavioral perspectives, which are easier to manualize and which often show quick effects on symptom reduction (as that is their focus). Nevertheless, it is apparent at this stage that there is no substantial evidence for the superiority of any one approach over another (Cuijpers et al., 2012; Stiles,

Barkham, Mellor-Clark, & Connell, 2008a), mainly because we simply do not have sufficient high-quality data to make these kinds of evaluations, in spite of claims to the contrary (Clark, Fairburn, & Wessely, 2008; Stiles, Barkham, Mellor-Clark, & Connell, 2008b).

Personal therapy or work on self-development is also extremely helpful in learning the skills of working with emotion as well as the importance of relational empathy, alliance building, and overall interpersonal skills. Personal growth experiences in different forms are helpful and important. Thus, therapists' personal development and experiential training need to be incorporated into training.

PREVENTIVE APPROACHES

In the book *Emotion-Focused Therapy: Coaching Clients to Work Through Their Feelings* (Greenberg, 2015), I introduced the idea of therapists as emotion coaches, implying that therapy was actually a process of helping people increase their emotional competence. One of the most pressing needs is the development of preventive programs training people to become more emotionally literate. This would involve experientially based psychoeducation programs on how to use, manage, and change emotion. Emotion coaching programs for emotion literacy are highly needed. This would involve training people in new ways of thinking about emotion and in developing the associated emotional skills, such as how to identify emotion, differentiate what is felt from what others feel, synthesize contradictory emotions, tolerate emotion, use emotion as information, and articulate feelings. Good emotion coaching programs, as opposed to simply giving instructions, depend on creating the right type of relational environment and on a coach's continual responsiveness to clients' reactions to what they are doing. A core aspect of the art of helping is offering the right response or guidance at the right time.

An emotional literacy program has been developed and tested; it is based on the following principles of emotion-focused coping: (a) building awareness of secondary and primary adaptive and maladaptive emotional states, (b) developing emotional regulation and self-soothing skills and learning to get distance from and tolerate the discomfort of distressing

emotion, (c) transforming maladaptive emotional states through accessing adaptive emotions and needs, and (d) reflecting on emotional experience to make meaning.

Probably a key time to introduce training, especially in emotion awareness, management, and transformation, is in adolescence and young adulthood, when emotions often become problematic. Emotion in the workplace is also in need of attention. Emotion awareness training must be started in the home and with young children, but more extensive work on emotion processes could be begun in adolescence and young adulthood in schools and the workplace. To help develop emotional competence in children, however, their parents and teachers must be emotion friendly. Thus, in some way training adolescents and young adults may be the best preventive entry point so that as future parents, teachers, and managers they will be good emotion coaches for the next generation. However, emotion training for adults who currently are parents, teachers, and managers is also crucial because they are the ones who influence younger generations and the work environment.

Emotion coaching for parenting is crucial because parents' philosophy of emotion management clearly influences their children's emotional intelligence (Gottman, Katz, & Hooven, 1996). The degree to which parents feel that their own and others' emotions need to be suppressed, controlled, and avoided is the degree to which they stop attending to their children's emotions. Parents often believe that their children need to learn the lessons of emotional control and the merits of no longer being babies. Adulthood in this view involves reining in the emotions—at worst by not sparing the rod, at best by promoting rational control over emotion. Parents generally do not want their children to be crybabies or wimps. Being strong is a much-admired and desired quality, and popularity does not go with emotionality in childhood or adulthood. However, in the long run, strength and emotional intelligence come from the integration of reason and emotion rather than control over emotion; and parents who are good emotion coaches and approach their children's emotions as an opportunity for intimacy, in a compassionate manner, have been shown to produce children who are not emotionally labile or crybabies (Gottman et al., 1996).

Parents who see their children's emotions as an intimate opportunity for connecting with them and validating their children's experiences have been shown to be the best emotion coaches (Gottman et al., 1996). Being aware of children's emotions from birth onward is thus one of the most central tasks of parenting. Infants are very labile and easily aroused. Unable to control their own responses, they are prone to sudden frustration, boredom, and fatigue. They depend on adults to read their emotion signals. Emotion coaching of parents involves helping parents become emotion coaches for their children. Similarly, emotion coaching of teachers and managers involves coaching them in awareness and management of their own emotions and in how to deal with the emotions of others.

At times, work with the adults or people in management roles would involve coaching them alone on how to help the people for whom they are responsible and manage their emotions. At other times, it is useful to work with the ones in charge on how to respond to the emotions of those with whom they work as they emerge in actual interactions. For example, parents who are having problems with their children can be coached on how to hold their infants, how to be vocally responsive, and how to be attentive and reciprocating in their gaze. Teachers would be coached on managing destructive emotionality in children; managers would be coached in managing conflict in the workplace.

A crucial step in applying EFT work more broadly, therefore, is the development of preventive programs for children, adolescents, young adults, parents, teachers, and managers, where they can learn about their emotions and be encouraged to practice attending to their emotions, become more compassionate to themselves and others, and learn to regulate emotion and to reflect and transform emotions. I hope to help promote the development of these types of efforts.

INTEGRATION

The term *emotion-focused therapy* will, I believe, be used in the future, in its integrative sense, to characterize all therapies that are emotion focused, be they psychodynamic, cognitive–behavioral, systemic, or humanistic (Foa & Jaycox, 1999; Fosha, 2000; Greenberg, 2015; McCullough et al., 2003). Many

of the major schools are in the process of accomplishing an essential shift in view from cognitive psychology and cognitive neuroscience to emotion and affective neuroscience (Davidson, 2000a; Frijda, 1986; Schore, 2003) and attending more centrally to the role of emotion in therapy. What will distinguish and differentiate an approach as emotion focused will be its emphasis on the importance of affect in human functioning and on the experience of emotion in sessions.

CRITICISMS

There are three major criticisms of EFT, which will continue to be inspected and addressed. The first is that working with emotion can be dangerous in that emotions can be disorganizing or overwhelming and activating them can be dangerous. Although it is true that emotions can be frightening and destructive, often EFT is promoting the experience of adaptive emotional resources, and these are far from destructive. However, facing avoided emotion can sometimes be painful, and people clearly dread and fear these emotions. EFT, therefore, is sensitive to the need for sufficient internal and external support before accessing painful emotions. Relationships need to be built before emotion is accessed, and internal soothing and regulation skills need to be in place before emotion is activated in therapy.

The second criticism is that people are rational, and some, and possibly men in particular, will not respond to an emotion-focused approach, will see being emotional either as irrational or weak, and will not form an alliance with the therapist. Similarly, some say that EFT may not be suitable for some cultures, such as some shame-based East Asian cultures in which rules govern social expression, or that more hierarchically organized cultures may not respond to emotion-focused methods and egalitarian relationships. Although it is true that there are strong cultural and subcultural views of emotion and rules of emotional expression, it also is true that all people have emotions, regardless of their socialization, and they need to be able to deal with them. Thus, it may take longer and may need a stronger alliance to help people from certain cultural groups feel comfortable expressing emotion, but in the long run, the same principles of emotional functioning apply to all human beings. Third, the empathic explorations

and conjectures that form an important part of the EFT empathic style are seen by some as too leading, intrusive, or possibly as distorting clients' experience, resulting in client compliance as to what they are feeling. In essence, the criticism is that therapists may impose their own views on what the client is feeling. We counter by noting that EFT therapists privilege following over leading and are highly sensitive to coexploration and establishing collaboration, and that clients have been found to more willing to disagree with EFT therapists' reflections than with the interventions of cognitive–behavioral therapists (Watson & McMullen, 2005).

CONCLUSION

EFT invites people to approach, attend to, regulate, use, and transform emotions, and learn when to facilitate the emotion change process. EFT also recognizes the power of human relationships to heal, and the therapist thus offers a real relationship to the client. EFT has achieved the momentum to be recognized as a fruitful approach to therapy. It is essential that this momentum be maintained. This depends on a new generation taking the baton and running with it. I hope this book encourages you to do this.

Glossary of Key Terms

ABANDONED Left alone psychologically or physically (or both).

ACCESSING Activating emotion schemes.

ADAPTIVE Functional and aids survival.

ALLIANCE Collaboration on the goals and tasks of therapy.

ATTACHMENT Emotional connection that produces feelings of security.

AVOIDANCE Distancing from experience.

AWARENESS The process of symbolizing experience.

BOND Secure affective connection between client and therapist.

CONJECTURE Guessing at what is being felt.

CONSTRUCTIVIST The process of creating meaning from the constraints of the environment.

CORRECTIVE EXPERIENCE Having a new experience that changes an old experience.

DENIED Not acknowledged in awareness.

DIALECTICAL The opposing of multiple aspects.

DIFFERENTIAL Different approaches to different phenomena.

DIRECTIVE Leading or guiding by the therapist.

DYNAMIC Changing in time.

DYSREGULATED Emotion that is too intense to deal adaptively with the situation.

EMOTION Automatic appraisals of situations in relation to wellbeing.

EMOTIONAL AROUSAL Degree of activation of expressed emotion.

EMOTIONAL PROCESSING Making meaning of aroused emotion.

EMOTIONAL REGULATION Organization of emotional experience.

EMOTIONAL SCHEME Internal emotion producing structure/organization of elements.

EMPATHY Imaginative entry into the worlds of the other.

EMPTY-CHAIR DIALOGUE Method of having a person speak to an imagined other.

EVOCATIVE Activating experience.

EXPERIENCING Result of attention to and awareness of the ongoing flow in the body.

EXPLORATORY Searching for the implicit.

EXPRESSION Bodily engagement in what is being talked about.

FACILITATE Act as an aid to promote the clients self-organizing process.

FOCUSING Paying attention to a bodily felt sense.

GOAL Implicit or explicit aim of therapy.

IDENTITY The sense of unity of experience formed by a narrative.

INSTRUMENTAL EMOTION Experienced or enacted to achieve an aim conscious or unconscious.

INTERVENTION Therapist action.

MALADAPTIVE No longer functional.

MARKER A performance indicator of a task or concern the client is working on, or a current experiential state.

NARRATIVE The organizing of experience into a coherent organization structured in time with agents, actions, intentions, and a plot line.

NONVERBAL Facial, gestural, or vocal expressions.

PRIMARY EMOTION Initial automatic emotional reaction (aware or unaware).

PROBLEMATIC REACTIONS In-session state of puzzling over one's reaction to a situation.

PRODUCTIVE Therapeutically useful.

REFLECTION Creating meaning by a process of abstraction of meaning.

SECONDARY EMOTION Reaction to a prior internal stimulus; often a reaction to a prior emotion.

SELF The changing organization of experience that encounters the environment.

SELF-INTERRUPTION Method of having an agent in the self enact the action (often of suppressing an emotion) on the other part of the self.

SELF-ORGANIZATION The changing experience of self.

SELF-SOOTHING Being tender or caring towards oneself.

SPLITS Two parts of the self in conflict.

SYMBOLIZING Representing experience in some form, often language.

SYSTEMATIC EVOCATIVE UNFOLDING Revoking experience in a vivid manner to enhance exploration.

TASK Affective/cognitive problem that the client is working on and trying to resolve.

TRANSFORMATION Changing emotionally based self-organizations.

TWO-CHAIR DIALOGUE Method of having two parts of the self in opposition encounter each other.

UNDOING Transforming one emotion by synthesis with another.

UNFINISHED BUSINESS Unresolved bad feeling toward a significant other.

VALIDATING Confirming another's experience.

VOCAL QUALITY Different types of voices that are more or less therapeutically productive.

VOICES The articulation of different self-organizations.

Suggested Readings

MAIN TEXTS

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Emotion-Focused Therapy Clinic: http://www.emotionfocusedclinic.org

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About the Series Editors

Jon Carlson, PsyD, EdD, ABPP, is distinguished professor, psychology and counseling at Governors State University and a psychologist at the Wellness Clinic in Lake Geneva, Wisconsin. Dr. Carlson has served as editor of several periodicals including the *Journal of Individual Psychology* and *The Family Journal.* He holds Diplomates in both family psychology and Adlerian psychology. He has authored 175 journal articles and 60 books including *Time for a Better Marriage, Adlerian Therapy, Inclusive Cultural Empathy, The Mummy at the Dining Room Table, Bad Therapy, The Client Who Changed Me, Their Finest Hour, Creative Breakthroughs in Therapy, Moved by the Spirit, Duped: Lies and Deception in Psychotherapy, Never Be Lonely Again, Helping Beyond the Fifty Minute Hour, Psychopathology and Psychotherapy, How a Master Therapist Works and Being a Master Therapist.* He has created over 300 professional trade video and DVDs with leading professional therapists and educators. In 2004 the American Counseling Association named him a "Living Legend." In 2009 the Division of Psychotherapy of the American Psychological Association (APA) named him "Distinguished Psychologist" for his life contribution to psychotherapy and in 2011 he received the APA Distinguished Career Contribution to Education and Training Award. He has received similar awards from four other professional organizations.

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