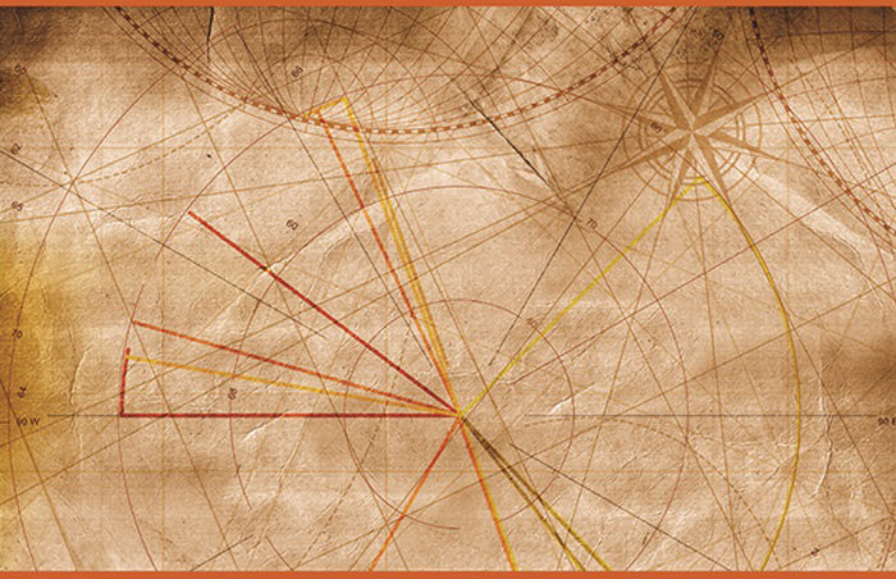
CASE FORMULATION *in* EMOTION-FOCUSED THERAPY

Co-Creating Clinical Maps for Change



RHONDA N. GOLDMAN
LESLIE S. GREENBERG

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AMERICAN PSYCHOLOGICAL ASSOCIATION
WASHINGTON, DC

Published by
American Psychological Association
750 First Street, NE
Washington, DC 20002
www.apa.org

To order
APA Order Department
P.O. Box 92984
Washington, DC 20090-2984
Tel: (800) 374-2721; Direct: (202) 336-5510
Fax: (202) 336-5502; TDD/TTY: (202) 336-6123
Online: www.apa.org/pubs/books
E-mail: order@apa.org

In the U.K., Europe, Africa, and the Middle East, copies may be ordered from
American Psychological Association
3 Henrietta Street
Covent Garden, London
WC2E 8LU England

Typeset in Goudy by Circle Graphics, Inc., Columbia, MD

Printer: Maple Press, York, PA
Cover Designer: Berg Design, Albany, NY

The opinions and statements published are the responsibility of the authors, and such opinions and statements do not necessarily represent the policies of the American Psychological Association.

Library of Congress Cataloging-in-Publication Data

Goldman, Rhonda N., author.
Case formulation in emotion-focused therapy : co-creating clinical maps for change / by Rhonda N. Goldman and Leslie S. Greenberg. — First edition.
p. ; cm.
Includes bibliographical references and index.
ISBN 978-1-4338-1820-2 — ISBN 1-4338-1820-5
I. Greenberg, Leslie S., author. II. American Psychological Association, issuing body. III. Title.
[DNLM: 1. Emotions. 2. Psychotherapy—methods. 3. Narration. 4. Patient Care Planning. WM 420]
RC480.5
616.89′14—dc23
2014015803

British Library Cataloguing-in-Publication Data
A CIP record is available from the British Library.

Printed in the United States of America
First Edition

http://dx.doi.org/10.1037/14523-000

For my family, for all their love, support, analysis, and insight.
—Rhonda

For Brenda, who we both loved.
—Rhonda and Les

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PREFACE

When we started the process of writing this book, we were somewhat in conflict. Steeped as we were in our humanistic-experiential tradition, both of us were trained to believe that diagnosis, and by extension, its close counterpart, formulation, were unimportant if not secondary to other core aspects of psychotherapy, such as the therapeutic relationship and the dialectical constructivist process of meaning-making. Acts of formulation and diagnosis, so the thinking went, were seen as impeding, if not prohibiting, the establishment of the key relational elements of therapy that led to its success.

At the same time, we recognized that the development of emotion-focused therapy (EFT) over the course of the last 30 years has grown not only from the integration and development of theory but also through research. Research has allowed us to specify the therapeutic process. Our research has also enabled us to describe and communicate more exactly what it is we do in therapy and how it leads to a positive result. Specification has helped us define the key therapeutic processes that clients engage in and the core tasks that therapists undertake in facilitating those processes. Specification and its close counterpart categorization have thus been extremely helpful in the development of EFT.

It was thus not such a large stretch for us to move from specification to formulation. Through the evolution that can be traced in our writings of the past 15 to 20 years, we have come to recognize that we not only follow our clients but are in fact active, meaning-making agents, co-constructing together with our clients what is the problem and how to solve it. We have encapsulated this idea best in the phrase "combining leading and following," suggesting that at times we follow our clients while they unfold their emotions and meanings, but at other times we lead clients and suggest that they engage in in-session tasks and exercises designed to deepen emotion and emotional processing and ultimately work toward transformation of painful emotion. For the EFT therapist, leading and following is a constant balancing act.

Another force leading to the development of EFT case formulation was the recognition and acknowledgment that we do in fact work toward "forming a focus" fairly early in the treatment, and this focus seems to center on the core maladaptive emotion scheme. This came out of research studies in which we spent a good deal of time observing what we actually do in therapy. Quickly and collaboratively, we work with our clients to form an understanding of the core underlying emotional processes that are driving the behavioral and relational problems people bring to us. The "core maladaptive emotion" tends to relate to the client's "chronic enduring pain," and we find ourselves using the two terms synonymously. This pain is what many people have struggled to cope with throughout their lives, and it is the stuff that we try to get at when we work with people in therapy.

We see formulation therefore as a natural evolution and further specification of what we do in therapy. To some extent, it is the glue that binds everything together and provides a guide to therapists. For us, EFT case formulation is a process that leads to the development of a framework of understanding that therapists use through the course of working with a person in therapy. As we emphasize throughout this book, case formulation in EFT is not done a priori, before the therapeutic process begins, but rather throughout the course of therapy and emerges out of the relational process and emotional connection. Once a framework or case formulation is formed, it serves as a guide, a road map of sorts, that helps the therapist organize his or her understanding and make informed decisions about what to do next. Formulation continues the tradition of balancing "leading and following" and aids therapists in forming a focus for expedient but meaningful therapeutic work that addresses people's core pain, leads to new meaning, and helps heal core wounds.

CASE FORMULATION *in* EMOTION-FOCUSED THERAPY

1

INTRODUCTION TO CASE FORMULATION IN EMOTION-FOCUSED THERAPY

Throughout the ever-evolving process of therapy, therapists must continuously make complex decisions to meet client needs and advance favorable outcomes. Case formulation provides a map or blueprint that therapists can consult throughout the creative process of promoting productive therapeutic work.

A *case formulation* is an explanation of how the client's problems have developed and what maintains them, as well as what can be done in therapy to address them. Case formulation paints a picture and builds a narrative of a particular person. It applies the guiding principles of a therapy to an individual's particular problems or issues. It helps therapists organize their thoughts about a client and determine how to proceed most productively through the psychotherapeutic process.

Emotion-focused therapy (EFT) has traditionally provided therapists with a set of overarching theoretical principles and detailed maps for how to

http://dx.doi.org/14523-001
Case Formulation in Emotion-Focused Therapy: Co-Creating Clinical Maps for Change, by R. N. Goldman and L. S. Greenberg

conduct therapy but without a high degree of differential guidance. Much has been written in the EFT literature about the importance of empathy in forming safe, trusting relationships, deconstructing and deepening underlying painful emotion, and forming a strong interpersonal bond to carry the relationship through to the resolution of painful problems. In addition, in more recent years emotion-focused theoreticians and researchers have developed a comprehensive set of tasks with accompanying in-depth models of change, specifically tailored to treat a variety of clinical problems in a wide range of therapeutic settings. A detailed approach to case formulation has thus arisen out of the EFT theory and techniques that have been developed in the past 25 years.

The emotion-focused approach to case formulation presented in this book has only recently been integrated into the theory and process of EFT (Elliott, Greenberg, & Lietaer, 2004; Goldman & Greenberg, 1997; Greenberg & Goldman, 2007; Greenberg & Watson, 2006; Paivio & Pascual-Leone, 2010; Watson, 2010). We consider it to be an important addition that brings together the different pieces of EFT theory and practice and contributes to the success of the therapy. Case formulation provides an organizing conceptual framework to aid clinicians both in establishing a thematic focus and in determining what to do in response to specific problems that arise at particular moments throughout treatment. Case formulation facilitates a clearer explication of the theme, focus, and planning of treatment. It provides a co-constructed, global framework and ever-shifting map that guides change. The emotion-focused case formulation method offers practicing clinicians a framework that incorporates the various pieces of EFT theory and practice. It helps clinicians to organize their thinking and better understand client problems. It can also be helpful to therapists as they try to determine the most advisable task to undertake in a given session or at a particular moment, or when they face perplexing questions about the best way forward.

Case formulation represents an evolution in EFT theory in that it (a) provides the therapist with a way of understanding the emotional source of presenting problems, (b) guides clinicians in developing a treatment focus, and (c) helps therapists create a map to guide process formulation. The formulation narrative connects underlying emotional difficulties with presenting problems, and when it emerges from the process of therapy, the therapist has a framework that continues to guide the case. Case formulation also provides a much-needed strategy for clinicians to help organize the marker-guided process formulations so central to an EFT approach.

In the remainder of this chapter, we provide a brief introduction to EFT and explain the importance of case formulation and the guiding principles of emotion-focused case formulation. We then outline the process of emotion-focused case formulation and conclude the chapter with a brief description of how the rest of this book is organized.

EMOTION-FOCUSED THERAPY

EFT focuses on reworking emotional processing in therapy to help people transform their emotional pain and solve their relational and behavioral problems. Within the context of a safe, trusting therapeutic relationship, and using a variety of experiential tasks specifically designed to treat diverse emotional processing problems, a course of EFT works to resolve the underlying emotional difficulties seen as the source of problems that clients encounter in life and present in therapy (Elliott, Greenberg, & Lietaer, 2004; Goldman, in press). Constructivist, existential, and emotion theories are integrated to inform our understanding of human functioning, dysfunction, and emotional change (Greenberg, 2010). EFT emphasizes the importance of the person-centered relational principles (empathy, genuineness, unconditional positive regard and presence) because a strong therapeutic relationship is understood to be crucial in helping clients to feel safe and allow themselves to be as emotionally vulnerable as is necessary to work through problems in this manner.

In EFT, dysfunction is regarded as arising from four possible sources: lack of awareness or avoidance of emotion, dysregulation of emotion, maladaptive emotion response, or a problem with making meaning of experiences (which is a problem related to emotion and narrative). Treatment involves changing these emotional processing problems and their associated relational and behavioral difficulties. This requires that emotion is activated in order to access and transform it: "One cannot leave an emotion until one arrives at it" (Greenberg, 2002a, p. 109). Research supports the idea that emotions must be activated in therapy so that they can be brought to awareness, soothed, regulated, or transformed (Missirlian, Toukmanian, Warwar, & Greenberg, 2005). In other words, emotions must be activated through the course of therapy and emotional processing problems diagnosed so that they can ultimately be changed through more adaptive emotional processing.

EFT is driven and informed by research. Studies have been conducted to test the efficacy of EFT for specific problems, develop the theory, inform the practice, and understand the change mechanisms (Goldman, in press). EFT can be adapted and integrated to treat a host of problems. It has been most studied and developed for the treatment of depression (Goldman, Greenberg, & Angus, 2006; Greenberg & Watson, 2006; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003); more recently, it has been shown to be effective in the treatment of complex trauma caused by childhood abuse and neglect (Paivio, Jarry, Chagigiorgis, Hall, & Ralston, 2010; Paivio & Pascual-Leone, 2010), social anxiety (Elliott, 2012), and intimate partner violence (Pascual-Leone, Bierman, Arnold, & Stasiak, 2011). In addition, EFT has been specifically developed and used for the treatment of eating disorders (Dolhanty & Greenberg, 2008, 2009; Robinson, Dolhanty, & Greenberg,

2013; Tschan, Goldman, Dolhanty, & Greenberg, 2010) and generalized anxiety (Elliott, 2013), and adapted for the treatment of avoidant and borderline personality disorders (Pos, 2013; Pos & Greenberg, 2010). EFT is also used in the treatment of couples' problems (Goldman & Greenberg, 2013; Greenberg & Goldman, 2008), although this specific application is not discussed in this book.

CASE FORMULATION IN PSYCHOTHERAPY

The field of psychotherapy in general, and psychotherapy research in particular, has increasingly moved toward adopting case formulation as a useful method to organize conceptual understanding, connect symptoms with underlying problems, guide treatment procedures and planning, and evaluate and monitor progress and outcome in therapy.

In most major psychotherapeutic approaches, case formulation involves an explicit step in which the therapist conducts an individualized assessment and then develops and implements an individual treatment plan based on the theory of the proposed therapy. For example, Luborsky's (1984) psychodynamic therapy consists of formulating an individual's core relationship conflict and developing interventions to address it. Beck's (1975) cognitive theory posits the presence of particular maladaptive cognitive vulnerabilities that are associated with symptoms of depression, anxiety, and other psychological disorders. Behavior therapists (e.g., Lazarus, 1981) practice individualized assessments of the stimuli and reinforcements that elicit and shape problematic behavior.

While emotion-focused case formulation does not involve an individualized assessment out of which a treatment plan is developed, therapists do form a working hypothesis about the mechanisms underlying the client's problems. The working hypothesis is central to case formulation. The proposed mechanisms are determined by the theory that underlies the psychotherapy model, and the case formulation provides a basis for an individualized treatment plan that is then delivered. Thus, through the provision of an individualized plan that deemphasizes psychiatric diagnosis in favor of problem identification and focus, case formulation aids clinicians in developing a framework from which they can perform problem identification and resolution.

Case formulation may present an exciting alternative to controlled outcome studies and could prove highly beneficial in assessing and monitoring progress and outcome. Eells (2013) and Persons (2008, 2013) have proposed that the case formulation method is a viable alternative to randomized controlled trial outcome studies in the provision of information and guidelines for how best to treat clinical problems. The argument is that outcome studies

in which both assessment and treatment are standardized and rigidly separated are not reflective of most clinical settings; such studies provide recommendations for treatment planning based on large-scale studies of clients who meet a common diagnostic criteria, but without information gleaned from the specific, idiographic assessments that are inherent in case formulation.

Moreover, case formulation, as it is practiced in EFT, has a built-in feedback mechanism wherein the therapist and client form a shared understanding of the nature and source of the problem or problems related to presenting symptoms and implicitly contract through the therapy process to work to change the mechanisms underlying these problems. Although some of the feedback process described here is implicit, it can be easily made more explicit, as has been done in many research studies (Elliott, Watson, Greenberg, Timulak, & Freire, 2013; Goldman, Greenberg, & Pos, 2005). That is, specific measures have been developed that track changes in specific problems and monitor changes in emotion and meaning and relate them to postsession progress as well as posttherapy outcome (Elliott, 1985, 2010; Goldman et al., 2005; Timulak, 2010). In this way, case formulation allows clinicians to monitor progress and outcome.

GUIDING PRINCIPLES OF EMOTION-FOCUSED CASE FORMULATION

Case formulation in EFT provides a guiding framework that allows the therapist to be highly process oriented in the moment without becoming chaotic or disorganized. It is guided by a few important principles, which are the focus of this section. First, it is fundamentally process-constructive and process-diagnostic. This means that diagnosis is a moment-by-moment process of discovery that always takes place in consultation with the client. Second, case formulation is ultimately guided by the client's emotional pain. Third, it occurs in the context of an emotion-focused therapeutic relationship that highlights an empathic, collaborative alliance. Fourth, case formulation is emotion and narrative/meaning making, through an ever-evolving, dynamically interactive process throughout the course of therapy.

Process-Constructive/Process-Diagnostic

A key feature of case formulation in EFT is that it is fundamentally process-oriented (Goldman & Greenberg, 1997; Greenberg & Goldman, 2007). Case formulations are not based on a priori assessments but rather evolve and emerge, particularly through the early stages of therapeutic exploration. As therapy progresses, working hypotheses are developed, in

cooperation with the client, about the underlying mechanisms related to symptoms and problems. As such, case formulation is an extremely useful guide to alliance formation and to treatment.

In EFT, process is privileged over content, and process diagnosis (Greenberg, 1992) is privileged over *person diagnosis*, or the application of traditional diagnostic categories. Process-oriented case formulation takes into account both the moment and the in-session context, as well as an understanding of the narrative of the client's life. However, the present moment is given priority in the development of case formulation. Taking a process orientation means that rather than bringing theory to bear in a hypothetical or deductive manner, or assuming that there are rigid structures or causes that produce problems, people are instead viewed as dynamic self-organizing systems continually re-forming in response to both the current context and their past. An EFT approach to case formulation comprises process diagnosis, marker identification, and theme development rather than person or syndrome diagnosis.

In the dialectical constructivist view adopted by EFT (Greenberg & Pascual-Leone, 2001), the person is viewed as a complex, ever-changing, organized collection of various aspects of the self; there is no view of a permanent, hierarchical organization topped by an executive self. Rather, the process of constructing the self is seen as ongoing in relation to a shifting environment. At times, syntheses of different voices or aspects function to construct a sense of coherence or unity, integrating various aspects of emotional experiencing in a given situation and across time (Elliott, Watson, Goldman, & Greenberg, 2004). In this process-constructivist view, the self is seen as wanting to change in therapy, and the therapeutic process is seen as the vehicle through which change is achieved. It thus becomes essential that case formulation be flexible with the evolving construction of the person across the therapy situation. The case formulation process is fundamentally defined, then, as a *moment-by-moment process*—one that is constructed and redefined from session to session.

Rather than determining which content should be the focus of which session, as is done in typical treatment planning, the EFT therapist assumes the role of a process-diagnostic expert who does not presume to know more about the client's experience than the client. EFT therapists are *process experts* who carefully attune to the client's moment-by-moment experience, listening for that which is most poignant or ambiguous (Rice, 1974) and calling for further exploration.

The Client's Emotional Pain as the Guide

EFT therapists focus on clients' painful emotional experiences and their immediate responses. We give primacy to clients' presently felt painful

experience because it indicates what the difficulty is and whether problem determinants are currently accessible and amenable to intervention. Even though clients may unwittingly or habitually avoid pain, their pain necessarily becomes the focus of the therapy. The client's expression of pain and emergent markers of emotional processing difficulties provide more of a guiding framework for intervention than a diagnosis or even an explicit case formulation. The therapist's focus is on following the client's process and identifying markers of current emotional concerns and core pain rather than developing a picture of the person's enduring personality, character dynamics, or core relational pattern. Exploration aims at following experience in particular events rather than identifying patterns of experience and behavior across situations. The client's chronic enduring pain is, in a sense, an entry point into his or her core concerns. Therapist and client collaborate to track and identify the problematic underlying cognitive–affective processes that generate symptoms.

EFT therapists hold a metaphorical "pain compass" and are seemingly magnetically drawn toward clients' painful experience that calls for deeper exploration. This is akin to using an emotional tracking device for following the client's painful experience (Greenberg & Watson, 2006). Within this framework, the therapist attends to and assesses a variety of emerging markers of the client's in-session emotional problem states and processes.

An important caveat here is that EFT therapists are not interested in promoting never-ending, intractable painful experiences, but therapy must first focus on maladaptive emotions in order to shift them. For example, when working with a client with core shame, the therapist validates and bypasses the secondary anxiety (which may in fact be painful) and rage (which may in fact be destructive) and focuses instead on the underlying primary painful shame, which is at the heart of the client's problem. (This approach is supported in other therapies that focus on emotion; see Fosha, 2000; Fosha, Siegel, & Solomon, 2009.) It is well understood that pain is approached with greater ease within the safety of the therapeutic relationship.

Emotion-Focused Therapeutic Relationship

It is only in the context of a safe, trusting therapeutic relationship that clients feel comfortable to disclose significant emotional information. The establishment of a strong working alliance leads to agreement on goals and tasks as well as to conditions of safety and trust; these have long been understood as basic building blocks of successful EFT (Elliott, Watson, et al., 2004; Greenberg, Rice, & Elliott, 1993; Horvath & Greenberg, 1989). Empathic attunement, strong therapeutic presence and genuineness, and unconditional positive regard on the part of the therapist are fundamental to the formation of a successful therapeutic relationship.

These conditions allow the relationship to solidify and the client's story, or narrative, to unfold. It is only from this place that therapists hear how clients process emotion and create meaning. Furthermore, these conditions influence accessibility to clients' inner experience. Rather than forming a priori hypotheses about the nature of the problem, we work from within the relational context to make moment-by-moment process diagnostic formulations about clients' manner of processing and capacity to productively engage. The emotional bond allows quicker exploration and formulation of the underlying generating determinants that are seen as the source of presenting problems.

Because EFT therapists see the therapeutic process as a discovery-oriented one (Elliott, Watson, et al., 2004; Greenberg et al., 1993), they do not present themselves to their clients as experts. Instead, they convey that client and therapist are both in a process of discovering what is important in the client's experience. This is not only a philosophical principle in concert with the humanistic-experiential tradition but also a necessary element of the therapeutic change process. Clients are considered experts in their own experiences; provided with the right therapeutic environment, clients' experiences act as a compass that guides therapy to the core issues and provides a sense of direction (Elliott, Watson, et al., 2004).

Emotion and Narrative: Two Interactive Tracks

EFT case formulation relies on two sources of information about the client: narrative and the emotion that is embedded within it. The narrative provides a context for understanding life events (i.e., what happened) and their meaning, whereas the emotional process indicates how experience feels; this in turn informs the therapist of the significance of the experience and the current accessibility of the client's internal state and processes (Angus & Greenberg, 2011). Overall, emotion and narrative merge to help provide a focus on the underlying determinants of the presenting relational and behavioral issues. Throughout the case formulation process, the therapist and client are continuously deconstructing the narrative, mining and exploring the emotions that relate to it, proposing and engaging in tasks designed to shift emotional processing, and ultimately understanding how changed emotion fits back into the changing narrative structure.

Thus, from within the therapeutic dialogue wherein clients tell their stories, emotional processing is initially assessed, markers of problems in emotional processing emerge, and their emotional valence indicates whether it is problematic and thus worthy of further exploration. As therapy proceeds through the deeper emotional exploration of problems, the formulation process becomes one of deciding from moment to moment how to proceed in

order to produce relief and meaningful change. This includes assessments of whether to continue in a relational mode (i.e., focusing on building or maintaining the therapeutic relationship) or to move into a task mode (i.e., focusing on the therapeutic tasks and determining which one to undertake; see Chapter 6). Different tasks yield different emotional states. New emotions and meanings are then tied back into existing narratives and understood in terms of how to best address the relational and behavioral difficulties that brought clients to therapy.

CASE FORMULATION PROCESS

Case formulation in EFT is highly focused on the client's emotional state and his or her current process. The process of case formulation moves back and forth between attending to and observing emotional states, forming a conceptual framework for understanding and iteratively using this information to inform plans for resolving the emotional difficulties that are causing the client's problems.

Case formulation proceeds in a three-stage sequence: follow, lead, and follow. We begin by listening to what ails our clients and where they get stuck. Our aim at this point is to determine the cause of the problems, which we conceptualize as lack of emotional awareness, emotion dysregulation, a crisis of emotional meaning, or maladaptive emotional processing. We then take a more active role and facilitate emotional change, responding to markers and facilitating tasks until clients move into different, less painful, more satisfying and fulfilling emotional states. At that point, we once again follow them as they integrate new emotional meaning into their ongoing narrative framework and apply the changes to the presented relational and behavioral problems.

Put differently, we move from macro (deconstructing the client's presenting problems and accompanying narrative), to micro (focusing on specific emotional determinants underlying problems and shifting problematic emotional processing), and back to macro (relating emotional shifts achieved through the process back to narrative themes and discussing how meaning has changed in relation to themes).

In a macro-global sense, therapy can be seen as a process of helping people move from a more blaming or complaining position to one in which they are asking questions about their own process and how it contributes to their current problem. Another way of putting this is, therapy involves switching from a stance that the problem is "out there, happening to me, I am a passive victim" to "I am an active agent in my own life and I need to accept or change it." Formulation and focus are needed to facilitate this

process. In a purely process-following approach one simply waits for problems to arise, whereas in a process-formulaic approach one is alert to and guides people toward exploration of how it is that they are suffering, what in their life history and their makeup leads them to have this difficulty, and how they might go about changing the emotional processing that is leading to the difficulty. The process-formulaic approach moves from current understanding, to a tracing back to the most painful emotions in relation to core narrative themes, and reaches inward to find new emotions. This contributes to narrative change. Together, client and therapist connect changes back to presenting problems.

Steps of Case Formulation

The steps of case formulation are summarized in Exhibit 1.1 and described in detail in the chapters that follow. The process is divided into three stages. One can see the weaving of emotion and narrative throughout, as well as the move back and forth between the process/state level and conceptual understanding.

Stage 1 focuses on an initial framing of the presenting relational and behavioral problems and understanding them in terms of narrative themes.

EXHIBIT 1.1
Stages and Steps of Case Formulation

Stage 1. Unfold the narrative and observe the client's emotional processing style.
- Step 1. Listen to the presenting problems (relational and behavioral difficulties).
- Step 2. Listen for and identify poignancy and painful emotional experience.
- Step 3. Attend to and observe the client's emotional processing style.
- Step 4. Unfold the emotion-based narrative/life story (related to attachment and identity).

Stage 2. Co-create a focus and identify the core emotion.
- Step 5. Identify markers for task work.
- Step 6. Identify underlying core emotion schemes, either adaptive or maladaptive.
- Step 7. Identify needs.
- Step 8. Identify secondary emotions.
- Step 9. Identify interruptions or blocks to accessing core emotion schemes.
- Step 10. Identify themes: self–self relations, self–other relations, existential issues.
- Step 11. Co-construct the case formulation narrative linking presenting relational and behavioral difficulties to triggering events and core emotion schemes.

Stage 3. Attend to process markers and new meaning
- Step 12. Identify emerging task markers.
- Step 13. Identify micromarkers.
- Step 14. Assess how new meaning influences the reconstruction of new narratives and connects back to presenting problems.

Here therapists begin to hear the core pain and observe the client's emotional processing style. At this beginning stage, therapists need to gain an understanding of just how clients are making sense of current events in their lives and the accompanying emotional impacts. Through this exploratory process and discussion of the history of current problems, key aspects of the narrative (or focal topics and issues) emerge. Narratives tend to be heard, organized, and understood around core themes of identity and attachment. As the narrative unfolds, the therapist simultaneously observes the nature of the client's emotional style of processing, attending to the client's emotional engagement with material, the nature of vocal quality, facial expression, bodily expressions, posture, and other nonverbal aspects of communication. In addition, at this early point, the therapist is assessing whether the client's emotional style is overregulated, indicating that she is having difficulty accessing emotion or symbolizing it in awareness, or underregulated, indicating that she is having trouble controlling her emotional expression and is generally overwhelmed by emotion.

Stage 2 is guided by the client's chronic enduring pain but is focused on identifying core emotion schemes seen as determining presenting problems and on co-constructing emerging, related themes. The acronym MENSIT describes the steps of this stage: markers, emotions, needs, secondary emotions, interruption, and themes. Exploration of emotionally poignant and painful material is seen as creating windows into emotion schemes that ultimately become the focus of therapy and objects for transformation. During this stage therapists are listening for markers that indicate they can initiate tasks for particular types of emotion processing problems. In so doing, the formulation process here involves listening for the need, the secondary emotion as well as interruptive blocks to these core emotions. Ultimately, the aim is to transform core emotion schemes through the therapy process. Themes emerge at this stage of case formulation and are seen as further organizing the formulation. As themes emerge through the process, they are symbolized, named and subsequently understood in terms of the larger narrative. This is a reflexive process that grows out of emotional processing (Pascual-Leone & Greenberg, 2007b).

Themes tend to fall into three separate categories: self–self, self–other, or existential. Examples of *self–self* themes might be self-criticism or self-annihilation. *Self–other* themes might center on unmet needs for validation or security from developmentally significant others. *Existential* themes involve coming to terms with life changes or disappointments related to grown children or careers. In the final step of this stage, therapists help clients tie emotion schemes and narrative themes back to the presenting relational and behavioral difficulties as a way of providing a further direction and goals for the ongoing therapeutic work. This is a formulation narrative that links

the MENSIT to the core elements of the emotion schemes back to the presenting problems. Clients come to understand what triggers the core emotion schemes, as well as the behavioral responses and consequences of their current emotional coping process, and this deepens understanding and the alliance as client and therapist work toward emotional change.

By the third stage of case formulation, therapy has been organized around key thematic issues and related underlying emotion schemes, and thus the focus is on observing and formulating ongoing emotional states, or markers that indicate the initiation of tasks that will ultimately be used to resolve emotional processing difficulties. Throughout this stage, EFT therapists attune to and listen for markers and micromarkers and suggest tasks or subtasks that are designed to address particular processing problems. In Stage 3, as pieces of the narrative puzzle are continually taken apart, emotionally explored, reorganized and put back together, tasks resolve, new emotions and meanings emerge, and new markers appear that suggest further tasks or subtasks. In the final step of this stage, emergent new meaning is tied back into existing narrative themes and connected to the relational and behavioral difficulties that brought people to therapy. In this regard, case formulation in this last stage is a process of moment-by-moment process-diagnostic formulation and continuous narrative reworking and meaning making.

The three stages of EFT case formulation fluctuate between the two modes of case and process formulation. *Case* here refers to a conceptual understanding of the case. It serves to form a focus for the treatment. *Process* here refers to the moment-by-moment assessment of current emotional states or markers that indicate what to do next. In Stage 1, therapists engage in case formulation when understanding the presenting problems and their relationship to the clients' narratives of their life stories and themes. Therapists also engage in process formulation by observing emotional processing style. The goal of process formulation in this first stage is to gain a better understanding of the case and the nature of emotional processing difficulties. In Stage 2, therapists engage in process formulation to recognize markers that indicate particular tasks. In this stage they are also involved in case formulation as they work toward an understanding of core painful emotion schemes and develop explicit conceptual, thematic understandings and narrative frameworks that tie together presenting problems and underlying emotional, source difficulties. Therapists carry over this conceptual case formulation and understanding of core emotion scheme into Stage 3, as it provides a framework out of which they engage in a high degree of process formulation, recognizing ongoing markers and micromarkers to guide the ongoing process of intervention. In the final step of case formulation, therapists tie the emergent emotions and meaning back into the narrative framework, and this informs the overall understanding of the case.

Examples of Case Formulation

Our approach to case formulation emerged out of a more pragmatic way of thinking along with a recognition that the theory needed to adjust to problems that clients were bringing to us. Take as an example a severely anorexic woman who is willing and able to do therapeutic work but is barely above threshold for a normal weight. A pure following mode would mean that we follow her as she talks endlessly about symptoms and content related to the number of calories in a slice of Havarti versus a tablespoon of cream cheese. An entire session may continue unproductively in this manner. After many sessions, she may or may not begin talking about underlying feelings. By this point, however, she may have been rehospitalized and may therefore be completely out of emotional access.

Adopting a case formulation approach, however, we would first form a safe, trusting relationship, listen and follow content as she focused on the cheese, but additionally begin focusing on that which brings pain and hearing markers of underlying emotion dysregulation or distress. After a few sessions, we might suggest a chair work task designed to more specifically access the underlying emotional difficulties with the aim of emotional restructuring and repair (and ultimately relief from symptoms; see Chapters 2 and 6 for a description of chair work). We would work to access the client's underlying sense that "I am a bad person, and I don't deserve to live." We would understand that up to this point, a focus on such feelings was so painful and hopeless and met with such despair that she came to avoid feelings at all costs. The sole emphasis on her weight, body image, and minute-by-minute caloric intake would be understood as part of the avoidance. Through a process formulaic focus on her underlying shame and self-contempt, the therapeutic process would eventually help her transform the underlying shame into a sense of pride and self-confidence. Eventually, she could come to see that the extreme focus on eating and "how fat she is" is driven by her corrosive shame and that a focus on body weight and body image is serving to avoid the ensuing bad feelings. After the core sense of shame is transformed and replaced by a stronger sense of self and different emotions such as pride and self-confidence, she will feel less powerless, more hopeful, and less inclined to engage in negative symptomatic behavior.

In another example, consider a man who is dealing with complicated grief around his son's death 10 years earlier in a motor vehicle accident. This man talks about his loneliness and sadness and also his anger at the truck driver responsible for his son's death. For many years and in a prior therapy he had bottled up his sadness, but now he is able to access it, and he cries about how lonely and abandoned he feels. Although this is an important step, he remains somewhat stuck in this loneliness. His previous therapist

had encouraged him to leave his hometown, where he had been living close to his parents, and having done this, he is depressed and blames the therapist for suggesting this move.

Through the therapy process, this man can learn to move away from his hopeless, depressed, secondary stuck feelings and trace his underlying sense of aloneness. Client and therapist come to understand the source of his feeling that "I can't survive on my own," his dependence on others, and his subsequent feelings of abandonment and disappointment. They also discover that he had an anxious, overprotective mother who kept him close and sent the message that "the world is a dangerous place and you need protection." This ongoing formulation of his loneliness and feelings of abandonment as the sources of emotional distress helps form a contextual understanding of the gravity and meaning of the loss of his son. Through the formulation process, therapist and client first work on self–other issues, starting with the expression of feelings toward the truck driver (in an empty-chair exercise). Formulation eventually leads therapy to work on the feelings the client had as a child with an overprotective mother. It is important to note that it is not the understanding of how his mother's overprotectiveness led him to feel insecure that is curative; it is the transformation of the insecurity by the generation of new emotional responses in therapy to old situations that is curative. That is, he moves from a sense of "I am alone and abandoned and not OK" to "I am strong; I will get through and move forward toward having a meaningful life." Formulation thus helps set up the conditions as well as follow the process through toward emotional and narrative transformation.

IN THIS BOOK

The book is divided into three sections. In Part I, the model and basic steps of case formulation are presented and described. Chapter 2 reviews basic EFT theories, concepts, and methods relevant to case formulation. Those familiar with EFT might choose to skip this chapter or refer to it as needed. Chapter 3 presents the philosophical argument behind an EFT approach to case formulation, situating this approach in relation to the wider field of psychotherapy theory.

Part II (Chapters 4–6) presents the basic theory of emotion-focused case formulation. Each chapter in the section focuses on a major phase of case formulation, explaining each step in detail and providing examples.

In Part III, theory is applied and illustrated directly through case material. Chapters 7 and 8 present an emotion-focused approach to therapy for Sophie and Jina, respectively. Chapter 7 emphasizes Stage 1 of case formulation, and Chapter 8 emphasizes Stage 2; taken together, they illustrate the entire process.

Chapter 9 presents a chart that summarizes all stages and accompanying steps of case formulation in EFT and illustrates how clinicians might use it to map out treatment for clients with depression, generalized anxiety, social anxiety, eating disorders, and complex trauma.

In presenting the steps of EFT case formulation, we detail the process through which narrative change occurs and clients become more coherent and learn to access their whole selves. Specifically, we describe the following:

- how EFT therapists move from presenting relational and behavioral difficulties to formulate related narrative identity and attachment-based themes;
- how therapists build therapeutic relationships, assess initial emotional processing style, and empathically formulate how core pain relates to problematic emotion schemes that are emblematic of problematic affective-meaning states that are in need of transformation or repair through the therapeutic process;
- how therapists formulate markers, tasks, core emotions, and needs as well as different forms of emotional interruption in the process of accessing and identifying core emotion schemes;
- how themes emerge over the course of therapy through a focus on underlying emotion schemes;
- how narratives form that identify the triggers and behavioral consequences of emotion schemes, identified through the case formulation process, and how this understanding is tied back into presenting problems, thereby creating a deeper focus for therapeutic work;
- how to continuously use formulation throughout therapy to assess emergent markers and micromarkers, to inform micro-decisions about how to work with underlying emotional processing problems that are the source of the relational and behavioral difficulties initially presented; and
- how through formulation, emotion-based and associated narrative themes are identified and consolidated across therapy and through the process of resolving tasks, thereby transforming and repairing emotions and meanings.

I

OVERVIEW AND PHILOSOPHY OF EMOTION-FOCUSED THERAPY

2

FUNDAMENTALS OF EMOTION-FOCUSED THERAPY

In this chapter, we review the concepts that form the basis of EFT and are central to an understanding of case formulation.

We begin with a review of emotion and emotion scheme theories and a brief summary of an EFT view of dysfunction, and then we discuss the interweaving of narrative and emotion through case formulation. A brief overview of key structural elements of EFT theory is provided, including a description of basic empathic and microresponses and an overview of the key emotional processing tasks that compose the fabric of EFT work. Cultural issues in EFT are addressed. Finally, we review empirical support for the approach.

http://dx.doi.org/10.1037/14523-002
Case Formulation in Emotion-Focused Therapy: Co-Creating Clinical Maps for Change, by R. N. Goldman and L. S. Greenberg

EFT VIEW OF DYSFUNCTION

In EFT theory, dysfunction is thought to spring from many possible routes, including lack of awareness or avoidance of internal states, failure in emotion regulation, maladaptive responding based on traumatic learning or developmental deficits, protection against injury to one's self-esteem (shame), internal conflict, and blocks to the development of meaning. EFT gives a strong constructivist interpretation to the earlier theories of dysfunction (which it also incorporated): these include Rogers's incongruence theory, Gendlin's (1997) view of blocked process, Gestalt's notions of disclaimed experience (Perls, 1969), existential theories views of loss of meaning (Frankl, 1959), learning theory views of traumatic learning (Bandura, 1977; Foa & Kozak, 1986), and psychodynamic views of developmental deficits (Kohut, 1977).

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 the underlying determinants and maintainers of his or her problems. Emotion is fundamentally adaptive in nature, helping the person process complex situational information rapidly and automatically in order to produce action appropriate for meeting organismic needs such as self-protection or self-support. Emotion, considered the basic datum of awareness, is attended to throughout therapy sessions (Greenberg, 2002a). Emotion schemes provide an implicit, constantly evolving higher order organization for experience but are not available to awareness until activated or reflected upon. They are idiosyncratic and highly variable from person to person and even within the same person over time. Although emotion schemes serve as the basis of self-organization, they are not static entities: They are instead continually synthesized in a person's moment-to-moment experience (Greenberg & Pascual-Leone, 2001). It is the experienced or felt emotion, however, that organizes all the other elements around a particular emotion and its felt quality (e.g., intense sadness, paralyzing fear). Whereas emotions guide and tell us what we need (which makes it important to be aware of and attend to them), they can also be a major source of dysfunction.

We have found that different types of emotional difficulties contribute to many forms of dysfunction. Four major types of processing difficulties are described in this section (Greenberg & Watson, 1998; Watson, Goldman, & Greenberg, 1996; Watson, Goldman, & Greenberg, 2007): (a) a lack of emotional awareness, (b) maladaptive emotional responses, (c) emotion dysregulation, and (d) problems in narrative construction and existential meaning (Greenberg, 2010).

Lack of Awareness

A common difficulty 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. For example, a client may not be aware of or may not be able to make sense of the increasing tension in his or her body and therefore may be unable to identify it as fear. Alexithymia is the most extreme form of the inability to label one's feeling. Avoidance of (or the inability to label) emotion and internal experience can be a major cause of both 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, such as when anger conceals sadness or 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. Emotions that are often not experienced or avoided include adaptive anger or healthy sadness; then, in these instances, there is maladaptive fear or shame instead. Healthy needs for connection or boundary protection are as likely to be disowned as unhealthy shame or traumatic fear. Dysfunction thus arises from the disowning of healthy growth-oriented resources and needs, the suppression of unacceptable aspects of experience, and the avoidance of painful emotions. Re-owning promotes the assimilation of experience into existing meaning structures and the creation of increased self-coherence and integration.

Maladaptive Emotion Schemes

Maladaptive emotion schemes develop for a variety of reasons. Besides possible 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. Thus, a child who is abused may learn to associate connection with people as fearful and withdraw from contact. If particular early experiences of emotion are repeatedly met with less optimal, or problematic, responses from caregivers, core maladaptive emotion schemes develop rather than healthy or resilient ones. The developing self organizes to cope both 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 dangerous and a source of fear and humiliation. The inability to be protected or soothed by the caregiver results in unbearable states of anxiety and aloneness, leading in turn to pathogenic fear and shame and possible rage.

An empty sense of the self as unlovable, bad, defective, worthless, and powerless is formed, and the person experiences secondary despair, helplessness, and hopelessness. There can also be a sense of fragmentation; the person may feel as though he or she is falling apart and is unable to regulate his or her own affect. Thus, 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 an adult who was abused as a child may experience maladaptive fear at the thought of (potentially nurturing) closeness.

In other circumstances a family rule that one must not show anger may result in the 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 in 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 or houses, experiencing rejection or trauma such as sexual assault, or losing a loved one.

If the present triggers past responses, the newness, richness, and detail of the present moment are lost. With certain evocative triggers, the past can suddenly seem to impose on the present. Dysfunction occurs when a person's weak or faulty self-organization is triggered or when such self-organizations (e.g., dysfunctional styles of coping with difficult emotional experiences such as shame, fear, or sadness) become dominant. Fear and abandonment sadness are at the center of the "weak me" organization, and shame is at the center of the "bad me" organization. Intense shame, based on 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 manner of coping with these feelings by means of avoidance and withdrawal or secondary destructive anger can further exacerbate the problem. Symptoms such as depression or anxiety set in when an emotional sense of some combination of feeling insecure, unloved, humiliated, or trapped and powerless dominates and the person is unable to mobilize alternative responses. (For a more thorough explanation of dysfunction from an EFT perspective, see Greenberg, 2010.)

Emotion Dysregulation

In EFT theory, the inability to regulate one's emotions is another general form of dysfunction. Problems in emotion regulation involve having either too much emotion (underregulated) or too little emotion (overregulated).

People can either be overwhelmed by strong, painful emotion or, alternatively, numb and distant from emotions. Clients who come to therapy are frequently experiencing acute and chronic conditions related to underregulation in their emotion systems. Many presenting symptoms, such as depression and anxiety, and other disorders, such as substance abuse and anorexia, are often dysfunctional attempts by clients to overregulate underlying emotional states. The development 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. Affect regulation thus is a major developmental therapeutic task.

Problems With Narrative Construction and Existential Meaning Making

A general source of dysfunction stems from how people make sense of their experience as expressed through their narrative accounts of self, other, and world. The capacity to make narratives from, understand, and integrate our most important life stories is key to adaptive identity development and the establishment of a differentiated, coherent view of self (Angus & Greenberg, 2011). 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 transformation of emotion and the creation of new meaning wherein people find purpose or reconstruct their understandings of their role or the other's intentions in past events. The articulation of more coherent, emotionally differentiated accounts of self and other that facilitate heightened self-reflection, agency, and new interpersonal outcomes is a corrective emotional experience. People can alter incoherent stories of disempowerment and victimization, for example, to more coherent stories of agency with positive outcomes.

In addition, clients come to therapy with problems of meaning and existence. In this view, dysfunction is related to the anxiety that arises from defensive unawareness of the possibility of nonbeing. Dysfunction is experienced here as a lack of authenticity, alienation from experience, and a lack of meaning, all related to the anxiety of being (ontological anxiety). The making of a personal life meaning is a key aspect of healthy living; meaning provides a way of coping with the existential issues of death, loss, freedom, and isolation.

TYPES OF EMOTION

Case formulation requires that therapists differentiate between different types of emotional experience and expression throughout the process. In EFT, differential intervention is performed by categorizing emotion into four

different categories. Each of these is relevant to our description of the case formulation process.

Primary adaptive emotions are direct, uncomplicated reactions (i.e., reactions that are consistent with the immediate situation) that help the person take appropriate action. As noted, the normal function of emotion is to rapidly process complex situational information in order to provide feedback to the person about the reaction and to prepare her or him to take effective action. For example, if someone is threatening to harm your children, anger is an adaptive emotional response, because it helps you take assertive (or, if necessary, aggressive) action to end the threat. Fear is the adaptive emotional response to danger, and it 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 to us 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 in order 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. Access to these emotions increases overall emotional awareness, a necessary first step: Part of case formulation involves recognizing these emotions in order to help clients feel them. Not all emotions are functional or fit the situation, however. The three types of emotions that follow are generally dysfunctional.

- *Primary maladaptive 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 based on 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 with anger and rejection to caring or closeness, as if it were a potential violation. These emotions are at the heart of maladaptive emotion schemes. The goal of case formulation is to access them so that they can be transformed.
- *Secondary reactive emotions* follow a primary response. Often people have emotional reactions to their initial primary adaptive emotion, and this "reaction to the reaction" obscures or transforms the original emotion and leads to actions that are 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 angry behavior is not functional or adaptive. Many secondary emotions obscure or defend against painful primary emotions. Other secondary emotions are reactions to primary emotions; for example, the rejected man might feel ashamed of his fear (i.e., secondary shame). Thus, people can feel afraid of, or guilty about, their anger, ashamed of their sadness, or sad about their anxiety. Secondary emotions can sometimes be responses to interceding thoughts (e.g., feeling anxiety at the thought of being rejected). 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. Formulation involves recognizing secondary emotions in the moment, so that they can be validated and bypassed by the therapist.

- *Instrumental emotions* are expressed to influence or control others. For example, crocodile tears may be used to elicit support, anger to dominate, and shame to indicate that one is socially appropriate. These responses may occur deliberately, or the person may act 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 have been called *manipulative* or *racket feelings*.

Formulation involves helping clients to recognize these emotions and to become aware of their primary aim.

THE NARRATIVE AND EMOTION TRACKS

EFT therapists help clients engage in more adaptive emotional and narrative processes. EFT adopts a dialectical–constructivist model that interweaves emotion and narrative processes (Angus & Greenberg, 2011; Greenberg & Pascual-Leone, 1995, 2001) in its contribution to a powerful and effective therapy. Narrative and emotion tracks are seen as mutually influencing each other across therapy, both interwoven through and guiding the formulation process. In this view, emotion is given meaning through the identification and understanding of narrative themes, which in turn influence and organize emotions. This process of narrative theme consolidation and emotional exploration continues in an iterative fashion until emotions change and the narrative becomes more coherent.

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

Emotion and narrative are the two major processes that organize the case formulation process in EFT. Emotion cannot be understood outside the context of the narrative, and the narrative does not have meaning without emotion. These two tracks thus run through and provide a scaffold for all three stages of case formulation. The overall goal of the therapeutic process is to create a more secure and coherent sense of self-identity. Emotional change contributes to and occurs through that process.

In performing each stage of case formulation, the therapist has a somewhat different purpose with respect to emotion and narrative and how they interact. In Stage 1, through the unfolding of the narrative, we hear the story and learn what brought the client to therapy. We begin by attempting to understand how the client makes sense of self and the world. McAdams and Janis (2004) suggested that during adolescence, core themes emerge that connect different life episodes together and serve as a coherent interpretive lens for understanding self and others (Habermas & Bluck, 2000). Autobiographical memories organized according to self-defining themes also provide a sense of self, both current and past. All stories are shaped by emotional themes (Sarbin, 1986) and help us make sense of our emotions. In Stage 1, it is those themes and those stories that we want to unfold. We tend to organize information and hear those themes in relation to attachment relationships and identity formation. We hear how they have formed and now maintain attachment

relationships in clients' lives, on the one hand, and are curious about how they view themselves and seek validation, on the other. An additional goal in the first stage is to observe emotional processing style. We empathically explore and track emotion in relation to the narrative, and this helps us understand (for example) how clients regulate emotion and whether emotional processing is productive. Further specific work may be indicated to engender productive emotional processing.

In Stage 2 of case formulation, we form a clearer understanding of the maladaptive emotion scheme. Out of the exploration of markers, secondary and maladaptive emotions, core needs, and client interruption of these processes arises a clear understanding of the core maladaptive emotion scheme. Therapy becomes thematically focused on the maladaptive emotion schemes.

In Stage 3 of case formulation, a thematic focus driven by the core emotion scheme has been established. The third stage focuses on formulation of emotional state and process so that one can understand how to most productively move exploration forward; in the last step of formulation, narrative themes are readdressed. By the time that clients have reached Stage 3, therapy has given a form to new emotions and meanings by offering a space for self-reflection and self-construction, and clients re-form the narrative, reinterpreting and making meaning of experience in light of new information. In the last step of Stage 3, we work with our clients to reconstruct the existing themes and narratives.

EMPATHIC EXPLORATION

Case formulation is shaped through empathic exploration and various types of empathically attuned responding (Greenberg & Goldman, 1988). In the first stage of formulation, as clients recount current happenings and tell stories about meaningful events and the relationships that run through them, therapists pay rapt attention to how clients are processing emotion and making meaning. As stories unfold, so too do current events and their history as well as current relationships and their histories. EFT therapists adopt a specific style and method of listening and responding to clients that require ongoing tracking of and attunement to experience. In developing their formulations, EFT therapists try to stay responsive to new and emergent experience in their client's narratives and attend to shifts in clients' perspectives and understandings. Microresponses are designed to maintain therapeutic safety and trust while at the same time helping clients to feel emotion in the session. Empathic exploration also provides a window through which therapists can observe emotional processing style at the outset of formulation. Empathic exploration is also used in Stage 2 to ascertain the MENSIT

(markers, emotions, needs, secondary emotions, interruption, and themes) and to facilitate meaning making as therapy ties underlying emotional processing back to relational and behavioral difficulties. Empathic exploration continues to be used to identify emerging and micromarkers in Stage 3 as well as to facilitate the client's integration of new emotion and meaning back into existing narrative themes.

Exhibit 2.1 lists the various microresponses that therapists engage in EFT formulation to help clients unfold, unpack, and explore experience and make meaning. The exhibit, adapted from Elliott, Watson, et al. (2004), lists possible therapist experiential responses. (For a fuller description of these responses as well as examples, see Elliott, Watson, et al., 2004.) Therapists differentially use a variety of empathic responses to help clients emotionally explore the meanings of their stories. Thus, empathic reflections are used to accurately reflect the most central, strongly felt aspect of the client's message. Empathic affirmation more specifically offers validation and support when the client is in distress or pain. Evocative reflections are used to access and heighten experience through vivid imagery, powerful language, or dramatic experience. Empathic conjectures, on the other hand, are tentative guesses at immediately felt, implicit client experience.

All EFT therapists must become proficient in these response modes because they form the basis of moment-by-moment responding that is a signature of the EFT approach. These necessary skills are used to make process formulations as well as to facilitate EFT tasks. EFT practitioners are trained to differentially provide these kinds of responses—they are not simply "background variables" for the "real interventions." We therefore recommend a thorough training in empathic responding.

We have delineated different types of empathy that help clients access and symbolize their emotions. These range from purely understanding empathic responses, through validating and evocative responses, to exploratory and conjectural responses as well as empathic refocusing (Elliott, Watson, et al., 2004). Empathic exploration (seen as the fundamental mode of intervention in EFT) 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 in turn is focused on this aspect of his or her experience, and the client is more likely to differentiate this leading edge of his or her experience. By sensitively attending, moment by moment, to what is most poignant in clients' spoken and nonspoken (nonverbal) narrative, a therapist's verbal empathic exploration can help capture clients' experience even more richly than can clients' own descriptions. This helps clients symbolize previously implicit experience consciously in awareness.

EXHIBIT 2.1
Therapist Experiential Response Modes

A. Basic empathy: Responses are intended primarily to communicate understanding of immediate client experiencing.

Empathic reflection: Accurately represent the most central, poignant, or strongly felt aspect of client's message.

Empathic following: Brief responses that indicate that the therapist understands what the client is saying (acknowledgments and empathic repetitions).

Empathic affirmation: Offer validation, support, or sympathy when the client is in emotional distress or pain.

B. Empathic exploration: Responses are intended to encourage client exploration while maintaining empathic attunement.

Exploratory reflection: Simultaneously communicate empathy and stimulate client self-exploration of explicit and implicit experience, through open-edge or growth-oriented responses.

Evocative reflection: Communicate empathy while helping the client to heighten or access experience, through vivid imagery, powerful language, or dramatic manner.

Exploratory question: Stimulate client open-ended self-exploration.

Fit question: Encourage the client to check representation of experience with actual experience.

Process observation: Nonconfrontationally describe client in-session verbal or nonverbal behavior (usually with exploratory questions).

Empathic conjecture: Tentative guess at immediate, implicit client experience (usually with fit question).

Empathic refocusing: Offer empathy with what the client is having difficulty facing in order to invite continued exploration.

C. Process guiding responses: Responses intended to directly facilitate useful client experiencing.

Experiential formulation: Describe the client's difficulties in process experiential terms, such as emotional avoidance or action on the self.

Experiential teaching: Provide information about the nature of experiencing or treatment process or tasks.

Structuring task: Set up and offer specific help for continued work within a specific therapeutic task (including proposing, creating context, or offering encouragement for task engagement).

Process suggestion: Encourage the client to try things out in the session (coaching: feeding lines, proposing mental actions, directing attention).

Awareness homework: Foster experiencing outside of sessions.

D. Experiential presence: Responses that are intended to reveal the therapist's emotional presence to the client. Generally communicated through speech or in a paralinguistic, nonverbal manner (e.g., warm/gentle vocal quality, responsive facial expression, self-deprecatory humor, exploratory manner, respectful silence).

Process disclosure: Share one's own here-and-now reactions, intentions, or limitations.

Personal disclosure: Share relevant information about oneself.

E. Content directives (nonexperiential): Responses are intended to provide expert external perspectives on the client's problems and include interpretation, problem-solving advice, expert reassurance, disagreement/criticism, introducing nonexperiential content, and pure information questions. These responses are not central to process experiential therapy and occur infrequently; they are carried out briefly, tentatively, and with an experiential intent.

Note. Adapted from *Learning Emotion-Focused Therapy: The Process-Experiential Approach to Change* (p. 81), by R. Elliott, J. C. Watson, R. N. Goldman, and L. S. Greenberg, 2004, Washington, DC: American Psychological Association.

THE EMOTION-FOCUSED THERAPY TASKS

The process diagnosis of markers and associated tasks is undertaken throughout formulation and is the basis for intervention aimed at addressing relational and behavioral difficulties and their underlying determinants and transforming emotional pain. After the first phase of formulation, at the beginning of Stage 2 in Step 5, therapists begin to listen for markers that indicate the initiation of tasks (see Exhibit 1.1). Markers indicate various types of emotional processing problems and signal possible engagement in particular tasks that aid in both emotional deepening and transformation of difficult emotional states. This continues throughout Stage 2. Stage 3 focuses largely on the ongoing process/state formulation of emerging markers and micromarkers.

The core tasks of EFT have been delineated and models have been constructed through a research methodology called *task analysis* (Greenberg, 2007). The tasks are described in this section and are summarized in Table 2.1. (For a thorough discussion of the various tasks and their association, markers, microsteps, and resolution points, see Elliott, Watson, et al., 2004.)

Empathy-Based and Relational Tasks

Empathy-based and relational tasks include (a) alliance dialogue at a marker of a complaint about therapy or rupture in the alliance and (b) empathic affirmation at a vulnerability marker. An alliance dialogue is undertaken when there is a therapeutic misunderstanding, therapeutic error, empathic failure, or a mismatch between client expectations and treatment. Such events, inevitable in any therapy, warrant immediate attention and the suspension of other therapeutic tasks. The alliance dialogue is particularly relevant to work with clients who have histories of abuse or other forms of victimization; such persons routinely perceive the therapist as just another potential victimizer. It is therefore very important that therapists listen carefully for and respond to such claims. Empathy becomes paramount in these situations. (For a full discussion of the alliance and working with alliance difficulties and therapeutic misunderstandings, see Watson & Greenberg, 2000.)

Empathic affirmation (Keating & Goldman, 2003) is offered when clients present a vulnerability marker, indicating the emergence of general, self-related emotional pain. The client reluctantly confesses to the therapist, often for the first time, that he or she is struggling with powerful feelings of personal shame, unworthiness, vulnerability, despair, or hopelessness. The sense is that the client is experiencing a pervasive, painful feeling and has run out of resources.

TABLE 2.1
Emotion-Focused Therapy Tasks

Task	Marker	Intervention	Resolution
Empathy-based and relational tasks	Therapy complaint or alliance rupture	Alliance dialogue	Alliance repair in terms of exploring own role in difficulty, increased therapeutic bond or investment
	Vulnerability or shameful, painful emotion	Empathic affirmation	Self-affirmation/ reconnection with therapist (feels understood, hopeful, stronger)
Experiencing tasks	Unclear feeling (vague, external, or abstract)	Experiential focusing	Symbolization of felt sense. Sense of easing (feeling shift); readiness to apply outside of therapy (carrying forward)
	Attentional focus difficulty (e.g., confused, blank, overwhelmed state)	Clearing a space	Therapeutic focus, to work productively with experiencing (working distance)
Reprocessing tasks [situational–perceptual]	Difficult or traumatic experiences (narrative pressure to tell painful narrative gaps)	Trauma retelling	Relief, validation, and restoration of understanding life stories
	Problematic reaction point (puzzling overreaction to specific situation)	Systematic evocative unfolding	New view of self-in-the-world functioning
	Meaning protest (life event violates cherished belief)	Meaning creation work	Revision of cherished belief
Active expression or enactment tasks	Self-evaluative split (self-criticism, torn-ness)	Two-chair dialogue	Self-acceptance, integration
	Self-interruption split (blocked feelings, resignation)	Two-chair enactment	Self-expression, empowerment
	Unfinished business (lingering bad feeling regarding significant other)	Empty-chair task work	Let go of resentments, unmet needs regarding other; affirm self; understand or hold other accountable
	Dysregulated anguish/familiar despair	Compassionate self-soothing task work	Emotional/bodily relief, self; compassionate self-soothing

Note. Adapted from *Learning Emotion-Focused Therapy: The Process-Experiential Approach to Change* (pp. 102–103), by R. Elliott, J. C. Watson, R. N. Goldman, and L. S. Greenberg, 2004, Washington, DC: American Psychological Association.

Experiencing Tasks

Experiencing tasks are aimed at helping clients develop access to and symbolize their emotionally tinged experiences. They include clearing a space when clients are feeling overwhelmed and dysregulated and experiential focusing at an unclear felt sense. Both of these tasks derive from the work of focusing-oriented therapists, including Gendlin (1996), Cornell (1996), and Leijssen (1996).

Experiential focusing has been described by Gendlin (1996, 1997) and others as a general task for helping clients deepen their experiencing. For example, the client may be experiencing emotional distancing in the session, which might take the form of speaking in an intellectual or externalizing manner or talking around in circles without getting to what is important. The therapist may ask the client to slow down and look within. As focusing progresses, the client shifts to internal self-exploration. Resolution involves developing an accurately labeled felt sense, accompanied by an experienced sense of easing or relief and a direction for carrying this "felt shift" into life outside the therapy session.

If the client feels overwhelmed by worries or by strongly painful experiences (e.g., trauma memories), the therapist can use the clearing a space process (Gendlin, 1996), which requires the client to mentally set aside each problem and generate a safe, clear internal space. Here, resolution involves the attainment and full appreciation of the imagined safe space.

Reprocessing Tasks

Reprocessing tasks are tasks in which clients work on some form of problematic experience that has happened to them outside of therapy. They examine the experience closely to make sense of it and to create new meaning about it in the broader context of their life.

The retelling of difficult or traumatic experiences is common in EFT for posttrauma difficulties. Although telling stories of difficult or traumatic experiences is usually painful, people typically have a strong need to tell others about such experiences. The narrative marker is an indication that the client is experiencing some internal pressure to tell the story (e.g., "When he came to sexually attack me, there was nothing I could do to stop him"). Often, it is useful for the therapist to encourage the client to "Tell me the story of _____ in as much detail as you feel safe giving." This also signals the therapist's willingness to "hear the client through their pain" (Egendorf, 1995, p. 5).

A resolved retelling is a relatively complete narrative experienced by the client as making sense, with a clear point or overall meaning in the broad

context of his or her life. Resolved retellings may also be marked by an indication from the client that he or she has developed a greater awareness or understanding of something in the story. For example, a client in couples therapy retold her story of being raped while serving in the military, and as she told her story she began to see how her need to "protect" herself in her marriage through emotional distancing was to some extent a way of coping with her feelings about being raped.

Systematic evocative unfolding is used for problematic reaction points or instances in which the client is puzzled by an overreaction to a specific situation (Elliott, Watson, et al., 2004; Greenberg et al., 1993). This task is particularly relevant to clients who experience sudden episodes of unwanted emotion, including posttraumatic flashbacks, panic or anxiety attacks, anger outbursts, impulsive acts, or episodes of strong emotion dysregulation. Unfolding tasks resemble retelling tasks in that both involve helping the client elaborate narratives with immediacy and vividness, but unfolding is driven by curiosity or puzzlement (like a mystery story), whereas retelling is driven by the need to share distress or emotional pain (like a history).

When the client presents a problematic reaction point, the therapist suggests that he or she describe the episode in detail, together with the events that led to it. The therapist helps the client alternately explore both the perceived situation and the inner emotional reaction in the situation. The client re-experiences the reaction while the therapist encourages an experiential search for the exact instant of the reaction and its trigger. As with the other tasks, resolution is a matter of degree; at a minimum, resolution involves reaching an understanding of the reason for the puzzling reaction, (referred to as a *meaning bridge*). However, the meaning bridge is usually just the beginning of a self-reflection process in which the client examines and symbolizes important self-related emotion schemes and explores alternative ways of viewing self. Full resolution involves a clear shift in view of self, together with a sense of empowerment to make life changes consistent with the new view.

Meaning creation work involves a meaning protest against a life event. Clarke (1989) described the meaning protest marker as the expression of strong emotion and confusion or puzzlement about a painful life event, in conjunction with description of a challenged cherished belief. Meaning protests often involve loss, disappointment, or other life crises, and so meaning creation work is particularly appropriate with grief or chronic illness or following a trauma. This task involves helping clients in states of high emotional arousal to capture their experience in words and images that symbolize and begin to contain their emotional experience. Therapists help clients clarify and symbolize the cherished belief (e.g., bad things don't happen to good

people), the discrepant experience (a trauma or other painful life event), and the discrepancy between belief and experience.

Active Expression Tasks

The active expression tasks come out of the gestalt and psychodrama traditions and require the client to enact a conversation between aspects of the self or between the self and others. These tasks are used to allow clients to evoke, access, and change disowned or externally attributed aspects of self; and they are particularly useful for helping clients change how they act toward themselves (e.g., moving from self-attacking to self-supporting). The models for two key tasks, the two-chair dialogue for negative self-evaluative conflict splits and the empty-chair dialogue for unfinished business, are provided in Figures 2.1 and 2.2, respectively.

Two-chair dialogues are used when the client presents some form of conflict split marker (Goldman, 2002; Whelton & Greenberg, 2005). The following are common markers:

- Decisional conflict: The client feels torn between two alternative courses of action (e.g., to end a relationship or not).
- Coaching split: The client tries to encourage himself or herself to do or feel something; here, the conflict is between the coach and self-aspects of the person.
- Self-criticism split: The client criticizes himself or herself; this is seen as a conflict between the critic and self aspects.
- Attribution split: The client describes what he or she perceives as an overreaction to a perceived critical or controlling other

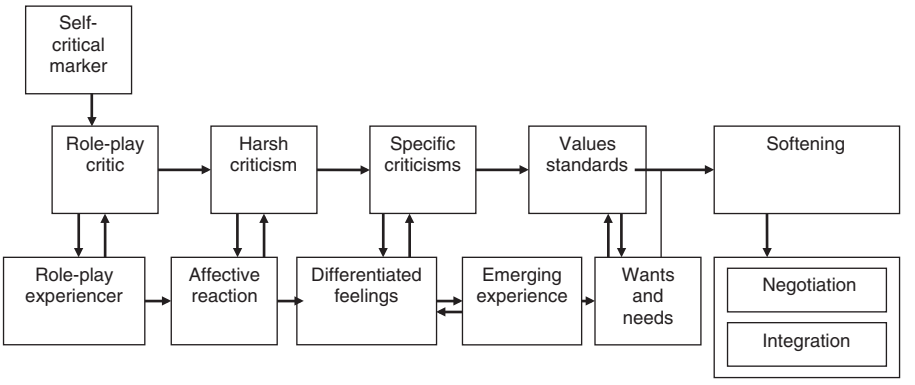

Figure 2.1. Model of resolution of two-chair task for negative self-evaluative conflict split.

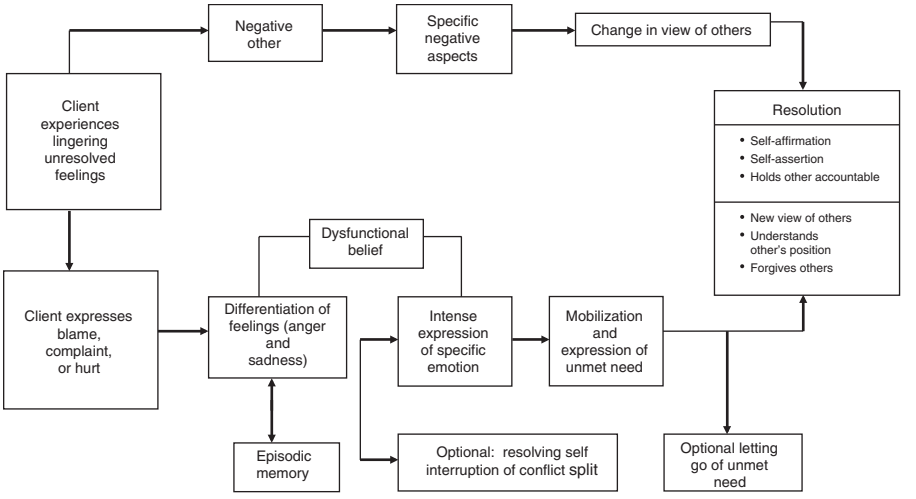

Figure 2.2. Empty-chair task for unfinished business.

person or situation; this is understood as a conflict between the self aspect and the client's own critic or coach aspect, projected onto the other person or situation.

Anxiety splits and depression splits are common split forms found in anxious or depressed clients. The therapist initiates two-chair dialogue by suggesting that the client move back and forth between two chairs, each representing one self-aspect, in order to enact the internal conversation between the two parts. In the case of an attributional split, the client is asked to enact the other or the external situation.

Another form of the split dialogue is the two-chair enactment for self-interruption task that is relevant for addressing immediate within-session episodes of emotional avoidance or distancing, which indicate self-interruption (Elliott, Watson, et al., 2004). Depressed, anxious, and traumatized clients often suffer from an underlying emotional processing split between emotional/experiencing and intellectual/distancing aspects of self. These processing splits result in emotional blocking or "stuck-ness." Self-interruptions markers are most readily recognized when the client begins to feel or do something (e.g., express anger) in the session, then stops himself or herself, often with some kind of nonverbal action (e.g., squeezing back tears) or reported physical sensation (e.g., headache). However, self-interruptions are also indicated by statements of resignation, numbness, being stuck, or reports of feeling weighted down.

In a two-chair dialogue in which the process of interruption is enacted, the therapist directs the client's attention to the interruption and suggests that the client show "how you stop yourself from feeling [e.g.] anger." The

intervention aims to help the client to bring the automatic avoiding aspect of self into awareness and under deliberate control; this in turn helps the client become aware of the previously interrupted emotion, so that it can be expressed in an appropriate, adaptive manner. Minimal resolution involves expression of the interrupted emotion, with more complete resolution requiring expression of underlying needs and self-empowerment.

Empty-chair work is based specifically on the idea that primary adaptive emotions (e.g., sadness at loss, anger at violation) need to be fully expressed; this allows the client to access unmet needs and to identify useful actions associated with the emotion. Thus, this task is aimed at helping clients resolve lingering bad feelings (usually sadness and anger) toward developmentally significant others (most commonly parents). The marker, referred to as *unfinished business*, involves interrupted expression of the negative feelings, often in the form of complaining or blaming. Empty-chair work is used extensively with clients with depression and posttrauma difficulties.

In this task, the therapist suggests that the client imagine the other in the empty chair and express previously unstated or unresolved feelings toward that person. Where appropriate, the therapist suggests that the client also take the role of the other and speak to the self. At a minimum, resolution consists of expressing the unmet needs to the other; full resolution requires restructuring the unmet needs, shifting toward a more positive view of self and a more differentiated view of the other (Greenberg, Elliott, & Foerster, 1990; Greenberg & Malcolm, 2002; Greenberg, Warwar, & Malcolm, 2008).

Research by Paivio and Greenberg (1995) supports the effectiveness of empty-chair work for helping clients resolve trauma-related issues. It is also used extensively with depression (e.g., Greenberg & Watson, 2006), especially with clients whose depression is characterized by interpersonal loss.

Compassionate self-soothing is the most recently developed EFT task (Goldman & Fox, 2012; Goldman & Greenberg, 2013) and is used when the client experiences stuck or dysregulated anguish, typically in the face of a powerful existential need (e.g., for love or validation) that has not or cannot be met by others. Compassion is the opposite of self-criticism; expressing compassion toward oneself is a way of changing painful emotions (e.g., shame, fear, sadness) by internally confronting them with a different emotion. In this task, the therapist first helps the client deepen his or her sense of anguish in order to access the core existential pain and express the unmet need associated with it. Then, in a two-chair process, the client enacts providing what he or she needs (e.g., validation, support, protection). This can be done either directly or with the needy part symbolized as a child or a close friend experiencing the same things as the client. The comforting aspect is represented either as a strong, nurturing aspect of self or as an idealized parental figure.

CULTURAL ISSUES IN EMOTION-FOCUSED THERAPY

EFT therapists strive for cultural competence (Goh, 2005; D. W. Sue & Sue, 2008). We hold the belief that "people should not only appreciate and recognize other cultural groups but also be able to work effectively with them" (S. Sue, 1998, p. 440). The philosophical assumptions of EFT provide a theoretical framework that allows for cultural competence (i.e., primacy of empathy, respect for plurality and difference), and therapists must consciously work to attain it. Whereas ethnic match (i.e., ethnically similar client and therapist) and service match (i.e., utilization of ethnic-specific services) are seen as important and reflective of more favorable outcomes (Goh, 2005; S. Sue, 1998), cognitive match (i.e., clients and therapists thinking in the same manner) has also been shown to be predictive of positive outcome. Cognitive match studies reveal that when therapists and clients share conceptions and expectations about the therapeutic process, outcomes are better (Goh, 2005). S. Sue (1998) suggested, and we concur, that culturally competent mental health professionals should possess the following characteristics: (a) scientific mindedness, testing hypotheses when uncertain about cultural meanings; (b) the ability to *dynamic-size* (a term borrowed from computer science and applied to mental health practice), which refers to knowing when to individualize and generalize about clients; and (c) the development of culture-specific expertise, which refers to developing specific knowledge.

Many people inquire about whether EFT is suitable or appropriate for all cultures, depending on attitudes toward emotion. Research has demonstrated (and this is supported by our experiences training therapists from around the world) that emotion itself is universally felt, although display rules differ across cultures. It is interesting to understand cultural attitudes and display rules with respect to various emotions (Safdar et al., 2009). Part of our job as culturally competent therapists, then, is to apply the suggestion made by S. Sue (1998) above and (a) avail ourselves of culturally specific knowledge about emotion and (b) know when to individualize and when generalize such information in application to our clients.

EMPIRICAL SUPPORT FOR EMOTION-FOCUSED THERAPY

There has been extensive research on the effectiveness of EFT for the attainment of productive therapy outcomes. For example, more research has investigated the process of change in EFT than in any other treatment approach (Elliott, Greenberg, & Lietaer, 2004; Goldman, in press; Greenberg, 2013). EFT for depression, in which specific emotion activation methods are used within the context of an empathic relationship, has been found to

be highly effective in three studies (Goldman, Greenberg, & Angus, 2006; Greenberg & Watson, 1998; Watson et al., 2003). EFT was shown to be effective for the treatment of social anxiety (Elliott, 2013). EFT was found to be equally or more effective than client-centered empathic treatment and cognitive behavior therapy (CBT; Watson et al., 2003). Both treatments with which EFT was compared were themselves found to be highly effective in reducing depression. EFT, however, was more effective in reducing interpersonal problems than both the client-centered therapy and CBT and in promoting more change in symptoms than the client-centered treatment; it was also highly effective in preventing relapse (77% nonrelapse; Ellison, Greenberg, Goldman, & Angus, 2009).

In the York I depression study, Greenberg and Watson (1998) compared the effectiveness of EFT with that of client-centered therapy for 34 adults with major depression. The client-centered treatment emphasized the establishment and maintenance of the client-centered relationship conditions and empathic responding and is viewed as a central component of EFT. The EFT treatment added to the client-centered treatment the use of specific tasks: systematic evocative unfolding, focusing, two-chair, and empty-chair dialogue. There was no difference in reducing depressive symptoms at termination and 6-month follow-up. However, EFT for depression had superior effects at midtreatment and at termination on the total level of symptoms, self-esteem, and reduction of interpersonal problems. Thus, adding these specific tasks at appropriate points appeared to hasten and enhance the treatment of depression.

In the York II depression study, Goldman et al. (2006) replicated the York I study by comparing the effects of client-centered treatment and EFT on 38 clients with major depressive disorder; they obtained a comparative effect size of +.71 in favor of EFT. They then combined the York I and II samples to increase the power of detecting differences between treatment groups, particularly at follow-up. Statistically significant differences among treatments were found on all indices of change for the combined sample, with differences maintained at 6- and 18-month follow-ups. This provides further evidence that the addition of emotion-focused interventions to the foundation of a client-centered relationship improves outcome. In addition, and of great importance, 18-month follow-up showed that the EFT group was doing distinctly better than the client-centered group (Ellison et al., 2009). Survival curves showed that 70% of EFT clients were available for 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 with CBT in the treatment of major depression. Sixty-six clients participated in 16 sessions of weekly psychotherapy. There were no significant

differences in outcome on depression between groups. Both treatments were effective in improving clients' level of depression, self-esteem, general symptom distress, and dysfunctional attitudes. However, clients in EFT were significantly more self-assertive and less overly accommodating at the end of treatment than CBT clients. At the end of treatment, clients in both groups developed significantly more emotional reflection for solving distressing problems.

The relationships between the alliance, frequency of aroused emotional expression, and outcome were examined in depression treatment (Carryer & Greenberg, 2010). The frequency of expression data showed that a frequency of 25% of moderately to highly aroused emotional expression was found to best predict outcome. Deviation toward lower frequencies, indicating lack of emotional involvement, represented an extension of the generally accepted relationship between low levels of expressed emotional arousal and poor outcome, whereas deviation toward higher frequencies showed that excessive amount of highly aroused emotion was negatively related to good therapeutic outcome. This suggests that having the client achieve an intense and full level of emotional expression is predictive of good outcome, as long as the client does not maintain this level of emotional expression for too long 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 rather than a lesser but still desirable goal.

Supporting the basic emotional change hypothesis of EFT that posits the importance of making sense of aroused emotion, process-outcome research on EFT for depression has shown that higher emotional arousal at midtreatment, coupled with reflection on the aroused emotion (Missirlian, Toukmanian, Warwar, & Greenberg, 2005) and deeper emotional processing late in therapy (Goldman et al., 2005), 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 et al., 2005). EFT thus appears to work by enhancing the type of emotional processing that involves helping people experience and accept their emotions and make sense of them. Adams and Greenberg (1999) tracked moment-by-moment client–therapist interactions and found that therapist statements that were high in experiencing influenced client experiencing and that depth of therapist experiential focus predicted outcome. More specifically, if the client was externally focused, and the therapist made an intervention that was targeted toward internal experience, the client was more likely to move to a deeper level of experiencing. Adams's

study highlights the importance of the therapist's role in focusing on internal narrative processes. Given that client experiencing predicts outcome and that therapist depth of experiential focus influenced client experiencing and predicted outcome, a path to outcome was established that suggests that therapists depth of experiential focus influences clients depth of experiencing and that this affected outcome.

Another study was able to further discriminate between productive and unproductive arousal. In an intensive examination of four poor and four good outcome cases, Greenberg, Auszra, and Herrmann (2007) did not find a significant relationship in these cases between frequency of higher levels of expressed emotional arousal measured over the whole course of treatment and outcome. They measured both aroused emotional expression and productivity of the expressed emotion, and concluded that productivity of aroused emotional expression was more important to therapeutic outcome than arousal alone.

The measure of productive emotional arousal used in the above study was further developed and its predictive validity was tested on a sample of 74 clients from the York depression studies (Auszra & Greenberg, 2007). *Emotional productivity* was defined as being contactfully aware of a presently activated emotion, whereas *contactfully aware* was defined as involving seven necessary features: attending, symbolization, congruence, acceptance, agency, regulation, and differentiation. These represent the ability to reflect on and generate meaning from emotion. Emotional productivity was found to increase from the beginning through 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, the working alliance, and expressed emotional arousal. These results indicated that the productive processing of emotion was the best predictor of outcome of all variables studied thus far.

This chapter has reviewed basic EFT theory, including its view of emotion and narrative, the different sources of emotional dysfunction, empirical support for the approach, and the basic operations of the therapy. The information provided here can help readers to understand the EFT therapy that case formulation is embedded in and helps to organize.

3

HISTORICAL, EPISTEMOLOGICAL, AND PHILOSOPHICAL UNDERPINNINGS OF CASE FORMULATION IN EMOTION-FOCUSED THERAPY

Diagnosis and formulation are not concepts or activities that have been typically associated with humanistic and experiential therapies in general or emotion-focused therapy (EFT) specifically, probably because traditional diagnostic assessment (and by extension formulation) having been associated with the medical model. Diagnosis, although only a description of a presenting pattern of symptoms, has traditionally been confounded with explanation of the causal mechanisms of disease. In medicine, where much more is known about causal mechanisms of disease, diagnosis has often come to be synonymous with the explanation of the underlying cause of a disorder. This is far from the case in psychotherapy. For example, the diagnosis and symptoms presentation of depression tell us very little or nothing about the underlying causal mechanism, or what we call the *underlying determinants of the depression*.

http://dx.doi.org/10.1037/14523-003
Case Formulation in Emotion-Focused Therapy: Co-Creating Clinical Maps for Change, by R. N. Goldman and L. S. Greenberg

Case formulation in EFT, however, has evolved in an attempt to provide the clinician with an explanatory framework for understanding the client's problem in terms of its underlying determinants. This causal explanatory framework guides the therapist's understanding that informs treatment decisions and therapeutic action. In this chapter, we briefly review the historical views of diagnosis and case formulation in humanistic and experiential therapies, exploring the evolving development of the approach to case formulation theory in EFT. We then explain the epistemological underpinnings of formulation in EFT. Finally, we explain the reasoning processes that therapists performing case formulation use to identify problems and generate explanatory theories to account for those problems.

HISTORY OF CASE FORMULATION IN EMOTION-FOCUSED THERAPY

EFT is firmly rooted in the humanistic–experiential field, which includes theoretical traditions such as client centered (Rogers, 1957, 1961, 1975) gestalt (Perls, 1973; Perls, Hefferline, & Goodman, 1951), and focusing-oriented psychotherapy (Gendlin, 1978, 1996). Humanistic–experiential psychotherapies, however, have not always considered case formulation to be in keeping with the core principles of the basic theories. This may be in part because formulation has been associated with therapies that conceive of the therapist in a more "expert," knowing role (psychodynamic), and in part because case formulation has traditionally involved a priori hypothesizing about the causes and precipitants of behavior and the subsequent categorizing of people in a manner seen as taking into account the whole human (cognitive behavioral). Concerns about psychological diagnosis and formulation have mainly centered on how both might compromise the therapeutic process or violate core relational principles linked to nondirectivity, egalitarianism, authenticity, and understanding.

Carl Rogers (1951, 1957) viewed diagnosis as interfering with the therapeutic relationship, which was seen as the foundation of client-centered therapy. Client-centered therapists, to some extent, originally defined themselves in opposition to psychodynamic therapists, and in so doing placed much emphasis on the creation of an egalitarian therapeutic relationship. Empathy is a core fundamental aspect of the therapeutic relationship and involves the therapist working hard to continually "stand in the shoes of the other" (Rogers, 1957, p. 97). The empathic relationship was seen as the primary vehicle through which therapists facilitated clients' experience and symbolic expression of feelings. It was through this process that clients could

arrive at new understandings, and by reflecting on feelings and emotions, they develop new ways of being. Rogers (1951) made this very clear:

> The counselor makes a maximum effort to get under the skin of the person with whom he is communicating, he tries to get within and to live the attitudes expressed instead of observing them, to catch every nuance of their changing` nature; . . . the understanding must be acquired . . . and this through the most intense, continuous and active attention to the feelings of the other, to the exclusion of any other type of attention. (p. 29)

The act of formulation was thus seen as potentially impeding a core, fundamental therapeutic process, preventing therapists from being maximally present and emotionally available to clients. It was thought that if therapists' attention is focused on how thoughts and feelings relate to actions and core dynamics, they could not give full attention to the ongoing feelings and meanings being created by their clients. It was also thought that if therapists have a preformed or organized set of hypotheses, they are prone, somewhat by default, toward fitting their understanding of their clients into their hypotheses and thus exerting undue influence on the clients rather than allowing their experience to stand on its own (Rogers, 1951).

Gestalt therapy places a strong emphasis on the therapist developing an authentic relationship (Yontef, 1993) with the client wherein the subjectivity of the other is recognized and promoted over a more distant, objective view of the other. The I–Thou relationship (Buber, 1970) is adopted, which views the relationship as one between two subjective beings in interaction; this is in contrast to the I–it relationship, in which the other is seen as an object and does not reveal the subjectivity of the helper. The other comes to be seen in more objective terms. Furthermore, the self is seen in holistic terms, rather than as a set of component parts (Perls, 1973). The act of diagnosis, and by extension formulation, can be seen then as potentially placing the therapist in a more cold, distant, analyzing role wherein the client is viewed as a mechanistic automaton, as a set of parts not functioning well together, rather than a whole complex, dynamic self-organizing system.

Concerns regarding formulation expressed by humanistic–experiential theoreticians and therapists have thus mainly been twofold. One concern is that formulation (and its close counterpart, diagnosis) creates an unwanted emotional distance between client and therapist. The very act of diagnosis or formulation involves standing back from the client, diverting one's attention toward analysis and categorization and potentially not freeing the therapist to be emotionally present and available. Second, diagnosis and formulation are potentially seen as putting the therapist in a more powerful, "one up"

position, placing the therapist in an "expert" role and thereby creating an unwanted and inhibiting relational imbalance. Rogers (1951) also expressed this concern in social philosophical terms, stating that diagnosis may in the long run place the "social control of the many in the hands of the few" (p. 224).

In our approach to case formulation, we maintain adherence to the core relational principles of both client-centered and gestalt therapies and regard formulation as fundamentally compatible with its humanistic theoretical roots. Refinements, advancements, and additions to the theory have helped us see the utility of case formulation, particularly the idea of co-constructing an evolving narrative structure that organizes the therapeutic process and provides a focus. We do not feel that case formulation as practiced in EFT interrupts the emotional immediacy of the therapeutic relationship. We recognize that we engage what Harry Stack Sullivan (1954) referred to as the *observing ego*, acting as participant–observers in the process, and this is a necessary part of formulation. Engaging the observing ego means absorbing without judgment and not weighing any thought, gesture, or action. Then we step back and make decisions about how best to proceed; we make processing proposals to our clients and emotionally reengage. This complex process occurs rapidly over split seconds and transforms and is reworked many times in the therapy hour.

ON DIAGNOSIS

EFT places a high premium on clients being able to identify their own emotions and experiences. We emphasize to our clients that they are indeed the "agents" of their own experience; change is not possible without this recognition. It is precisely because of our fundamental belief in the premise of this therapeutic relational condition that we do not share Rogers's (1951) concern that the act of formulation (which we refer to as *process diagnosis*) necessarily puts the power "in the hands of the few" (p. 224). A core aspect of our relational theory is that we do not presume to know more about what our clients' experience than they do. We enter into an egalitarian relationship with our clients, jointly embarking on a journey to better understand how their emotional processing has gone awry. We work together with our clients to understand how we can best address their problems. Implicit in the theory, then, is the view of EFT therapists as process experts possessing the skills and abilities necessary to facilitate the successful transformation of emotional experiencing.

Although we have concerns regarding the stigmatization that can be generated from diagnostic labels (and generally refrain from using them with our clients), we do not see the process of formulation as contributing to

stigma; rather, we regard it as helping to create coherence. It is our view that diagnostic labels can be limiting and even damaging, particularly those that include highly connotative terms (e.g., *borderline*). The available diagnostic categories often seem unhelpful in providing adequate descriptions of our clients' experiences.

Diagnostic categories, on the other hand, have allowed the accumulation of a great deal of information and knowledge generated by both research and a vast set of clinical experiences. For example, a great deal of information is available on the etiology and treatment of depression. Such diagnostic categories can thus be seen as additive and helpful as long as they are understood as providing a set of tentative hypotheses rather than absolute facts. As such, they help us to understand a person, but they should never take precedence over the person's experience or be used as a lens through which to limit a view of the person to a category. In addition, stigma resulting from diagnostic labeling is to some extent created by society and perpetuated by therapists (and in fact sometimes shared by clients). It is therefore necessary at times in therapy to work with these stereotypes and actually see the therapy process as functioning to undo them. Concerns about stigma, however, are more applicable to diagnosis than formulation (which we regard as separate processes).

Formulation in EFT practice does not involve a priori categorization. It is a collaborative, co-constructive process undertaken between client and therapist. We see ourselves as consultants and coaches who can help people undo difficult and problematic emotional experiences and generate and re-create new, more satisfying ones.

OTHER APPROACHES TO CASE FORMULATION

Kendjelic and Eells (2007) proposed a generic model of case formulation through which an "inferred explanatory mechanism" (p. 68) identifies and accounts for (a) symptoms and problems, (b) precipitating stressors, and (c) predisposing events and conditions. Eells (2013) suggested that formulation comes from two basic sources of information, theory and evidence, and that it should follow a sequential path: creating a problem list, diagnosing, developing an explanatory hypothesis, and planning a treatment. Although EFT case formulation does not emphasize these components in the same manner, EFT therapists do develop an explanatory hypothesis. Kim and Ahn (2002) showed that, despite being trained in the use of an atheoretical diagnostic manual (*Diagnostic and Statistical Manual of Mental Disorders*, 4th ed.; American Psychiatric Association, 1994), clinical psychologists use causal theories to make sense of their clients' clinical problems. What seems to vary across therapists, however, is the manner in which clinicians infer causal mechanisms.

Psychotherapists and clinicians often distinguish between overt difficulties in emotion, mood, behavior, and cognitions (e.g., sadness, feeling down, poor work performance, self-criticisms) and underlying psychological mechanisms (e.g., core emotion schemes, core beliefs, conflicts, attachment insecurity). The overt difficulties are the phenomena to be explained, and the underlying psychological mechanisms are explanations for those phenomena. More behaviorally oriented approaches advocate intervention primarily with overt difficulties. They generally focus on teaching coping skills to help clients adjust to their difficulties, and this is in turn is thought to change whatever underlying mechanisms are present. In her book outlining a cognitive behavioral approach to case formulation, Persons (2008) suggested that intervention is most effective at the level of overt difficulties and that change in overt difficulties changes the underlying beliefs that are posited as producing the problem. This is tantamount to suggesting that changing the effect (overt difficulty) changes the cause (underlying psychological mechanisms), although Persons does in addition acknowledge that changes in underlying attitudes can produce change in overt difficulties. Overall, however, case formulation in behavioral and cognitive behavioral approaches is more focused on identifying overt behaviors and environmental reinforcers rather than underlying determinants.

In-depth approaches to treatment, such as EFT and psychodynamic therapy, on the other hand, assume that underlying causal mechanisms produce phenomena and that intervention is most effective at the level of the underlying determinants to produce enduring changes in the phenomena. Thus, there is a significant difference between those approaches that intervene at the level of the overt problem and those that aim at the underlying determinants. In the depth-oriented approaches, the therapist hypothesizes about underlying causes and attempts to treat them. In some psychodynamic approaches, for example, underlying mechanisms are made up of conflicts and wishes, along with various defense mechanisms such as denial and idealization. By contrast, underlying determinants in EFT consist of a person's underlying emotion schemes and the associated schematic self-organizations, and possible causes are mechanisms such as lack of emotional awareness, disowning of emotional experience, overregulation or underregulation of emotion, and the nature of narrative construction.

In the next section, we argue that EFT adopts a qualitative–hermeneutic approach and an abductive method (Peirce, 1931–1958) to formulate general determinants, whereas psychodynamic approaches primarily adopt an inductive–inferential method to abstract inferences across situations. EFT uses bottom–up processing to explore and discover individual and idiosyncratic details in specific experiences rather than top–down, or inferring of patterns across situations, as in psychodynamic approaches (Pascual-Leone & Greenberg, 2007b).

A QUALITATIVE–HERMENEUTIC APPROACH TO CASE FORMULATION

An EFT approach to case formulation is consistent with a qualitative–hermeneutic approach to investigation. Qualitative inquiry involves the building of structure but from the ground up (Glaser & Strauss, 1967). Similarly, emotion-focused case formulation involves the building up of a structure that emerges from the therapy process. We find it helpful to think of case formulation as a dynamic interactive process rather than as a fixed or structured plan (Eells, 1997, 2010). Formulation grows organically from the process and is constantly being altered on the basis of new client and process information. Information is organized into an existing framework, and when information is discrepant with it, the formulation is altered. Thus, formulation is an ever-changing process in itself, so that markers emerge, tasks are undertaken, and emotional processing problems are resolved, all of which lead to new, often deeper, emotional processing problems and emerging meaning that informs new views of the self. Formulation is constantly being created and re-created based on new information entered into the system, and this iterative process continues until there is a sense of resolution of the core presenting problems.

For example, a formulation may initially focus on a male client's presenting problem of how to control destructive anger and lashing out that is compromising relationships. After several sessions of EFT, the formulation shifts to the client's underlying shame, a feeling that is difficult to tolerate. The client may discover that at moments of perceived invalidation, he quickly flashes to anger. The formulation may involve noticing that the client lacks awareness about what triggers his anger. Therapy may help him become more aware of the rising of the anger in its early stages so that he can calm himself. When the underlying shame-based self has been accessed in therapy, he may be able to experience shame and express it in relationships rather than get angry. The reorganization thus leads to a reformulation that the focus now needs to shift to how to transform the shame into pride, self-confidence, and a sense of worth. This results in a new sense of self and a possible reaching out to others or perhaps taking on new tasks. Formulation is an iterative process and leads to particular tasks aimed at deepening emotional exploration that in turn lead to emergent emotional states that may contribute to formulating new emotional processing problems and new meaning. Formulation subsequently leads to new, deeper explorations and new emotional states and meanings until a coherent, whole sense of self emerges from the process.

EFT case formulation is responsive to what emerges over time. A formulation is constructed as therapy progresses; it is conducted in the context of a safe, trusting relationship, grounded in observations of current emotional processing, takes into account new information that is provided by clients

from week to week in the context of their changing life circumstances and ongoing relationships that are in part occurring as a result of the therapeutic process. Formulation is thus constantly altered based on changes that clients make in their lives and in the therapy session.

MODES OF REASONING IN CASE CONCEPTUALIZATION AND SCIENCE

The case formulation process can be likened to the process of theory construction in science. The identification of psychological mechanisms is an extremely complex task in carrying out scientific research. It is even more difficult in clinical work, where therapists are presented with individuals' varied meanings and behaviors, which are inherently fraught with ambiguity and variability, and where therapists must produce a comprehensive formulation that provides a framework for psychological intervention.

EFT is based on a dialectical constructivist epistemological approach, a form of critical realism (Bhaskar, 1993). Dialectical constructivism essentially argues that in coming to know something, both the state of our knowledge and the thing itself are changed (Elliott, Watson, et al., 2004; Greenberg & Pascual-Leone, 1995, 2001). What we come to know is a joint construction of the "things themselves" and our knowing process. Rather than simply processing information in a logical manner, we create new meaning through a dialectical process of acting upon and synthesizing components of experience.

This position differs from what might be called "radical" constructivism, the postmodernist or relativist view that reality is irrelevant and only "versions" or interpretations of the world are of interest. In contrast, dialectical constructivists argue that reality constraints limit our constructions. Thus, not all constructions fit the data equally well, although it does seem likely that several different accounts (or versions) might end up being plausible or valid. Thus, dialectical constructivism is compatible with contemporary critical realist philosophies of science that attempt to steer a course between relativism ("anything goes") and realism ("nothing but the facts").

Much clinical reasoning in psychotherapy has been guided by deductive or inductive methods imported from the realist scientific method adopted in psychological research. *Deductive* reasoning, or deduction, starts out with a general statement, or hypothesis, and examines the possibilities to reach a specific, logical conclusion. The scientific method uses deduction to test hypotheses and theories. Theories are first constructed and client difficulties are understood in terms of these theories. Use of this method can be seen in early psychoanalytic theoretical formulations that theorized that depression was produced by anger turned against the self (Freud, 1917/1957) or in

cognitive therapy that theorized that negative cognitions produce depression (Beck, Rush, Shaw, & Emery, 1979). Thus, one would reason, depression is caused by anger turned inwards or negative cognitions (Bill is depressed either because he turns his anger against himself or because he thinks he is stupid). This method of clinical problem-solving is weak, however, because it does not bring in the clinician's prior knowledge of the particular disorder or the particular client to extend beyond explicit theory. Clinical work, in fact, uses much more than deductive logic; it relies heavily on relevant prior knowledge, based on theory, clinical experience, general human, experience, and the client in question.

In case formulation in psychotherapy, then, phenomena come before theory and the formulation is constructed to understand and explain the phenomena. With a particular client, for example, we may notice lots of anger toward a parent. Working from the phenomena, we construct a formulation that the person felt unloved and that he or she has unmet attachment longings. In another client, the anger may be a reaction to feeling humiliated.

In contrast to deductive reasoning, *inductive* reasoning is also used in theory generation in scientific research. This form of reasoning seems more applicable to case formulation but still only partially describes what actually occurs in EFT formulation. Inductive reasoning is the opposite of deductive reasoning. Inductive reasoning makes broad generalizations from specific observations. It connects isolated facts to form a general hypothesis; it infers causes and involves pattern recognition. While the conclusion of a deductive argument is supposed to be certain, the truth of an inductive argument is supposed to be probable, based upon the evidence given. For example, if we observe that a depressed client is repeatedly self-critical, then we may infer self-criticism as the probable underlying cause of his depression. Inductive forms of reasoning use more bottom-up (vs. top-down) means of reasoning forward from data to formulation.

EFT therapists do use inductive reasoning to guide the case formulation, but they do not adopt a hypothesis-building approach that is either deductive or purely inductive. Formulation from deductive reasoning methods involves forming hypotheses that are deduced from specific premises devised prior to therapy. An example might be that obsessive compulsions are caused by thoughts of a specific content. This is based on a theory-driven assumption rather than phenomenologically grounded observation of an individual with this condition. Inductive reasoning methods are more phenomena driven and involve observation of behavior and the continuous search for associations and patterns in the data, all of which inform a generalization (e.g., the generalization from a number of reports of a number of interpersonal events of a core conflictual relationship theme of wishing for closeness and anticipating rejection and feeling unappreciated based on inferring wishes and

expectations of others and self's response moves away from the phenomena, and in this case, away from the client's lived experience).

However, another not well-recognized form of reasoning more closely describes the emotion-focused approach to formulation: *abductive* reasoning (Peirce, 1931–1958). The fields of law, computer science, and artificial intelligence research have shown a renewed interest in the subject of abduction (Josephson & Josephson, 1996; Lipton, 2001). Diagnostic expert systems frequently use abduction. Neither deductive nor inductive, abduction involves guessing or using imagination to construct a model of what is occurring. Abductive reasoning is used to make a medical diagnosis: Using what they know, doctors consider a set of symptoms and apply the diagnosis that best explains most of them.

Peirce (1931–1958), the American logician and philosopher, maintained that science proceeds by *abduction*, a type of inference that "consists in studying the facts and devising a theory to explain them" (1934, Vol. 5, p. 90). He introduced the term *guessing* to highlight the difference. Peirce said that to form a hypothetical explanation (A) from an observed surprising circumstance (B) is to surmise that A may be true because then B would be a matter of course. Thus, to abduce A from B involves determining that A is sufficient (or nearly sufficient), but not necessary, to produce B. Abduction, therefore, is a reasoning process that starts from a set of observed phenomena and derives their most likely explanations. For example, the lawn is wet. But if it rained last night, then it would be unsurprising that the lawn is wet. Therefore, by abductive reasoning, the possibility that it rained last night is reasonable. Moreover, abducing that it rained last night from the observation of the wet lawn can lead to a false conclusion. In this example, dew, lawn sprinklers, or some other process may have resulted in the wet lawn, even in the absence of rain. So we guess at the cause, imaginatively constructing the step not acknowledged in inference. Einstein's work, for example, was not just inductive and deductive but also involved a creative leap of imagination and visualization that scarcely seemed warranted by the mere observation of moving trains and falling elevators. In fact, so much of Einstein's work was done as a "thought experiment" (for he never experimentally dropped elevators) that some of his peers discredited it as too fanciful. In EFT the therapist abducts what the client's underlying core pain is by reading the signs and imagining what it must be.

In other words, abductive reasoning is inference to the best explanation. Abductive reasoning typically begins with an incomplete set of observations and proceeds to the likeliest possible explanation for the set. Abductive inference involves reasoning from phenomena, understood as presumed effects, to their theoretical explanation in terms of underlying causal mechanisms (Haigh, 2005; Vertue & Haig, 2008). In this view, new knowledge

never comes from deduction, which like mathematics contains its findings in its premises. Nor does it come from induction alone, because observation alone does not account for the imagination needed in the recognition and constructive description of something truly novel. As has been shown, one cannot easily see what one does not attend to, and does not expect, because it has never been seen and therefore is not easily envisaged. Instead, the novel emerges from the interaction of induction and abduction. In induction, the therapist empirically observes clinical phenomena. The therapist sees the client drop his or her eyes, hears a quiver in the voice, finds the words and images to be evocative, and imagines that the client feels humiliated. In abduction, the therapist oscillates between imagination and observation guided by imagination, to create a type of picture theory (Hanson, 1958) or guess and thereby generate a hypothesis (i.e., "Seems like you felt diminished") to explain an observed novel occurrence (a particular look on the face and tone in the voice plus a statement of being criticized). Essentially, abductive reasoning is a form of inference that moves from descriptions of data patterns or phenomena to one or more plausible explanations for those phenomena. This explanatory move is from a presumed effect or effects to underlying causal mechanisms; it is not an inductive move to regularity or a law, nor a deductive inference to or from an observation of statements.

Elaborating on the above example, the client talks about having not protected her sons from an abusive husband. The therapist observes a slight slowing of her voice, a hesitation, a dropping of her eyes, and he imagines (guesses) that the client's guilt feelings have activated her core sense of shame and worthlessness, developed from a history of parental invalidation. In this example, formulation involves the generation of a hypothesis from the observations in order to explain the observed. In another example, the therapist notices the client's high-pitched voice while complaining about unfair treatment by a parent and imagines that the person's anger is a reaction to underlying feeling of rejection and that there is a great deal of unresolved sadness at loss. Note that these assessments are neither simply deductions from theory nor inductions from repeated observations up to generalizations. Rather, they are theory-informed, phenomenologically grounded, creative guesses that are inferences to the best explanations.

The selection of which phenomena are to be explained is crucial in EFT case formulation, just as it is in scientific research. The phenomena to be explained in case formulation, however, are not the raw data of clinical observation but rather particular phenomena that are imaginatively organized to cohere into a meaningful pattern. The concept of markers is fundamental in EFT. The clinical phenomena of markers such as problematic reactions, unfinished business, self-critical splits, emotional dysregulation, avoidance, or an unclear bodily felt sense are constructed from noticing the occurrence

of particular types of verbalization patterns and their affective co-occurrences (raw data). Abductive inference or creative imagining is informed by the raw data of the client's verbal and nonverbal performance that are observed in order to detect the robust empirical regularities, or phenomena, of markers of underlying determinants. A variety of causal mechanisms might be abductively inferred from markers; for example, the core emotion schematic fear may be abductively inferred from observation of a marker of unfinished business; a core emotion schematic sense of shame may be abductively inferred from a statement of self-criticism; core fear, trauma, or the inability to symbolize experience may be abductively inferred from a symptom presentation of an eating disorder. These possibilities are considered in figuring out which causal explanation best fits the observed phenomena.

The case formulation approach being presented here, which involves observing and detecting phenomena over several sessions and then abducting causal reasons, necessitates a slower approach than many interview assessment procedures. This slower form of case formulation is valued in EFT because it aims at diagnostic accuracy. Research suggests that one of the factors contributing to diagnostic accuracy is the time taken to arrive at decisions; more accurate diagnosticians take longer to arrive at their decisions than do less accurate diagnosticians (Falvey et al., 2005). Spengler, Strohmer, Dixon, and Shivy (1995) suggested that the process of slowing down decision making may be one of the most effective strategies for reducing premature closure, which is possibly the most common assessment error: "Otherwise counsellors tend to form hypotheses in the first hour that they resist changing" (p. 524).

It is important to note that the formulation and its components being constructed by this method are always tentative, never absolute, and their development is a function of repeated observation by the therapist and with growing consensus among supervisors or consultants involved in repeated observation. Thus, all aspects of the formulation are abductions (constructed hypotheses), awaiting validation by continuing observations. Components (subhypotheses) are altered, discarded, or combined with other components, depending on an ongoing understanding of the process in the case.

ABDUCTIVE REASONING, CASE FORMULATION, AND TASK ANALYSIS

Greenberg (1984, 1986, 2007; Greenberg & Pinsof, 1986; Rice & Greenberg, 1984) proposed a task analytic model and constructive measurement procedures to be used in clinical scientific research for understanding the process of change in psychotherapy. Clinical reasoning processes involved in case formulation are similar to the process used in these task

analyses. As in the building of models by task analysis, formulation results in the construction of explanatory mechanisms that are a mix of empirical reality and construction (Greenberg & Pascual-Leone, 1995, 2001; Neimeyer & Mahoney, 1995). The goal of a task analytic approach to case formulation is to construct explanatory models of underlying processes that help capture some of the invariants of client performance. This guides the clinician toward intervention designed to help access and transform the underlying determinants of the problematic phenomena. We liken this to Husserl's (1962/1977) notion of "thought experiment." By freely varying in imagination possible causal mechanisms to best describe the phenomena presented, we arrive at the most plausible, elegant, and coherent formulation.

The steps of the internal reasoning processes of the clinician follow our task analytic research method of identifying change processes (Greenberg, 1984, 2007). The task analytic approach emphasizes identifying phenomena and engaging in discovery-oriented model building. The clinician does something similar, adapting the task analytic method to develop a model (formulation) of the underlying cause of a client's problem. Note that the six steps below are an explanation of the knowledge-generating processes involved in building an explanatory model, not the 14 steps of the clinical process of case formulation.

1. Identify the phenomena. Phenomena are not, in general, directly observable, as they have already been constructed from the data (i.e., depression, anxiety or panic, unstable relationships, aggressive behavior, eating disorders).
2. In consultation with the client, the clinician begins to form an implicit cognitive map that is made more explicit over time by articulating in language both the phenomena and an understanding of its origins.
3. A hypothetical model of underlying cause is abductively imagined.
4. Inductively derived, empirically observed phenomena are constructed from observations of client's ongoing functioning and are checked against the hypothesis.
5. The model being formed that is both imaginatively driven and empirically observed is reflected back to the client and thus synthesized into narrative and iteratively revised as more instances of relevant phenomena emerge.
6. Abductively generate explanations of the model.

Detecting empirical phenomena is a major goal of case formulation, and successful detection constitutes an important type of formulation in its own right. However, once detected, phenomena serve the important function of

prompting the search for understanding by constructing an explanatory theory. EFT formulation thus goes beyond observation by imagining underlying causal mechanisms and this guides intervention.

After a number of plausible explanatory hypotheses have been abductively generated, the immediate task is to ensure that they are developed to an acceptable degree into a causal model of a client's problems to identify the most appropriate therapeutic target. It usually becomes apparent that some mechanisms are more centrally involved in generating a client's phenomena than others. The decision regarding what might be most central is obviously theoretically informed but perhaps more influenced by observation. Eventually, we observe that exploration during therapy continues to return to a particular central roadblock that is often a fundamental causal mechanism (sometimes referred to as *core mechanisms*).

When the causal mechanism formulation is developed, it is assessed against rival formulations with respect to their explanatory goodness. This assessment involves making judgments of the best of competing explanations. What is required is that the formulation be plausible enough to be provisionally accepted. It is important to distinguish between truth and justification as approximations for truth, based on criteria such as predictive success, simplicity, and explanatory breadth. An evaluation of the explanatory consistency of a theory then is made in terms of such criteria as explanatory breadth, simplicity, and analogy (Thagard, 1992). The criterion of explanatory breadth, the most important one for choosing the best explanation, suggests that a theory is more explanatorily coherent than its rivals if it explains a greater range of phenomena. The notion of simplicity holds that preference should be given to theories that make fewer special assumptions. Finally, explanations are judged more coherent if they are supported by analogy to theories that scientists already find credible.

THE CHOICE OF CAUSES

Formulation is guided by our theoretical model, which posits that psychological causal mechanisms are affective in nature (e.g., lack of awareness of emotion, maladaptive emotion schemes emotion regulation difficulties, unresolved attachment yearnings or issues of meaning or ultimate purpose) and interact with biological, systemic, cognitive, and behavioral factors. In EFT a causal mechanism, such as a core scheme of fear or a shame-based feeling of worthlessness, may produce effects such as thoughts of incompetence, avoidance of challenge, anxiety, and low mood. A causal mechanism such as insecure attachment style may produce unsuccessful personal relationships and the avoidance of social interaction.

Psychological strengths and vulnerabilities are also considered. Other distal variables such as heritability, organicity, and trauma history need to be included, as well as proximal factors from the current context, such as the stresses associated with a divorce or the loss of a job. Maintaining factors and the roadblocks that may be encountered through the change process (including environmental factors) need to be articulated to provide an adequate explanation of the client's difficulties. Orienting frameworks such as the biopsychosocial model or the diathesis-stress model thus help to structure the search for plausible causes.

CONCLUSION

Our perspective on formulation has evolved in an attempt to represent as veridically as possible how EFT is practiced. By studying our practice we recognize that our therapies develop themes across time and that in fact we do develop a formulation and a focus while remaining committed to a process approach, which privileges process over content, and a relational approach which values emotional immediacy, safety, and equality.

In this chapter, we have discussed formulation as proceeding from the detection of phenomena, through the proposal of explanatory causal mechanisms, to the construction of a model of these mechanisms, and finally to the evaluation of this model. However, it is important to note that clinical work also includes the collection of data prior to the processes described above and to the construction of a narrative of the case often in written form for case files or insurance. The central clinical process of formulation is one of abductively imagining plausible underlying causes rather than simply deducing or inferring. In addition, the probabilistic nature of the causal mechanisms is recognized as an aspect of the process by which formulations are constructed. No claim to certainty is made.

II

THREE PHASES OF EMOTION-FOCUSED CASE FORMULATION

4

STAGE 1: UNFOLD THE NARRATIVE AND OBSERVE THE CLIENT'S EMOTIONAL PROCESSING STYLE

This chapter presents the theory underlying Stage 1 of EFT case formulation and involves the following steps:

1. Listen to the presenting problems (relational and behavioral difficulties).
2. Listen for and identify poignancy and painful emotional experience.
3. Attend to and observe the client's emotional processing style.
4. Unfold the emotion-based narrative/life story (related to attachment and identity).

Case formulation in Stage 1 shuttles between the two levels of the dialectical process fundamental to EFT: emotion and narrative. The therapist is continuously engaged in the dual process of attending to the more biologically based organismic experience on the one hand and the quest to make

http://dx.doi.org/10.1037/14523-004
Case Formulation in Emotion-Focused Therapy: Co-Creating Clinical Maps for Change, by R. N. Goldman and L. S. Greenberg

sense of and organize experience on the other. The initial phase begins on a microanalytic level, as the therapist listens for the relational and behavioral difficulties in the presenting problems. Throughout the stage, the therapist moves between the emotional process (attending to pain and observing emotional processing style) and attending to the conceptual organization of material (hearing narrative themes in the person's life). Information learned through attending to the client's moment-by-moment emotional processing style in the context of the narrative description of problems and life story is used to build an initial picture of the case.

In this phase, the relationship is forming. The therapist listens carefully, and gathers information in order to hear the presenting relational and behavioral difficulties. Throughout the stage, the therapist validates the client's pain in relation to core difficulties while attending to the style and nature of the client's emotional processing. The therapist forms a picture of the client's emotional processing styles and the degree of access to the underlying emotional experience. Treatment is not planned a priori from session to session; case formulation is not a linear process. Rather, we start with as few assumptions as possible, and in each session we ask clients to focus on experience occurring in real time. The initial traces of narrative themes are formed, although not yet distinctively delineated, by the end of the first stage. The emphasis is on understanding more enduring aspects of the person (i.e., case formulation) by listening to their moment-by-moment process in order to begin to develop an overall treatment focus. The focus becomes fully crystallized only in Stage 2. By Stage 3, the focus turns to process formulation and what is occurring in the moment, as the therapist guides the client through new emotions and the discovery of new meanings, which are then used to further adjust the case formulation.

STEP 1: LISTEN TO THE PRESENTING PROBLEMS (RELATIONAL AND BEHAVIORAL DIFFICULTIES)

The process of case formulation begins at the first meeting with our clients. We do not conduct a formal assessment or engage in hypothesis testing, and as such formulation begins with the presenting problems, seen as initial windows into the core underlying determinants. The work of formulation here is to enter into a client's subjective world and empathically understand how she perceives and constructs her problems. Eventually we want to understand the core emotion schematic processing that generates experience and therefore problems, but this is understood only in Stage 2.

The problems that bring people to therapy generally are either relational or behavioral. Relational difficulties might be high distress and conflict in relationships, sensitivity to rejection, feelings of inadequacy, anger and

impulse control problems, recent heartbreak, a failing or troubled marriage, and feelings and fears of loneliness. Behavioral difficulties include performance anxiety, debilitating anxiety such as panic attacks, social anxiety, a psychological inability to work, phobias, addictions, eating problems, negative body-image, feelings of low-self-esteem, or depression.

We want to know how clients construct, present, and make sense of their problems. We are interested to know how they view their problems and how they have tried to solve them. We get a sense of how long they have lived with or suffered with their problems and what they might see as the source of them. As we move forward in therapy and as exploration deepens, we know that the narrative will be elaborated and core determinants will emerge. In other words, embedded within the presenting problems lies the source of the problem, and this emerges from the exploration. At this stage, we are attempting to understand how clients see things and what they hope to gain from entering the therapeutic process.

As indicated previously, we do not separate the assessment phase from the initial therapy sessions; to do so would not make sense in our approach. EFT therapists do, however, place weight on building a strong therapeutic alliance and a trusting emotional bond because these are seen as essential to the success of the case formulation process and therapy itself. Additionally, in the first session, therapists may want to obtain particular information relevant to the case formulation process, and thus query certain topic areas. In the following sections, we briefly outline how the therapeutic alliance and relationship are formed and review what happens in a first therapy session.

Building the Therapeutic Relationship and Establishing the Alliance

Alliance formation is essential to case formulation. We work with clients to establish mutual trust and a safe environment so that clients can engage in experiencing and exploring more painful experiences (Elliott, Watson, et al., 2004; Watson & Greenberg, 1998). Alliance formation unfolds through several successive stages, culminating with the achievement of a productive working relationship.

It is also important for clients and therapists to establish shared agreement on therapeutic goals (what to work on) and tasks (how to go about working) early in therapy (Horvath & Greenberg, 1989). To do this, it may be useful for therapists to inform clients explicitly about the nature of the relationship and the tasks and goals of therapy, including the role of emotion in the change process, and to reflect clients' main difficulties, interrupted life projects, and main therapeutic foci back to them.

In EFT, the initial general tasks that clients need to perceive as relevant to meeting goals are those of disclosure, exploration, and deepening of

experience. When a client is engaged in these tasks, formulation can begin. The early establishment of a focus, and a discussion of the underlying determinants of the presenting problem, act as a broad framework to initially focus the exploration. Any formulation about what the problem is, and what it is focused on, is held very tentatively and constantly checked with the client for relevance and fit; the client's moment-to-moment processing in the session remains the ultimate guide.

Therapists facilitate collaboration with their clients toward the tasks and goals of therapy. This becomes paramount to the exploration of problems and the background to the life narrative. Collaboration will continue to be essential throughout the case formulation and therapy process. Client and therapist agree to come to understand the source of the problems and work together to create emotional change. It is important that clients agree that talking about their feelings and their personal experience can be productive and that they acknowledge that they might be unwittingly engaging in emotional processes that contribute to their problems. Clients need to feel that the way in which their therapists are thinking about their problems and the suggestions they make to try to facilitate clients' resolution of their problems are consistent with clients' expected goals and outcomes. Clients must feel that they are active in their own change process (Bohart, 2000).

As we unpack the relational and behavioral difficulties in this initial step, essential relational conditions must be created. Therapists establish a therapeutic presence with their clients (Geller & Greenberg, 2012) that conveys genuineness, empathy, and unconditional positive regard. Forming a therapeutic relationship out of which formulation can occur requires therapists to be present and highly focused on their clients' experience as they attend to the nuances of clients' narrative meanings and integrate these with the information from other nonverbal sources. In this beginning stage, we are also formulating what kind of relationship we need to form with the person in front of us. Given that it is vital to the success of this therapy that we explore emotion, we assess what kind of relationship we need to form in order for this person to be able to access it. Empathic attunement is necessary to make assessments of emotional fragility and emotional accessibility. We ask ourselves, is this relationship strong enough? What kind of a relationship conditions do I need to develop to ensure that trust is created? Some clients emerge from backgrounds wherein there was a great deal of neglect, physical or sexual abuse, strong experiences of violation by abusive others, or strong degrees of conflict, chaos, and instability. They present as fragile and broken, fearful and self-protective, unwilling to trust, or very distant from their emotions. In part based on the stories they tell us, but mostly based on their emotional presentation, we assess the amount of time required to form a safe, trusting relationship so that they can forge into emotional work.

The client's verbal and nonverbal interaction with us is an important window into his or her relational style at this stage of formulation. The patterns of nonverbal expression, their vitality affects (Stern, 1985, 1995), whether they are fast or slow, and the interpersonal pull are all aspects that are being felt and not yet fully identified in awareness by the therapist. Thus, therapists are alert to any interpersonal sensitivities that may affect the formation of a good working alliance. This information is used to help them interact with the client in an accepting, nonreactive, nonjudgmental fashion to help the client internalize a soothing and validating relationship (Vanaerschot, 2007).

When we assess clients to be fragile, we are careful, move slowly, and tread lightly. We do not suggest tasks in the early phase of therapy because they involve a quicker deepening of emotional experience. Instead, we spend time forming the relationship and creating empathic conditions of safety. Tasks that may be suggested are considered empathic tasks that do not involve "doing" or intervening but rather listening, exploring, and accessing. These include empathic affirmation at a marker of vulnerability, focusing in order to increase access to emotional experience, and self-soothing to be able to calm or soothe painful emotions (see Chapter 2 for a discussion of tasks).

As EFT therapists listen and interact with their clients, they also begin to observe how clients respond to specific events and to tailor their treatments so that interventions are relevant and meaningful. For example, a therapist might observe that a client consistently compares himself to others with similar roles or status and feels he comes up short. He then finds himself feeling depressed and on edge. Listening to the client's life story, the therapist may learn that the client's father was an alcoholic who was not directly critical of the client but generally disapproving and dismissive and that his mother was physically "available" but emotionally distant. At the same time, the therapist may also observe that the client habitually invalidates his moment-to-moment experiencing and constantly pushes himself to be better and do more, regardless of how he is feeling or what he needs.

The First Session

This section outlines what an EFT therapist might typically cover in the first session. For the most part, the topics described are relevant at the outset inasmuch as they impinge on the relational and behavioral issues. In listening to problems, we are guided by and tend to follow that which is emotionally salient. These areas give us greater insight into current emotional processing and functioning and suggest topics that may need to be addressed.

Appropriateness of Therapeutic Treatment

Therapists should ascertain whether EFT is appropriate and whether it is advisable to supplement it. EFT therapists see themselves as integrative and open to combining EFT work with other forms of treatment if clinically indicated. Thus, EFT work may be combined with family-based treatments in the case of eating disorders (Dolhanty & Greenberg, 2008, 2009; Robinson et al., 2013; Tschan et al., 2010), motivational interviewing in the case of addictions (Miller & Rollnick, 2012; Westra, 2012) and dialectical behavior therapy (Pos & Greenberg, 2010; Warwar et al., 2008) in the case of personality issues. In addition, EFT may best be done at a particular phase of treatment. For example, it may be advisable for a client with anorexia nervosa to go through a residential treatment program that directly addresses eating behavior and attain a normal weight before beginning a phase of emotion-focused work. On the other hand, a therapist may determine that a client is showing signs of cognitive deficits and refer the person for a neuropsychological assessment. Alternatively, a client reporting severe psychotic disturbances or dissociative tendencies must be referred for a more suitable treatment. Decisions about how to proceed with treatment are co-constructed in consultation with the client.

Precipitating and Maintaining Factors

Precipitating and maintaining factors are not formally assessed at the outset but are rather considered part of the narrative that is heard at the beginning of therapy. Important precipitating factors are thought to emerge in the course of unfolding narratives. It is assumed that relevant aspects of client history emerge throughout the process of building the therapeutic relationship through emotional exploration and deepening of experience. Emotional work activates the relevant episodic, autobiographical memories that reveal the maladaptive emotion schemes that become the focus of therapy. Through therapy, important early experiences are accessed and explored and their meaning integrated or transformed. In therapy, this happens through the process and not through a set of questions asked at the beginning of therapy. When such topics emerge, however, they are of interest to therapists and may contribute to greater understanding of the source of emotional pain or the core emotion scheme.

Maintaining factors are addressed when they are relevant. EFT is a response-based approach. Factors that "maintain" current problems are seen as learned survival strategies. People have creatively responded to difficult problems that they have encountered in a manner that has helped them survive but not necessarily thrive. For example, comfort eating that has become

habitual in the case of a binge eating disorder would be understood as an emotional process: It is the most adaptive response one has been able to construct, but it is maladaptive in some manner. Therapy includes an exploration and deconstruction of those emotional responses in order to access their adaptive components, such as (in the case of binge eating) the need for soothing or comfort. We work to help clients construct new, more adaptive emotions that in this case would include recognition of the need. We then help them develop new strategies to meet those needs such as form example, the engagement in self-soothing, compassion, and care that that does not involve destructive eating.

Attachment and Identity History

Given the importance of experiences of childhood attachment relationships and family-of-origin experiences in forming people's views of themselves and their relationships (Fosha, 2000; Greenberg & Goldman, 2007; Watson, 2010), we are interested in people's core attachment and identity histories. Thus, therapists are likely to address this in a first session if clients do not broach this topic on their own. (For details about how this is ascertained in the context of case formulation, see the section on Step 4 in this chapter.)

Emotional Resilience and Resources

It is well established that some clients are more resilient than others (Brom, Pat-Horenczyk, & Ford, 2009), and this is considered at the beginning of treatment. Some clients emerge from chaotic or traumatic backgrounds with a particular emotional resiliency, resolute and determined to succeed and thrive. Others feel less able to encounter the many challenges and hardships that everyday life presents and recount a string of suicide attempts, a series of chaotic and unstable relationships, engagement in self-destructive behavior such as drug use or cutting, multiple hospitalizations for clinical disorders, or many years on psychotropic medication that they have no intention of giving up. Early experiences are deemed important, and therapists want to know what emotions they felt in relation to the situations, what emotions continue to linger, and how they regulated such emotions then and now. Those who emotionally collapsed and turned to drug use or attempted to take their own life are seen as having fewer emotional resources and needing more specific help with emotion regulation, at least initially. The work for this type of client might well be to integrate traumatic experiences into a "survivor" identity. In part, client resources are assessed at the outset to ensure that clients have the necessary supports to endure a temporarily destabilizing, unbalancing process

and that they possess the necessary resilience to overcome obstacles or roadblocks that may present during the therapeutic process.

Environmental, School, or Peer Group Experiences

EFT therapists hold the view that certain early environmental experiences can be equally formative in development as early attachment histories. Thus, we are curious about such factors particularly if they emerge at the outset of therapy. Research has established that peer relationships significantly shape development and that persistent difficulties with peers increase the chances of clinical disorders later in life. Children come to know themselves partly from how they are treated by peers (Parker, Rubin, Erath, Wojslawowicz, & Buskirk, 2006). EFT therapists will therefore be interested in experiences in school or with peers in general. This would include stories of being bullied, socially outcast, or rejected. Such experiences can be strongly internalized so that a person comes to live with an ongoing fear of rejection or shame. These experiences may have been especially traumatic if reinforced by ongoing experiences of rejection felt throughout childhood by developmentally significant adults or siblings, or if competent and caring adults were not available to help negotiate such experiences.

Religious experiences are also of potential importance, particularly when they have dominated people's social and moral understandings of their identity. In particular, religious experiences that include negative expressions toward a sexual or gender identity may foster in clients a strong sense of rejection and shame.

Previous Therapy

At the outset of therapy, EFT therapists are interested in prior therapy experiences. We might ask about previous therapy relationships and experiences to gain insight into one's relational style and better understand what clients may be looking for in a therapist. Relational style is not seen as fixed, however. For example, we do not assess for an anxious versus an avoidant relational style, assuming that the same dynamic will express itself in the therapeutic relationship (Goldman & Greenberg, 2013). This would be seen as overly reductionistic and not in keeping with our constructivist view of human functioning (Greenberg & Pascual-Leone, 2001). A client who has not had a prior positive experience in therapy cannot be assumed to be "difficult." Experiences are understood at face value (Elliott, Watson, et al., 2004). It is possible that a client has not found a therapist or a treatment that he felt to be "a good fit." Therapists are interested to know what clients found difficult in their prior experiences so that they can learn how to meet the needs of their clients.

STEP 2: LISTEN FOR AND IDENTIFY POIGNANCY AND PAINFUL EMOTIONAL EXPERIENCE

As we unfold clients' problems and related stories, we are guided by two major criteria that can be expressed as questions that we implicitly ask ourselves: What is most poignant in the story—what moves us and pulls at our heartstrings? A related question—what is the pain that brought the client to therapy? In other words, what is the pain that ails them or propelled them to enter therapy at this particular point in time (assuming they are in therapy of their own volition)?

What may be painful may also be poignant (and vice versa), but the two feelings are different. We discuss them as two separate factors that guide our listening at this stage and throughout therapy.

Poignancy

A fundamental distinguishing feature in EFT is the ongoing focus on the client's current internal world. Meaning is unfolded with an emphasis on the present impact of the events on the client's inner subjective emotional world. Here, therapists are guided by poignancy; those stories that are emotional tinged with meaning and in some way move or "pull at the heartstrings" of the therapist are reflected back, deepened and further explored to identify core painful emotions. This is poignancy. It is one of the major criteria that guide us in being able to capture, from all the complexity of what the client says, what is most important. We believe that clients will tell us what is most important and that the task at this stage is hearing it. Rice (1974) first discussed poignancy as a criteria that guides therapist responding in her seminal paper titled "The Evocative Function of the Therapist":

> Poignancy, or liveness, seems to be the therapist's best guide. How then is poignancy recognized? How can we recognize that the client is moving into an "unfinished" experience? . . . The most obvious sign is that the client feels something inconsistent or discomforting in the situation. In other cases, a kind of intensity comes through in the voice. On the other hand, the feeling may not be especially intense but the client may feel that he somehow can't quite assimilate the experience. (p. 304)

In other words, as clients talk we hear, from among the many things they are saying, something that stands out with more force or concern behind it. It captures our interest and attention and compels us to move toward it. This might be represented by a change in vocal quality. There may be stronger emotional intensity in the body, facial expression, or physical posture. There may be stronger emotional expression perhaps in the form of cries of distress

or explosions of anger. Or there may be confusion or puzzlement combined with a sudden, more diffuse or vague presentation. These are all indications of poignancy. Another way of thinking about this is to compare it with being immersed in a good novel or film. At a particular moment, we are suddenly drawn further into the plot (Martin, 2010). As we read or watch, we are moved inside and there may indeed be a reference point in our body for this. This may indeed be visualized and felt by the therapist in the form of a twinge in the chest that indicates that something is important or meaningful in what the client is describing. It somehow captures your attention and compels you forward.

The Pain Compass

EFT therapists have adopted the notion of a "pain compass" that we carry through our therapy sessions. It can be likened to a magnet for painful experience, particularly the client's emotional responses. The compass directs the therapist to an area on which to focus attention. Identifying and articulating the problematic affective–cognitive processes (primary goal of Stage 2 case formulation) always begins with the identification of the client's chronic enduring pain (Bolger, 1999; Greenberg & Bolger, 2001; Greenberg & Paivio, 1998), which sets the goal of the treatment (i.e., resolution of the painful issue). Beyond signaling distress and a need for comfort from the other, pain is a strong cue for us that something has broken down or is no longer working. In terms of case formulation, we guide ourselves toward pain as it provides windows into experience and lets us know what requires further exploration and change. We are drawn toward pain and at first are eager to affirm and explore it. Eventually we help clients change it. We "hear" people's pain through a variety of sense mediums, including seeing, listening, and sensing. Acknowledgment and affirmation of pain helps people feel connected and begin to reveal what is important about their experience. This also serves a validating function as we communicate the importance of experiences that clients may have minimized or devalued. Accurately hearing another's pain helps them bring experience to life so that it can in fact be deconstructed and changed if necessary. We most definitely endorse the powerful healing function that can occur when one human hears and acknowledges another's pain, and we see therapy as facilitating this process (Egendorf, 1995; Fosha, 2000). Although the therapist cannot "make it all better," we do believe that the therapeutic relationship can help others both live with and heal pain.

Beyond hearing and affirmation, we believe that pain can be alleviated through the therapeutic relational process (Greenberg, 2002a) and that the exploration of painful feelings (e.g., a sense of low self-worth) can lead to transformation and an alleviation of painful feelings. It is the shared witnessing of

the painful experience by the therapist and the validation of it that brings relief. In fact, one of the core EFT tasks (see Chapter 2) is devoted to listening to pain and providing affirmation. We call this *empathic affirmation at a vulnerability marker*, and it has been studied extensively through task analysis. It involves providing sheer empathy; staying with a person as he or she hits "rock bottom" and reemerges, affirming a stronger relational stance and an appreciation of the therapist for staying the course (Keating & Goldman, 2003). Again, we do not expect to engage in tasks at the very early stages of therapy, although this task highlights the importance of accepting and validating painful experience as an independent change mechanism. Should clients present a marker of vulnerability in the first few sessions of therapy (and they are not likely to do so until greater relational safety is formed), the therapist would "stay with them" in an affirming mode, not engaging in a task but rather continuing in a validating and affirming mode. We thus "move toward" pain as it is seen as rich in meaning and providing opportunities for further exploration, transformation, and healing. At this early stage, we are drawn toward pain and poignancy, and this guides the process of formulation.

STEP 3: ATTEND TO AND OBSERVE THE CLIENT'S EMOTIONAL PROCESSING STYLE

Attention to emotional processing style helps the therapist determine the client's emotional accessibility and immediate amenability to EFT and whether more specific work is needed to increase emotional accessibility. The therapist assesses the client's ability to name and symbolize emotions or the degree of alexithymia. This section describes the features and dimensions of manner of processing that are considered and the criteria that have been developed to help therapists make these determinations.

Affective Meaning States

Pascual-Leone and Greenberg (2007a) and Pascual-Leone (2009) have shown that most clients in experiential therapies present with predominantly global distress and oscillate between maladaptive (e.g., global distress) and adaptive (e.g., self-soothing) emotions. This process of change and movement through different affective meaning states is nonlinear and may take various "paths." Progress occurs when clients experience new adaptive affective-meaning states, positive self-evaluations, and a sense of agency. Successful therapy also includes the client's ability to identify emotional concerns and an overall growth over time toward more adaptive emotion processing of distress (Pascual-Leone, 2009). Global distress is characterized by a feeling of

pain, hopelessness, helplessness, complaints, self-pity, confusion, and despair. Clients in this stage are usually in a state of high expressive arousal (e.g., tears, emotional voice) and low specificity in meaning (e.g., the object of distress is often unknown, the client has no sense of direction). Typically the marker of global distress emerges suddenly, the person becomes dysregulated, and the specific concern at hand is often vague and global. Sometimes, when therapists initially explore, they explicitly state that they do not know why they are feeling so inundated with distress. For example, a client might say, "I feel hurt, miserable, and angry and I'm tired of it. It's so overwhelming," followed by, "I don't know what that pain is."

EFT therapists are familiar with this process and the different affective meaning states. At any given time they are able to identify whether the client is in a state of global distress or another state such as fear, shame, or unacknowledged anger. Case formulation then involves both an assessment of where a client is in the process toward change, an assessment of what might be missing, and future directions that might be taken.

Therapy that does not promote experiencing and exploration of underlying maladaptive emotions is likely to stagnate or fail. The general sequence of change progresses from global distress, through to secondary emotion, then to maladaptive emotion, after which an expression of need occurs, and eventually primary emotion is accessed (Pascual-Leone & Greenberg, 2009). At this stage of case formulation, therapists are assessing whether (and to what extent) global distress is different than maladaptive fear or shame. For example, they might consider whether a client's particular expression of tears has the quality of global distress (i.e., said in a wistful but hollow, high-pitched, whiny tone, "It seems like I am just not the kind of person who can be loved") or primary maladaptive fear (e.g., "maybe I am just not that lovable.").

When a client makes an emotional expression, the therapist must determine whether the emotional expression is primary, secondary, or instrumental (Herrmann & Greenberg, 2007). For emotional processing to be productive (a primary aim of therapy), only primary emotions should be explored. Thus, the EFT therapist must know how to determine what type of emotion is being expressed in order to proceed. Based on the explanation of differences between primary adaptive, maladaptive, secondary, and instrumental emotions given in Chapter 2, the following criteria are used in formulating these moment-by-moment emotional assessments:

1. Nonverbal expression, including facial expression and tone of voice, is observed, as is manner of expression. When adaptive emotion is expressed, there tends to be a natural body rhythm and the person's whole system appears coordinated and congruent. (This is discussed in the section Emotional Productivity.)

2. Therapists also have knowledge about universal emotional responses. Thus, we know that when people are violated, they are angry and that when they lose someone important to them, they are sad. As therapists, adaptive emotional responses make sense to us and we naturally reverberate to them. So with each emotional expression made by clients, we are implicitly asking ourselves, "Is this anger boundary setting or a destructive lashing out?" "Is hurt expressed when they don't get what they want or are they mourning a loss?"
3. Therapists also use knowledge of their own emotional responses to circumstances and emotional awareness to assess client's emotions. EFT therapists have engaged in their own therapy and personal growth work fairly extensively and thus rely on their own experiences to tell them what clients are feeling. Thus, as clients describe their experiences, we ask ourselves, "What might I feel in my body?" or "What would I feel in their situation?"
4. Over time, through listening to client stories, therapists start to hear characteristic ways in which clients respond. Thus, we may come to know that when they feel dismissed by another, they tend to feel diminished and get angry. Or when they feel rejected, they become angry, even though they are very shame ridden. As we have observed these processes in the past, we quickly are able to validate the secondary responses (anger in both examples) and then focus on the underlying shame.
5. Therapists are always keenly aware of what's going on in the session and give most precedence to currently felt emotion even when it is a response to an event that occurred outside the session. Thus, the context of the session allows us to read what has just been experienced and ask ourselves what is missing or how clients have got stuck in the past. For example, a client who becomes hopeless and sad when describing an abusive person is helped only to a certain point by focusing on those feelings; should the same situation arise again, we might instead raise the possibility of unexpressed anger.

We thus think of therapists as emotion navigators. Therapists are always coexploring client's experience with curiosity and interest. Case formulation always involves a series of questions that therapists ask themselves, for example, "In this emotional experience, what was missing previously?" "When we follow it, do they become stuck in it?" "What happens after they express it?" "Does deepening it allow it to change or do we need to engage a particular

task to help them transform it?" "Does it change?" The answers to these questions inform our next steps.

In observing emotional processing style, then, therapists are making moment-by-moment judgments or diagnoses (Greenberg, 1992) about how clients are processing emotion. The following four process cues and factors are considered in this step: client vocal quality, degree of emotional arousal, levels of experiencing, and the productivity of the particular emotion.

Client Vocal Quality

Formulation involves distinguishing, in a given moment, the quality of the client's voice. Client vocal quality has been divided into four mutually exclusive categories, describing a pattern of vocal features that reflect the momentary deployment of attention and energy of the speaker (Rice & Kerr, 1986; Rice & Wagstaff, 1967). Each of the four categories—focused, external, emotional, and limited—describes a particular type of participation and can be detected by attending to the following aspects: accentuation pattern, regularity of pace, terminal contours, and disruption of speech patterns. *Focused voice* indicates that the client has turned inward, is tracking experience, and attempting to symbolize it in words. *External voice* is indicated by an even, rhythmic tone and of energy turned outward. It has a prerehearsed, speechlike quality and indicates a lack of spontaneity. It may indicate expressiveness, but it has a "talking at" quality. It is unlikely that content is being freshly experienced. *Emotional voice* is indicated by emotion breaking through in the voice as the client talks; it is characterized by "an overflow of emotion into a speech pattern" (Warwar & Greenberg, 1999, p. 5; see also Rice, Koke, Greenberg, & Wagstaff, 1979). *Limited voice* often sounds squeaky and reveals wariness, indicating that affect is being strangulated and that the speaker perhaps finds trusting difficult. The presence of focused and emotional voice has been found to predict positive outcome in experiential therapy (Rice & Kerr, 1986; Watson & Greenberg, 1998). Knowing the outcome of research, when clients express themselves with a low proportion of focused and emotional vocal quality overall, therapists work to encourage them toward higher proportions of each.

Emotional Arousal

Case formulation also involves moment-by-moment assessments of levels or degrees of emotional arousal. Therapists understand emotional arousal in terms of degrees of intensity in the voice and body. An understanding of emotional arousal is derived from the Emotional Arousal Scale (Warwar & Greenberg, 1999), which assesses the quality and intensity of client emotions based on an evaluation of the client's degree of arousal in the voice and

body and the degree of restriction of expression. When assessing emotional arousal, therapists think first about whether a primary emotion is identified and second about the overall level of intensity of the client's primary emotion. Higher degrees of emotional arousal (measured on the scale) indicate higher arousal intensities. In extreme forms, emotional arousal is extremely intense and full in voice and body. Usual speech patterns are completely disrupted by emotional overflow. Arousal appears uncontrollable and enduring. There is a falling apart quality. Low arousal indicates that a client does not express emotions; voice or gestures do not disclose any emotional arousal. Moderate arousal is moderate in voice and body; ordinary speech patterns are moderately disrupted by emotional overflow as represented by changes in accentuation patterns, unevenness of pace, changes in pitch. However, although there is some freedom from control and restraint, arousal may still be somewhat restricted. Research has shown that moderate levels of emotional arousal in combination with meaning-making, rather than pure high emotional arousal, predicts positive outcome in experiential therapies (Carryer & Greenberg, 2010; Missirlian et al., 2005).

In the beginning of therapy, therapists are particularly aware of whether clients are able to achieve any emotional arousal. A complete lack of emotional arousal indicates alexithymia, which in turn indicates that more work needs to be done to access bodily based emotional experiencing. As therapy progresses, assessments of emotional arousal continue. Therapists are more alerted when clients can never achieve any emotional arousal even when talking about meaningful and significant events or topics. An example is a client who was heavily berating and criticizing herself in a contemptuous, abusive manner (e.g., "You deserve to bleed and have bruises all over your body"). When asked what she felt in reaction, she said, "nothing," and perhaps more importantly showed no expression in her face, voice, and body. This would indicate that further exploration of bodily felt experience is necessary.

Client Experiencing

Client depth of experience is assessed with the Experiencing Scale (Klein, Mathieu, Gendlin, & Kiesler, 1969), a 7-point annotated and anchored rating scale that has been widely used in research to evaluate the extent and quality of clients' exploration of their inner experience to achieve self understanding and problem resolution. The Experiencing Scale has been studied extensively and related to positive outcome in therapy. Research has shown that higher depth of experiencing during therapy, expressed while clients are talking about thematic issues, is related to positive outcome in EFT (Goldman et al., 2005; Pos, Greenberg, Goldman, & Korman, 2003) and the finding of a positive relationship between experiencing and outcome holds across other

therapeutic modalities (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996). Adams and Greenberg (1999), found that client–therapist interactions that were high in experiencing increase the chance of client experiencing being high by a factor of 8 and that this was predictive of positive outcome.

When clients enter therapy, therapists become aware of clients' capacity for experiencing. Therapists notice when clients are continuously low on the Experiencing Scale. For example, the therapist will offer empathic reflections and explorations and subsequently observe whether clients respond by focusing inward (i.e., "I feel so torn up inside") or continue to focus externally (i.e., "You know, I didn't know when he was going to come home"). That is, they notice that clients are reporting on meaningful events of their lives without any sense of depth of engagement and without personal meaning or subjective emotional involvement. Therapists continually reflect on the client's inwardly felt, subjective experience throughout the session. When such efforts do not succeed, however, the therapist will take a step back and work to understand what might be blocking the client and consider how to work on deepening the client's emotional experience.

Emotional Productivity

One of the key judgments that EFT therapists make in conducting case formulation and observing emotional processing style is whether emotional processing is productive (Auszra & Greenberg, 2007; Greenberg, Auszra, & Herrmann, 2007; Herrmann & Greenberg, 2007). In part, this judgment is informed by assessments of levels of experiencing, arousal, and vocal quality, but it also involves higher level judgments about the nature of emotional expression, defined here as observable, verbal, and nonverbal behavior that communicates or symbolizes emotional experience (Kennedy-Moore & Watson, 1999) and that can occur with or without self-awareness.

Case formulation is first guided toward assessing whether an emotion is activated through a focus on verbal and nonverbal expression. That is, if the client verbally expresses emotion, the therapist has to determine whether the client is simply talking about an emotional experience or intellectualizing or whether there are some signs, either verbal or non-verbal, indicating that an underlying emotion-schematic structure is "up and running."

Nonverbal emotional behavior is present if an expressive action tendency is present, such as clenching of fists (as in anger), shrugging or clear and distinct sighing (as in resignation), shrinking back (as in shame or fear), or crying (as in sadness or pain). This also includes clear and distinct facial expressions in line with the characteristic facial expressions laid out by Ekman (2003; e.g., distinct wrinkling of the nose and a raised upper lip, indicating

disgust). Nonverbal behavior is judged in combination with verbal content that fits the emotion expressed facially.

When a determination is made about the type of emotion being experienced, formulation involves judgments about whether an activated primary emotion is being processed in a contactfully aware manner. Therapists make this assessment using seven dimensions: attending, symbolization, congruence, acceptance, regulation, agency, and differentiation. Clients may have difficulty on any of these dimensions, and this provides an indication of how productive emotion processing is at present as well as pointing to areas that require attention. When an emotion is considered productive on all of these dimensions, the client can be said to demonstrate emotional productivity.

Attending

At a basic level, formulation involves checking to see whether clients are attending to emotions. Thus, the client has to be aware of his or her emotional experience and attending to it. Symbolized emotional reactions are not necessarily being attended to in awareness. Thus, the therapist looks to nonverbal expressions to determine whether a client is attending to an emotion. Nonverbally expressed emotions are considered attended to unless there are clear indicators that the client is not aware of and does not attend to what he or she is feeling. Thus, the therapist might empathically reflect emotional expression to bring attention to it and check whether client is attending. For example, in an empty-chair task, a client might make a fist while talking to an abusive parent in the other chair. The therapist might ask whether the client is aware of making a fist, thereby bringing the action to the client's attention.

Symbolization

Therapists assess whether clients attend to and are aware of their emotional reactions or resort to symbolizing them in words. Sometimes clients symbolize their experience even if they don't name it; in therapy, they are helped to clarify it. For an emotional experience to be considered symbolized, the client simply has to be engaged in the process of describing it in words. For example, a client might say, "I don't really know how I feel about this issue. All I know is that I am not happy about what happened." The therapist might respond, empathically, "It just didn't feel right?" and the client could say, "Yeah, it wasn't fair. I guess that is what it is. It just feels unfair. He shouldn't have treated me that way." This would constitute symbolized emotion. On the other hand, a lack of symbolization is indicated when a client attends to and acknowledges a nonverbally expressed emotion (e.g., a sigh) but cannot elaborate on its meaning.

Congruence

When therapists sense emotion incongruence, they are drawn toward it. For example, a mismatch may occur between the emotional expression and the reported content (e.g., laughing while talking about having been abused indicates an emotion is not being fully experienced). Other examples of mismatch or incongruence include smiling brightly while talking about feeling miserable and hopeless, appearing fully crushed and speaking in a meek voice when expressing anger, and laughing while talking about being angry. Mismatches become very focal for EFT therapists. When therapists formulate incongruence, they know they need to bring incongruities to awareness but without damaging the emotional therapeutic bond or threatening the client. The goal is not to get clients to defend such incongruities but rather to become curious, together with the therapist, about how they occur or what they mean.

Acceptance

Case formulation at this microlevel also involves assessments of whether clients are accepting their emotions. *Acceptance* refers to the stance the client takes toward his or her emotional experience. It is best for clients to assume an exploratory attitude toward their emotional response and listen to it in an open and receptive manner. This means that they accept both the emotion and themselves for having the emotion. *Nonacceptance* is indicated by the client negatively evaluating himself or herself (e.g., "I hate it when I get so weepy"; "Feeling this way just shows how weak I am") or expressing discomfort instead of fully expressing the emotion (e.g., blushing, squeezing back tears, laughing, switching the topic, moving to a purely rational level of analysis).

Regulation

As part of case formulation, therapists assess clients' ability to regulate their emotional experience appropriately (Paivio & Greenberg, 2001). Overregulation is indicated when clients cannot identify emotions at all and stare back blankly in response to empathic reflections and exploratory questions. Underregulation of emotion is indicated when clients are unable to develop and maintain a working distance from the emotion (Gendlin, 1996) and to cognitively orient toward it as information, thus allowing for an integration of cognition and affect. Clients have to be able to make sense of the emotion. Indicators that a client is overwhelmed by the intensity of the emotional arousal include an inability to maintain contact or a loss of contact with the therapist, or the inability to respond to the therapist's interventions (e.g., entering into a dissociative state), or the inability to control the intensity of his or her emotional arousal. Such clients cannot respond to the therapist's empathic

reflections or exploratory questions because they are awash with emotions (typically anger or sadness). When therapists detect such dysregulation, they should focus on it. For overregulation, the therapist might decide to conduct focusing work (Elliott, Watson, et al., 2004) or introduce the self-interruptive task (see Chapter 2); for underregulation, more self-soothing might be necessary.

Agency

As part of case formulation, therapists assess the client's self-perceived role in the emotional change process. Ideally, the client needs to take responsibility for the emotion as opposed to taking the stance of a passive victim. This means acknowledging that the emotional response is a personal construction of self and reality based on his or her personal goals, needs, and concerns in a particular situation. It also means that the client is willing and motivated to actively work with the emotion (exploring it, using it as information, reflecting on it). Indicators that a client is taking the stance of a victim include attributing responsibility for the felt emotion to external sources, which ignores the inner flow of experience. Clients who lack a sense of agency will attribute responsibility for the felt emotion to external sources (e.g., "My husband always makes me feel so sad"); they will engage in blaming behavior when they are angry; they will focus on the actions of others when they are hurt ("My children don't love me and it hurts not to be loved"); and they will attribute responsibility for resolution on others (e.g., "If I find someone who loves me, I will feel better"). Moreover, clients who lack agency see themselves as incapable of changing how they feel and are not motivated to work toward change. They interrupt the emotional experience (e.g., by changing the focus of therapy), they express resignation, or they treat the emotion as a symptom that they want to be rid of without doing the required work.

Differentiation

Case formulation involves an assessment of the extent of change in the client's level of emotional awareness. Over time, one expects to notice increasing awareness, as indicated by the client verbally differentiating an initial emotional reaction into more complex feelings or meanings or into a sequence of other feelings or meanings (Lane & Schwartz, 1992). It is important to note that differentiation does not only refer to the cognitive side of the meaning-making process; it could also mean that an emotion is more fully allowed or more freely expressed or that its expression changes.

For example, if a client responds to an abusive other by freezing in fear and then crying, the emotional process is moving forward and fluid, even if this is nonverbal and not yet accompanied by words. The client's emotional

processing is stuck or blocked. The client freezes to control strong emotional reactions and is not able to elaborate, explore, or reflect on them. By expressing a distressing emotion and not being able to go beyond a basic symbolization, the client expresses a lack of differentiation (sadness and nothing else).

STEP 4: UNFOLD THE EMOTION-BASED NARRATIVE/LIFE STORY (RELATED TO ATTACHMENT AND IDENTITY)

We are focused on forming a coherent picture of our clients' problems. We want to know the story that lead up to them making the decision to come and what they want to change. We are interested in whether the stories clients tell possess coherent meaning; when they do not, we inquire further. Clients most often begin by revealing the story of what is happening in their current life. As therapy progresses, the process quickly moves to what is specifically problematic and the maladaptive emotional processing that drives it.

When clients sit down with us, they relay their relational and behavioral difficulties, such as high conflict or distress in relationships or feelings of depression or boredom at work. Then they begin to tell their story. We listen to the story intently, being particularly moved by the emotional tone that pervades it. The emotional tone of the narrative appears to be one of the ways in which personal memories and narratives are linked to each other. Through the stories clients reveal to us what they feel, along with implicit needs or concerns that may or may not have been addressed. These elements form the narrative framework around which emotion is organized (Angus & Greenberg, 2011; Angus, Lewin, Bouffard, & Rotondi-Trevisan, 2004). In other words, we listen to the unfolding content of the story but are guided by the emotion that pervades the telling of it. As clients describe their current relationships or early childhood, we ask ourselves: Are they sad, angry, exuberant, or emotionally distant? When they tell us of a recent interaction with a spouse, we wonder: Do they sound sad and lonely, angry and distant, or happy and fulfilled? Especially at the beginning of therapy, we are attentive to the manner in which they unfold their stories because clients tend to reveal what is problematic through the manner of telling. We are also interested in how this might be related to their attachment history. When a client tearfully describes a current relationship and feels unable to be vulnerable without mentioning past family relationships, therapists might ask, "I wonder when you started feeling this sense of fragility" or "Who, when you were growing up, made you feel like you did not matter or your feelings were not that important?"

If exploration of current problems and relationships does not lead to exploration of past significant relationships, therapists ask about family history and constellation. Thus, a therapist would specifically want to know

who the client lived with, the family constellation, whether the family went through death or divorce, and which relationships had most (positive or negative) impact. We would also want to know whether there is one particularly problematic sibling relationship that was developmentally influential, again, in either a positive or negative manner.

For example, a client who came to therapy was one of seven children and fourth in the birth order. She was sandwiched between a sister who was 1 year older and described as mean and bullying and two younger twins who garnered a great deal of their mother's attention. The father was described as emotionally absent. Through initial exploration, it became clear that she felt unimportant and dismissed in current relationships, particularly in her relationship with her significant other. Explorations of current relationships continued to lead back to early experiences, particularly a preadolescent phase where the client felt particularly awkward and socially outcast. She craved her mother's nurturance and attention but felt lost between the repressive older sister and the two needy younger twins. Thus, birth order and family constellation were meaningful and important. The therapist took note of it in the first session but placed greater emphasis on it later in therapy when emotional exploration continuously led back to memories of these earlier times. It was then that she understood how formative such experiences were.

On the other hand, if clients' backgrounds were particularly chaotic and fraught with conflict or trauma, therapists also inquire at an early point as to whether there was one significant relationship, even if it was a distant aunt or grandparent, that the client experienced as positive (i.e., someone who made him or her feel particularly loved or regarded; Sandler, 2011). This knowledge can become important information. Later in therapy, when clients are recounting painful, traumatic memories or accessing fragile, vulnerable feelings and cannot access positive feelings toward themselves or remember ever receiving this from anyone, the therapist might inquire about this particular relationship. Accessing the emotional memory of feeling loved at this particular moment may help forge new neural connections so that feelings of self-pride or love are accessed in the future rather than sadness or grief (Fosha, Siegel, & Solomon, 2009).

Therapists become curious when clients tell stories of early upbringings that are particularly unstable, chaotic, and abusive. In severe cases of past instability, therapists want to understand whether clients have achieved stability (and if so, how that came about). Again, clients who experienced severe trauma or abuse may require more time to form the emotional bond and build the therapeutic relationship, and therapy may not involve task work until greater internal stability and self-structure has been formed. Task work may also be adapted or altered depending on differential capacities for self-regulation (Pos & Greenberg, 2010).

We are interested in hearing what stories are important to clients, because stories carry emotional themes. At this beginning stage, themes are not fully formed. We do, however, listen through the narrative to themes related to issues of either attachment or identity. We see both attachment and identity as fundamental (Greenberg & Goldman, 2008) in people's lives. Attachment concerns are revealed in the stories of relationships with others, whereas identity concerns reveal how they feel about themselves. Core emotional concerns organize around these two themes. Thus, we may hear that clients feel happy or grateful when they are relaying narratives of situations in which they see someone as having been kind to them, feel angry or scared when their partner is angry, or when they see others as intending to hurt them (attachment related). On the other hand, a story where they feel bad about a performance review at work, or a coworker in a stronger position of authority getting angry with them may reveal them to be very self-critical and this would be more related to identity themes. Listening to client stories helps us hear the main emotion themes. Thus, when they tell a story about a romantic experience, we ask ourselves what is "really going on" in their inner world and assess what the experience is subjectively like for them. What are their intentions, purposes, goals, hopes and desires? If they describe finding a partner untrustworthy and attribute sinister motives to their actions, we ask about what they fear or resent (attachment-related concerns). If they often feel put down by others, we may ask ourselves how to understand their sensitivity to criticism by others, and wonder if they have a negative view of themselves. The narrative organization of emotional experience allows one to understand what an experience means to the client.

Themes of attachment and identity are also attended to on the interpersonal, interactional dimension. In addition to the more subtle indicators of approach and avoidance, shyness and expressiveness, we specifically note at this early stage what the client's behaviors are indicative of on the two interpersonal dimensions of connectedness (closeness and distance) and influence (dominance and submission). Is the client sensitive to intrusion or control? Is she or he seeking contact or even clinging? Is the client very leading or defining of the relationship or highly following and making appeals to be led?

Exploration of current narrative constructions provides windows into how clients perceive and make sense of their lives. They reveal their relations with themselves and with others. Revealing the story helps make space for the type of self-reflection that helps unveil underlying determinants. The case formulation process moves clients from these initial attachment and identity-related themes through to the next stage where the core emotion scheme, embedded in the stories, is revealed and articulated. By the end of Stage 2, therapy themes emerge and coalesce and they may in fact be related to these initial attachment- and identity-related themes. At the beginning,

themes are generally revealed only at level of conceptual symbolization. Underlying emotion in relation to these themes must be explored and the emotion scheme unpacked. This does not happen, however, until through the second stage of case formulation, once the core pain has been accessed, and the core emotion scheme has been identified and explored.

At this point in the process of formulation, themes have not coalesced or solidified, but collaborative foci are established. Multiple examples of collaborative foci and goals may be formed at this stage. For intellectualizing or avoidant clients, the inability to focus inward and be aware of their experience is the main source of pain, and the very ability to attend to their emotions and make sense of them may become the focus of treatment. For other clients, the focus and the goal might be to acknowledge and stand up for themselves in their jobs and relationships. For clients with low self-esteem, the focus and goal might be to become more aware of and more clearly able to express their feelings and needs. For other dependent clients, the focus and goal might be to assertively express and resolve their resentment at feeling dominated by partners. For anxious clients, it might be to develop a means of self-support. Other clients may wish to address their deep fears of abandonment and insecurities based on trauma or losses in the past. Others may want to work through and face painful existential issues. First, though, underlying determinants in the form of emotion schemes must be explored with the ultimate aim of therapy being transformation. We move forward to Stage 2.

The case of Graham more specifically exemplifies how the first stage and steps of case formulation are conducted. Graham came to therapy because he was tired of feeling panicky, frustrated, and out of control. A small business owner, he found himself feeling frustrated in his interactions with coworkers and employees; he judged himself as disrespectful, a bad boss, and a bad coworker. In his marriage, he lived in fear of disappointing his wife. He had met her in a foreign country, and together they had moved to a U.S. city. He constantly worried that she would become unhappy and move back her country of origin, leaving him alone. When they would fight, he would get particularly panicky about her leaving. In the past he had struggled with addictions to cocaine and anxiolytics. He felt free of this habit, although he constantly looked for alternative ways to calm and reassure himself.

In observing his emotional processing style, the therapist noticed that Graham's capacity for experiencing was at a low to mid-level, meaning he was engaged with personal material but with a very external focus (as opposed to internally exploring). His vocal quality tended to be external with little focused (eyes turned inward and internally processing) or emotional voice. His capacity for arousal was high, although most of the time he kept it under control during therapy sessions. The therapist observed that his natural style of processing emotions was deemed unproductive as he was not often attending to

his emotion as he talked about it. Graham spent little time symbolizing emotions, and he did not differentiate emotions into a sequence. He tended to be very underregulated rather than overregulated when processing his emotions, although in his natural way of being he avoided processing his emotions. When emotions arose, he would have trouble breathing and become panicky. He most often started sessions with a high degree of global distress and exhibited little capacity for self-soothing (e.g., "I don't know; just everything feels wrong.").

The therapist determined that more specific work was needed to help Graham develop internal awareness of his emotional world, and once emotion was accessed, he would have more capacity to self-soothe. Although the emotion scheme was not yet fully articulated early in the process, the therapist heard his core theme as being nested within the attachment domain. Graham's core maladaptive fear was of lonely abandonment. His parents were perceived as very controlling and emotionally smothering on the one hand but anxious and emotionally unavailable on the other. He told poignant stories of his younger brother being very sick, having been diagnosed with diabetes Type 1, and thus having seizures and nearly falling into diabetic comas. He remembered being very afraid. He recalled one particular memory of being 5 years old and his brother being rushed to hospital. In a panic, his parents had left Graham with relatives. He had a strong painful memory of being afraid they would not come to fetch him. His present-day core concerns related to letting others down or disappointing them (boss, father, wife) and their being upset and leaving him.

Therapy progressed beyond this stage to more clearly identify the core maladaptive emotion scheme and core themes. Specifically, the therapy focused on Graham's need to please others and his core fear of abandonment and being unlovable.

CONCLUSION

In Stage 1, narrative and emotion are interwoven, and clients are in constant motion between them. Clients come to therapy to tell their story. As we listen to presenting relational and behavioral difficulties, through attention to pain and poignancy, and through observation of both the client's experience and our own, we distill the important attachment and identity pieces that form the beginnings of the narrative themes. We listen through the stories to the manner and style of emotional processing as we begin to gain windows into the potential emotional processing difficulties that will eventually be seen as the source determinants of the presenting problems. The next stage is focused on clarifying the exact nature of the core emotion scheme, its different aspects and how it functions in the person's life to create problems.

5

STAGE 2: CO-CREATE A FOCUS AND IDENTIFY THE CORE EMOTION

This chapter presents the theory underlying Stage 2 of EFT case formulation. In this stage, we engage in six major interrelated activities (MENSIT; see Figure 5.1) to develop a co-constructed narrative to understand the clients' experience and difficulties.[1] The first step involves identifying markers of underlying processing difficulties, such as in-session, experiential states of puzzling over a problematic reaction, un-storied emotions, criticizing oneself, or experiencing a lingering bad feeling toward a significant other. The main focus of Stage 2 is the identification of core emotion schemes and accompanying self-organizations. This is usually facilitated by marker-guided intervention that helps the client access underlying feelings to reveal the core painful emotion schemes but may also be accessed by deep empathic exploration. Core schemes can be either adaptive or maladaptive. When the core

[1]This conceptualization has been influenced by Ladislav Timulak (2010) and his students' work on EFT cases.

http://dx.doi.org/10.1037/14523-005
Case Formulation in Emotion-Focused Therapy: Co-Creating Clinical Maps for Change, by R. N. Goldman and L. S. Greenberg

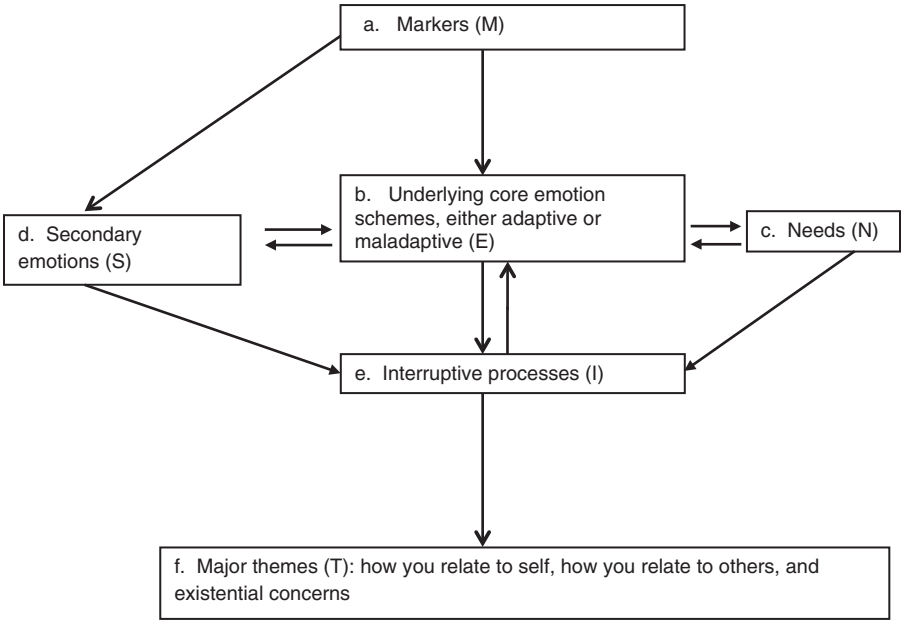

Figure 5.1. Core Elements of Co-Creating a Focus. *Note.* The six elements that are explored in Stage 2 are referred to collectively by the acronym MENSIT, formed by combining the initials of each element.

scheme is identified, the core needs at the center of the scheme and the secondary emotions that obscure the core emotion scheme are also identified. Because the core emotions are often dreaded feeling states, therapists also need to identify the client's interruptive processes that block access to these painful states. Over time coevolved themes emerge.

Emotions carry enactive plots of core relational themes. Many situations that elicit specific types of emotion such as sadness or fear enact core relational themes such as loss or danger. Each emotion arises from a different plot or story about relationships between a person and the environment. Anger involves a sense of violation, shame about being diminished in the eyes of others, and pride in being elevated. The emotion-based narratives that formed around an initial understanding of attachment and identity-related issues become more clarified and solidified in Stage 2. We have found that these emotion-based stories tend to cluster around self: how the self treats the self or how the self treats or is treated by one or more selfs. (Sometimes, however, themes are more about more global existential concerns of dealing with limit situations, such as aloneness, loss, choice, and death.) By the end of Stage 2, through a focus on the MENSIT, narrative themes have formed and are understood in terms of

how they relate to the core behavioral and relational difficulties that brought clients to therapy. Clients also come to understand how the triggering events spark core emotion schemes and how the consequences of their particular style of emotion coping has contributed to their presenting problems.

As depicted in Figure 5.1, the therapist generally starts with identification of a marker, which is an opportunity to intervene in a particular fashion. The aim of intervention is to gain access to the core emotion scheme; however, secondary emotions may be the first emotions accessed, and they should be understood as obscuring the underlying emotion. As the primary emotion scheme and need are approached, the interruptive processes also may become activated and made more apparent. When the emotion scheme and the cluster around it are clarified, the major theme is brought into focus. Note that in the figure, the emotion scheme is placed at the center; it is at the heart of formulation. The other processes surround it, and the bidirectional arrows from and back to the core scheme convey the idea that clarification of each surrounding component helps to clarify the core emotion scheme.

IDENTIFY MARKERS FOR TASK WORK

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 et al., 1993; Rice & Greenberg, 1984). In each session, clients relay the story of what has happened to them and how they feel about the events in their lives. Therapists imaginatively enter and attune to their world and begin to hear client markers, indicators of the client state, the type of intervention to use, and also the client's current readiness to work on the problem. EFT therapists identify markers of different types of problematic emotional processing problems and intervene in specific ways that best suit these problems. Markers and task interventions thus are entry points that provide access to core self-organizations when worked on in a particular way.

The therapist thus is constantly making *process diagnoses*, formulations of what is occurring in the client at the moment and how best to proceed with productive emotional exploration at this time. The therapist then suggests working on tasks appropriate to the markers in order to gain access to the underlying core emotion. Process diagnoses of client markers provides a formulation of the client's current in-session processing difficulties and establishes a focus for the session and (depending on what unfolds in working on it) adds to the development of an overall treatment focus.

Research has demonstrated that particular client in-therapy states are markers of particular types of dysfunctional processing that can be resolved in specific ways (Elliott, Greenberg, & Lietaer, 2004; Greenberg et al., 1993; Rice & Greenberg, 1984). Markers signify particular types of affective problems that are currently amenable to particular interventions. The therapist therefore notices when a marker emerges and intervenes in a specific manner to facilitate resolution of that type of processing problem. We have identified and studied the following markers and affective tasks:

- *Problematic reactions* expressed through puzzlement about emotional or behavioral responses to particular situations indicate a readiness to explore by systematic evocative unfolding, which helps gain access to what is coded in episodic memory but not yet in the condensed narrative of the experience. (For example, a client might say, "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"; this statement takes the client from the remembered experience back into the re-experienced event to access what triggered the reaction.)
- *Conflict splits* are states in which parts of the self oppose one another. Most often one part of the self is critical or coercive toward the other part. For example, a woman who judges herself to be a failure in the eyes of her sisters quickly becomes both hopeless and defeated but also angry in the face of these criticisms.
- *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").
- An *unclear felt sense marker* is demonstrated when a person feels confused and is unable to get a clear sense of his or her experience (e.g., "I just have this feeling but I don't know what it is"). Clients who express confusion are ready for focusing, which helps them symbolize their experience and shift their bodily felt sense.
- An *unfinished business marker* involves the statement of a lingering unresolved feeling toward a significant other (e.g., a client stating, "My father, he was just never there for me, and I have never forgiven him" in a highly involved manner in the first session).
- A *vulnerability marker* denotes an indication of client fragility, deep shame, or insecurity (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").

- A marker for self-soothing is indicated by a state of emotional dysregulation, which is expressed in the form of anguish and familiar despair (e.g., "I don't feel like I am going to be OK, I feel like I could break. I don't feel like I can take care of myself and that is the whole problem. Nobody has ever been there for me and I don't know how.").

A variety of markers of other important research-based problem states and specific intervention processes have been identified: alliance ruptures, the creation of new meaning when a cherished belief has been disconfirmed; trauma narrative, retelling at first disclosure of a trauma; anguish and self-soothing; and confusion and clearing a space (Elliott, Watson, et al., 2004; Goldman & Fox, 2010; Greenberg, 2002a; Greenberg & Watson, 2006; Keating & Goldman, 2003). In addition, a new set of narrative markers and interventions combining working with emotion and narrative have been specified (Angus & Greenberg, 2011): the same old story and focusing on re-calling (re-experiencing) specific event memories; the untold story and empathic exploration of the emerging story; the empty story and empathic conjecture to the implicit feelings; and the broken story and promoting coherence. (For more information about markers and task descriptions, see Chapters 2 and 6.)

A defining characteristic of EFT is the use of specific in-session tasks to address unresolved emotional problems. As EFT therapists listen to their clients' narratives, they identify what specific in-session behaviors are indicators of emotional processing difficulties. The identification of specific client statements as problem markers is informed both by therapists' understanding of the narrative of painful and difficult aspects of clients' experiences that have been inadequately processed and by the client's current verbal and nonverbal manner of communicating.

A focus on underlying determinants and the accessing and working through of maladaptive schemes is aided by the facilitation of client tasks that enable clients to access, explore, and reintegrate previously disallowed or muted self-information. Particular affective problem markers and tasks may become increasingly more central as therapy progresses. Although each marker and task has a specific resolution process and outcomes, all tasks involve activation of the core painful emotion. This creates a type of bifocal lens for formulation. One can organize a case around the type of markers and tasks that characterize the case, or one can think of the case in terms of the core painful maladaptive emotion scheme and self-organization. The former highlights the in-session process and the latter highlights the person's self-organization and underlying emotion scheme. The self-organization and emotion scheme are underlying forms that are common across markers and tasks and therefore have emerged as being at the center of formulation,

although markers and tasks are still an important lens through which to view cases.

IDENTIFY UNDERLYING CORE EMOTION SCHEMES, EITHER ADAPTIVE OR MALADAPTIVE

At the core of the EFT approach to case formulation is the identification and following of the client's core pain (primary emotion). This requires distinguishing between primary, secondary, and instrumental emotional responses (Greenberg et al., 1993; Greenberg & Safran, 1987) and between primary adaptive and maladaptive emotion. EFT therapists develop a pain compass, which acts as an emotional tracking device for following their clients' experience (Greenberg & Watson, 2006) and leads to the core schemes and self-organization. Therapists focus on the most painful aspects of clients' experience and identify clients' chronic enduring pain. Pain or other intense affects are the cues that alert therapists to potentially profitable areas of exploration as they focus on clients' moment-to-moment experience. Embedded with the core painful emotion is the core need or goal that is not being met.

The core pain to which we refer here is a psychological pain, and its phenomenology has been studied in-depth and is well-understood. In a qualitative study of clients' subjective experience of pain, clients described a feeling of being broken or shattered (Bolger, 1999; Greenberg & Bolger, 2001). The clients often referred to their bodies and to deep, dark places and visceral experiences of damage (e.g., like having a part being torn away and left bleeding) or feeling ripped apart.

We define *psychological pain* or *emotional pain* as the experience of being unable to escape a strongly unpleasant internal sensation that comes from a need not being met. When the pain comes from an internal source, the person feels powerless to get the need met or to stop the psychological intrusion or damage and protect oneself, and thus she or he feels helpless. Pain differs from grief, which is a biologically based response to loss, in that pain additionally involves an unmet need that feels important to survival and an attendant feeling of helplessness to get the important need met, whereas grief involves acceptance of the loss and an attendant feeling of compassion and soothing of the self. So we can say that pain is a feeling of being shattered and helpless in relation to the inability to getting an important need met. The central painful emotions that we observe most often are the fear of being abandoned, the sadness of loneliness, and the shame-based feelings of diminishment and powerlessness to protect or sustain self-coherence or identity. Emotional pain is produced when a bond vital to survival and well-being has been broken and one's identity has been shattered.

A key aspect of identifying the core painful emotion involves helping determine whether a core experience once accessed is a primary adaptive emotion (by which to be guided) or a primary maladaptive emotional experience generated by a core dysfunctional emotion scheme (which must be transformed; Greenberg, 2002a). Client and therapist collaboratively need to decide whether a primary emotion is a healthy experience that can be followed as a guide to change or is maladaptive and must itself be changed. If it seems that the core painful emotion is a disowned adaptive emotion such as grief or suppressed anger that enhances the client's well-being, then the therapist guides the client to stay with this experience and be guided by the information it provides. If, however, client and therapist jointly determine that the core painful feeling is no longer functional and does not enhance the client, it is recognized as a core maladaptive primary emotion. When clients in dialogue with their therapists decide that they cannot trust the feelings at which they have arrived (e.g., feeling lonely and abandoned or feeling worthless) as a source of good information, then the feelings must be transformed. To get to a core maladaptive emotion, EFT therapists first listen for what is most poignant in clients' presentations. They also immediately begin to flag or mark the painful life events their clients have endured. Painful events such as abandonment, humiliation, and trauma provide clues as to the sources of important core maladaptive emotion schemes that clients may have formed about themselves and others, and these clues in turn provide therapists with an understanding of clients' sources of pain and vulnerability.

The two master maladaptive emotions, fear and shame, are related to attachment security and identity validation, respectively. In addition, the sadness of abandonment often accompanies the fear of basic insecurity. Other core maladaptive emotions emerge, such as anger from mistreatment, complicated grief, and disgust. According to EFT, only through the experience of these painful emotions can emotional distress 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-organizations. The generation of alternate schemes is based on accessing adaptive feelings and needs that get activated in response to the currently experienced painful emotion. It is the person's response to symbolized pain that is adaptive and must be accessed and used as a life-giving resource.

The core of transformation in EFT thus lies in accessing primary adaptive emotions. The core of formulation is identifying which emotions are the core painful emotions that underlie the presenting problem. The goal is to acknowledge and experience previously inaccessible nonsymbolized primary adaptive emotion and needs. The experience of primary emotion, together with the accessing of the needs, goals, and concerns and the action

tendencies, has a curative effect. When a core primary adaptive emotion is aroused, accepted, and tolerated, it follows its own course, involving a natural rising and a falling off of intensity (Greenberg 2010). Decrease in intensity allows for reflection. Arousal also leads to associations and the activation of many new schemes, especially when attention is explicitly focused on the task of making sense of the aroused emotions. Thus, the combination of arousing, accepting, tolerating, regulating, symbolizing, and reflecting that carries forward the process of change.

A core primary maladaptive emotion is understood to be at the base of a complex emotion schematic experience. Core schemes that are maladaptive result in self-organizations such as a feeling of basic insecurity and anxious dependency; a core sense of powerlessness; a deep sense of woundedness, shame, or worthlessness; or a feeling of invisibility or being unloved or unlovable. These core emotions tend to underlie the secondary bad feelings such as despair, panic, hopelessness, or global distress (Greenberg, 2002b; Greenberg & Paivio, 1997). We have found that negative self-feeling is a core self-critical process and that at the core of dependence is a sense that one cannot hold together without support. A sense of self as weak or inadequate is a core emotion-based self-organization, and the primary maladaptive feelings of worthlessness, weakness, or insecurity have to be accessed in order to allow for change.

The emotion schematic system is seen as the central catalyst of self-organization, often at the base of dysfunction and ultimately the road to cure. For simplicity, we use the term *emotion schematic process* to refer to the complex synthesis process in which a number of coactivated emotion schemes coapply, to produce a unified sense of self in relation to the world (Greenberg & Pascual-Leone, 1995; Greenberg & Watson, 2006). The experiential state of the self at any one moment is referred to as the *current self-organization*. In depression, for example, the self generally is organized experientially as unlovable or worthless and helpless or incompetent because of the activation of emotion schematic memories of crucial losses, humiliation, or failure in prior experience (Greenberg & Watson, 2006). These emotion memories are evoked in response to current losses or failures and cause the self to lose resilience and collapse into powerlessness. This state is symbolized by clients as feeling hopeless, worthless, or anxiously insecure.

The schematically based self-organization thus generates the enduring bodily feeling of who one is, but there is a further (and higher) level of organization of self, expressed through one's narrative identity (Greenberg & Angus, 2004; Whelton & Greenberg, 2004). This identity involves the integration of accumulated experience and of various self-representations into some sort of coherent story or narrative. People's identities and experience

of self-in-the-world cannot be understood outside of these narratives. To assume coherence and meaning, human lives must be "emplotted" in a story. In this process, events are organized by narrative discourse such that disparate actions and experiences of a human life are formed into a coherent narrative. These stories are influenced by different cultures that have complex rules about the form meaningful narratives can take. The stories that tell us who we are emerge in a dialectical interaction between the experiencing and the explaining aspects of self-functioning (Greenberg, 2010).

IDENTIFY NEEDS

A central aspect of formulation involves identifying unmet needs accompanying the core painful emotions. Emotion schemes involve core needs. Generally, these can be broken into attachment-related needs (e.g., to be close and accepted, loved, and avoid conflict) and identity-related needs (e.g., to be recognized and validated, to be in control, to achieve, to be capable). These unmet needs accompany the core painful emotions in that they are the adaptive goal of the emotion that has not yet been attained and are pressing to be satisfied. When the core painful emotions have been accessed, the problem narrative is illuminated and is collaboratively formulated. Each emotion sets in motion a particular plot or story about relationships between a person and his or her environment. Feeling sad includes the need to be close and connected; feeling angry is about needing to assert boundaries or overcome obstacles. Change occurs through the shift into primary emotion and its use as a resource. Thus, in some cases change occurs simply because the client accesses adaptive underlying anger and reorganizes to assert boundaries, accesses adaptive sadness, grieves a loss and organizes to withdraw and to 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 an alternative way of responding. Action replaces resignation and motivated desire replaces hopelessness. In contacting the unmet need in a maladaptive scheme, the person is helped to feel deserving of having the need met.

IDENTIFY SECONDARY EMOTIONS

Case formulation involves recognizing and understanding how the secondary emotions obscure clients' more primary emotions, both at a momentary and at a more characterological level. Some people have

characteristic styles of expression of secondary emotions, which protect them from underlying emotions; for others, this might only occur momentarily. A *secondary emotion* is an emotion that is based on a stimulus that is not the original situation; it is a secondary reactive response to more primary emotional experiences (Greenberg & Paivio, 1997; Greenberg & Safran, 1987). Secondary emotions are not associated with a primary need, and they obscure the more primary experience. They might be a secondary response to another emotion (e.g., feeling scared or ashamed but expressing anger) or to thought (e.g., feeling anxious after excessive worrying); or they might be about another emotion (e.g., feeling guilty about feeling angry or feeling ashamed of one's fear). The emotion often has the purpose of covering a more threatening, painful, or overwhelming underlying primary emotion. A secondary emotional state can either take the form of a distinct emotion (e.g., fear, anger, shame) or of a fused or global emotional state. Secondary emotions are often part of the symptom the client suffers from (e.g., anxiety, depression, hopelessness, irritability), and they are usually apparent when clients first enter therapy.

People often have emotional reactions to their initial primary adaptive emotion, and these initially dominate their emotional landscape. This "reaction to the reaction" obscures or transforms the original emotion and leads to actions that are 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 angry behavior is not functional or adaptive. Some secondary emotions obscure or defend against painful, primary emotions (e.g., anger defending against shame). Other secondary emotions, however, are more simply emotional reactions to primary emotions. A man might feel ashamed of his fear not as an avoidance but as a reaction. So now we have secondary shame. Thus, 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 (e.g., feeling anxiety because of anticipated rejection). However, the thought itself stems from a more primary mode of processing set in motion by a maladaptive emotion scheme, probably the fear of rejection. Thought can produce emotion, but this does not mean that all emotion is produced by thought.

Another form of nonprimary (secondary) emotion is *instrumental emotion*, or misdirected attempts to achieve an aim rather than obscuring a more primary emotion. They are learned expressive behaviors or experiences that are used (consciously or unconsciously) to influence or manipulate others (Greenberg & Paivio, 1997; Greenberg & Safran, 1987). The emotion can be manipulative or have a secondary gain. Typical examples are the expression of anger to control or "crocodile tears" to evoke sympathy.

IDENTIFY INTERRUPTIONS OR BLOCKS TO ACCESSING CORE EMOTION SCHEMES

Because the core painful material is so dreaded, people interrupt its emergence in therapy in numerous ways. Therapists must not only follow the pain but also identify how the painful emotions are avoided or blocked. It is helpful to see that these processes are generally instigated by fear (that the painful emotion cannot be survived). Emotions also are interrupted by a shutting down of the need (because unmet needs are painful). Some interruptions come from strong cultural or familial rules against feeling certain emotions in certain situations or against feeling in general. Markers of ways of blocking serve as further opportunities for specific interventions to address the blocks. (A specific task designed to address self-interruptive processes is described in Chapters 2 and 6.) Sometimes emotional interruptive processes can be useful coping mechanisms. Therapists must observe the types and varieties of coping strategies that clients use to cope with their pain and to modulate their painful emotions and identify coping skills that might be lacking.

IDENTIFY THEMES: SELF–SELF RELATIONS, SELF–OTHER RELATIONS, EXISTENTIAL ISSUES

Themes tend mainly to cluster around self–self and self–other, but sometimes existential themes emerge of dealing with limit situations, such as aloneness, loss, choice, and death. Goldman et al. (2005) identified core themes in 36 clients treated for depression and found that all of them had at least one theme in each of the self–self and the self–other categories. Themes that contribute to clients' painful core emotions emerged over time, and these themes fell into one of the following four major classes: (a) problems in intrapersonal relations; (b) problems in interpersonal relations; (c) existential concerns; or (d) some combination of interpersonal, intrapersonal, or existential problems or concerns. Intrapersonal issues generally relate to treatment of self (e.g., being critical or rejecting of self) or to avoidance of emotion (e.g., suppressing or numbing of emotion), whereas interpersonal issues generally entail treatment by others and relate to attachment and interdependence (e.g., feeling abandoned or rejected) or to issues of control, feeling humiliated, invalidated, or abused. These involve either problems of neglect or maltreatment. Existential issues relate to limit situations involving loss, choice, freedom, alienation, and death. In Chapter 9, we give examples of themes that emerge out of case formulation, in different diagnostic groups. Existential themes often occur more in people who present with problems in living rather than with clinical symptoms (e.g., loss of a spouse, a limb, or of

meaning; facing death; alienation; and restriction of freedoms). A subset of themes that were found in the York I (Greenberg & Watson, 1998) study of experiential therapies for depression are listed in Exhibit 5.1 (Goldman et al., 2005).

In case formulation, what is important is the identification of the types of issues that are emerging as the focus and the manner of relating them. In other words, how the self treats the self or how one feels treated by or treats others becomes an important part of the thematic understanding. Thus, in the self–self area, one might be self-critical or self-interruptive or avoiding or dismissing one's emotions—or punishing, abandoning, scolding, denigrating, doubting, frightening, squeezing, caging, squashing, or silencing the self. In relation to others, one might withdraw from others, pursue, attack, blame, abandon, and control them; more idiosyncratically one might shrink; run or hide from; protect; or push, chase, instruct, or advise others. These understandings of the client's idiosyncratic manner of relating to self and others form part of the theme, which then is constituted by type (self, other, existential), content (e.g., unfinished business with abusive father), and relational manner (withdrawing from others). In another person it might be other related (e.g., loss of mother at a young age resulting in clinging to others). In a self–self theme, the content might be low self-esteem and the manner of scorn for self, whereas in another client it may be about being very rigid, and the manner of relating to self might be highly demanding.

EXHIBIT 5.1
Subset of Themes

Unresolved anger toward husband (self–other)
Conflict between and critical and vulnerable aspects of self (self–self)
Feeling trapped in an unhappy marriage (self–other)
Conflict between task-oriented, condemning, and passionate parts of self (self–self)
Conflict between practical and free, pleasure-seeking self (self–self)
Feeling judged and criticized by others (self–other)
Feeling of "flatness" or absence of feelings (self–self)
Difficulties with self-assertion; feeling wants and needs are not legitimate (self–other)
Loss of a job (existential)
Unresolved feelings toward ex-husband and his family (self–other)
Strong sense of failure; feeling of inadequacy (self–self)
Vulnerable, fragile sense of self (self–self)
Unresolved feelings toward mother (self–other)
Lack of direction and meaninglessness (existential)
Difficult, troubled relationship with daughter (self–other)
Difficulty trusting others in relationships (self–other)
High needs for perfection (self–self)
Feelings of dread and related fear of the future (existential)
Feelings of loss and sadness regarding children leaving home (self–other)

Existential themes, in which people find themselves faced with certain ultimate limits of existence, sometimes emerge as core concerns in EFT. Clients with problems in living or in dealing with adjustment have existential themes that dominate: limits to freedom and choice; belonging and alienation; and concerns about sickness, loss, and death.

Although therapists do not direct content from one session to the next, they do facilitate a continuing focus on themes that relate to underlying painful emotional issues that appear to impede healthy functioning. Empathic exploration and engagement in tasks leads clients to important thematic material that forms a thread of interpersonal understanding. In therapy, this is weaved into a coherent, shared narrative around the client's concerns. We have found that in successful cases, core thematic issues do emerge across the therapy and serve to provide a focus for therapeutic work. For example, a client who worked on self-critical markers and tasks might have accessed a "thematic" harsh critic who activates his core feelings of worthlessness; this then becomes the focus. For another client, markers of unresolved anger and hurt toward a significant other might activate his core sense of insecurity and hurt, and this may emerge as a thematic focus.

CO-CONSTRUCT THE CASE FORMULATION NARRATIVE, LINKING PRESENTING RELATIONAL AND BEHAVIORAL DIFFICULTIES TO TRIGGERING EVENTS AND CORE EMOTION SCHEMES

Based on the MENSIT elements (markers, emotions, needs, secondary emotions, interruption, and themes), a co-constructed narrative is formed and serves as a shared framework that reflects the relationship between the above elements of the formulation and the presenting problem, the triggers, and the behavioral responses and consequences of the person's emotion coping process. This narrative ties the different elements of the client's experience to the client's difficulties in the world. The formulation narrative is offered to the client to help organize what is being done in therapy and is further jointly developed in dialogue with the client. The narrative serves to organize the client's experience into a coherent account that acts as a type of anchor for self-understanding. This understanding helps to clarify goals and more particularly the relevance of the tasks on which one is working in therapy. Different elements are woven into a coherent explanatory narrative that uses components of the MENSIT model to form a greater understanding of how the symptom is produced. Usually the therapist organizes the elements into a coherent narrative and presents it to the client as a current integration of what has been discussed up to this point. Together client and therapist

put forward their integrated understanding of what has emerged from their therapeutic explorations. This understanding is a co-constructed narrative.

One client's narrative might be summarized by a therapist as follows:

> It seems that your husband's gambling or continual criticism (trigger) leaves you feeling hopeless and depressed (consequence). When you see him gamble or he criticizes you, you feel guilty (secondary) that you are a bad wife and feel you should be able to help him more, but you also feel angry (primary adaptive). However, you avoid confronting him and generally try not to express your anger (interruption) but end up feeling lonely. As we have explored, you interrupt your anger and express your needs mainly by feeling guilty and undeserving and afraid of being alone. Understandably, given how it was for you growing up with your parents, this all triggers your underlying core fear of not being loved (emotion scheme) and also of feeling small and insignificant and worthless. What you really need and want and deserve (need) is more support and understanding and to have your voice heard, but it's hard for you to feel you deserve this given you were constantly not given this growing up.

Take the example of a client who presents with depression triggered by being laid off from her job. Her secondary feeling is one of hopelessness (secondary), but what emerges from an exploration of that is a core feeling of rejection and emotion schematic memories of unresolved sadness and insecurity (emotion) from being abandoned by her husband, who 15 years ago walked out one morning and never returned. This is a marker of unfinished business (marker). Her core unmet need was to be loved (need). In addition, she interrupts (interruption) her feelings of lonely abandonment and fear with shrugs of resignation and blocks her adaptive anger at having been unfairly treated with self-blame and guilt. The main theme is self–other (theme), in which she feels rejected and unwanted; there is also some self-criticism in which she sees herself as worthless based on these rejections. Her behavioral response is to withdraw from others to avoid rejection and the consequence is to feel lonely; these exacerbate her feelings of loneliness.

The following example is a more detailed co-constructed narrative formulation for Mary, a 51-year-old client who suffered from psychosomatic symptoms and a major depressive disorder. Her painful maladaptive emotion schemes were found to be fears of abandonment and the shame of feeling not good enough (emotion). Her self-organization thus involved feeling anxiously insecure, unworthy, and flawed. The client's childhood experiences with her mother—she had felt neglected and believed her mother favored her sister—were central to the development of this mixed self-organization of fearing rejection and feeling unworthy. This history resulted in her attachment-related fears of rejection and an inability to assert herself for fear of rejection. She also suffered from a deep sense of shame about her inadequacies (more

identity-related concerns). Her unmet needs (needs) for closeness and validation left her wishing for closeness from her family and her husband and wanting recognition of what she had done for them all.

In early sessions, Mary's emotional processing style was overregulated. She had little access to underlying primary emotions or even to her secondary emotions. She stifled her emotions because she feared losing control and falling apart and being rejected or being judged as not good enough. As therapy progressed, she was able to access and express primary maladaptive emotions of both fear and shame; however, these emotions at first were generally experienced as overwhelming and rapidly turned into secondary distress. The client's core emotional pain appeared to be unbearable to her, and she avoided it; she collapsed instead into secondary emotions such as hopelessness and helplessness. Mary's mother had repeatedly neglected and invalidated her when she was growing up, and as a consequence, Mary developed a need to please her mother from an early age by helping with tasks around the house, but she never felt recognized or appreciated. Markers of unfinished business with her mother were plentiful ("She preferred my sister." "I always tried to get her attention but she was always too busy." "My mother's criticism was hurtful. I didn't feel loved by my mother." "I was second best." "I was a little girl who wanted to be taken care of"). There also were markers of unfinished business with her husband. ("My friend accepts me but my husband does not give me what I need." "I feel very vulnerable and ah, more susceptible to [my husband's] comments; you know how painful they are").

Markers of lack of self-worth were also quite evident ("I shamed my parents being the first divorce in my family and not protecting my children." "I'm not the perfect daughter." "There is something wrong with me and that's why nobody loves me"). The client also described herself, as an adult, as feeling similar to how her absent submissive father had felt; as "not wanting to rock the boat" by asserting herself and confronting people.

Mary had left home at the age of 20; she got married and, 12 years later, divorced. Her ex-husband had physically and emotionally abused her, confirming her sense of worthlessness. In session 15 or so, she revealed a painful feeling of shame (emotion) that she had not sufficiently protected her sons from their abusive father. Central, thematic identity concerns emerged; Mary experienced shame and guilt because of her perceived inability to cope adequately with her life, as well as her inadequacies as a mother and a wife. A central attachment theme related to fears of being rejected or abandoned in relationships because she was unworthy. The behavioral consequences of her feelings of fear, shame, and loneliness were to control and to be overly caretaking. She also avoided conflict. She was unable to confront her current husband, to whom she had been married for 15 years, because she feared that he would abandon her; as a result, she shut down emotionally. This

emotional and behavioral avoidance inhibited her from fully processing her core emotional pain and hurt, which consequently prevented access to her primary adaptive emotions of anger at being taken advantage of and sadness at loss of love that would have allowed adaptive action. As a result, Mary experienced widespread secondary emotions, including generalized distress and hopelessness (secondary). Because she had never realized she could tolerate her primary painful emotions of worthlessness and her sense of abandonment, her fears of emotional collapse were maintained, but she ended up with stomach and skin problems as well as depression and unexplained outbursts of tears.

The main triggers of Mary's core maladaptive state of shame and fear were such things as unwashed dishes in the kitchen sink, which activated her conflict over her wish for her husband to take more responsibility and her fear of abandonment. Interpersonal triggers of rejection and exclusion by her parents, sister, and husband were planned meetings with her family. These activated her feelings of being unfavored and undeserving; any desire for assertion activated her fears of rejection. In response to her inability to deal with her primary feelings, her secondary emotions were hopelessness and despair, as well as rejecting anger at her husband and family. The primary theme of the therapy was related to how Mary treated herself: She had difficulty asserting herself with others, especially her husband, and she treated herself both harshly with general criticisms of inadequacy and with condemnation for having left her sons with her ex-husband.

A narrative was co-constructed that helped tie her presenting problem, markers, emotion scheme, and blocks to thematic relational and behavioral difficulties. In the fourth session, the therapist suggested that they work on her unfinished business (marker) with her current husband and with her mother and observed that it appeared that her core painful emotions were her fear of abandonment, supporting a self-organization of anxious attachment, and her shame, supporting a self-organization of lack of worth. These indicated that Mary's unmet needs were for closeness and validation of her worth. When these needs were not met, her secondary emotions were distress, hopelessness, and depression. Over time, the therapist also helped highlight that her fear of her pain associated with rejection and invalidation set in motion interruptive processes of deflection, rationalizing, and suppression of anger. The themes that emerged were ones of how she took take care of others and needed to be a superwoman in order to gain the love and approval of others. The formulation narrative was that triggers that set off Mary's maladaptive emotional process were cues of rejection from her family and husband and feeling taken for granted by him. Her resulting behaviors were withdrawing from her family and coworkers, placating her husband and withdrawing from him, outbursts of tears, and psychosomatic symptoms.

In therapy, Mary faced her primary maladaptive emotions of fear of rejection and abandonment associated with feeling unsupported and unloved by her parents and husband and feeling that people did not accept her. As therapy progressed, Mary was able to express assertive anger, an emotion she had suppressed, and the painful core emotion of loneliness related to a sense of being unloved and unsupported by those closest to her. She began to feel deserving of love and of having her needs met. Additionally, she explored her fear that by confronting her husband about not being home on time each night, she would lose him and end up on her own. However, she was able to access her assertive anger associated with her need for recognition (shame related) and closeness (loneliness related) with her husband, as well as engage in self-soothing and self-compassion rather than condemnation with respect to her loneliness. As therapy ended she was describing the love she shared with her husband and her sense of entitlement to stand up to him. For example, at the end of a two-chair dialogue, in the resolution phase, Mary said to the part expressing her need, "So maybe this time you should stand your ground." She also accessed her unmet needs to be loved and to feel validated as a person worthy of love and support. This then led to her being able to grieve the losses of her childhood. With the empathic attunement of the therapist, she was able to be compassionate to her need, assert her value, and feel that she deserved to be loved.

CONCLUSION

Stage 2 forms the heart of the formulation process. Through the identification of markers to guide intervention, core painful emotion schemes become clear. In formulation, the therapist follows a pain compass. Aided by marker-guided intervention, the therapist identifies and accesses the core painful emotions and unmet needs that are the underlying determinants of presenting problems. During this process, secondary emotions, interruptive processes, and core themes are identified and connected to triggers and consequences and presenting problems.

6

STAGE 3: ATTEND TO PROCESS MARKERS AND NEW MEANING

This chapter presents the theory underlying Stage 3 of EFT case formulation, which involves identifying emerging task markers and micromarkers and assessing how meaning influences or fits in with the reconstruction of new narratives and connects to presenting problems and existing narrative structures.

In Stage 3, therapists work within the thematic structures and narrative framework co-created in Stage 2 to determine productive interventions. In Stage 2, initial markers were identified and associated interventions were applied. Through clarification and emotional deepening, core maladaptive emotion schemes and emotional interruptions have been identified, and treatment themes have coalesced. Emotion schemes and related themes have been linked with presenting relational and behavioral difficulties, and this has served as further impetus to resolve difficulties. Stage 3 represents a shift from this case perspective to a primarily state perspective: The therapist

http://dx.doi.org/10.1037/14523-006
Case Formulation in Emotion-Focused Therapy: Co-Creating Clinical Maps for Change, by R. N. Goldman and L. S. Greenberg

moves into a mode of continuously formulating what is happening in the moment and making split-second decisions about how best to proceed.

Process formulation refers to observing what is happening in the nonverbal and verbal emotional expressions and displays of the client and, based on what is being seen, making decisions that lead to proposals to clients about how to proceed with the emotional exploration. Process formulation in Stage 3 leads to finer and finer discriminations of the client's internal processes, and these enhance the case formulation by yielding a richer, more in-depth understanding of the core maladaptive scheme and how it was formed. At the same time, as treatment continues, the focus is on an accurate reading of the moment. These process diagnostic formulations guide the next intervention.

From session to session, therapists listen for what has become figural for the person. As clients tell stories of fights with their partners, terrifying panic attacks, conflicts with coworkers, embarrassing social interactions, perceived attacks, or feelings of inner anguish or failure, therapists relate empathically and listen for markers and engage in interventions. They listen for moment-by-moment markers of emerging states and intervene accordingly to deepen emotional processing and access the core emotion scheme. This process-sensitive work is conducted within the overall treatment framework formulated in Stage 2.

This chapter outlines how to formulate commonly emerging task markers and micromarkers and which processes to undertake at these points. For example, whereas negative self-evaluation and conflict may have been the initial marker that led to the two-chair work early in therapy, progress in that work may unearth a new marker of unfinished business with a developmentally significant other.

Micromarkers also occur throughout sessions and within tasks and represent moments when therapists must decide which direction to take. At different points along the path of facilitating access to core emotions and facilitating the process in key EFT tasks, therapists face decision points about how best to proceed. Drawing on our clinical experience, we have developed a map to guide therapists through some common stuck points and make the best assessments to guide interventions. Most micromarkers that we identify here occur in the context of two of the key tasks that have been well-studied in EFT: the two-chair dialogue and the empty-chair dialogue. In the two-chair dialogue for negative self-criticism, clients criticize themselves in one chair, move to the other, and agree with "the critic." Therapists are typically faced with formulating what is occurring and how to intervene.

In the last and final step of Stage 3, therapist and client explore the ways in which changes in feeling and meaning create new narrative structures.

STEP 12: IDENTIFY EMERGING TASK MARKERS

Throughout the case formulation process, therapists can identify emerging markers that are apparent in client speech. However, it can be confusing to determine what state the client is in at a particular point and what is the best intervention to use. This section outlines common markers with accompanying choice points.

Markers of Interpersonal Conflict

When clients talk about a current, ongoing conflict with a significant other who was developmentally important, the salient issue for them is generally to solve the current relational problem, but that can be complicated by past, unresolved issues within the relationship. The therapist must discern whether the best route is to treat the issue as "current" or "unfinished" business related to unmet needs from the past (Elliott, Watson, et al., 2004; Paivio & Greenberg, 1995). One way to determine this is by imagining the other in the chair and learning what is most relevant and current for the client. By accessing a "younger" version of the self, the client works on unprocessed feelings and the assertion of unmet needs. By contrast, current interpersonal conflict is most often related to setting boundaries in the current relationship. When the relational issue is with someone the client currently lives with, such as an adolescent living with a parent, teasing apart the past and present is the therapist's task, and it can be challenging. One approach is to attempt to first resolve the current issue and then go back to unfinished business. When the issue is related to a current romantic partner, the therapist may take a more systemic couple therapy approach, first trying to understand the negative interactional cycles and how it is operating.

Markers of Shame

Through emotional exploration, and particularly when people are exploring how they feel about themselves, a sense of shame may arise. This is evident in such statements as "I just feel fundamentally flawed" or "There is just something wrong with me." This is often described as a *defective sense of self*. Clients describe this as a feeling they have carried with them for a long time. This feeling tends to emerge in two contexts: in emotional exploration or in self-critical chair work. For example, the client may be sitting in the "experiencing self" chair and exploring underlying emotions in response to harsh self-criticism. Feelings of shame most commonly arise within a context of emotional exploration (Greenberg & Iwakabe, 2011).

In the illustration that follows, the client talks about a recent fight she had with her boyfriend:

Client: Well, he got so angry when I told him that I had not liked the way he spoke to my daughter. I was just trying to make simple suggestions about how he might address her in a kinder manner. But he got so mad and started calling me all kinds of hurtful names (voice cracking) and I really wondered why I even brought it up and I just shut right down. And I wasn't into talking to him for the rest of the evening.

Therapist: Sounds like you felt really hurt, like the name calling just got you inside and it was difficult to respond.

Client: Yeah. It makes me question the whole relationship and why did I choose him as a partner. It reminds me of so many experiences I have had feeling like this.

Therapist: Yeah, like what are you reminded of right now? Are you remembering something specific?

Client: I have an image of just hanging out with my family on the front lawn and everybody is kind of talking and laughing. This is, when I was I guess 11 or 12, and just feeling invisible, like I might as well not be there or I wasn't wanted or something (voice cracking, becomes choked up, struggling to get words out).

Therapist: So, just feeling invisible, so unseen, like you don't matter.

Client: Yeah, I think this is a feeling I felt kind of all the time (crying).

Therapist: Yeah, the feeling of "I don't matter" or "it doesn't matter if I am here or not."

Client: Yeah, and there is just something wrong with me.

Therapist: Yeah, like there is something wrong with me, like nobody is paying attention to me 'cause there is just something about me that is wrong or off.

Client: Yeah, like I am flawed.

Therapist: Yeah.

Two markers have emerged: a vulnerability marker that reveals a core sense of fragility and shame with accompanying distress (Elliott, Watson, et al., 2004; Keating & Goldman, 2003) and a negative self-evaluative split marker where one side is harshly evaluating the other (i.e., "You are defective") and the accompanying feeling of having been ignored and neglected. At this point, the therapist must decide whether the client is fragile and needs empathic

attunement and whether the major current process is one of self-contempt calling for two-chair dialogue or humiliation by a significant other calling for unfinished business with parents (Elliott, Watson, et al., 2004; Greenberg et al., 1993). Chair work for a negative self-evaluative split would involve bringing a chair in front of her and asking, "How do you make yourself feel like you are you are just so defective, not worthwhile. Can you come over here and do that?" For unfinished business, chair work would involve the therapist suggesting, "Put your parent(s) there and tell me what you feel as you see them." An empathic relational mode would mean continuing on in the same vein, saying, "So somehow there is just this deep feeling of 'I am fundamentally flawed, defective, just not worthwhile.'"

In the situation depicted in the dialogue, the therapist made the decision to stay within an empathic relational framework. She judged that the client was already feeling the pain associated with that feeling and that it did not need to be heightened (a function of chair work). The therapist heard and understood how the client might have been making herself feel judged (self-critical chair work) and that she had unfinished business (empty-chair work); she also felt the client at that moment was in need of validation and support about her fragile feelings (Greenberg, 2004b). Because the therapist felt that productive emotional exploration was occurring and saw her support as most necessary to deepen exploration, she decided to stay within a relational mode. (Note that had the client not expressed a strong sense of fragility, the therapist might have chosen to initiate a two-chair dialogue; had the client expressed fragility with a sense of resignation and named specific developmentally significant others in relation to this feeling, the therapist might have initiated an empty-chair dialogue.)

Markers of an Inability to Access Emotion

The marker connoting an inability to access emotion most often occurs in the context of chair work (although it could happen at any point in therapy). The client is guided to access an emotion, most often a primary, vulnerable emotion, and is unable to do so. The exchange in the following example takes place in the context of the two-chair dialogue, with the client in the critic chair:

Client: (speaking as critic to other aspect of self) You are just so useless. I can never rely on you because sooner or later I know you are going to blow it.

Therapist: Yeah, so you really are going to blow it, because you always do, and I am just waiting for you to make another mistake. Yeah, tell him.

Client: (to self) Yes, you will inevitably fail. You always do.

Therapist: Yeah, you are just a failure.

Client: Yeah, just such an incredible failure (looking contemptuous).

Therapist: And what do you feel toward him (pointing to experiencing chair)?

Client: Well, I think he is pathetic. I don't like him.

Therapist: So what is the feeling toward him (pointing to other chair)? You kind of look down your nose, or . . . what is that feeling? Contempt?

Client: Yeah, pretty much, yeah, he is such a loser. I just feel contempt for him. He's such a loser.

Therapist: OK, can you tell him? "You're a loser, a nothing."

Client: Yeah, you make me sick, you are so pathetic.

Therapist: OK, come over here (pointing to other chair), can you sit over here? (Client moves to the other chair.) So, what do you feel inside when you hear this, "you're pathetic?" what is that like inside?

Client: Well, I don't know . . . (blank stare) I guess I kind of want to just ignore him. I want to tell him he is wrong.

Therapist: And what does it feel like inside. What is it that you feel inside your body when you hear "you're pathetic?"

Client: Well, I don't know . . . (pause 15 seconds), kind of numb, I guess, like nothing (turns to therapist and stares blankly).

Therapist: Numb . . . I see, sort of hopeless,

The client is stuck in the two-chair dialogue and is unable to access emotion, particularly underlying primary emotion. Two possible formulations exist here. One part is understood to be actively, even if automatically, stopping, inhibiting, squeezing back, or preventing the other part, the one that likely feels hurt by the self-criticism of "you're pathetic," which would suggest a self-interruptive task. The other possibility is that the client has an unclear felt sense and is unable to symbolize the bodily felt sense of what it is like to feel ashamed (in relation to self-contempt) because he or she is not attending to bodily felt experience, which would indicate a focusing task.

The therapist considers initiating a self-interruptive task but then decides that a focusing task is the best route to follow. Self-interruption would be more fitting if the client had accessed some emotion (e.g., pain, sadness, shame) but then following this, the therapist noticed him or her stopping it. For example, the client might visibly clench the jaw, squeeze a fist, or hold the breath. In the case from which the preceding exchange

was taken, the therapist had worked with this client for a number of prior sessions and knew that the client had difficulty accessing bodily felt experience in general; this emerged as problematic at this juncture when the client tried to access vulnerable emotion. The therapist decided to initiate a focusing task.

Therapist: So, if you could just focus on your body at this moment. Where in your body do you feel that hopelessness? (focusing on currently felt feeling)

Client: Well, it's just a sinking feeling in my stomach.

Therapist: OK, so if you could just focus there for a second. It may help to put a hand there. Yes, that's right. Now as you focus on that place in your stomach, is there a word, or phrase, or image that comes to you?

Client: (hand on stomach, eyes closed) Yeah, it's like a deep well, it's so empty and I see myself over there kind of hiding in the corner it feels so bad.

Therapist: Yeah, just hiding, and small in the corner, like it hurts. It hurts when you hear yourself say "you disgust me."

While a focusing task was the most fitting one to initiate in this dialogue, there are times when it makes more sense to initiate a self-interruptive task, particularly in the midst of a task that is not progressing smoothly. Take, for example, the following unfinished business task in which Tamara is very angry with her mother but having trouble expressing it to her in the empty chair:

Tamara: Yeah, nothing was ever good enough for you. She wanted me to take piano when I was little. I had no interest. I took it anyway. Then she thought it would be better if I switched to violin. I also didn't like it. But I did it. And I played, hard. I worked so hard. I hated practicing but I did it. I didn't make first chair and you were angry at me. I mean how dare you . . . (voice quavering).

Therapist: So it's like I didn't want to play these instruments, but you wanted me too. So I did it. But then it still wasn't good enough for you. What do you feel about that?

Tamara: I guess I am angry. (mumbling)

Therapist: Yeah, so can you tell her. I am so angry at you that no matter what I did it wasn't good enough for you.

Tamara: (looking across at the image of her mother in the chair) Well, I guess I am angry, but I can't say it to her face.

Therapist: It sounds like you are angry at her, though. Tell her what you resent. Try saying "I resent . . ." and finish it. Like "I resent never being able to measure up to your standards" . . . or . . . ?

Tamara: Ahh, ahh, I resent (voice soft and questioning) . . .

Therapist: Yeah, it is hard to be angry at her, even though you are angry, can you come over here (pointing to the other chair).

Tamara: (Moves to other chair and looks at the therapist.)

Therapist: (initiating self-interruptive chair work) Now instead of your mother being here, I want you to be the part of yourself over here that stops her (pointing back to other chair in which she was previously sitting) and . . . somehow you stop her; you don't allow her to be angry. What do you say to her?

Tamara: Well, you cannot be angry with your mother. I mean she is your mother. She loved you, fed you, clothed you.

Therapist: OK, well, tell her.

Tamara: Yeah, well, "Don't be angry at your mother."

Therapist: Yeah, and what else, how do you stop her, do you squash her, push her down, push her back, what do you do to her to not let her be angry?

Tamara: Well, I think I kind of sit on her. Like I am just this huge weight, like a vice sitting on her shoulders, and muffling her.

Therapist: OK, so be that vice grip and sit on her, muffle her, don't let her express (therapist also demonstrates a squashing motion with her hands).

Tamara: (Client, mimicking the therapist, holds her hands in the air and motions pushing down on herself.) Yeah, just don't be angry, don't express it, you cannot tell your mother, she is your mother.

In this example, the therapist, in the context of the empty-chair dialogue for unfinished business with a significant other, formulates that the client is having difficulty expressing her anger to her (imaginary) mother and that it would be best to switch to a self-interruptive dialogue. Although the client has acknowledged that she is angry, she is not able to fully express it. The formulation is indicated in her voice (high pitched), posture (hunched over), and the manner in which she simply repeats the words of the therapist without conviction. The therapist senses that because of the client's inability to express her anger, she cannot move forward through the process and thus formulates that specific work is needed on anger expression, helping her to

be aware of and gain an agentic understanding of how she prevents her anger expression. When the client gains this awareness, she is freed up to allow herself to express anger.

Markers of Overwhelmed Emotion

> I don't know, I am just all over the place today and kind of everything is wrong. It is just not one thing. It is everything (beginning to cry). I just can't handle life anymore. Let's say I am glad I can come here because all I want to do is cry.

When a person begins a therapy session in such a state, the therapist must decide whether the client is in a vulnerable primary emotion (in which case arriving there and validating the client's experience helps to strengthen the self), whether the person is in a state of anguish and has a primary need for comfort (in which case self-soothing to transform the pain with compassion is advised), or whether the person is overwhelmed and swamped by the emotion (in which case a clearing-a-space task is advised to help regulate and cope with the emotion; Greenberg, 2004b). Self-soothing (Goldman & Fox, 2012; Goldman & Greenberg, 2013) is designed to transform painful emotion while the clearing-a-space task (Elliott, Watson, et al., 2004) would help create emotional distance and an internal working space to help the client better manage emotions and thus tackle and solve problems. This formulation decision depends on a momentary assessment of (a) how overwhelmed the person is by the particular emotion (the intensity of the arousal), (b) how much they feel anguish accompanied by a feeling of familiar despair that the feeling and needs will never be met, (c) the degree to which the person is in crisis, and (d) the fragility of the emotional state. Clients with a high amount of expressed familiar despair and a feeling of disorientation and disorganization will benefit from a self-soothing task. Clients who present as unsure of how to begin to tackle the various issues in their life and cannot sort through things may be unable to get enough perspective to create a working distance, breathe, and approach solutions. In this scenario, it is best to suggest a clearing-a-space task (Elliott, Watson, et al., 2004).

Markers of Traumatic Experience

When the specific focus of the therapy is trauma or unfinished business, therapists often must decide whether the client has not yet assimilated the emotional experience and developed a coherent narrative or has blocked feelings that need to be activated and processed more fully. A distinction needs to be made between the "storytelling" client who typically organizes to elaborate

the content or events of the story, thereby emotionally distancing from the emotional impact of the event, and someone who has been through a traumatic event and needs to reprocess the story in order to address the shame, re-experience and work through the associated emotions, eventually mend the broken narrative, and thereby establish a sense of coherence. In the latter case it is important that the therapist make room for the client to share the story, thereby allowing for the coexistence of all pieces of the fragmented narrative and its emotional counterparts (Angus & Greenberg, 2011). This may necessitate a trauma-retelling task. The therapist must judge, however, whether the telling of the story is helping clients to freshly access experience at a safe level of intensity or is distracting clients from difficult emotions such as pain or anger. When the story has been told and a safe, trusting therapeutic bond has been established, it may be time to for imaginal confrontation or an unfinished business task to begin to deepen and access some of the difficult emotions that clients may fear exploring. Research has shown that some clients who have suffered trauma may prefer not to engage in the empty-chair dialogue with their abuser (Paivio, Jarry, Chagigiorgis, Hall, & Ralston, 2010). Such clients might benefit from empathic exploration instead. This does not involve the use of chairs, but it does entail working through the steps of the dialogue.

Another way to distinguish the storytelling client from the client who needs to tell the story is to pay close attention to the client's momentary emotional expression. Sometimes clients will access a troubling emotion such as fear, shame, or anger and quickly move away or interrupt it by clenching down or holding their breath or looking away. This is an indication that emotion has been aroused and the client is quickly distanced from it; the therapist should find a way to help these clients come back to the emotion.

Crisis-of-Meaning Markers

Two tasks that often overlap are meaning creation and unfinished business work. Meaning creation work (Clarke, 1989; Elliott, Watson, et al., 2004) is often done when clients are facing painful life crises and can include current and past trauma and loss; empty-chair work is initiated in response to stuck, painful feelings and unmet needs in response to a developmentally important significant other. In experiences of trauma and loss, deeply held, cherished beliefs are challenged that have often been implicitly held for a long time and have come to form part of the person's identity. Cherished beliefs include previously taken-for-granted assumptions that the world is sensible or just, that we are invulnerable or worthy, or that others will always be there to provide support or protection (Elliott, Greenberg, & Lietaer, 2004). Therapeutic work in response to such events often includes both tasks. When markers are presented, however, the therapist must distinguish between them

and decide which to address first. The main distinguishing factor is related to the emotional presentation. Unfinished business markers are presented in a more global fashion and can include a variety of secondary emotions such as blaming, complaining, or feeling hurt and emphasize the significant other. Clients are often stuck in their emotions. For example,

> I noticed when my mother visited this past weekend that she always has to be right, and she is pretty oblivious to the other. She knows my wife has struggled with an eating disorder and she kept talking about different cuts of meat. I had to work very hard not to just blow up at her.

The client appears angry and irritated but is not overwhelmed by emotion. His anger is secondary to more primary emotions and there is a sense of despair and hopelessness in his tone. The therapist formulates the marker to be unfinished business and elects to bring another chair in front of him, requesting that he conjure an image of his mother and express his feelings to the empty chair.

At a different point in therapy, however, this same client was talking about his mother:

> She called me up this weekend, wondering why I did not send a gift for her birthday. She just does not get it. When she was last here, I tried to tell her about feeling abandoned and neglected when I was little, and she just started crying, saying how she is the lowest priority and no one ever considers her important. Somehow no matter what, she always manages to twist things so that she is the victim.

The client began to sob. The therapist saw him express a great deal of sadness and thus decided not to bring an empty chair over but rather reflect and validate his emotions: "It hurts so much. It felt like nobody was there for you. There was no echo." With sorrow on his face and tears in his eyes, the client recounted a story of how, as a 19-year-old, he read his grandfather's diaries. As a young man his grandfather, a Holocaust survivor, had to walk his two children to the death camps and say goodbye to them. After surviving the war (although his children did not), he fled to North America and began a new family, of which the client's mother was a part. The client turned to the therapist at this point and said in deep, existential despair, "So there is nothing. If humans are capable of such atrocities, what does anything mean?" The therapist nodded, reflected back his despair, and sat with the client while he wept. The client continued, describing how he was in a very hollow cavern, alone, where nobody could hear him if he called out. When the therapist asked him what he wanted from inside that place, he replied, "Nothing." He wept more. Eventually, the therapist said, "And if I were to reach a hand down to that cavernous place where you are, would you take it?" When the client replied in the affirmative, the therapist reached out her hand, and the

client took it and began to calm down. A couple of minutes later he said he felt more whole, calm, and hopeful.

In the preceding example, the client was not stuck in an emotion, and the emotion did not require deepening or expressing to the other; consequently, the therapist empathically explored the meaning protest rather than put the image of his mother in the empty chair and express feelings and unmet needs. The therapist sensed that the client's greatest need was for understanding and to make sense of the events. Had the therapist initiated an empty-chair exercise, the client might have experienced this as a failure of empathic understanding or abandonment. At a later point, in a different session, client and therapist again worked on unfinished business with his mother.

Identification of Emerging Task Markers Within Other Tasks

The most commonly engaged tasks are the empty-chair task for unfinished business and the two-chair task for a negative, self-evaluative conflict split (Elliott, Watson, et al., 2004; Greenberg, Rice, & Elliott, 1993). In the context of such tasks, although there are many occasions when therapists follow the model through to completion, sometimes in mid-therapy they face a formulation decision about an emerging emotional state—in other words, they must make a decision in the moment on how best to proceed with the emotional exploration.

Formulating Self-Interruption During Empty-Chair Work for Unfinished Business

A marker for self-interruption occurs frequently in the empty-chair dialogue (Elliott, Watson, et al., 2004; Greenberg et al., 1993) when the self tries to express core painful emotions and needs to the "other" in the chair, although it can very often occur with the two-chair task for self-criticism task and in other contexts. Given that the strategy adopted for dealing with unmet needs was often a matter of survival, it is very difficult to automatically and rapidly make oneself vulnerable by exposing and expressing unmet needs, even in the imagination. The inability to do so is a major block. When the client is stopped and cannot move forward, the therapist may suggest that the client stay in a chair and take on the role of the "interrupting" aspect of the self. Similarly, in the two-chair dialogue, clients may be critical of the self but also begin to shut themselves down and retreat into silence. The therapist may ask the client to specifically be or enact the interrupting aspect of himself or herself, such as the wall or door, describing vividly both its qualities and function and then ask the person to come over to the self chair once again and respond.

Formulating Markers in the Context of Two-Chair Work for Self-Criticism

When the critic has been evoked and the secondary, reactive emotions have been expressed, followed by the underlying primary emotions and associated needs, often the dialogue gets stuck: The critic, often vociferous and contemptuous, will not "stand down" even in the face of the expression of primary, vulnerable emotion. Two options are available to break the impasse, and the decision depends on the moment-by-moment formulation of the therapist: The *stuckness* (feeling blocked) can be attributed to unresolved issues with significant others that must be addressed, or the critic is in need of further emotion regulation before he or she can soften. These options are described in the following sections.

The Stubborn Critic. Contemptuous criticism often originates from internalization of the voice of a significant other, and so the therapist determines that going to the "source" will help unblock the process. Given that the client is already in the chair, the therapist can suggest that the client become the introjected voice of the critical parent (which is most often a judgmental or invalidating). The critic is now enacted as the parent, but the work is still self-critical work and not unfinished business. The following example illustrates this approach:

Client: (as critic, said in contemptuous tone) You are just so stupid. You are an imbecile . . . you should have known better than to get involved with him in the first place. The fact that he beat you is your fault because you saw the signs at the beginning of the relationship and you simply ignored them.

Therapist: Yeah, so you are stupid, you should have seen the signs, that is what you are telling her. Can you please switch chairs. (Client moves to the opposite chair.) So what is it like to hear this, you are stupid, it must hurt?

Client: Yes, it hurts, deeply. (crying) I just want to die, because I think she is right. It is so painful. I want to curl up into a ball and hide.

Therapist: Tell her how painful it is.

Client: It really hurts, I just want to curl up into a ball and hide (motioning as if shielding self).

Therapist: Yes, "I just want to hide," and tell her what you need.

Client: I need you to know how much you are hurting me, and I need you to understand that I did not stay with him because he was abusive but rather because I was vulnerable at the time when we met and he made me feel good about myself.

Therapist: Right, OK, switch chairs (client does so). What do you say back from this place? She is saying she needs you to understand how much she is hurting and how she stayed in the relationship because he made her feel good, not because he hit her. How do you respond?

Client: (in a derisive tone) I say she is a naïve little tart.

Therapist: I am wondering as I listen, who does it feel like is in this chair? Are you aware of your dismissive, critical tone?

Client: Indeed, I am. I don't like her and I am looking down on her.

Therapist: Right, and who in your life does this remind you of, who was it that you felt dismissed and invalidated by?

Client: Umm (biting lip) . . . Well, a few seconds ago, I did have a flash, like an image of my mother. She was often very critical of me.

Therapist: OK, yeah, so can you actually, stay in this chair, and instead of being your self, can you be your mother? Can you look at her and tell her what you think of her.

Client: Yeah, OK. (enacting mother) Well, you are just a naïve little girl and you have never made a good decision in your life.

Several factors influenced the therapist's formulation decision to ask about the source of the criticism. First, the therapist sensed in the client's tone an other-ness, as if the contempt and derision had been born out of or learned in an earlier relationship. The therapist's momentary assessment of the client's tone is influenced by knowledge of the client's historical relationships with the significant other. In addition, the client has fully expressed primary, vulnerable emotion, and this has not moved the critic from its contemptuous position. Having engaged in two-chair work in the past and become stuck at the same point, the therapist concluded that the criticism was deeply ingrained. The decision to bring the mother into the other chair, however, was made in the moment mainly in response to the presently heard tone of voice and manner of expression, which sounded like a rigidly learned criticism. Curious, the therapist asked the client where the voice came from and is open to the possibility that the client may not be able to name the source. Had the client answered, "I don't know," the therapist would have left it at that. Instead, they proceeded.

Therapist: I see, so she was very critical of you, in fact.

Client: Yes, she never thought I was very bright or able to make my own decisions. It's like she didn't believe I was capable.

Therapist: OK, and as your mother, you kind of turn up your nose and look down on her, right? Tell her, "You are just not capable."

Client: (enacting mother; derisive laugh) You have never been the brightest bulb, if you know what I mean. As long as I can remember, you made stupid decisions. I just don't think you have a good head on your shoulders.

At this point, the dialogue could go in two possible directions depending on the therapist's clinical assessment. The therapist might see the preceding exchange as the internalization of the mother's voice across situations in the past. In this case, the "mother" would be seen as an "introject" in that she was indeed critical of her daughter, thus providing an appropriate echo and reflecting the internalized criticism of her daughter. The most important objective from this point would be to resolve the internalized criticism within the self.

It may be, however, that the critic does not soften, and may not until such time as the unfinished business has been resolved. It will become clear to the therapist through the course of the dialogue that the main issue is unfinished business with the parent. The therapist will listen for whether or not the client brings up specific painful memories of abandonment, nonresponsiveness, humiliation, or maltreatment or expresses unmet needs to the significant other. From the preceding dialogue excerpt, the therapist decided to switch into an unfinished business mode and continue with an empty-chair task.

Therapist: OK, so come over here. As you, how do you respond? What do you say back to your mother?

Client: (from self-experiencing chair) Well, I just feel so hurt that you think so ill of me. It just brings an ache inside my heart. I feel kind of wiped out.

Therapist: Yeah, tell her what that is like for you.

Client: Well, it hurts so much. I can't stand this feeling. You never really liked me. I knew that. I remember once you said I was a disappointment because I wasn't strong and you always left me alone and never came to me at night when I cried.

Therapist: Yes, and tell her what you needed from her . . . to feel worthy in her eyes.

Client: (to mother) I needed to know that I was alright, that you thought I was OK.

It is clear to the therapist that the client carries pain and anguish and has an unmet need for love and respect from her mother. This must be resolved either through coming to a greater understanding, forgiving and letting go, or coming to terms with what she did not get from her mother. This would entail the resolution of the unfinished business.

In general, the therapist's decision to pursue the two-chair or empty-chair work depends on the material that is emerging. It may be that both need

to get resolved and will in turn. It may be that the impasse illustrated above occurs 10 minutes before the end of the session and the therapist chooses not to pursue the unfinished business but notes and shelves it for a later session. On the other hand, the therapist may choose to immediately switch and pursue unfinished business.

Finally, the opposite of what is depicted in the preceding scenario may occur. It emerges in the course of unfinished business work that a strong critic exists which may have in fact been originally personified by the parent. This may signal to the therapist that some self-critical work may be necessary.

The Scared Critic. With an intransigent or intractable critic, the therapist sees a marker of anguish and underlying, dysregulated emotion and formulates that the client is suffering. The therapist may decide to switch into self-soothing rather than wait for the alternate emotion to emerge, as is the usual course in the working through of the two-chair dialogue. Most often in this situation, the client reports being unable to remember prior experiences of being treated with kindness or gentleness.

Another indicator for a move to self-soothing is the presence of an annihilating critic and a self that lacks resilience. Typically, in response to the critic, the self collapses into deep hopelessness and begins to disintegrate. The following exchange occurred in the context of a two-chair dialogue:

Client: (speaking in experiencing chair, to critic) I need you to support me. I need to know that you are on my side, that you have my back.

Therapist: Switch chairs. (Client becomes the critic.) Right, "I need to know you have got my back." Can you respond to that, as the critic?

Client: (as critic) Well, I cannot do that because I think you are weak, and you are such a pathetic piece of crap. You simply do not deserve support. What have you actually done to be worthy of it? Nothing. Why should I give that to you?

The client carries on in this vein and exhibits signs of intense facial contempt, remaining rigidly annihilating. Sometimes one sees deep vulnerability and anguish emerging in the person. When clients respond in this manner, it is best for the therapist to introduce a self-soothing dialogue in an attempt to facilitate or even spark compassion for the self that seems out of reach:

Therapist: Can you come over here? I want you to imagine a child there who feels this deep pain and feels so invalidated as you did as a child. What would you say to this child?

Client: (throwing hands into the air) That's the whole problem; I cannot do that. I never have done that, no one ever has

done that for me and I simply don't know how. I may be a "lost cause."

Therapist: (empathizing with the difficulty) So it's hard and it feels like you cannot do that for yourself. (pauses) I wonder if you could imagine, if you had a child who really needed some support and was kind of saying I need to know you got my back . . . a little while ago you mentioned your father and how even though he was not always available when you were a kid, he used to take you to the circus or the amusement park, and I don't know what you felt then but I imagine you felt pretty loved, pretty special, so I don't know if makes sense to be him or someone else who could be loving toward her, but could you come over here and maybe tell her, "It's OK, I got your back?"

Client: (sighs) Well, I could be my father . . . it's hard for me to remember him, but I do have a fond feeling. I could also imagine being an adult as I am now, and her being little and me saying, "Don't worry, I got your back, kid."

Therapist: OK, good. So can you say that to her?

Client: Yeah, I got you, kid. I am going to be here. You don't have to worry. I am behind you. You are a good kid. You do deserve to be loved.

Therapist: Good, and can you switch back to this other chair (pause while switching). So, tell her what it's like for you to hear that.

Client: It feels really good. (crying) It's like I really needed to hear that.

Therapist: Right, so that is what you need, to hear you are OK. Tell her.

Client: Yes, I needed to hear that. It feels good to hear it. I feel stronger hearing that.

STEP 13: IDENTIFY MICROMARKERS

At times during task work, therapists come upon what we term *micromarkers* both outside of and nested within ongoing tasks. These guide formulation microdecisions that lead *to* moment-by-moment intervention. The thought processes involved in making these formulation decisions are elaborated below. Note, however, that EFT therapists acknowledge that there is an art to therapy and that intuition plays a strong role in moment-by-moment decisions. Here we merely offer further guidance by sharing what cues us to make the decisions when faced with these choice points. Exhibit 6.1 summarizes the decision points and criteria described in the following sections.

EXHIBIT 6.1
Micromarkers

A. Two-Chair Work
   1. When do you switch chairs?
      a. When a critic emerges in self-chair (separate and create contact).
      b. When affective reaction to criticism emerges in critic chair. (Handle with caution, don't switch too soon, take baseline into account; separate and create contact.)
      c. After the critic has expressed a message in a poignant or succinct fashion.
      d. After a need has been expressed in the self chair.
   2. When do you ask, "What is your attitude or what do you feel towards self?"
      a. To heighten the stimulus quality of the critic—making the implicit explicit (e.g., when contempt appears on face and in gestures).
      b. If the critic shows signs of softening (e.g., softening in fear or expressing compassion).
   3. How to deal with collapsed self (e.g., client agrees with the critic).
      a. Focus on the emotional process (e.g., it is like you agree and how do you feel when you get that?)
      b. Try to get to the emotional reaction beneath "agreement."
   4. When do you go for the need?
      a. If the client has accessed a primary emotion.
      b. To deepen the process (as you expect the need to get frustrated by the other side when the client has not yet accessed primary emotion).
   5. How to deal with critic not softening after expression of need in the self chair.
      Heighten arousal of the critic; make explicit the implicit affective quality (e.g., contempt).
   6. When do you ask the critic what it fears?
      When it appears that a softening is possible but the self is assertive (sets boundaries, pushes the critic out) and the critic is protective.
   7. How to identify a coach split.
      When the criticism is a second-level criticism about a feeling or symptom. Thus, 'you shouldn't be depressed or anxious', or 'you should be more confident or outgoing'. The problem here is that you are depressed or anxious and are not confident or withdrawn. Need to move to how you make yourself depressed or not confident.
   8. When do you "split the split"?
      When the person is in the self chair and he or she is differentiating feeling but the feeling itself reflects a criticism. Example: When, after being the critic, which has said "you are boring" or "you shouldn't get angry at your mother," the self says, "I feel afraid people won't like me" or "I feel guilty," it is helpful to say, "Come back over here and make her feel afraid or guilty." This serves to deepen the split work.

B. Empty-Chair Work
   1. Current interpersonal conflict vs. unfinished business
      a. In dealing with current interpersonal conflict: formulation of negative interpersonal cycles: Use "negative other" in the empty chair as a stimulus to activate primary maladaptive emotion in the client; if an unfinished business marker (e.g., with parents) emerges, switch to unfinished business with significant other.

EXHIBIT 6.1
Micromarkers *(Continued)*

b. In case of current conflict with significant others: If it connects to unfinished business, go for unfinished business but make clear that the focus is not on conflict resolution but on resolution of internal emotional processes (i.e., "This is with you as a young boy (or girl) and your father.").

2. When do you play the other in unfinished business?
   a. "Negative other": to heighten stimulus quality of the other in order to deepen affective process, when either of these conditions is present:
      • Low arousal/no access to emotion/undifferentiated secondary emotion
      • Interruption of need (anticipated frustration of need)
   b. To make explicit change in negative other (e.g., after unmet need has been expressed).
3. When do you ask for the need?
   a. If the client has accessed primary emotion
   b. To deepen the process (as you expect the need to get frustrated by the other side when the client has not yet accessed primary emotion)
4. When do you facilitate letting go of unmet need?
   When the other is not responsive to the unmet need or when need validation by the other is not possible.
5. When do you go to elaborate the worldview of the other?
   When the other is not responsive to the unmet need, or when the other does not validate the need; to deblame the self by fostering emotional understanding of the other (e.g., "so in her inner world").
6. When do you move to self-soothing?
   When the primary emotion or need has been expressed and the other is not responsive to the need and there is a sense of hopelessness or inability to cope with unmet need or primary emotion; when the activation of the need does not lead to more resilient emotion but to hopelessness; when the fear underlying the critic needs soothing.

C. Self-Soothing

1. How to deal with the client's protest: either when trying to access a need (e.g., it wouldn't be met anyways) or when building soothing self-aspect (I don't know how to do it, I can't do it)?
   What stops you? If you can do it for others, what stops you from doing it for self?
2. When do you use positive introject vs. inner child v. universal child?
   a. When positive introject/memories of being soothed by caregiver spontaneously emerge (e.g., after expression of need), use positive introject.
   b. If there is very little empathy for the self or little compassion for the self, use inner child instead of own child, because asking the client to soothe himself or herself will trigger the response "I won't."
   c. With anxious clients who are highly fragile: Starting off with a positive introject is often better, because asking the client to soothe himself or herself will trigger the response "I can't."
3. What do you do when you move clients to the soothing chair after the need has been expressed and pain comes up?
   Don't move the client back so as to not interrupt emotion.

(continues)

EXHIBIT 6.1
Micromarkers *(Continued)*

D. General Issues in Chair Work
1. Decide whether to stay with hopelessness or try to do something with it.
   - If hopelessness is a marker for vulnerability (sense of having come to an end, sense of confession) → empathic affirmation
   - To raise agency in depression → hopelessness split
   - To activate the core sense of self (weak me, bad me) → hopelessness split
2. When do you go for anger or sadness when the other one is being felt?
   - When one has been expressed and signs of the other begin to emerge
   - When the client has a tendency toward one and difficulty expressing the other
3. In self-critical work, discriminate if it is anxiety split or depressive.
   - If anxiety, get catastrophic expectations.
   - If depressive, get a negative evaluation.

Relational or Task Mode?

An important formulation decision is whether to continue to operate within an empathic response framework or to initiate a task. In general, we encourage task work when clear markers are present because it is the quickest and most efficient way to find a focus and deepen the process. However, we believe that task work should not be initiated until a sufficiently strong alliance and bond have been established between the therapist and the client. Another consideration is the client's fragility. Extremely fragile clients are seen as needing a longer periods of a strict, empathic and relational mode to help build a stronger sense of self-structure and safety within themselves. With fragile clients, one may wait 6 to 12 months before initiating chair work.

Another consideration when deciding whether to initiate a task is a pragmatic one that involves a calculation of time. In general, we will not initiate a task (especially for the first or second time) when less than 15 minutes are left in a session; it is necessary to allow sufficient time to get into the task so that it might be experienced or remembered by the client as a success experience. An unsatisfactory experience might make the client less open to trying other tasks.

Explore Underlying Emotions or Encourage Experience of Expressed Emotion?

A common micromarker therapists face is whether to encourage the exploration of underlying emotion or encourage experience and its expression. The answer often relates to whether the emotion is primary, secondary, or instrumental, and thus differential assessment is required in the moment.

A description of the different types of emotion as well as the different types of therapist responses that facilitate exploration or expression is provided in Chapter 3. Therapists may want to encourage clients to allow or express an emotion when it is primary or validate and bypass it when it is secondary or instrumental.

To illustrate, we present the following excerpt from the case of Melba. In the excerpt, client and therapist are talking about her current marital problems and the issues with her two grown sons, whom she feels do not respect her. Vocal descriptions are embedded within the client's utterances to clue readers to the nonverbal cues that are available in sessions that may not be apparent on the page—cues that help therapists determine whether emotions are primary, secondary, or instrumental. It also is important to remember that how something is said is as important, if not more so, than what is being said. As the client talks about her husband, she begins to cry. Being less experienced and less able to differentiate between primary and secondary emotion, the therapist automatically encourages her to allow the emotion and further explore it, instead of validating but accessing primary underlying emotion:

Therapist: I am going to encourage you to stay with that feeling and tell me more about it.

Client: (in a high-pitched, whiny voice) It is going to hurt.

Therapist: (calmly) Yes, but I want you to stay with that feeling.

Client: It hurts (covering mouth with her hands and then waving them vigorously up and down in front of her face, as if to shake off the feelings). It is really going to hurt. It wasn't that much (looking up at therapist again and gulping). It wasn't material things, like my husband keeps yelling or my mother kept yelling. It was love and respect and a warm family (said with strong emphasis, bringing voice down). I really wanted a warm family (high-pitched, whiny tone, wiping away tears although little water is coming from her eyes). I thought I worked so hard on getting it and I'm so angry (voice sounds forced out and lilts down). I worked so hard at something I feel like I've got nothing (beating fists on lap and gasping for air) in return. And it hurts. It hurts so much and it's not even material things. He (waving hands vigorously) keeps yelling at me that I'm materialistic and I'm not. (very low grunting and gasping) I could stay in a little shack some place if the man I was married to would just love and respect me (beating fists, looking to therapist).

The client expresses a secondary emotion. The therapist has read her as primarily sad when she is in fact primarily angry and instrumentally sad and

hopeless. Her voice has a complaining and whining quality, and in actuality she is not deeply experiencing her emotions of anger or sadness. The hand shaking, mouth covering, and crocodile tears, as well as repeating herself without advancing in her exploration, suggest she is neither experiencing deeply nor exploring what she is feeling to access or create new meaning. This is not to suggest that the client is fabricating content or being insincere. Her feelings and concerns are real, although her primary feeling of anger is not being felt at the moment. Further exploration of her tears, her secondary sadness, and her hopelessness in this manner will not lead to productive processing. It is advisable for the therapist to focus the client on her awareness of her current bodily-felt experience to see what is actually happening inside her body. That will likely yield more productive processing than the type of exploration demonstrated in the excerpt. The following excerpt shows how the therapist could have responded to validate and promote productive processing.

Therapist: It sounds like this is very upsetting to you. You don't feel understood and you certainly don't feel respected. Can you just breathe and tell me what is happening inside your body as you talk about this? What is happening inside your chest at this moment?

Client: (puts a hand on chest) Well, it is sort of a constricted feeling in my chest and my palms are sweaty. (Here the client is experiencing anxiety, which may be preventing her from feeling the intensity of her anger.)

Therapist: Right, it is scary to think about all of this. And what happens when you imagine telling your husband some of this?

Client: Well, I just feel so pissed off with him. Sometimes I really hate him. I am angry with him.

Therapist: Do you think you might be able to tell your husband about this feeling if we were to put him in this chair in imagination?

The therapist has facilitated the exploration of the underlying primary emotion of anger. After it has been accessed and acknowledged, the therapist encourages the client to express it.

Focus on Meaning or Focus on Emotion?

A 63-year-old client, Jim, who has been married several times, is talking about his current wife, who has two adolescent kids from a previous marriage:

So we are getting ready for Thanksgiving dinner and she seemed kind of down and sad, so I said, 'I am sorry your kids could not be here with

> you.' She says, 'I have been thinking about that. I think divorce should be illegal.' Well, that was it. That comment just killed the dinner. For the meal, we sat together in silence and tension for 2 hours.

Moment-by-moment formulation involves a choice about whether the client is unclear about what he is feeling or whether he is unclear on what this means. A response focused on feelings might be, "And you were hurt," whereas a response focused on meaning might be, "That felt like such a slight." In terms of choice points such as these, we believe that while some paths may be more ideal than others, "many roads lead to Rome," and that if you choose one first, you can always follow with the other. What is needed is "good enough" responding and not necessarily perfect responding.

Clients who have more difficulty with accepting or focusing on painful or vulnerable emotion are less likely to naturally organize themselves to focus on feelings, often because their feelings have been invalidated in the past by significant others. In response to an empathic response that focuses on meaning, such clients tend to explore meaning devoid of feeling. In response to the therapist's focus on meaning, the client may engage in an assessment of how his wife meant the comment or justify his reaction (anger). Eventually the client would become "lost in his head," putting forward different theories about why he was so angry and what is wrong with his wife. With clients who generally have trouble readily accessing emotion (see Chapter 4 on assessing emotional processing style), we consider it essential to focus specifically on currently felt internal experience.

Micromarkers Within Tasks

Many micromarkers emerge at particular technical points through the facilitation of specific tasks. (See Chapter 3 for a description of specific task models and tasks.)

Formulating Expression of Need

Therapists new to EFT tasks often ask, "At what point do I facilitate the expression of need?" The answer to this is in part intuitive: When a core emotion has been expressed, such as "I feel so alone" or "I am so afraid I don't matter," knowing that emotions and needs are associated in embedded emotion schemes, the therapist will hear the client as implicitly expressing need. It is almost as if clients want to move forward but do not know how; to propel them forward, the therapist asks them to focus attention on the currently felt emotional experience and ask what they may need, either from within or from the imagined other.

Formulating Hopelessness and Despair

The emotional expression of hopelessness and despair is most often a part of the process in the unfinished business task and the two-chair task for self-criticism. In accessing core adaptive and maladaptive emotions, hopelessness is often discovered. The formulation question emerges in a given moment, when the therapist must decide whether it is best to make space or give voice to hopelessness, thereby allowing and perhaps deepening it, or whether to try to intervene in a manner to help the person push past it. There is no fixed answer to this question; the ultimate response to the question is a judgment that is based on knowing the client, having knowledge of the processing that may have occurred previously with regard to this feeling of hopelessness, and the degree to which the particular client may be able to tolerate such a state.

Naming it can help clients to stop fighting against a feeling of hopelessness and move beyond it. On the other hand, therapists may get concerned that staying too long in a state of hopelessness is nonproductive, overly painful, and potentially damaging, particularly when clients are prone to severe depressive states or are extremely fragile. Hopelessness is part of the emotional landscape that one must move through. Acknowledging hopeless states helps clients feel validated and safe to move to more fundamental, core emotions.

Micromarkers Specifically Occurring With the Two-Chair Task for Self-Criticism

Formulating Anxiety Versus Depressive Split

One formulation decision point in the two-chair dialogue for self-critical work involves what kind of criticism to encourage expression of. That is, when clients are in the self-critic chair, the therapist will either hear an anxiety or depression-related split. An anxiety-related critic has more of a quality of fear-mongering, catastrophizing, or engendering future-oriented doom (i.e., critic: "If you do not start pulling up your socks and completing your work, you are going to end up on skid row"), whereas the depressive critic has a more decisive negative evaluation, for example, "You are simply weak. You have no backbone." Likewise, in the anxiety-related split, in response to the critic, the self tends to experience more fear, and the self in the depression-related split tends to experience more sadness, hopelessness, and shame. Anxiety and depression are highly interrelated, and clients may experience both; however, when issues emerge, it is useful for the therapist to recognize what "type" of critic is emerging and be able to facilitate the most fitting process.

Formulating the Expression of the Attitude Toward the Self

In self-critical chair work, therapists make formulation decisions regarding when to ask the critic about its attitude toward the other part of itself. This does not occur at the beginning of the task. Rather, in the beginning, the therapist is facilitating the critic to articulate the harsh, specific criticism toward the self. The therapist then facilitates the client to move to the self chair and respond, expressing both secondary (often hopelessness) and primary emotions (often shame and sadness), as well as needs, back to the critic. Then the therapist moves the client back into the critic chair and asks the critic to respond to the expression of need. Unless the critic immediately softens into a compassionate stance, the therapist may observe that the critic is not "making contact" with the self and is remaining detached and obstinate. It is at this point that the therapist will ask the critic to elaborate on its attitude toward the self. This will serve to access and deepen the emotion, which in this instance is most often contempt, and help the critic make contact with the other part of the self. This will move the dialogue forward.

For example, after switching back into its chair and in response to an expression of shame or sadness on the part of the self, the critic may respond:

Client: You are just not worth the ground you stand on.

Therapist: How do you feel toward him (or her)? (checking attitude)

Client: Well, I think he sucks. I hate him.

Therapist: So you don't like him, you are kind of looking down your nose at him, like he disgusts you.

Client: Tell him.

Therapist: You make me sick. You do not deserve to exist.

In this case, the accessing of contempt helped the client access primary shame.

Formulating When to Encourage Expression of Feelings Underlying the Critic

Another common formulation question EFT therapists face is when during the self-critical task to ask the critic about its own feelings. It is important to recognize that the critic is not asked (and should not be asked) to elaborate its feelings or internal experience until there is the sense of a shift on the part of the critic. As in the previous example, the critic might be asked about its attitude toward the self, but this should be differentiated from asking the critic what it feels like (as in the example above). In the latter instance, the critic is being asked to elaborate upon and deepen its experience with respect to the self, although this is only after primary emotion that underlies the contempt of the critic has been accessed. The point is that we do not wish

to heighten the contempt. In the previous example, the contempt is indeed present, although it is not being accessed in relation to the self. The question about the attitude serves to promote contact between the two sides and leads to further deepening of the self. When the emotion underlying the contemptuous critic emerges, which is most often fear, it does need to be deepened, explored, and expressed. Thus, any indication of a shift or partial softening should be carefully followed. When a new primary emotion emerges (in this case, fear), the therapist can then begin to explore it. Following the exploration of fear, the therapist will want to make sure that the person articulates the needs that underlie the critic. Thus, when fear emerges, often the need is to feel in control or to have a purpose. Fear is the most predominant emotion that underlies the critic and often pops up somewhat unexpectedly. If the person does not talk about feeling afraid, it may be important for the therapist to ask about or have the client elaborate on it. So, after the self has asserted and clearly stated its needs, the critic may soften into a more protective stance, saying things such as "I understand that you need a voice, and I am sorry you have felt unheard but I cannot allow people to see you as you may bring us both down. This could be the death of us both." The critic here has shifted from a contemptuous to a protective stance, and the therapist may help the person voice this but then become unsure of what direction to move the dialogue. The dialogue may become stuck at this point. It is important to understand that at these moments, when the once-harsh critic is talking in this manner (saying things such as "I cannot let you be heard because then I will not have a purpose" or "I will cease to exist"), this is actually an implicit expression of protective fear. It is a new emotion; the critic has previously been aware only of contempt. It is thus important that the therapist help the client articulate the fear by asking the person now in the critic chair, "What are you afraid of?" "What do you fear?"

Micromarkers Specifically Occurring With the Empty-Chair Task for Unfinished Business

Formulating When to Encourage the Expression of the Negative Other

A common formulation question that therapists ask is, "When do I have the client play the negative other?" One indicator might be that the client expresses sad or angry feelings toward the other but emotion is not strongly aroused or felt. Alternatively, when facing the other in the chair, the client may be able to access secondary feelings or global distress (e.g., "I can't believe you would do this to me"), but primary emotions are not aroused. The therapist might choose to ask the client to switch and play the negative

other when the client is interrupting a need and imagining how the other might respond by frustrating the need. For example, while exploring feelings in the self chair in relation to the significant other, the person might say, "I cannot tell her (mother) how sad I am because she just does not hear; she will just talk about how her coworker is bothering her so much. She just does not hear." The therapist would then ask the client to come over and enact or play the mother "not hearing" and being preoccupied.

Formulating When to Encourage Elaboration of an Episodic Memory Versus the Expression of Emotion

In the middle of the empty-chair dialogue, when the client is expressing emotion to the significant other in the chair, he or she may begin to spontaneously recall an episodic memory. The therapist must decide whether to encourage the elaboration of it or move toward the expression of emotion. An *episodic memory* is marked by the client remembering a specific (not generalized across situations) autobiographical memory in which the core emotion was felt. As such, the therapist may not recognize that emotion is embedded within the story and discourage the telling of the story in favor of staying focused on the task. In fact, the therapist should remember that allowing for the story may deepen the emotion. The therapist should listen to this story, hearing the core emotion embedded in it and fold it back into the dialogue. When the core emotion is accessed, the therapist can encourage its expression to the other, integrating the meaning into the ongoing dialogue. For example, a male client performing a chair task may be elaborating on a feeling of loneliness and remember a time of panic when he was 8 years old and taken to a toy store, got very engrossed in the toys, and suddenly could not find his parent. The therapist would then listen to the story, reflecting feelings of fear and loneliness, and encourage the client to express the sadness and loneliness he felt to the image of the mother in the other chair: "I was just so scared and I felt so alone. I did not know if you were going to come back for me." The therapist must ultimately decide, however, whether the episodic memory is most productive to explore. Therapists should watch for clients telling too many stories that no longer hold embedded core emotions and serve to take the dialogue off course. If core emotion has already been accessed or explored, it may be the wrong time to explore the episodic memory.

Formulating When to Express Sadness or Anger to the Significant Other

Sadness and anger are primary emotions with respect to the significant other, so it is important to have the full expression of both in order for the unfinished business to resolve. Primary emotions should be expressed in "I"

language (e.g., "I feel sad that you were not there when I needed you," "I am angry that you never saw what I needed"). The expression of sadness and anger takes a natural rhythm, so that when one emotion is completely expressed, the other most often follows. Often in empty-chair work, we facilitate the strong expression of anger, where the person might say to the father in the other chair, "I hate you. When you raged out of control like that I was so frightened. I never knew what you might do, and sometimes indeed you became violent, and I hate you for that." A few minutes later, the client may in fact express deep sadness at the loss of closeness to his father, saying, "I just wished I could be close to you. I never felt safe with you and so I never wanted to be close to you." The task for the therapist is simply to allow and facilitate the expression of both. If one of the two emotions is "missing" or has not been fully expressed, the therapist might consider this a micromarker and wait for the other emotion to emerge, and then encourage its expression. Sadness follows anger and anger follows sadness, but both must be deeply expressed for resolution to occur.

Formulating When to Elaborate the View of the Other

When is it best to elaborate the view of the other in empty-chair work? When the client has made full contact with the negative other and fully expressed primary emotions and needs, the client is asked to move into the chair of the other—sometimes clients spontaneously let the therapist know they would like to—and sometimes, to the therapist's surprise, the client will begin to speak from the subjective perspective of the parent, saying in effect,

> (as mother) I was not able to hear you because it brought me closer to my own pain and sadness and I just could not bear to feel it, it felt like a bottomless pit, so I avoided and focused on all those meaningless details and gossip about friends, but I know I was not there for you in the way you might have needed.

When the therapist senses a shift in tone of voice and hears the client move from a withholding or critical position to a more flexibly disclosive one, even if slightly, it behooves the therapist to switch the client to the chair of the other and not encourage the direct expression of emotion, but rather, to explore and be curious about feelings underlying the other. The other must say how it is from his or her perspective, and the goal is to give the client space to do it.

Formulating When to Help the Client Let Go of an Unmet Need

In empty-chair work for unfinished business, there are times when the client has explored and expressed core adaptive emotions and needs and

elaborated the positive feelings underlying the other, and yet the dialogue cannot move forward because he or she cannot let go of the unmet need. When the client is very stuck in this manner, the therapist must make a microdecision formulation. Indicators for this are that the person has been through the same process a number of times, enters into a state of hopelessness, but nevertheless cannot let go. This is accompanied by a sense of despair. Clients might get stuck on the feeling that they deserve their father's approval and are determined to still prove it, or they might just feel ripped off that they did not get the loving nurturance from their mother and are not able to accept that they did not get it. This is an indication that the therapist must devote special consideration to work on letting go of the unmet need so that the person can move forward. This usually involves an explicit discussion wherein the client and therapist jointly formulate what is blocking the client from letting go, discuss the benefits and drawbacks of letting go versus holding on, and sometimes construct a ritual that focuses on the letting go process. We know of a client who was having a great deal of difficulty letting go of his need for his father's approval. Together the client and therapist decided that the client would go to the seaside and gather rocks, each one symbolizing a different feeling and significant painful memory about his father, and slowly throw them into the sea. The client completed the ritual and relayed the experience to the therapist, who listened and validated. At the end of the session, the client reported feeling relieved, as if a weight had been lifted off his chest.

Micromarkers Specifically Occurring Within the Systematic Evocative Unfolding Task at a Marker of a Puzzling Problematic Reaction

In the context of implementing the systematic evocative unfolding task, when a client presents with a puzzling overreaction to a particular situation, therapists sometimes confront a micromarker wherein they must formulate whether to further deconstruct the situation to which the person reacted or explore the underlying emotional response in reaction to the situation. For example, a therapist might clarify all components of a particular marker and tell the client, "So, you just felt so down after lunch with him and you don't understand why." Client and therapist together have then revisited the situation and rebuilt the scene. The therapist knows that next, when exploring the reaction to the situation, it is necessary to slow down the process and follow two strands: the rebuilding of the stimulus or situation and the exploration of the internal, emotional response. Here the therapist must formulate which to explore first (a microdecision point). The therapist will choose to deconstruct or explore that which is less available to current awareness. Thus, the person may say, "After the lunch we had together I just felt so depressed,"

and the therapist reflects, "You just felt so down." This reflection communicates understanding but does not increase awareness. Instead, the therapist should then choose to explore in more depth what it was in the situational interaction that triggered the underlying response. Here the therapist may use empathic explorations and conjectures (e.g., "There was just something about his dismissive tone, that left you feeling cold and distant"; "It was just the way he seemed to be looking down his nose at you that made you feel so little, so diminished, is that it?") Thus, whether the therapist should reevoke the stimulus or deepen and explore the internal emotional response is guided by a momentary judgment of which aspect of the emotion is perhaps poignant but unexplored and thus stands out and requires further deconstruction.

STEP 14: ASSESS HOW NEW MEANING INFLUENCES THE RECONSTRUCTION OF NEW NARRATIVES AND CONNECTS BACK TO PRESENTING PROBLEMS

The last step of the last stage of formulation occurs through task work in relation to important narrative themes when emotions and meanings have emerged. Here therapists play an important role in helping clients to integrate the new experience into ongoing narrative structures in an attempt to re-form a coherent and consistent whole from which the client can continue to live and make sense of the world. At this stage, therapists help to fit and make sense of new discoveries and meanings in terms of the particular relational and behavioral difficulties that clients presented with and in terms of existing attachment and identity-related themes that have emerged throughout therapy. For example, after some sessions working on self-criticism that has previously garnered a great deal of contempt, shame, and hopeless despair (and that has been apparent through ongoing stories the client relayed in each session), and after having accessed pride or anger in a particular session, Sam came to a session and reported an incident (with a colleague) in which he previously would have felt put down, criticized himself, and become despairing, but instead stood up for himself and felt strong. In response, the therapist said,

> In the past you might have got very down on yourself, really beat on yourself and then felt bad, almost like a shame hangover for a few days, but in this situation you were able to refrain from turning in on yourself, you stood up for yourself and got assertive and you felt better, stronger. So, I guess this is really important, and it is important to stay aware of this because when you don't criticize yourself you feel better and stronger, and it is important to find that strong part of you that feels "I am worthwhile, and I am not going to take this and speak from that." Is it a good idea to practice that?

A client, Jen, who had been prone to feeling abandoned and rejected by her husband, started a session with a description of a recent event where her husband left for a holiday and instead of feeling abandoned, she felt "a little sad" but was able to felt calm and serene inside and even enjoy the time to herself. She described how instead of feeling rejected, she felt understanding of his need for time with his friends and was able to soothe herself. The therapist then said,

> So it seems you were able to access this internal, calm part of you that we got in touch with last session, and this is important as you are now able to take care of and soothe yourself even when he is not there.

The formulation question in this step, then, is one of knowing when to facilitate the process toward helping clients fit new meaning back into existing narrative structures and helping them to connect it to presenting problems. The answer to this question is that people are naturally motivated toward meaning making. When emotion has been explored, new insight tends to follow (Pascual-Leone & Greenberg, 2007b). In our experience, when new emotion has been deeply explored, clients have a tendency to "make sense" of it and fit it into their ongoing understanding of themselves in the world. What is important here, then, is that therapists are able to hear when clients need help to facilitate meaning making. The therapist's role in response is a "following" one (as opposed to "leading" as is done at other points in therapy, e.g., when deepening emotion; Elliott, Watson, et al., 2004; Greenberg, 2004a). This is, however, very important; the encouraging, supportive, and facilitative role that the therapist plays helps clients to reflect on their own experience and to consolidate changes conceptually (Angus & Greenberg, 2011; Greenberg et al., 1993). They can thus carry new meaning forward and apply it in an active way in their everyday lives (Elliott, Watson, et al., 2004; Greenberg et al., 1993).

CONCLUSION

After the initial stages of unfolding the narrative, observing emotional style, and formulating underlying core emotion schemes and determinants, case formulation involves process diagnosis of markers and micromarkers and subsequent microdecisions about how to best facilitate the next moment. This chapter has provided a number of therapeutic scenarios that therapists encounter at given moments across treatment and has illustrated how EFT therapists might choose to proceed. At the end of this stage, new meaning that is attained through the process is ultimately tied together in a co-constructive fashion with the ongoing, re-storied narrative and connected back to originally presenting relational and behavioral difficulties.

III

CASE ILLUSTRATIONS

7

SOPHIE

In this chapter, we describe a case that illustrates the steps of a Stage 1 case formulation. The client, Sophie, entered therapy when her life felt progressively more difficult to bear. (This was her second time in therapy.)

STAGE 1: UNFOLD THE NARRATIVE AND OBSERVE THE CLIENT'S EMOTIONAL PROCESSING STYLE

Step 1: Listen to the Presenting Problems (Relational and Behavioral Difficulties)

In the first session, Sophie relayed how she had felt depressed for a long time:

Therapist: This is our first session and our opportunity to get to know one another, so I thought we'd use this first session for you to

http://dx.doi.org/10.1037/14523-007
Case Formulation in Emotion-Focused Therapy: Co-Creating Clinical Maps for Change, by R. N. Goldman and L. S. Greenberg

tell me what brought you here and what you've been feeling, how you got to be feeling how you are . . .

Sophie: Do you want me to start in any particular order?

Therapist: Uh, just whatever is most pressing now . . . whatever comes to your mind.

Sophie: (laughs) Well, I have been struggling with depression most of my adult life, I'd say from about my mid-20s on, Yeah, it has been pretty bad, really, for a long time.

Therapist: So for a long time now, you have been kind of hurting.

Sophie: Yeah, it's been a struggle. I'm afraid it's hereditary. I do believe my mother's a manic-depressive. She's never been diagnosed as such; I remember her struggling with depression all the time. So it's a real fear for me.

Therapist: Yeah, so it is very scary.

Sophie: It seems like it's just . . . It seems like it's something you can't get away from. It's not, it's not like you've got a cold and you get a medicine and you're all better.

Therapist: So, yeah, sometimes it feels kind of hopeless. Like no matter what you do it, it comes back, like you just can't beat it.

Formulation initially involves problem deconstruction in the context of relationship building. The exchange provides a good example of how a session might open and how meaning is initially unfolded with empathic tracking responses. Sophie's request as to "whether she should start in any particular order" is an inquiry about the structure of the process. The therapist conveys immediately that what she talks about should be guided not by any imposed structure but by what emerges in her awareness or consciousness at the present time. This communicates the discovery-oriented nature of the therapeutic process as well as the idea that clients are meaning-making agents of change who guide their own process.

The therapist's curiosity drives the process of formulation at this stage. She aims to clarify the problem through the empathic process. Case formulation at this stage does not, however, involve agenda setting. Rather, Sophie is encouraged to "turn eyes inward" to her own internal emotional process to see what is important and ought to be the focus of the session. This is based on the core principle of EFT that emotion gives us information about what is significant to us and about our reaction to situations, so it necessarily becomes the compass that guides formulation.

When Sophie starts describing her problem, the therapist empathically follows, putting her at ease and conveying an understanding of her

meaning. The therapist is empathically mirroring Sophie's experience and in so doing, helping to focus her attention on underlying feelings and core meanings. This is the beginning of the dialectical-constructivist formulation process wherein client and therapist begin to form a focus for the therapy by their shared construction of the problem. It is important here that the therapist does not just follow with sympathetic acknowledgment of listening and head nodding. Although these nonverbal and paralinguistic forms of communication are important signs of empathy, the therapist must verbally communicate her understanding and help Sophie "name the hurt." This naming is key in the validation process and in forming a focus. Developing emotional safety through validation is the key first step in formulation in that it will promote more intimate disclosure and deeper processing, which will help lead to the core underlying emotion schemes and the focus of treatment.

Sophie has clearly articulated one of the main presenting problems, and the therapist immediately picks up on and reflects it. As Sophie says, she is suffering from a painful and intractable depression. The therapist wants her to know that she understands and comprehends the scope and depth of her presenting problem. By reflecting it back to her with empathy, the therapist is "bookmarking" it for future attention; she underscores that she hears that this is a problem. In addition, the therapist infuses the emotional track into the process by saying it feels scary or hopeless. Here Sophie and the therapist are implicitly stating that Sophie's depression is a problem to focus on in therapy and that the emphasis will be on the emotional impact it has on her.

One of the tasks of therapy is to explore emotion in order to access aspects that will help the client build the resources she needs for her goals (in this case to alleviate depression). This is the overarching goal, but at this point the exploration of experience has only begun. The third aspect of the alliance, the bond of trust between therapist and client, is being formed through the therapist's accurate reflection of the client's experience, coupled with acceptance and validation. This attitude, over time, will help secure the bond and create a safe, trusting environment for formulation.

The therapist does not inquire further about Sophie's relationship with her mother but notes that her mother was depressed. She imagines the issue will emerge again in an emotionally laden context, when it will be explored. That is, EFT formulation is not content guided; there is no assumption that has been made that psychogenetic causes are necessarily worth pursuing or the source of problems. Even though Sophie's relationship with her mother may turn out to be part of the source of her current emotional pain, the therapist judges that an exploration of it at this point would likely be abstract in nature. Because EFT is an experiential, bottom-up therapy, the therapist is more interested in promoting emotional exploration to get at the source of

Sophie's problems. Sophie presents her other main concern while the therapist continues to empathically explore:

Sophie: What brought on my last one is that I have a 16-year-old. And I haven't been getting along with him and we've always been really close. He's always been just a wonderful kid from the time he was little. Now he's 16 and he hasn't been going to school and got himself involved in drugs. He hangs out with the wrong crowd and I had a lot of trouble dealing with all of that. And I felt really guilty about how I'd failed him. And it just kind of brought me back into that same spiral again.

Therapist: Tailspin. And so the feeling was sort of "I failed him."

The therapist responds to Sophie's presentation of the problem with an emotion-focused, exploratory empathic response. The therapist does not attempt to reflect the total content of Sophie's statement in her empathic response (e.g., "Let me get this right: Your son started taking drugs and then you . . ."). Rather, it is important that empathic responses be concise and vivid. The attempt is to pick up on key important aspects of the message rather than be comprehensive and summative. This helps to focus the therapy and establish an emotional focus. The therapist is thus guided here by poignancy (that she feels she has failed with her son and has been left feeling so down). Here a trace of the underlying maladaptive emotion scheme related to failure is emerging and will eventually become central to the formulation. This will form the focus and the goal. Formulation is not guided here by specific content or conceptual understanding. Rather, the therapist notices that when Sophie says "failed," her voice cracks, lilts, and falls down; the tone in her voice connotes anguish and distress. This is what moves the therapist and leads to the focus.

Thus, an alliance, the bedrock of formulation, is being formed. In fact, although they aren't discussed explicitly, all three aspects of the alliance—tasks, goals, bond—are addressed in this short exchange. By exploring what brought Sophie to therapy, client and therapist are establishing goals: (a) to work on the feelings of failure that have been activated and are painful and paralyzing, and (b) to explore related problematic issues with the client's son. One of the major general tasks that occurs throughout therapy is being communicated: to explore emotions related to her problems in a present-centered fashion within the context of a safe relationship. The bond is being formed through the nonjudgmental and accepting exploration of all aspects of her painful experience. The major presenting problem has been identified: Sophie feels very depressed (and has been that way for a long time), and the beginning of a focus has been identified: She feels like a failure as a mother because her son has a drug habit.

Step 2: Listen for and Identify Poignancy and Painful Emotional Experience

The therapist is moved by Sophie's statements and the tears that begin to form in her eyes. Guided by poignancy, the therapist is moved by what she hears as painful for her. The therapist is very careful here to not "skim" or pass over Sophie's emotion, making sure to help her "stay with" the sadness. She makes simple empathic reflections that help Sophie pay attention to her experience rather than become distracted or move away from it, which she would likely be inclined to do. Sophie occasionally laughs, and it is important that the therapist does not get put off by Sophie's laughter but rather considers it as part of the formulation that laughter might be an emotional avoidance strategy.

Sophie: Yeah. I have invested all this time.

Therapist: So your sadness grows.

Sophie: (crying) I was doing fine until (weak laugh) all that.

Therapist: Yeah, somehow that really touches something. This feeling of, I've failed or what did I do wrong again?

Sophie: Right.

Therapist: Yeah, yeah. It's lingering, it stays with you.

The therapist is beginning to formulate Sophie's pain. When she begins to cry, the therapist validates the pain, suggesting that this whole experience is important. Her voice softens but does not lose conviction. There is an interest behind her statement (demarcated by the questioning tone). This is not an interrogative request for an explanation but rather an invitation to join together and for Sophie to experience how the pain holds important information and may be important to listen to.

Step 3: Attend to and Observe the Client's Emotional Processing Style

At this early stage, formulation involves attending to Sophie's particular emotional style in order to formulate her most central concern and also ultimately how to intervene with it. Emotional style is judged on many different dimensions, each of which will be broken down and explained as it applies to Sophie. The therapist observes but is not in the process of making discrete or even explicit judgments about emotional style. In the following excerpt, the therapist talks with Sophie about her feelings about her son and his drug use.

Sophie: Um, it makes me angry with him.

Therapist: Yeah. So there is kind of an anger.

Sophie: I've discovered through this whole thing, spent a lot of time sitting at home and really thinking, I actually had to take some time off from work because I couldn't function at work. Like I just really didn't know what to do and he was fighting me on everything. I just realized that I'm just a really angry person in general.

Therapist: Really. Uh-huh.

Sophie: And I never realized. Actually people don't think that of me.

Therapist: Yeah.

Sophie: (inaudible) . . . who I am really.

Therapist: Um, yeah. You're angry, really angry at . . .

Sophie: Everything (laughs) . . .

Therapist: There's somehow an . . .

Sophie: I'm angry at people.

Therapist: Anyone in particular. I mean, you're saying lots of people (laugh).

Sophie: I'm angry at human nature sometimes, people just have a tendency to . . . the closer you let people to you, the more likely they are to let you down.

Therapist: So there's just like this feeling you have about everyone.

Sophie: I don't trust people very easily. I know. And it's shown me that I really can't rely on them. It's only been my son and I. And there's never, there's never really anybody I can rely on.

Therapist: Yeah. There's just a feeling of disappointment I guess and loneliness.

Sophie: Um, I don't know if I would say lonely as much as alone.

Therapist: Alone. Yeah.

Sophie: Yeah, if I'm gonna do this, I have to do it myself. But I wouldn't say I feel lonely. Through it all.

Therapist: So it's more like . . .

Sophie: I'm too busy being angry at the whole thing. (laughs)

Therapist: Yeah and you find yourself feeling blaming or angry at people? Like when you say you're too busy being angry.

Sophie: (big sigh) That's a really hard one to explain. I kind of shut down when people let me down. Fine, whatever. I can do it by myself.

Therapist: Oh, I see. Like I'll just take my things and go elsewhere.

Sophie: Yeah, I just kind of shut right down. And, I guess that's partially anger, like I don't get angry. I don't yell at anybody. I don't lose my temper at anybody. I think I just shut down.

Therapist: Fine.

Sophie: Yeah (laugh). And so I don't make the first step towards people. It's like I don't want to open myself to . . .

Therapist: Being with them.

Sophie: Yeah. So I just kind of close off. And, I guess I've done that gradually over the years more and more, more and more. And I'm really aware of how closed off I really am. To think that it's personal. If you can talk about things but it doesn't matter when you don't let anybody in.

Therapist: So it's like I'm not gonna let anyone too close to me.

Sophie: Yeah.

Therapist: 'Cause they could hurt me, right?

Sophie: Yeah.

Therapist: I don't want to go through that. It's too painful. Yes. (silence: 5–10 seconds, noticing the beginning of tears) It's hard to feel so . . . alone.

Sophie: (crying) I'd rather be angry inside.

Therapist: It's hard to . . .

Sophie: Because when I get sad I get depressed, and then I don't function. I don't have (wavering voice) the luxury of not being able to function.

Therapist: Yeah, that just cannot happen. You have too much responsibility to take care of your son, your job . . .

Sophie: I have to take care of myself and I have to take care of my son. So I can't afford not to (tears and sniffling). I can't afford to fall apart.

Therapist: So it's just that there's never any time for you to let down and to just cry and say . . .

Sophie: I don't like it 'cause I don't think it solves anything. (crying)

Therapist: Feels unproductive.

Sophie: (sigh) Uh, absolutely. It's feels counterproductive. I'd rather just, if I'm really angry I can clean my house in like a half an hour (laugh). If I feel sad, I don't want to get out of bed.

Therapist: Mm hmmm. So it's like sadness leads to more sadness.

Sophie: Sadness makes me very lethargic.

Here the therapist is exploring different aspects of her emotions, including anger, sadness, disappointment, and feelings of betrayal.

Sophie suggests that she is very angry in general. Case formulation involves a moment-by-moment assessment of how pervasive Sophie's anger is and whether the anger she describes is primary, secondary, or instrumental in nature. This is part of an emotion assessment. The therapist first explores who Sophie is angry at; it seems to the therapist that anger is not her primary emotion. The evaluation is based on an exploratory process in which it co-constructively emerges that there is something underlying the anger. Clients are always experts on their own experience. The therapist's job is to help them explore and arrive at what is primary. There are different ways to coassess with clients whether an emotion is primary or secondary and those include the therapist listening to voice and manner of expression and the client attending to his or her own experience. In this case, Sophie's anger is not activated when she talks about it. Thus, the therapist's assessment is based on Sophie's vocal quality and bodily cues not indicating anger, and more hurt being communicated in response to the question of who she is angry at. She responds by talking about her disappointment and hurt and it then becomes clear that disappointment underlies her anger. She feels that people have continuously let her down. Theoretically and conceptually, the therapist understands that primary anger is felt in response to violation (with the action tendency being to stand up and protect oneself.) Secondary anger, on the other hand, hides, defends, or protects a more fundamental, primary emotion. It is clear that Sophie is attempting to protect herself from a more primary vulnerable emotion and that this disappointment and hurt fuels her anger.

This formulation is confirmed when after the therapist's reflection of the disappointment and hurt, her voice softens and cracks and she stays with the exploration of this emotion. Sophie talks of "shutting down"; she refers to a protective mechanism that may indeed be part of a maladaptive emotion scheme. It seems that when Sophie has felt hurt and disappointed by others, she has felt a great deal of despair and has concluded that no one has been able to share in or soothe her hurt. Not having had this experience, she has had no means to soothe her hurt. The sense is then that her hurt and disappointment have a deep history. At this point, the therapist has no knowledge of this history and does not want to impose a particular meaning to the hurt or its source; she simply understands that it is significant. Rather than ask questions about her prior relationship with her mother at this point, the therapist feels that they have hit upon an important emotion scheme that merits further emotional exploration; in other words, they have gotten closer to the core, maladaptive emotion scheme. What has emerged so far is the early identification of a maladaptive scheme that is expressed through feelings of the sadness of lonely abandonment and closing down in order to protect herself from the

pain of disappointment. This will eventually become a focus for therapy: She feels anger very acutely, but it is secondary to the hurt that feels painful and unbearable. She feels powerless to change it, though, and shuts down in an effort dam up the pain. This type of process has been described in terms of emotional responses to sadness and loss (Bowlby, 1980) and their neurobiological correlates (Panksepp & Watt, 2011).

Client Vocal Quality

The therapist is aware that Sophie's vocal quality changes as she talks. At times, her energy is turned outward. For example, she opens with "I do believe my mother's a manic-depressive. She's never been diagnosed as such; I remember her struggling with depression all the time." The therapist notes that even though Sophie is talking about an emotion, she discusses it in objective terms. In addition, it is said in an even, rhythmic tone, taking on a prerehearsed quality. At other times, however, she has a more focused voice (Rice & Kerr, 1986). For example, Sophie says, "And I never realized. Actually people don't think that of me, who I am really." Here her voice has a focused searching, "eyes turned inward" quality. Her tone is more ragged and broken; voice contours are uneven. Her exploration has a fresher quality, as if she is perhaps saying this for the first time out loud. This indicates that she is forming new meanings and has the capacity to use exploration productively. At other points, she is clearly emotional; for example, when she is crying, stating that she does not like to be sad, tears and sadness are clearly breaking through her speech.

In terms of case formulation, this client is able to move through a range of vocal qualities, which is prognostically positive for her capacity to explore internally across the course of therapy. Higher proportions of focused and emotional voice have been associated with outcome (Watson & Greenberg, 1996); with empathically guided exploration, this client is able to attain these vocal qualities. Someone who shows no focused voice is much more difficult to reach emotionally and requires more process guidance to help them shift attention inwards or evoke more felt experience.

Emotional Arousal

As part of the assessment of Sophie's capacity for emotional processing, the therapist assesses her capacity for emotional arousal (Warwar & Greenberg, 1999). As indicated in the preceding excerpt, Sophie begins to cry when she talks about feeling alone. Until this point her emotional arousal was low to moderate, but at this point it increases. Her voice gets lower, cracks a little, and she begins to cry. This is equivalent to about a 4 on the emotional arousal scale. It is not higher, because emotion is not significantly interrupting her speech or posture. In terms of formulation, however, it

suggests a capacity for emotional involvement. This indicates that the client is talking about material that concerns her, which should be considered as pointing toward the focus.

Client Experiencing

Therapists assess clients' capacity for involvement or engagement in the content of their speech. In the preceding exchange, Sophie is clearly involved and engaged with the content of her speech. She is highly subjective, referring to her own experience and elaborating upon it in detail. She is concrete and specific in her descriptions of herself and her personal interactions. Her descriptions are vivid and evocative. This indicates Levels 3 and 4 on the experiencing scale (Klein et al., 1969) and is associated with a moderate capacity for involvement in the content of her speech. At times, she is conceptual ("I am just an angry person"), which is considered lower on experiencing (Level 3); at times, she focuses further inward, with experiential statements like "I'd rather be angry (than sad) inside" (Level 4). From a formulation perspective, all of this signals to the therapist a capacity to focus inward on experiencing. That is, guided by therapist empathic responding, she is able to "turn eyes inward and explore." In some cases, clients have more difficulty "using" empathic statements to guide inner exploration and need more specific assistance in this activity. A client consistently low in experiencing in spite of accurate empathic explorations and conjectures on the part of the therapist would lead to a formulation that the person needs more focused work specifically helping him or her access core emotions. If the client is low in experiencing, more psychoeducation and process directiveness are needed; if the client is high on experiencing, then more following and exploratory responses help get to the core emotion schematic material.

Emotional Productivity

The therapist assesses the client's capacity for productive emotional processing (Greenberg, Auszra, & Herrmann, 2007) throughout therapy. Once again, these are not explicit judgments. The therapist is listening to the content as well as the manner of speech, including facial expression, bodily posture, and changes in vocal intonation.

Attending

Sophie appeared to focus on and attend to her emotions (sadness, anger, and hopelessness). She was able to use the therapist's empathic explorations to further explore emotion.

Symbolization

The therapist observed that Sophie was able to symbolize her emotions but was reluctant to do so; she explicitly states that she does not always trust her emotions. She demonstrates awareness of this process, however, which the therapist formulates as a positive indicator of her capacity for emotional exploration in the future. For example, in the excerpt above, she cries as she says, "I don't like to feel sadness. It is counterproductive." A few minutes later, while talking about not knowing how to make decisions about her son, she says, "Yeah, like I am often not sure what my feelings are. I can't even identify that. It just seems like such a difficult thing. I always have my head and my heart and they are at war with each other." Thus, she is able to symbolize emotion but is consciously aware of not wanting to feel it, particularly more vulnerable emotions like sadness. She is also not sure whether she can use the emotion to make decisions. She is definitely in conflict and describes multiple, disparate voices; she demonstrates a capacity for and fear of symbolization.

Congruence

The therapist was aware of incongruences in the way in which Sophie processed emotion. For example, in response to the therapist's question in the excerpt above about whom she might be angry at, Sophie laughs as she says, "Everything." EFT therapists are very attuned to incongruities and sometimes help clients become aware of them, saying things such as, "Are you aware that as you talk about your anger, you laugh?" Here, the therapist is aware that it is a first session and gave primacy to building trust in the relationship; the therapist deems it too confrontational to directly communicate such an observation and rather elects to bring Sophie back to her internally felt emotions through emotional exploration. In terms of formulation, however, the therapist notes her discomfort with the emotion at this point and considers the possibility that the anger may be strong and that other more deeply held, more vulnerable emotions may lie beneath.

Acceptance

At first glance, it seems that Sophie struggles to accept her emotions, especially her sadness. The statement that she would rather feel angry than sad is a clear example. Acceptance of emotion is indicated by an exploratory attitude and an open receptivity toward emotions as opposed to negative judgment about them. In terms of formulation, it is seen as a goal of therapy that clients are able to accept emotions, although it is quite common when starting out for them to struggle with doing so. Indeed, the acceptance of

emotion is often a major goal for treatment. Full acceptance of emotion may in fact be indicative of an ability to resolve emotional problems independent of therapy. It seems, then, that Sophie is not negatively judging herself for being sad but instead finds it difficult when she does feel sadness and pain. In many ways, Sophie is suggesting that she has more trouble regulating her emotion than accepting it. This adds to the formulation that avoidance of sadness out of a fear of being overwhelmed by it is one way that she protects herself. Again, we emphasize that these are all process, not person, formulations. We do not regard this as her character structure, nor do we conclude that her avoidance of sadness is dysfunctional. Rather, we formulate, at this point, that in therapy she may have difficulty getting too close to her sadness.

Regulation

Overregulation is indicated by an inability to identify emotion. Underregulation is indicated by an inability to take distance from the emotion, feeling overwhelmed by it and out of control. In terms of capacity for emotion regulation, Sophie presents a complex picture. She describes how she shuts down when she is angry. By doing so, she suggests that she is more overregulated than underregulated. On the other hand, she is able to access her emotion in the session and in fact becomes quite tearful. As she begins to access more pain, between talk turns, her arousal increases to a 5 on the emotional arousal scale, suggesting a strong interruption of emotional expression in her voice, body, and posture. Crying is now erupting through her speech, and at one point she stops talking and simply cries for 10 seconds. She then goes on to tell the therapist how sadness is "unproductive" and that she cannot function when she feels it. She is suggesting that she becomes overwhelmed when sad and generally become underregulated when feeling strong emotions, particularly sadness. Sophie's strategy of overregulating her emotions is understood as an attempt to control her underregulated emotion.

Agency

Agency relates to whether clients take responsibility for their own experience. Sophie mentioned almost immediately that she thinks her mother is "depressive." The therapist notes this as a concern for Sophie and also hears it as a statement of her pain and hopelessness regarding her depression that she feels she has been "struggling with most of her adult life." The therapist also notices that she is construing her depression as "visiting" her, that perhaps there is a hereditary or genetic component and that she is a victim of it. This applies to the formulation question of whether Sophie feels herself to be an agent of her problems, a subject at the center or her experience, or someone who experiences her problems as external to her (i.e., as their passive victim).

Sophie also says she is "too busy being angry about the whole thing," which the therapist hears as her blaming others. She wonders how much responsibility Sophie is taking for her own problems. On the other hand, in response to the therapist's queries, Sophie says she shuts down when people let her down and differentiates this experience into sadness, disappointment, and hopelessness. This piece suggests that she is in fact agentic with respect to her own emotions. In addition, she appears willing in the session to explore her emotion and even explore her role in interrupting or squeezing it back. This is indicated in a statement, said a few minutes later, when she shares feelings about pain related to her childhood.

Sophie: Some of them are time periods; some of them are mostly unpleasant events. I can't always remember specific events, I just remember feeling sad.

Therapist: So it is hard because you feel you should remember more but what you do recall is just feeling sad.

Sophie: Yeah, but maybe I don't want to remember. I think I am struggling with that. A lot of unpleasant memories are still there. The reason for them is still there, and my parents are a big part of it.

In terms of agency, then, Sophie presents a mixed picture. The therapist formulates that while she is not fully owning or taking responsibility for her own experience currently, she has the capacity and is in the process of becoming agentic with respect to her own emotion.

Differentiation

Sophie does not seem stuck in the same emotion and thus is capable of differentiation. When she talks about her emotion, she is quite able to sequence and differentiate out complex emotions. This is indicated when she says that she is "not so much lonely as alone" and moves forward to explore the emotion. It seems that she is able to check inside, see if the word fits, and use it to further differentiate an emotion. The therapist thus formulates that Sophie possesses a strong capacity to be able to differentiate her emotions and this is a positive sign for moving forward in therapy.

Step 4: Unfold the Emotion-Based Narrative/Life Story (Related to Attachment and Identity)

Sophie has begun to tell her story. Formulation at this early stage involves hearing the important story in order to identify and understand the core emotions and scripts that govern the narrative. The goal of formulation

is to figure out how to help access the core maladaptive scheme, and the narrative in the beginning provides a framework for understanding how the emotions are situated in relation to each other and how the core maladaptive schemes have been formed. Within the first couple minutes of therapy, she stated that her mother struggled with depression and that creates fear in her. Thus, the immediate emotional tone is fear, resignation, and hopelessness. A few minutes later, Sophie describes herself in more relational terms. She says she is pervasively angry and largely in response to people with whom she has been close having let her down. However, she sounds sad as she talks about this. Thus, empathic exploration is revealing complex, painful maladaptive emotions. Primary adaptive sadness, by definition, once acknowledged and felt, changes people, and they become aware of needs not presently met. New emotions emerge. Sophie's sadness here, though, does not seem adaptive. As she states, once she starts to feel it, it does not stop; it is overwhelming and leaves her (sometimes dysfunctionally) depressed for days. What is important to note for case formulation is that her sadness is not purely felt, discrete, adaptive sadness; rather, it is most likely part of a complex emotion scheme combined with hopelessness and perhaps fear of aloneness and/or shame. Additionally, shame is signaled when she talks of feeling inadequate in general. As of yet, these are just pieces. The whole puzzle has not yet come together, and the formulation of her major core emotion schemes is only beginning to become clarified. A few minutes later, Sophie mentions her relationship with her mother.

Sophie: Our contact is minimal. Very superficial. It is just so difficult to talk to her.

Therapist: Yeah. So you're saying there are some unpleasant memories that really haven't gone away and they still come to you.

Sophie: Yeah. And because my parents are still alive and still there it's like they don't ever go away. Unless I break that tie completely.

Therapist: So as long as they're still alive, you can't break the tie.

Sophie: Well, the same old reminders are always there.

Therapist: Oh, I see. So the things . . .

Sophie: My mother's very critical—extremely critical. I've never done anything right in her eyes. And I still don't. Even though she lives miles and miles away. So it's a constant reminder if I try in my adult life to work on not being so critical of myself and not be so critical of Jeremy (son), every time I talk to her it just . . . she's very critical. It's always in my face.

Therapist: I see. Yeah.

Sophie: So I can not talk to her for months and do great, and then in one phone call she could just . . .

Therapist: So she could wipe you out in that time.

Sophie: Yeah. . . . well.

Therapist: No?

Sophie: She doesn't wipe me out anymore because I try to realize this is the source. She'll never change. So she doesn't crush me, but it brings back all my feelings of not being adequate and not being good enough and then those are like the ones that I keep down.

Here the exploration is providing insight into her relational history with her mother, by whom she feels judged and criticized. In response, Sophie feels devastated and depressed, sometimes dysfunctionally so. In further exploration, a few minutes later she further describes the origin of this particular relational pattern with her mother. It is worth noting that the therapist has not prompted or asked specific questions about her childhood but rather is exploring her stated feelings of "detachment and coldness." In the course of the exploration, Sophie makes meaning, connecting her feelings into her familial background. This is the beginning of connecting the narrative and emotion tracks. When the exploration begins, Sophie shares her experiences of loneliness and disappointment. The therapist takes the opportunity to ask some "information gathering" questions about her past, so that she can fill in her developing picture of Sophie. It is much more meaningful precisely because the information emerges out of the narrative, relational historical context. It gives the therapist access to emotionally nuanced material in working towards the formulation of the core maladaptive emotion schemes. Observe how in the following emotional exploration, the relevant narrative pieces emerge.

Sophie: And it feels like I'm getting colder and colder. And that's also scary.

Therapist: It frightens you. So it's almost like somehow that you're just missing . . .

Sophie: Something (cries for 10 seconds).

Therapist: It almost seems like missing . . . some nurturing.

Sophie: Yeah. But I don't let any people give it to me. And the people that I want it from (crying) won't.

Therapist: The people you want it from won't.

Sophie: They haven't done it in 42 years, they're not gonna start now.

Therapist: Are you talking about your mother?

Sophie: And my dad.

Therapist: And your dad. So both of them . . .

Sophie: And my brothers.

Therapist: Older brothers?

Sophie: I have four of them

Therapist: Four older brothers.

Sophie: Three older, one younger.

Therapist: And so, you're saying, I've been . . . there for them.

Sophie: (crying) Right.

Therapist: My whole big family and I've been all alone. Really, it sounds like it's so painful.

Sophie: (crying) It is.

Therapist: There's a lot of pain, lot of sadness.

Sophie: And it never goes away.

Therapist: It just feels like it will never go away, it will always be with you.

Sophie: Well, yeah it does go away. When you shut it down.

Therapist: So there is this feeling of I want to get rid of it . . .

Sophie: Shut it out.

Therapist: Like these wounds, these scars forming, these wounds don't really go away.

Notice here that the maladaptive emotion scheme has been activated. The therapist is getting close to being able to formulate a more complete picture of its elements. Sophie is beginning to make connections that are reflected rather than interpreted by the therapist. The belief, and the goal, is that when new emotion is integrated into awareness, new meaning is being automatically constructed. The therapist's job at that point is to empathically follow. Thus, the therapist empathically explores as Sophie does the meaning-making, relating as she does the detached, withdrawn feelings in her current life to her past relationships with family members. When the therapist validates and acknowledges how much pain she is in, she begins to again discuss wanting to shut off those feelings. She is sending a clear message

that the pain she feels regarding the unmet needs and lack of validation and nurturance she received felt unbearable. She felt she had no choice but to "cut if off." The therapist begins to formulate here that the unresolved pain that is clearly palpable to Sophie (and right below the surface) is associated with unmet needs. She also formulates that as of yet, one of her difficulties is that she has not known how to soothe or take care of herself. Her solution to "shut it down" has clearly been the method of choice but remains problematic. It has reemerged in response to recent issues regarding her son and is currently causing pain and distress. The therapist can begin to formulate that unresolved unmet needs and emotion regulation difficulties are thematic.

A few minutes later, she continues, with the theme of feeling ignored and emotionally neglected, even criticized and judged, by family members, particularly her mother. Notice how very specific details of the client's family history begin to emerge without the therapist's specific prompting but with the therapist's interested in understanding her family dynamics. The organizing emotion scheme through which Sophie is relaying the story (and that has begun to emerge as a key theme in the formulation) is one of feeling neglected, ignored, and unseen by her family and her related feelings of disappointment, sadness, and despair. This is beginning to emerge as a very painful maladaptive relational emotion scheme.

Therapist: And, uh, so you are saying that it would be really nice if they seemed interested.

Sophie: They don't ever ask me about anything.

Therapist: So you kind of go through this not wanting to care whether they care, but then caring that they don't care.

Sophie: Yeah, yeah. And my mom is very good for telling all of her friends what a wonderful mother I am and how Jeremy is a wonderful child, but she just can't tell me.

Therapist: So it'd be nice if she could say these things to you.

Sophie: Yeah.

Therapist: Tell you what you do right.

Sophie: Yeah. And she just can't do it.

Therapist: So part of you really wants to let go and part of you feels resentful.

Sophie: My brothers have always gotten a lot more from her. Maybe just in the way of affection. She was very involved in their life. The boys can do no wrong.

Therapist: And you're the only girl. So you really got the raw end of the stick . . . your mother was different with you.

Sophie: Oh, yeah, both my mother and my father (crying). The boys can do no wrong. It's OK for a mom to pick up all the time after the boys, but it's unforgivable for a girl to have anything lying around. It's OK for boys to be late, girls can't be late.

Therapist: Wow, sounds like the expectations were much, much higher.

Sophie: Totally different. It's OK for boys to go out and have fun, it's not OK for girls to go out and have fun.

Therapist: Wow, so they were a lot more restrictive with you.

Sophie: They were extremely restrictive with me.

Therapist: So you are saying that when you turned 18.

Sophie: The day I turned 18, as soon as I could, I was gone. I think before that they would have hauled me back home. I was ready at 16.

Therapist: You would actually . . . so it was really quite unbearable.

Sophie: Uh, yeah. The teenage years are difficult enough, so I'm learning through Jeremy now. I don't remember mine too much. I went to school. I don't remember what I did every Friday; I know I wasn't allowed to go out. I couldn't tell you what I've done in the evenings at home. I went right to my room.

Therapist: So that's the blur. It's all a blank.

Sophie: Yeah, I went to school. I remember some girlfriends. I remember I had one really close friend. (crying) I was really envious of her. There were three girls in the family, and I always wanted a sister. I just wanted somebody to be close to.

Therapist: You really longed for someone to be close to.

Sophie: Yeah, I wanted a sister really bad. My brothers weren't very nice to me, they were only nice to me when they needed something. If they needed my allowance or something. And even though we were a large family, we didn't really grow up together. Most of us were either at boarding schools or summer camp; I don't think there was ever the five kids living in the same home at the same time.

Therapist: So you weren't close to any of your brothers?

Sophie: One. The second, I don't know how close I was, but he's the only one I have good memories of where I can remember

sitting on my bed crying and he actually came in to my room, to hold me and hug me.

Therapist: It's what you really needed.

Sophie: (crying) I don't think I ever got that from my dad or from my mom.

Therapist: Yeah, it's what you so crave.

Sophie: I wasn't allowed to be angry. I wasn't allowed to cry. I know I learned that feeling as a kid. It was do what you're told. This is how it is. You're supposed to be happy all the time. So they didn't talk about anybody's problems. It was a big front.

Therapist: Yeah. It's almost as if you weren't seen. You weren't heard from; it was like you weren't really there.

Sophie: (crying) No. The only time I wasn't was when I was supposed to be (laugh).

Therapist: The companionship, the closeness and the affection.

Sophie: Just that one brother. And that's when I think I was a teenager by then. He was a bit older. Or I'd say I was 10 or 11. I remember my brother being really nice, saying "don't cry, it's OK."

Therapist: Just sort of soothing you.

Sophie: Yeah.

Therapist: And that makes you sad just remembering.

Sophie: Yeah, that should be a happy thought, right (crying)?

Therapist: Well, I guess you got so little of that, it sounds like. You know, it's like those times were so few and far between.

Sophie: 'Cause he wasn't home much. He was in boarding school (crying). I wish he'd been home more.

In the course of her telling her story of growing up, a very important memory emerges here of one of her older brothers soothing her when she was distressed. It is the sharp contrast with the lack of love and affection Sophie received from other family members that brings the pain. She paints a picture of a barren landscape wherein she received little attention and affection and would retreat to her room to cry by herself. Her brother was the small beacon of hope that represented all that she was missing, but he was hardly available. In the following passage, we once again observe Sophie's self-interruptive process that she is indeed tracking as well. The therapist is

beginning to formulate this as part of her core maladaptive emotion scheme. She is crying and suddenly stops. Notice, though, that the therapist explores the emotion rather than interprets it. The therapist formulates that she is interrupting her emotion but will not initiate a self-interruptive chair task because it is too early in therapy. Rather, she takes the opportunity to explore how Sophie interrupts her own emotion. Through continued attention to this process, the therapist is beginning to formulate that she has difficulties with emotion regulation. Her current mode of emotion regulation seems to be self-interruption.

Therapist: Yeah, yeah. Because he (brother) was somebody who could actually understand. You needed a whole lot more of that. And . . .

Sophie: See I stopped (laugh) (referring to crying)

Therapist: How did you . . . you sorta cut off?

Sophie: I don't know how. I just kind of take a deep breath and cut if off. I just think it really scares me to go there. (crying)

Therapist: So you kind of cut it off, like I don't want to feel too bad. And yet you do go there. You do dip in. And access it.

Sophie: I just kind of scratch the surface.

Therapist: So you're saying it doesn't really speak to what I actually feel. I feel so much more, the wounds are so much deeper. And it scares me, yeah.

Sophie: (crying) I remember not wanting to live as a teenager . . . and it was really scary.

Therapist: So you felt like it would just be easier if you were dead.

Sophie: Oh, I just remember wishing I'd get leukemia or something then. (crying) If I was at a hospital dying somebody would probably . . . like maybe my mom would give me the last month of my life or something. Then she would notice that I was there.

Therapist: It sounds like you were just craving to be seen. To be held. To be loved.

Sophie: And I've pushed it away ever since. (crying)

Therapist: I guess it's just like it wasn't there. You couldn't get it and uh, you needed it. Somehow though it doesn't exactly go away.

Sophie: (laugh) No. As we know. It doesn't go away. Although I wish it would.

Therapist: Yeah, yeah. And I guess you're saying it is also scary when you get into these feelings because sometimes those feelings are pretty strong and intense. And you've even felt like you'd like to just stop living.

Here Sophie conveys the depth of her pain that began when she was a teenager feeling lost among four siblings, in a very restrictive, judgmental, and unsupportive environment. The feeling was one of being primarily overlooked and ignored. When she was attended to, the feeling was one of doing something wrong. Her accompanying pain and distress as she tells these stories reveal how formative and important these experiences were. For this formulation, two themes are emerging: a strong sense of self-invalidation that had its genesis in her family of origin experiences, and problematic emotional self-regulation which seems to be her adopted, albeit untenable, strategy of attempting to disavow or strangulate painful affect related to unmet needs that feel unbearable and never-ending. This leaves her feeling lonely, cold, detached, and depressed.

STAGE 2: CO-CREATE A FOCUS AND IDENTIFY THE CORE EMOTION

The major purpose of this chapter has been to elaborate in detail the steps involved in Stage 1 case formulation. Stages 2 and 3 are briefly elaborated here. (This is also the depression case that is summarized in Chapter 9 in chart form.) Sophie presents with depression triggered by her son's being caught with drugs. Her secondary feelings are of hopelessness and resignation, but what emerges from exploration of her hopelessness are core feelings of failure, inadequacy, and emotion schematic memories of unresolved sadness and shame from being unrecognized and invalidated by her mother. Inherent here but not quite formed this early in therapy are potential markers of negative self-criticism and unfinished business. Her core unmet need was to feel adequate and valid. In addition she interrupts her feelings of shame and inadequacy with shrugs of resignation and blocks her pain and sadness for fear of becoming overwhelmed. The main theme is self–self in which she feels inadequate and worthless; there is also unfinished business (self–other) as the original wound occurred in the context of feeling criticized and invalidated by her mother. The formulation narrative that was formed by Sophie and her therapist (a little later in therapy) is one in which they understood that her presenting problems of social withdrawal, depression, and despair are symptomatic of a maladaptive emotion scheme marked by shame and invalidation, which is triggered by her perceived sense of failure with respect to her mothering and work life. The overall theme, then, is of self-criticism, shame, and inadequacy.

STAGE 3: ATTEND TO PROCESS MARKERS AND NEW MEANING

The task markers that emerged later in therapy (Step 12) were related to unfinished business after the two-chair dialogue for negative self-evaluation had been worked on. Initially, self-evaluative conflict splits were triggered by issues with her son. At these markers, the therapist would ask Sophie to put herself in the chair and make herself feel like she had failed. Next she would come to therapy telling stories of conflict with her boss, by whom she felt invalidated. The task would then involve putting her boss in the other chair and having her boss invalidate and criticize her. Note that this was not unfinished business, because the boss was seen as the "projected introject" who embodied her own self-criticism. After enacting her boss, she came to realize that she was indeed very sensitive to invalidation and that in response she would get depressed and go to bed for a few days.

Over the course of the sessions, Sophie began to access assertive anger and stand up to her very harsh critic. She began then to access a sense of pride and self-confidence and a sense of herself as worthwhile. By session 8 she was still mildly depressed although she was no longer withdrawing and retreating to bed for days. She was also doing much better with her son. What emerged next was unfinished business with her mother. In subsequent sessions, therapy centered on empty-chair dialogues for unfinished business with her mother. Sophie would enact her mother being dismissive, come back to the other chair (self) and collapse into worthlessness and shame. After some time, she accessed unmet needs for validation, respect, and love. She was able then to come to an understanding of her mother's inability to meet her needs because of her own pain, shortcomings, and unmet needs. Sophie was able to see her mother more clearly, understand her, and feel more differentiated. Importantly, upon interacting with her mother, even though her mother was often still critical, Sophie did not become depressed and saw her mother as "doing the best she could." She also felt more compassion for her mother and herself.

Micromarkers that occurred (Step 13) in the course of the work related to self-interruption as Sophie would sometimes stumble upon strong feelings of painful shame, become frightened, and cut them off. The therapist would then help her detour into a self-interruptive split where she would enact this sudden self-interruption and in response, express the need for self-expression. She also engaged in self-soothing work that helped Sophie develop self-support and feel strong enough to be able to "withstand" strong, painful emotions. When new meaning emerged through the process (Step 14), such as "I am worthwhile" and "I can assert my needs with my boss," the therapist would facilitate its integration into the overall narrative so that Sophie came to develop a sense of "I am enough. I am OK as I am," as an

alternate narrative to "I am a failure" and a new script in the face of potential invalidation. Also, a result of a shift in her view of herself and her mother was that she felt a greater sense of self-validation and support and that she could "handle challenges that life handed her."

CONCLUSION

This chapter has provided a detailed illustration of how Stage 1 case formulation is applied in the case of Sophie. The focus in Stage 1 is on beginning the process of deconstructing and unfolding the narrative and observing the client's emotional processing style. In the next chapter, the focus is Stages 2 and 3 of case formulation.

8

JINA

In this chapter, we present the case of Jina to illustrate an in-depth application of Stage 2 case formulation. The entire process of case formulation as it applies to this case is outlined here, but the emphasis is on Stage 2.

Jina was a 38-year-old woman who came to therapy because of her depression. She was finding herself increasingly isolated and lacking in motivation. She was married for 2 years and had no children. When therapy began, she was not working; she had quit her job because she had not been feeling satisfied with her work. She wanted therapy to help her to alleviate depressive symptoms and to manage her extended family. The therapist was a 54-year-old man with 28 years of clinical experience.

In the intake/assessment interview, Jina tearfully reported feeling so down and depressed that she had finally decided to seek therapy (the first time that she had done so). In the previous year, she had not worked and had fallen into a pattern of rarely leaving the house or answering the phone or the

http://dx.doi.org/10.1037/14523-008
Case Formulation in Emotion-Focused Therapy: Co-Creating Clinical Maps for Change, by R. N. Goldman and L. S. Greenberg

door. She also reported that in the preceding year, she had experienced two significant losses: a good friend died of AIDS, and her brother-in-law (one of her favorite family members) died suddenly.

STAGE 1: UNFOLD THE NARRATIVE AND OBSERVE THE CLIENT'S EMOTIONAL PROCESSING STYLE

Step 1: Listen to the Presenting Problems (Relational and Behavioral Difficulties)

Formulation initially involves understanding the presenting problem and forming a safe relationship. Jina began therapy explaining her presenting problem:

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

Jina reported that her husband, who also suffered from depression, had been hospitalized against his will about nine months ago. He had thrown a plate in her direction, but it had not hit her. Her sisters had called the police, saying that his behavior was unpredictable and that he appeared violent. As a result of the police intervention, her husband was hospitalized and prohibited from living in the home for a number of months. She said, "It was very upsetting because he became violent, not so much towards me but he would break things and smash things, and his personality changed completely because he's not that type of a person—he's a very gentle, kind person. So when that happened I found my family very nonsupportive; their attitude was well get a divorce, get rid of him."

She decided, however, to stand by her husband and support him through his difficult time, but this decision alienated Jina from her family. She reported that her current relationship with her husband was draining at times, but solid nonetheless:

> *Jina*: I'm fine with him. I find it draining because I'm not feeling good, but I go out of my way to make him feel better when he's having a bad day, and I find that he just doesn't have what it takes at this point to give it back.
>
> *Therapist*: To give it back, so sometimes you sort of feel there's nothing left.
>
> *Jina*: Right, but I'm not angry at him about that. I think I'm more angry at my family.

With the therapist's empathic understanding it became clear that Jina experienced her sister's intervention as an invalidation of her marriage. After her husband returned home, she had happily reconnected with him, but she became more and more withdrawn from her sisters. The therapist, in establishing the initial relationship, followed Jina's feelings and empathized with her. The main focus of his empathic response was on her sense of depletion rather than on the content about the sisters or the external narrative about the husband. Using her feelings as the best guide to what is of major concern to her and should be focused on, the therapist helped unfold her narrative. As Jina articulated how angry she was at her sisters, she experienced how powerless and inferior to them she felt and articulated her need for support and validation. The therapist followed her direction in his case formulation.

In the first 20 minutes of the session, Jina she described her concerns, the therapist conveyed an understanding of her anger and empathized with her underlying feelings of hurt. Empathic responding, rather than asking questions or directing, conveyed immediately to the client that what they would talk about would be guided not by a structure imposed by the therapist but by whatever she wanted to focus on at the present time. Feeling understood and accepted by an engaged, empathic listener enabled Jina to disclose her most important and emotionally salient personal experiences to the therapist, who helped her focus on her current experience as she told her story, listening for what was most poignant.

Step 2: Listen for and Identify Poignancy and Painful Emotional Experience

About 20 minutes into the session, in response to her therapist's inquiry about whether her parents were currently together, Jina reported that they were divorced:

> And she (mother) does things like in the middle of the night call you up and call you 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. I haven't worked for a year, my husband's had a breakdown, even my best friend died. He's never called once. Not just this year, any year. Just doesn't, he just doesn't, he's not demonstrative.

When she said, "my father is just . . . he's just not there" the therapist hears Jina's vocal quality change from an external, talking-at vocal style to an internally focused voice—energetic, not outer directed like a lecturing voice, but the energy is directed internally, her voice has a searching quality, and the speech is punctuated by pauses, with irregular stress patterns (Rice & Kerr, 1986). Her voice quality indicates that Jina is focusing internally as she speaks these words, and it is like a window opening for a brief moment into

her soul, so the therapist guides her internally by selectively reflecting on the loneliness implicit in her current state: "So it's just you're feeling so alone. There's nobody really there."

In response, however, Jina moves into a more rapid external voice: "But I do have lots of friends and some I've had for 30 years, but I wouldn't want to burden them with my troubles." The therapist first reflects his understanding of what she has said but then empathically refocuses on her loneliness, leaving the last part of his response on the leading edge of her internal experience, saying, "But still this leaves you feeling so alone, like no one is really there for you." Jina's attentional focus now shifts to an exploration of her lonely, weak, and vulnerable feelings and she tears up.

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

Therapist: You're saying you hate getting weepy.

Jina: Oh, yeah, a waste of time.

Therapist: Somehow, though, your emotion is an important message that you're giving yourself.

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

Therapist: Yes, so what do you feel as you begin to cry? You feel so alone?

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

Therapist: Tired of the struggle.

Jina: Yeah, I'm tired of thinking about it. You know sometimes I'm preoccupied; I think, oh God, 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.

Jina: 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 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.

The therapist in this last statement identifies Jina's painful feelings as a potential focus of therapy, marking them for later consideration, while suggesting a rationale for EFT—that feelings give important messages and need to be resolved. He also suggests an alternative approach to dealing with

such emotions—by approaching and accepting them rather than rejecting and avoiding them.

Step 3: Attend to and Observe the Client's Emotional Processing Style

The therapist observes that the client often talks about external events but also is able to focus on internal experience, what she feels, particularly in response to the therapist's empathic responses that focus her internally. Thus, she is able to attend to her emotions, and this is a good sign that deeper feelings are accessible. In addition, the therapist notes that Jina's voice varies between a rapid, external one and, on occasion, an inner focused, exploratory voice or an emotional voice that breaks its normal register and she cries. He notes that she tends to avoid painful and difficult emotions. In fact, he notices that she seems to have an emotional pattern in which she moves into states of helplessness and hopelessness when she starts to feel her primary sadness or anger or in response to her experience of her needs for closeness and acceptance. This appears to be an unproductive emotional sequence as she moves from a primary emotion into secondary emotions of hopelessness and helplessness that obscure her primary emotion. The therapist also notes that while Jina moves into secondary hopelessness, she does not remain stuck in her emotional experience of hopelessness, and with the therapist's help is able to symbolize it in words and begin to differentiate it into her underlying primary emotions and needs. This capacity augurs well for developing a focus more rapidly, as her core concerns are relatively accessible.

Step 4: Unfold the Emotion-Based Narrative/Life Story (Related to Attachment and Identity)

In the first session, Jina tells of a difficult situation growing up in her family: All four of the sisters left the family in their mid-teens because of maltreatment at home. She considers her sisters the most important part of her family and has often viewed them in a parental role, rather than her parents. In her current view of her depression, she is not concerned about her husband but rather feels betrayed by her sisters:

> *Jina*: Most of my depression I think centers around my family dynamics. I don't feel close to my family, even like with my 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 'til I was 36. I moved around a lot and took all kinds of different—you know it's just not the same—a different type of life than they had.

Therapist: But you felt outside.

Jina: Yes, they ostracized me.

Therapist: So it's not only feeling ostracized but also criticized by them.

Jina: Yes, yes, my older sister didn't do it, but I felt my next-older sister did it. My other sister and I used to be very close, and then we're not close anymore and I don't understand that. I don't know, maybe she'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 . . .

Jina: Settled down.

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

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

Jina's relationships with her family members were difficult and often painful. Her mother was an alcoholic, and Jina and her three sisters had severed contact with her. Her father was an Eastern European concentration camp survivor. Critical and judgmental, he was emotionally disengaged from the family. Jina recalled a history of physical punishment throughout her childhood. She was 15 when she left home and went to live with her middle sister and her husband and then lived on her own while she finished high school and college. After college she lived with her oldest sister and her brother-in-law. She often saw her oldest sister and brother-in-law as surrogate parents who provided her with the affection and support that she did not get from her parents. This was what exacerbated the blow of the sisters telling her that she should get a divorce—it was the equivalent of the invalidation of a parent.

Formulation with Jina did not involve the therapist figuring out the meaning of her experience or the setting of an agenda. Rather, it involved deepening her current experience to point the way to her core concerns. By focusing Jina on her subjective experience in the moment, the therapist helped her to turn "eyeballs inward" to her own internal emotional experience so that she could see and articulate what was personally most painful and important to her. This is how a focus is co-constructed. It became clear that beyond her anger was her hurt from being both invalidated and abandoned and that these feelings were the painful emotions underlying her depression. Her emotions of sadness and shame provided information about what was most significant to her and also informed her that she felt invalidated and inferior. The compass that guided the therapist's formulation brought him toward following her painful feelings. It is important again to emphasize that

rather than focusing only on the content and meaning of what happened as reported by the narrating self, the formulation focuses more on the feelings in the moment in relation to the narrating of the story. Clearly, the story about Jina's sisters and her husband is what emerges first as most salient. Formulation suggests to both client and therapist that it is the lived story of feelings of humiliation and invalidation that needs to be focused on.

It became clear in the first session that throughout her childhood and into her adult life Jina often experienced herself as alone and unsupported and that she had internalized the critical voice of her parents and often judged herself to be a failure. Within the context of her physically and emotionally abusive past, she often felt unloved, inferior, and hopeless about this ever changing:

> 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 theirs (sisters) seems to be going, you know their life seems so much easier.

Toward the end of the first session, the therapist reflects:

> And I guess that's why this disapproval of your sisters is so painful, because it activates that I am a failure, and being told all along that I'm a failure, that's just like her voice (sister) almost in your head. And then it kind of diminishes you, and it's hard to stand up against it.

The client responds:

> Yes, too much of an effort. I don't want to talk to people. I don't want to see people. I haven't been out of the house in 4 days. I do that a lot. Then when I do go out I go by myself, and if I see somebody somewhere, when I see somebody I know, I'll go scoot down the other way.

The second session begins with the therapist asking Jina how her week was and empathically following her as she provided a daily report of her mood and activities (or lack thereof). After listening to this report and empathizing with her symptomatic feelings of being down and unmotivated, he guides the session to more core material by asking her what was most important for her to focus on.

Therapist: I'm really interested in whatever you want to bring up.

Jina: Right.

Therapist: I'm not going to say, let's do this; as I get to know you better we might develop something that we keep following.

Jina: Right.

Therapist: But I'm interested in whatever seems most important to you now. I remember from last week that your sister and

the family kinds of things seem pretty important, but I don't know where you are today and what you would like to talk about.

Jina: I guess I have a lot on my mind that I want to do, you know, I'm going through a real thing now of "do I want to work, do I want to go back to school at nights."

Therapist and client discuss this topic for about 15 minutes, and during this time, the therapist responds empathically with such responses as "So yeah, there's something about sitting at home and doing nothing that just leaves you kind of going in circles." Jina responds with "It's about time to sort of get out there and try to . . . be around people again" and the therapist reflects, "something about being with people." The client then recounts an external narrative detailing what happened when the friends came to visit. The therapist attempts to focus her on her subjective, internal experience of what happened during the visit.

Therapist: Yeah, there's this feeling inside of I've had enough.

Jina: Yeah, yeah.

Therapist: What's it like inside for you? I don't have anything to give.

Jina: Well, I get tired and I just want to sleep, just tired.

Therapist: Sleepy or what's it like?

Jina: Yeah, like not even so much—just seemed drained—yeah, I feel drained.

Therapist: Drained.

Jina: And I just wanna lay down.

Therapist: So it's like this is taking a lot of energy.

Jina: Yeah.

Therapist: Or I don't have any energy left.

Jina: Yeah, yeah. You know and I'm just—I'm just like even like talking on the phone it's just like "say what you have to say and then get off." I don't want to talk to people on the phone. It's just too much effort, and I don't know what happens but I just don't want to talk to people on the phone. . . . I just don't know why I withdraw from people so readily.

The therapist hears this as a marker of a problematic reaction [stimulus: people. reaction: withdrawing, puzzlement, "I don't know why"]. Initiating a systematic evocative unfolding task (see Chapters 2 and 6 for more detailed explanation of the task), he starts by saying, "So let's try and explore that a

little more exactly what's it's like; I understand that there's this feeling that somehow talking seems like work for you." He then attempts to help the client re-experience the moment of withdrawal by reevoking the "scene" of the situation and her reaction to it:

> So as you're kind of there sitting there in your living room with these people from the North, so they are there sitting on the couch and you are there and there's a feeling of, I have to fill the space with words . . . or what is it?

They explore her experience in that situation.

Jina: Well, I make conversation and show an interest of course in them being there, and drink, and just . . .

Therapist: Yeah, and what do you actually feel, if you were to give a voice to your inside?

Jina: I'd be like, it's really nice to see you and stuff and I'm tired and (laughs) could you go now? I'd rather be alone. I mean I have no problem being with my husband. I'm fine when he's there, we have good rapport, but with them . . .

Therapist: And if you were to say how you were (to the friends), what would you say? If you were to say I guess you would say I feel really bad.

Jina: Yeah, I would just say to them like I'm depressed and I really don't feel like talking, you know. I don't really feel I have anything to say.

She then goes on to say that she finds it an effort to get dressed in the morning and just wants to be alone during the day; the therapist guides her into the painful feeling. At this point the exploration shifts to focusing more directly on her internal experience.

Therapist: Yeah? So can you tell me more about how you come into that more depressed feeling? It's like I just wanna . . .

Jina: . . . be alone. I just want to be alone. I'm just very—it's like a sad feeling. It's just I have no energy. [secondary symptomatic feelings]

Therapist: Yeah, so let's go into that. So what if you were to give that a voice? And are you feeling that now or how are you feeling?

Jina: I feel sometimes I feel almost emotionally dead, like today I feel more, not like really sad, I just feel sort of wiped out, sort of . . .

Therapist: So kind of flattened or . . .

Jina: Yeah, just almost like there's no feeling. You know, I'm not sad, I'm not angry, I'm just (makes a sound) . . .

Therapist: You just feel kind of flat, no energy and just kind of—what's it like in your body? I mean, what do you actually feel inside, right now?

Jina: Just tired, yeah, just tired.

Therapist: So if you were to speak from that right now, I'm tired. Can you just try to be where you are?

Jina: I guess I'm just tired of life. I'm just tired of trying, you know? Everything just doesn't seem worth it. I think what is this all about and why am I, you know, trying to be something . . . I don't know what I'm trying to be. I'm thinking about going back to school. So I put another diploma on the wall (laughs), you know, like why am I doing this? What's the point?

Therapist: So what's the point? It's just too much effort and what's the point? [empathic affirmation]

Jina: Yeah. I'm perfectly content to sit in the house and be there by myself. There's parts of me that will say, you know, it's a really nice day out, you should get out and get some fresh air, you're wasting your life, there's that part of me.

The therapist's empathy and consistent gentle pressure toward greater exploration of feeling help Jina to move from the highly condensed story of what happened to the lived story of her internal experience of what happened. This is how a focus begins to emerge in this stage of case formulation. When Jina's lived emotional world is explored, markers of underlying processing difficulties and her core feelings and needs begin to emerge and provide the information for understanding problem areas that require therapeutic attention.

STAGE 2: CO-CREATE A FOCUS AND IDENTIFY THE CORE EMOTION

Stage 2 (the central aspect of case formulation) involves six major components captured in the MENSIT acronym. Marker identification (M) is a formulation of the client's in-session state and processes as being in a particular configuration amenable to a particular intervention. Intervention then is aimed at getting to the core emotion schematic processing difficulty (E) and the core need (N). Secondary (S) and interruptive (I) processes preventing

access to the core emotion scheme are identified along the way. Finally, a theme (T) is articulated, rounding out the formulation in a more narrative form. At the end of the stage, the formulation narrative ties the triggers to the emotion schemes back to the behavioral consequences and presenting problems.

Two main markers that appeared in the therapy were self-criticism and unfinished business, both related to parental emotional abuse. Often when there is parental maltreatment, it implies that the unfinished business will be the more fundamental process, but whatever emerges for the client in the session as most alive will be what is followed. Exploring the unfinished business helped the client get to her core maladaptive emotion schemes of both lonely abandonment and shame, and as well as some fear of physical abuse. She identified core needs for both support and validation. Her secondary emotions were anger and hopelessness, and her interruptive processes were resignation and laughter. Over time, her major themes were articulated: relating to herself very self-critically, feeling like a failure, and relating to others with feelings of invalidation. Finally, Jina's core feelings of not being good enough and her sensitivity to invalidation were tied together with her presenting problem of her sisters' invalidating comments about her marriage, which triggered her depression, social withdrawal being the behavioral consequence.

To understand the focus on Jina's shame and lonely abandonment, it is important to see how the therapist was formulating at the level of process rather than content. He started in a nondirective manner in relation to content and followed what was most poignant and painful. What emerged was her feeling of being disapproved of by her sisters and her father. Deepening exploration of her experience led to her primary shame-based sense of being not good enough and feeling unloved, which appeared to be the underlying determinants of her depression. Some of the following session material demonstrates how this was done.

Jina expressed feeling safe and comfortable alone and said that she enjoyed reading a good book. The therapist acknowledged the coziness and security of the activity but also recognized that it was a state of unstoried emotions (Angus & Greenberg, 2011).

Therapist: You know, in connecting to last week, it's like I feel like I've really been hurt and I want to just withdraw.

Jina: Yeah, it's the way I always deal with that type of thing and I've done that all my life when I'm feeling really hurt. I tend to withdraw because it's safer, I guess, if I don't talk to anybody and I don't have conversation with anybody. [Now she is getting to her more vulnerable painful experience and her need to protect herself this appears to be other related and suggests unfinished business.]

Therapist: I can't get hurt.

Jina: Then I can't get hurt and I don't have to deal with what they have to say. You know, it's a cover for me. [identifies interruptive process]

Therapist: It's protective but it says something about how wounded you feel. Kind of like you've lost the strength to take it anymore.

Jina: Yeah, I mean I do it and I withdraw and then I come back out, I've always thought I could sort of get back on my feet. Right now, I just don't care anymore. I just like (sigh) you know?

Therapist: Yeah, I hear that, it's kind of like, I just don't want to have to deal with it anymore. It's like I want to be in my own safe, secure kind of thing, but I guess it's the hurt, right?

Jina: Yeah, it hurts a lot.

Therapist: Can you tell me more about the hurt? Because somehow it's the hurt that's in there that seems so important.

Jina: Yeah, I guess just with things that have been said and reactions of people and especially, I guess particularly my family and stuff.

Therapist: I felt so . . . unsupported.

Jina: Yeah, I feel inferior to them, you know. I feel that I have no self-esteem left. [Now the core underlying determinants, both her feelings of lack of support (abandonment fear and sadness) and her inferiority (shame), emerge.]

We arrive at an understanding of her core hurt from the process of following her pain. Jina's core painful emotions are not seen as something she didn't know (they weren't unconscious), nor is it an irrational belief or the lack of a skill that is her core problem. Rather, it is a disallowed set of painful emotions, and her attempts to protect herself from them by avoiding them leave her feeling drained. Having responded to a marker of a problematic reaction and deepened her experience, her core emotion scheme was somewhat evident early in this therapy. It was becoming clear that it was the disclaiming of her painful feelings of shame and loneliness, their accompanying action tendencies, and the needs for validation and support embedded in the emotions that left Jina feeling so hopeless about getting her unmet needs met. Feeling wounded and vulnerable, she wanted to curl into a ball and hide to protect herself; these painful underlying feelings must be ultimately transformed by access to new emotional responses to the old situations that produced the painful feeling.

Jina: [regarding her sisters] I just feel like leave me alone.

Therapist: Yes, it's the leave me alone, I can't take being battered anymore with I'm not good enough so I'm just going to kind of withdraw into a safe place, which is inside my house with no demands but somehow there's a voice inside, their voice, your voice of I'm not good enough. What's the not good enough's voice saying? [The therapist focuses on internal determinants of self criticism.]

Jina: I don't know, that I'm a failure. That I'm a failure, you know, but I just feel as though my life, everything I've tried to do, and I mean I've been successful, I'm an educated person, but I couldn't get a job in my field when I graduated. It just seems to blow up in my face or it's a real effort, what seems to come, seems to be easy for some people, it seems to be very hard for me. (She describes how invalidating her sister can be.)

Therapist: Somehow her angry or disapproving tones have left you feeling like she really treats me like I'm nothing or inferior. I keep getting that message, and I don't really understand why, but I know it really hurts.

Jina: When she phones—I don't answer the phone—but when she used to phone and I used to answer and it would be her, I mean, I would break out in sweats, I thought oh my God, what is she going to say to me? Sometimes she would call, she would be very nice and I'd get off the phone and I'd be upset for weeks, you know?

Therapist: So somehow very vulnerable to her.

Jina: Yeah. I guess because she's successful and I want her approval, you know. I mean my sisters really are all I have, like my parents are *phff* I mean as far as I'm concerned, they're gone, you know and their approval really doesn't mean anything to me because they just haven't been a part of my life [marker of either self-critical dialogue where critic is projected onto sister or unfinished business work, but it is too early to intervene with a task as the therapy is still in the bonding stage]

Therapist: When did you first start feeling this feeling that you weren't good enough?

Jina: Probably since I was a child. When I was younger, I did very well in school and I was very athletic and I guess, you know, I was trying to impress my parents. Getting As for them was very important and I did, for years and years, and then I realized it didn't really make any difference. They really didn't

care. The only reason they cared was so they could tell the neighbors that their daughter got As so when I got into high school I went the complete opposite. I didn't fail, but I didn't try to get As anymore and I wasn't as athletic as I used to be and I started experimenting with drugs because I thought well, they don't care anyways so why am I trying so hard? [a marker of unfinished business emerges]

Therapist: This must have been hard, they didn't care, right. And you rebelled, almost like you felt they don't care. They're just dismissive of me.

Jina: Yeah, it wasn't just me. I think it was all of us, all of us sisters, like my parents should never have had kids because they didn't have the capacity to love that you should have for children I don't think and I'm sure they probably have their own horror stories from their youth, but you know, they weren't loving, they weren't nurturing. [Here her core feelings of being unloved emerge very clearly and are viewed as involving a mixture of the sadness of loneliness, the fear of being alone and the shame of being unlovable.]

Therapist: All of us, right, and I guess it left you marked with a feeling of being unloved.

Jina: Oh definitely, oh God, yeah. If someone asked, "Do your parents love you?" I'd have to say no. I don't even think my parents know I'm alive, and they don't care. It's not like the phone's ringing, you know what I mean? Like I said I've been . . . I mean my other sisters are in touch with my dad.

Therapist: I see, yes.

Jina: Nobody really speaks to my mother, and my father knows that I've been off work for a year and that my husband and I have had our troubles, and I've never heard from them.

Therapist: This must have hurt like hell at some point when you were a kid.

Jina: Growing up? Oh sure it does.

Therapist: Yeah, yeah, no wonder you feel vulnerable now. [Therapist provides validation.]

Jina: But then I guess I think how come it's affecting me this way and my other sisters seem to be coping better with that? Is it because they got married young and they had somebody loving and nurturing in their lives at 19? My oldest sister got married at 17 and my two younger sisters got married at 19.

Jina then talks about possibly not being as stable or successful as her sisters because she didn't have relationships in high school until her 20s and didn't get married and therefore had lacked the support of a loving relationship and the love of kids that her sisters had. The therapist hears that she feels judged and is self-critical and begins to reflect first her hurt and withdrawal in relation to her family's disapproval and her subsequent self-criticism.

Therapist: So there is another voice in you which says, so what's the big deal? This isn't being regular, and doing the right thing in their eyes isn't such a big deal, but somehow there is also another voice, but it's a very vulnerable voice, because somehow it hurts so much to be told or to think you didn't do the right thing and to feel like whoever you really are wasn't valued and supported. You were always being viewed with raised eyebrows and rolling eyes, right? Like you've been judged as not really good enough and then the only recourse right now is to just sort of say well if you don't love me the way I am, if you don't approve of me, I'm just going to . . .

Jina: Go and live my life.

Therapist: You know, it's a bit like "I'll take my marbles and go home."

Jina: Well, yeah, yeah (laughs).

Therapist: And it hurts but I don't know what else to do.

Jina: . . . because it hurts more the other way too.

Therapist: It hurts more to come out than to have them disapprove of me so somehow this has then left you feeling kind of depressed and withdrawn, and you battle with not quite being able to get the approval you want, feeling disapproved of, and it just activates all the sense I am not what they expected me to be, somehow that's gotten so deeply into you that it makes you feel like I'm not good enough.

Jina: Yeah, me and millions of others (laughs).

Therapist: Yeah, they're disapproving, but there is another voice . . .

Jina: Yeah and it's always been there. I mean there was a time where I was very verbal and I would fight back and stand up for myself and now I'm just like *phff*.

Therapist: So somehow this other voice, the more resilient you, has lost her energy and it feels like it's just too much to struggle against these overwhelming odds, and the only solution I can see right now is to withdraw and even run away but somehow I guess we're going to have to look at how

to find a way of being yourself and having some pride in yourself. [empathic summary of the narrative and proposal of a focus]

Jina: Well, I'm trying, I mean maybe that's why I'm thinking of going back to school. I'm just thinking if I go back and do something I really enjoy to begin with, maybe I'll feel better, but what if that doesn't work and I've gone back to school for nothing and hang that diploma next to the next one, it's doing nothing for me, you know?

Therapist: Yeah, but I think maybe you can go more into all the hurt and all the unresolved feeling that's left you feeling like the only recourse is to withdraw. Somehow by going into some of this hurt and also the anger—I guess there's anger at your sisters. [further clarification of the focus]

Jina: Yeah, I guess there is. I try not to be angry.

Therapist: Although maybe that anger is very important because it's sort of saying I am me and I want to be valued for me, not for you, what you think I should be.

Jina: Should be; or I get more angry that she compares me to my sisters.

Therapist: Yeah, I guess it's that hurt and anger that's sitting inside and you're feeling like I just want to withdraw, I don't want to have lunch with my sister but it's somehow this unresolved hurt and anger that's leading you to feel like just withdrawing and somehow we're going to have to deal with that to find a better solution for you. [The therapist acknowledges her immediate dilemma of dealing with her sister but emphasizes her feelings rather than the behavioral aspect of her conflict.]

Jina: Yeah, I know that and I'm still anxious, do I call her back? Do I not call her back? If I call her back, will I be more upset? That's my biggest fear. I don't want to call her back and start arguing on the phone, I just can't do that anymore. I don't want to do that because she doesn't understand and she's not going to understand and she will get defensive, like we all get defensive . . .

Therapist: So I guess that's where we need to go to help figure out how to deal with all these feelings inside and also somehow how to deal with hurt, because it's taxing you emotionally there's a lot of anxiety and . . .

Jina: For such a long time when I get around her, I can feel it.

Therapist: So you're saying, I don't want to talk to her on the phone, I'm afraid that we'll get into a conflict. What is it that is so scary about this? Being angry, I guess?

Jina: Well, it's not even so much scared, I just don't want to be angry. I just don't want to argue with her. I just don't have the energy—it's almost like if you can't figure out why I feel this way, then me telling you, is that going to make . . . if I say to her, well, you've said this to me and you've said that, because I've said that to her before. Well, she says, I realize I'm a little hard on you and it's like does it solve anything? I think she gets off the phone and she goes and does her life, (laughs) and she doesn't think about it anymore, whereas after I get off the phone I'm floored and it totally destroys whatever I've got planned for the day so I think I don't want to talk to her.

Therapist: What I really want is to be supported and validated for who I am and understood for who I am. I don't want to constantly feel like I have to justify my life, and that's what it feels like. [identifies her needs]

Jina: Yeah, that's what it feels like and to me, I almost feel like you had your chance to be supportive and you weren't and so what do you want from me now? Why do you want to talk to me now? Why didn't you talk to me for months when my husband was in the hospital, why didn't you call me and ask me if I wanted to go out for a cup of coffee when I was all alone?

Therapist: It's almost like I don't want to tell you how angry I am because somehow that would be even starting a relationship again with you and I just feel like I'm so offended and feel so badly treated. [summarizing the session] Yeah, so there's all this hurt and anger there but somehow it's like I don't want to deal with it, they could do that and they don't understand me, and I don't expect that they'll understand now. I don't even want to try.

Jina: Yeah. Well, they've never to this day come to me and said, "We should have been there for you," like I can't understand how they did what they did because if it had happened to them, I would've been there for them . . .

Therapist: But I guess it's so hard to feel angry at the ones you want love from and it's left you in turmoil because you're so angry, I mean understandably you felt so betrayed, somehow it's like I wanted love from you and I never got it. I wanted it and

now I'm so angry, but it's like I can't deal with it, and having wanted you to approve of and support me, it's just left me wanting to withdraw.

Jina: Yeah, I guess that's why I'm here, because I know that I need to deal with and I'm hoping that by dealing with this at some point that I will be able to pick up the phone and say "I'm ready to talk now" and do it calmly and without being too emotional so that I can say what I have to say without attacking her also. I don't want to say something out of anger.

So by the end of the second session, we see a focus on underlying determinants begin to emerge. Jina is plagued with the painful feelings that originate from parental neglect and disapproval. She feels unloved and inferior, she is sensitive to criticism and disapproval and is grappling with current feelings of lack of support and disapproval from her older sisters and of constantly feeling not good enough in comparison with them. Her core emotion schemes involve both the shame of inferiority and attachment-related feelings of being unaccepted and unloved. She experiences the attendant anxiety of basic insecurity, from never having felt supported or validated. Her core need is for validation and support from self and others. Jina's self-critical self-organization has been glimpsed, and she has a host of unresolved feelings toward her family members. This suggests both two-chair conflict split work and unfinished business work, with either sister or parents. The content and timing of what is worked on in future sessions will depend to a large degree on what markers emerge.

At this point, the therapist might conclude that Jina appears to have self-criticism related to issues of failure that emerge in the context of her comparisons with her sisters. She also appears to have unfinished business stemming from her early relationship with her parents and has unexpressed resentment and sadness toward her father. All this affects her own sense of self-worth.

Step 5: Identify Markers for Task Work

As the therapist listened to the client, he was alert to markers that indicated openings for possible work in future sessions. In the first session, he had heard two main markers of possible underlying difficulties: (a) unfinished business around feelings of being badly treated by her family and (b) a self-criticism in which one part judges herself as failure and feels unentitled to approval and acceptance and another part that needs approval and acceptance. As this was early in the therapy, these were simply noted as something to be alert to if they reemerged. The following exchange from Session 1

provides an example of Jina's self-criticism embedded in the context of lack of family support. At this early point in therapy, the therapist simply notes the marker rather than initiate a dialogue.

Jina: I don't think I'm bad, but 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, I have not done crazy things, there's no reason for them (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.

Jina: Yeah, I guess so, yeah.

Therapist: But the sadness is about all that you never got. The anger is.

Jina: Oh, yeah.

Therapist: But some part says I deserve more; how strong is that feeling?

Jina: Well, I say this but then I guess we all feel we deserve more and—yeah, I'm grieving for what I probably didn't have and know I never will have.

Therapist: Yeah, probably that too. Because it's how much you really can believe you are deserving even if they didn't give it to you. Then somehow it's how much can I get from other people . . .

Jina: For myself. I realize now you can't depend on other people to make you happy. Not to be happy, you need to be happy from within yourself. That's why I guess I'm doing this therapy. I figure if I can be content with myself, then that stuff won't matter to me as much. But don't forget, if you are told enough that you're a failure, you start to believe it.

Therapist: Yeah, so that's really an important piece to work on. And I guess that's why this disapproval is so painful because it activates that I am a failure and being told all along that I'm a failure, that's just like her voice almost in your head. And then it kind of diminishes you and it's hard to stand up against it.

In Session 2, a self-critical marker 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 suggesting that Jina put

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 self-critical dialogue because her hypersensitivity to her sisters' criticisms suggests that her internalized criticisms are being projected onto or attributed to the sisters. The sisters' criticisms are damaging because they activate the client's internal critic.

> Yeah, 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.

From this we see more clearly that what is of central concern is her shame-based feelings of being not good enough.

This core self organization of feeling not good enough is confirmed in Session 3 when the client talks about how she is so sensitive to criticism.

> *Therapist*: When you say you're so fragile and you're so sensitive, how do you understand that? What's that like for you?
>
> *Jina*: I guess because I don't have a lot of confidence, it doesn't take much for me to feel bad. Some people take constructive criticism well and some people take criticism! They don't care; I guess they're so sure of themselves. I guess I feel that I've had so much negative criticism, I don't have the tolerance for it that I used to. I guess I can't let it roll off my back as easily as I did when I was younger. I don't know.
>
> *Therapist*: So somehow it's like your self feels very fragile in relation to that. When you say you had so much criticism, what stands out for you?
>
> *Jina*: We talked about our parents and how much we didn't matter as children, it was never good enough. If you got a *B*, you had to get an *A*. If you got an *A*, you had to get an *A+*, how you cleaned the house, how you did things, I think we all have that insecurity and I think it's because we just were never good enough, we never got that reinforcement from our parents.
>
> *Therapist*: That kind of support.
>
> *Jina*: That we were OK and that we could do anything and we were successful young people.

By this point, self-criticism is emerging as a core theme. The therapist is confident that self-criticism is a central issue and that it relates to the invalidation Jina suffered from her parents when the above marker appears. He suggests a chair dialogue with her parents.

Therapist: Somehow you're still very fragile and vulnerable to their criticism, so I'm going to suggest we actually try to imagine bringing them in here and have a dialogue. [Jina puts both her parents in the empty chair, but this rapidly evolves into a dialogue with her father. This occurs not because the therapist has formulated that her relationship with her father is central but rather by following what is most alive in the client's emotional experience at the moment.]

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

Therapist: Can you imagine him over here (pointing to chair) and telling him how he has made you feel like a bad person?

Jina: 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. (She then talks about how he denigrated her and how he called her a devil.)

Therapist: Tell him what it was like to be called a devil and go to church every . . .

Jina: It was horrible. He made me feel that I was always bad 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.

Steps 6–8: Identify Underlying Core Emotion Schemes, Either Adaptive or Maladaptive; Needs; and Secondary Emotions

In Session 3, the therapist invites Jina to enact her disapproving father, and as him, she criticizes herself severely as not good enough and not as good as her sisters. On returning to herself in the chair, she is first reactive, expressing secondary anger; the therapist guides her to her deeper underlying feeling, asking what it was like for her.

Jina: Well, it was lonely. I didn't know my father—all I knew you as was somebody that yelled at me all the time and hit me. I don't remember you telling me you loved me or that you cared for me or that you thought I did well in school or anything. All I knew you was as somebody that I feared. [Her core painful emotions here are loneliness and fear, and the dialogue is shifting to unfinished business with father. The therapist guides her to say what she needed from him.]

I needed you to put an arm around me and hug me once in a while and tell me that you cared about me and that I was OK, that I was doing OK. [A core attachment need; the therapist then asks her to become the young girl and tell him what she felt.]

I'm afraid of being hit for something, afraid of being hit for everything, you know my whole childhood was always a fight. I hated special occasions because there was always a family fight, big, big fights. So Christmas was ruined, Mother's Day was ruined, Christmas and Easter were ruined, everything was ruined. [A core fear is accessed.]

I needed to, be hugged once in a while as a child or told that I was OK. I think that's normal. [Core needs for both comfort and validation; clearly, there is much unfinished business with the father, which will be worked on in future sessions.]

Step 9: Identify Interruptions or Blocks to Accessing Core Emotion Schemes

In Session 3, the therapist guided the client to play the father to heighten her experience of being physically punished by him. During the empty-chair work with her father, after the client connected with her need to be protected and loved, her emotional experience shifted in the self chair from initial loneliness and fear to adaptive anger at the maltreatment. Jina relayed an incident in which she was so angry at him for hitting her that she called him Hitler. She laughed as she said this. Throughout her recounting of maltreatment and humiliation, she tended to interrupt herself by laughing or making a joke, demonstrating her discomfort with expressing her anger. The therapist commented that he noticed that she was laughing when she said she had called her father Hitler.

Jina: 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 about things.

Therapist: Because underneath the laugh I guess there's a lot of hurt and a lot of hate. (She had already said she hated him.)

Jina: [in an empty-chair task with her father] 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. I guess I keep thinking that you will be a parent; that you will pick up the phone and just ask me how I'm doing. It hurts me that you don't love me.

Jina ended the session recognizing that what she needed was acceptable. Needing love had made her vulnerable to hurt and pain, but interrupting her needs has left her vulnerable to isolation and aloneness. She attempted to protect herself by shutting off her needs, but this denied her need to be loved and accepted and left her feeling hopeless.

Step 10: Identify Themes: Self–Self Relations, Self–Other Relations, Existential Issues

By the end of Session 3, the thematic intrapersonal and interpersonal issues have emerged clearly. How Jina treats herself and how she relates to others are clearly embedded in what she reports in her most painful experience. First, she has internalized her family's criticisms and is now highly self-critical. Her critical voice of failure and worthlessness is initially identified as coming from her sisters but clearly has roots in earlier relationships with her parents.

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 too vulnerable and alone. Jina has learned how to be self-reliant, but this independence has had a price—she feels unsupported and isolated. Her need for love is related to her unfinished business stemming from her early relationship with her father.

The other main theme of the therapy is the relationship with her father; it has made her feel hurt, angry, worthless, and unloved. Jina harbors a great deal of resentment toward him over his maltreatment of her as a child, but initially she had a tendency to minimize it (saying things like, "Being slapped was just normal"). She has internalized this as a feeling of worthlessness and as being unlovable. These underlying concerns lend themselves, respectively, to the emotional processing tasks of the two-chair for internal conflict and to the empty-chair for unresolved injuries with a significant other.

Step 11: Co-Construct the Case Formulation Narrative, Linking Presenting Relational and Behavioral Difficulties to Triggering Events and Core Emotion Schemes

Through work with her self-critic, Jina began to understand that her presenting problem of depression triggered by her sister's response (which she experienced as invalidating of her marriage) activated her core feelings of being disapproved of and being alone, which led to her withdrawal and depression. It was also clear that she coped with her unmet needs by both experiential and behavioral avoidance (feeling hopeless in reaction to her hurt and shame, and not seeing people) and that her feelings of shame at not

being good enough and sadness at rejection and loss of love lay at the base of her depressive difficulties. These deep-seated feelings of shame-based worthlessness originated from her treatment by her father; working through these was important in dealing with her depression. This was discussed in Session 4; Jina expressed her desire to deal with her issues rather than try to avoid them.

Although she had cut off her relationship with her alcoholic mother, Jina did not appear to have unfinished business with her. As the alliance was good, and a focus had developed early and clearly, each session seemed productive by simply following Jina's experience. EFT therapists follow what is most salient for the client in the belief that this will bring the most important material into focus. Jina's mother did not emerge as emotionally salient in any of the sessions. The therapist treated each session as a fresh encounter and waited to see what emerged. If something did not seem to be emerging, then he worked toward the focus based on the formulation to this point.

STAGE 3: ATTEND TO PROCESS MARKERS AND NEW MEANING

Step 12: Identify Emerging Task Markers

In Stage 3, the therapist shifted to more of a moment-by-moment style of formulation, identifying current states, ongoing markers related to core issues, and micromarkers within tasks. The task markers in this therapy emerged fairly early, and the only new marker that emerged more fully was a marker of self-interruption. In Session 7, Jina and the therapist identified the way in which she interrupts the feeling of wanting to be loved in order to protect herself against the pain of not having her needs met. In Session 9, during the other-chair task in which she played the part of her "interrupter," she told herself,

> You're wasting your time feeling bad because you want them, and they are not there. So it's best for you to shut your feelings off and not need them. That's what I do in my life. When people hurt me enough, I get to that point where I literally cut them out of my life, like I did with my mother.

As they continue through the therapy, the therapist notes shifts in Jina's emotional processing. For example, her expressions of sadness shift from sinking rapidly into hopelessness to remaining sad at a stable level of arousal so that her voice, body, and words convey her feelings within a coherent narrative. With the ability to tolerate her sadness, she begins the process of creating new emotional meaning; she realizes that it was her parents' inability to love rather than her being bad that was the problem. The therapist

notes that Jina experienced contentment and relief and integrates this as a loss of something she deserved: "Even though mom and dad 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—they still don't know how to love."

The therapist notes that Jina no longer experiences the hopelessness that had been so predominant in her earlier sessions. She has become more able to tolerate and stay with her experiences of anger, sadness, and pain/hurt toward her father. New emotional meaning has been created ("My parents didn't know how to love" rather than "I am unlovable").

Step 13: Identify Micromarkers

At several junctures, the therapist can identify indicators of certain steps along a path to resolution, which guide the next intervention. This is the moment-by-moment case formulation process that occurs continuously in EFT. In Stage 3, the therapist is involved in microformulations of what is happening in the client and what is needed to facilitate the next step in a change process. For example, he notes when Jina begins to experience the impact of her critical voice and how it has affected her life that she is able to respond resiliently. This occurs when the client voices her desire for the critic to "go away for ever" as the voice in the experiencing self becomes much stronger in response to the heightened critical voice. At this point Jina responds to the critical voice by challenging the idea that she was a loser.

> *Jina*: 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 sisters too. 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, there must be some kind of love there.

Step 14: Assess How New Meaning Influences the Reconstruction of New Narratives and Connects Back to Presenting Problems

The therapist sees that Jina is now beginning to reconstruct the old narrative (i.e., that she was not worth loving) and helps her consolidate a new narrative. In Session 10, Jina addresses her relationship with both of her parents. As she expressed anger toward her father, the therapist notes now that a number of things have changed. Having expressed her anger, she now no longer experiences the tension created by trying not to be angry. Her

reclaimed anger informed her of the ways in which her father was not a good father.

In an empty-chair dialogue with her father, Jina says,

> 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 any love, you never showed any affection, you never ever acknowledged we were ever there except for us to clean and do things around the house.

Later in the dialogue, the therapist sees that Jina began to soften toward him and solidify her new understanding of her father:

> I don't know if I feel resentment as much as I think by coming here too and talking about it I think I've understood. I think my father went through a hard life. You know, he went through war in Europe. He spent 5 years in concentration camps. I am sure that anyone who was in concentration camps saw horrendous things. I mean it was Auschwitz.

A few minutes later Jina addresses him in the empty-chair task:

> I understand that you've gone through a lot of pain in your life and probably because of this pain, because of the things you're 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. I can understand that now, whereas growing up I couldn't understand.

As the session progressed, the client was able to continue to hold her father 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: "You know being a concentration camp victim had a real impact on you. Instead of being a teenager, you're a prisoner of war. It obviously had a lasting impact on you and then as life went on and your marriage—I'm sure in the beginning it was good, I think at one point, mom and dad did at one point 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."

Her narrative shifted from "I am unlovable" to "my father (and mother) were unable to love and that was the problem." Having processed her anger and her sadness and transformed her shame, she has a more compassionate and understanding view of her father.

As new meanings emerged, the therapist assessed how the new emerging narrative connects back to the presenting problem. Jina's new view of herself and her shame and responsibility indicated a good degree of change

and readiness for termination. By the end of therapy, Jina had created new emotional meaning, and this had transformed her emotion scheme fraught with shame and feeling unloved. She was able to access feelings of joy and calm when needs for closeness, love, and acceptance came into play. She was able to experience sadness for not having felt loved and to construct a new self-organization of worth.

The therapist considered this to be a highly coherent and adaptive new narrative, noting that Jina is able to continue to hold her father 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. The need to be loved no longer triggers hopelessness; and by giving voice to her strong emotions and accessing new ones, Jina has validated that she is worth loving and can manage with what her father has to offer at this point in her life. Her ability to communicate her needs, to protect herself from feeling inadequate, and to be close to her sisters had also changed. In response to queries about her feelings toward her mother, she says that is just best to keep her distance from her and that she feels fine about leaving it this way. She appeared congruent in this, so the therapy ended.

CONCLUSION

Jina entered therapy feeling like a failure. Formulation led to focusing on self–other and self–self relationships. Her unresolved resentment and sadness toward her father affected her own sense of self-worth. She was very self-critical and felt criticized by family members.

Process-oriented formulation identified markers of self-critical splits and unfinished business. Her core emotion schemes of shame-based worthlessness and the basic insecurity from parental abuse and neglect and the attendant sadness of lonely abandonment were identified early on. The overall themes that emerged were resolving self-criticism and dealing with unresolved feelings with members of her family, especially with her father.

9

CASE FORMULATION APPLICATION CHARTS

The previous two chapters illustrated how case formulation is applied in specific cases, with an emphasis on Stages 1 and 2, respectively. Stage 3 is the process formulation stage. This chapter provides examples of case formulations mapped out in chart form with five clients whose conditions are typical of those with whom we work in therapy. Each of the problems in the five case studies—depression, anxiety, social phobia, complex trauma, and eating disorders—represents a major diagnostic category. A sample chart is presented for clinicians to use to map out a specific case formulation of their own, followed by a chart for each case.

http://dx.doi.org/10.1037/14523-009
Case Formulation in Emotion-Focused Therapy: Co-Creating Clinical Maps for Change, by R. N. Goldman and L. S. Greenberg

SAMPLE CASE FORMULATION CHART

Stage 1: Unfold the Narrative and Observe the Client's Emotional Processing Style

Step 1: Listen to the presenting problems (relational and behavioral difficulties).

Step 2: Listen for and identify poignancy and painful emotional experience.

Step 3: Attend to and observe the client's emotional processing style.

A. Vocal quality
B. Emotional arousal
C. Client experiencing
D. Emotional productivity
    i. Attending?
    ii. Symbolizing?
    iii. Congruence?
    iv. Acceptance?
    v. Differentiation?
    vi. Agency?
    vii. Regulation?

Step 4: Unfold the emotion-based narrative/life story (related to attachment and identity).

Stage 2: Co-Create a Focus and Identify the Core Emotion

Step 5: Identify markers for task work.

Step 6: Identify underlying core emotion schemes, either adaptive or maladaptive.

Step 7: Identify needs.

Step 8: Identify secondary emotions.

Step 9: Identify interruptions or blocks to accessing core emotion schemes.

Step 10: Identify themes: Self–self relations, self–other relations, existential issues.

Step 11: Co-construct the case formulation narrative, linking presenting relational and behavioral difficulties to triggering events and core emotion schemes.

Stage 3: Attend to Process Markers and New Meaning

Step 12: Identify emerging task markers. Marker: Task:

Step 13: Identify micromarkers.

EXAMPLE: In two-chair work, micromarker of fear emerges. Micro-formulation: encourage expression of fear and associated need underlying critic.

Step 14: Assess how new meaning influences the reconstruction of new narratives and connects back to presenting problems.

CASE FORMULATION CHART: DEPRESSION

Sophie, a 42-year-old single mother, suffered her second depressive episode.

Stage 1: Unfold the Narrative and Observe the Client's Emotional Processing Style

Step 1: Listen to the presenting problems (relational and behavioral difficulties): I am depressed. My son has gotten involved with drugs and I don't know what to do. I feel I have failed.

Step 2: Listen for and identify poignancy and painful emotional experience:

- I have suffered with depression most of my life.
- I am an angry person.
- I don't trust people.
- I shut down when people let me down.

Step 3: Attend to and observe the client's emotional processing style.

A. Vocal quality: mainly external, although responded with focused when empathic explorations offered.
B. Emotional arousal: moderate to high when talking on emotional topics.
C. Client experiencing: mostly external but capable of focusing internally when guided.
D. Emotional productivity
    i. Attending? Off and on.
    ii. Symbolizing? Yes. Clearly has capacity. Responsive to therapist's focusing on internal experience.
    iii. Congruence? Some mismatch (e.g., laughing when talking about vulnerable emotions).
    iv. Acceptance? Difficulty, less with anger than with vulnerable emotions such as sadness and hopelessness.
    v. Differentiation? Yes, has capacity.
    vi. Agency? Yes, she feels she is at center of her own experience.

vii. Regulation? Both under and over. However, overregulation is seen more as strategy to control underregulated emotions that get scary when expressed such as sadness and hopelessness.

Step 4: Unfold the emotion-based narrative/life story (related to attachment and identity): I live 5 hours away from my parents and I am glad there is distance between us. I see my parents approximately every 5 years, and yet I still feel devastated when I leave them. My mom is extremely critical and always has been. Now she is critical of my son. My father is generally not supportive. I grew up with five brothers, but none of them bothered with me, except for one, but he was not around much because he was away at boarding school most of the time. My parents never understood me; they always had different double standards for girls. I couldn't wait to leave when I was 18. I felt isolated and alone, and I still do. I am not married and never have been. My son was my light, my hope. He has always been such a good kid. Now he is involved with drugs and does not listen to me. I feel I have failed. In a way I have always failed. This is familiar.

Stage 2: Co-Create a Focus and Identify the Core Emotion

Step 5: Identify markers for task work: Negative self-evaluation ("You are not smart enough.") Task: Two-chair dialogue for self-criticism.

Step 6: Identify underlying core emotion schemes, either adaptive or maladaptive: The core emotion is maladaptive shame ("I am a failure."); it is mixed with fear, sadness, and loneliness that therapist and client work hard to access.

Step 7: Identify needs: Her core need is for self-validation and self-pride.

Step 8: Identify secondary emotions: The client often opens sessions with her secondary anger because she has typically felt this to be her source of strength. It is, in fact, a "straw man" protecting a vulnerable underbelly.

Step 9: Identify interruptions or blocks to accessing core emotion schemes: I cannot access core pain, as I will become severely depressed and dysfunctional; I will never get out of bed.

Step 10: Identify themes:

a. Self–self relations: I am not worthwhile. I am a failure.
b. Self–other relations: Others are not trustworthy; they will always invalidate me. It is better not to let anyone too close.

Step 11: Co-construct the case formulation narrative, linking presenting relational and behavioral difficulties to triggering events and core emotion schemes: When the various emotions and problems were deconstructed, the therapist helped clarify how they related to problems she presented, saying such things as,

> It is understandable that you feel depressed, given that you fundamentally feel like a failure. Your pride in your son was one area of life where you felt good and now you feel that has soured. This triggers a core sense

of failure and worthlessness that stems back to feeling criticized by your mother. With such negative experiences, you fear being invalidated and criticized, so you don't let people close to you. However, you feel lonely and unsupported in your life.

Stage 3: Attend to Process Markers and New Meaning

Step 12: Identify emerging task markers.

a. Marker: Through two-chair work for self-criticism, it becomes clear that the "critical voice" mirrors her boss and then eventually her mother. "She wipes me out every time I see her."
b. Task: Therapist and client undertake several rounds of empty-chair work for unfinished business with her mother, related to feelings of neglect and invalidation.
c. In two-chair work, stubborn critic had trouble softening (emerging marker). Formulation decision to switch and attempt self-soothing task.

Step 13: Identify micromarkers.

a. Micromarker: In empty-chair work, enacts mother sweeping and being dismissive; would then switch into self-chair, become hopeless and despondent.
b. Microformulation: Validate and empathize and then ask what she needs.

Step 14: Assess how new meaning influences the reconstruction of new narratives and connects back to presenting problems: In two-chair work, she was able to access a sense of assertive self-pride and a stronger sense of self-worth. Her sense of self-worth carried over to the relationship with her son. At later points in therapy, while she still felt he was involved with "the wrong crowd," she no longer felt it was her fault or that she was responsible. She was more able to make demands of him and set limits. In the empty-chair task, she got angry with mother and stated needs for support and validation. This led to her being more assertive with her boss at work with whom she had previously had difficulty standing up. She then felt better about going to work.

CASE FORMULATION CHART: GENERALIZED ANXIETY DISORDER

The client is a semiretired 64-year-old man, married for a second time, with one child and two stepchildren from his current marriage and two children from a previous marriage. He came to therapy to address his anxiety disorder. He suffered a heart attack a few years ago and now tends to fatigue easily. The client reports that he has been a worrier since he was a teen.

Stage 1: Unfold the Narrative and Observe the Client's Emotional Processing Style

Step 1: Listen to the presenting problems (relational and behavioral difficulties): His anxiety existed prior to the heart attack but now he reports worrying about "everything."

Step 2: Listen for and identify poignancy and painful emotional experience: Much of conversation in therapy focuses on the heart attack and its effects and while the therapist is compassionate to the client, it is also clear that this is not the most "poignant" because it does not evoke compassion in her. It does not speak of deep pain. The client recognizes that his worry is an avoidance of sadness and reports that the sadness is about the state of his life and opportunities that he has missed. He also has a great deal of anger with respect to both his mother and his father. He recalls his mother as being sick much of the time and unavailable. His father was physically abusive and uncaring. This has left him with a basic sense of insecurity and attachment anxiety. The client identifies feelings of emptiness and aloneness. He takes sleeping pills but only when he really needs to sleep. He also feels he has failed in many respects: career, marriage, and children. The client expresses the importance of having accomplished something but is not sure he has.

- I worry about everything.
- I feel insecure especially since my heart attack.
- I feel distant from others.

Step 3: Attend to and observe the client's emotional processing style

A. Vocal quality: mainly external. Will tell stories and give examples but not in a focused voice.
B. Emotional arousal: low to moderate when talking about emotional topics.
C. Client experiencing: Not capable of focusing internally unless specifically guided. Relays events and stories in an external manner. When empathic reflections focus on internal experience, will go inside for a moment but quickly jump out to tell another story.
D. Emotional productivity
    i. Attending? No.
    ii. Symbolizing? No, not on his own.
    iii. Congruence? Some mismatch. Not appearing or sounding sad when saying he is sad. Pressured speech.
    iv. Acceptance? Yes, of secondary emotions such as blaming anger but has more difficulty with vulnerable emotions such as sadness of loss.

v. Differentiation? Appears to be initially, as very expository and expansive. In essence, very abstract and not emotionally differentiated.
vi. Agency? Yes, around worry. Not agentic with respect to more vulnerable emotions.
vii. Regulation? Anxiety somewhat underregulated in the session but other emotions overregulated.

Step 4: Unfold the emotion-based narrative/life story (related to attachment and identity): The client worries a great deal about his children. One son from his first marriage won't speak to him, and the other son from his first marriage, who does speak to him, is currently going through a divorce and suffering with anxiety of his own. He says he doesn't know why they have become more distant, though he suspects that it might have to do with his abandoning them around the time of the divorce. As his child from his current marriage prepares to leave home, he reflects that she too has many insecurities and little interest in or need for him. He feels he has failed in matters of love. He was not able to make his first marriage work and sees his current marriage crumbling. He is unhappy and lonely. He considers leaving on a regular basis. In spite of a successful career as a professor, he feels that his colleagues do not respect him, and in his estimation he has accomplished little. The client shows high levels of worrying; the subject of his worries are his health, or other people, especially his children.

Stage 2: Co-Create a Focus and Identify the Core Emotion

Step 5: Identify markers for task work:

Marker: Worry split. "I worry about everything."

Task: Self-critical. This is the most fundamental task at the beginning. The key is getting at how the critic plays catastrophizing role, projecting fear, doom, and gloom into future, making him feel incompetent and bad. Critic says you are worth little and that is why you are unlovable.

Step 6: Identify underlying core emotion schemes, either adaptive or maladaptive:

His core maladaptive feelings are fear of loss and sadness of lonely abandonment. He feels insecure and unable to cope on his own. His need is for protection and security. Process of therapy is one of eventually accessing emotions of pride and anger and assertion of need for love. Client accesses emotions and is able to say, "I deserved to be taken care of." Sadness and grief are expressed at the loss of the mother and father he wishes he had had. Eventually, he is able to access self-soothing and compassion for the lonely child, with one part of the self saying, "I'll take care of" the more insecure part of the self.

Step 7: Identify needs: His core need is to be loved. He feels that if he achieves enough, he will be enough and therefore lovable.

Step 8: Identify secondary emotions: His secondary emotions are worrying (anxiety), hopelessness, and resignation that get expressed verbally as well as through psychosomatic symptoms.

Step 9: Identify interruptions or blocks to accessing core emotion schemes: Blocks to (fear of) accessing all emotions including core emotion schemes. Worry is the main form of avoidance of feelings.

Step 10: Identify themes.

a. Self–self relations: I am a failure and not worthwhile.
b. Self–other relations: I am lonely and unloved. I am afraid I will lose others if I am angry with them. I need them to approve of me so I know I am loved. I am a failure and that is because I am unlovable.

Step 11: Co-construct the case formulation narrative, linking presenting relational and behavioral difficulties to triggering events and core emotion schemes: So it seems like your worry is an attempt to protect against your feelings of anger and sadness and this basic feeling of aloneness and insecurity. Your worry is a like a sentinel that is on guard against feeling these painful feelings. If you worry you can anticipate anything bad before it happens and that seems to give you some sense of control. However, then you can never be relaxed; you are always on guard. What we need to do is help you deal with your underlying feelings. The main method through which this is achieved is by the therapist understanding that worry is secondary to more fundamental, primary emotions such as core anger and sadness. The therapist validates worrying as distressing but attempts to refocus on primary emotions.

Stage 3: Attend to Process Markers and New Meaning

Step 12: Identify emerging task markers. These emerge after two-chair work with a catastrophizing self-critic has been partially resolved, and self has been able to stand up to the critic and assert pride, anger, and needs.

a. Two unfinished business tasks, one with mother and one with father.
    i. Marker: Mother was sick and unable. Needed caring but couldn't get it. Felt shame at mother's infirmity. Task: Conduct empty-chair where he puts mother in chair and asserts and expresses need for caring and nurturing and anger at not getting support. Sadness at loss of a childhood.
    ii. Marker: Father abused me. Task: Conduct empty-chair where he puts father in chair and expresses anger, standing up to him: 'You were the one at fault. You should not have treated me like that. I did not deserve the way you treated me.'

iii. Marker: Inconsolable grief related to abandonment. Task: Self-soothing of the abandoned child whose mother was unable to be responsive.
iv. Micromarker in context of unfinished business: He interrupts his emotions of anger and sadness, saying such things as "Don't bother your mother, she is sick." Microdecision: Self-interruptive task. He shuts down and feels resigned to not being able to get his needs for comfort met. Working through his resignation and protectiveness helps him to contact his feelings of aloneness and needs to both grieve his loss and assert anger.

Step 13: Identify micromarkers. Micromarker in context of unfinished business task with mother: Episodic memory versus expression of emotion? Begins to tell a specific story: When he was 10 years old and coming home from school, he thought the house was empty and got scared. His mother was in fact home but sick in bed. Microformulation: Spend time listening to the episodic memory and processing before encouraging him to express sadness and fear to his mother in the chair.

Step 14: Assess how new meaning influences the reconstruction of new narratives and connects back to presenting problems: Through participation in chair work, client is able to feel that his needs are legitimate and that he is able to survive his painful feelings of abandonment and both soothe self and assert needs to his wife and children. After completion of chair work that involved the discovery of new emotion and during integration of new meaning phase of work when client tells therapist about event with wife where he asserted himself, therapist reflects, "So somehow you have become more aware of your needs and it is okay to express them. So that what you want is important and it does matter, and it is OK to tell her." Client replies with a grin, "Yes, I said what I wanted and at first she was resistant, but then she said OK, and that was that."

CASE FORMULATION CHART: SOCIAL ANXIETY

A 27-year-old university graduate science student comes to therapy because he is having debilitating anxiety. When contemplating public places, he becomes very scared and avoids many social situations.

Stage 1: Unfold the Narrative and Observe the Client's Emotional Processing Style

Step 1: Listen to the presenting problems (relational and behavioral difficulties): I am anxious. I am terrified of presenting in class. I start to shake when I am called on. I also have trouble making social connections. I don't like going out to public places and refuse to go to parties.

Step 2: Listen for and identify poignancy and painful emotional experience:

- I don't have anything to contribute.
- I have to know it's perfect before I speak.
- I don't know what to say to people.
- I can't risk being rejected.
- I feel like a nothing.
- I don't like living like this.

Step 3: Attend to and observe the client's emotional processing style.

A. Vocal quality: mainly limited, speaking softly and slowly. Sometimes external.
B. Emotional Arousal: low.
C. Client experiencing: mostly low but capable of focusing internally when guided.
D. Emotional productivity
    i. Attending? With difficulty; he is avoidant
    ii. Symbolizing? Yes, but abstractly: "I think what I feel is . . . " (vs. "I feel . . . ")
    iii. Congruence? No. Conceptual and anxious laugh.
    iv Acceptance? No.
    v. Differentiation? Yes, has capacity.
    vi. Agency? No.
    vii. Regulation? Highly overregulated.

Step 4: Unfold the emotion-based narrative/life story (related to attachment and identity): He describes his mother as both overly sensitive and intrusive and his father as mostly absent but having very high standards and never feeling he lived up to them and therefore never deserving of his regard or love. He reveals a few sessions into therapy that he always felt he was different because he was bullied in school. His main issue is freezing up and feeling tense before a social interaction. His main messages to himself are: don't reveal too much about yourself because people can use that information against you and you look awkward and you're going to make a fool of yourself so don't speak, or speak only after you are perfectly prepared to speak. He usually avoids asking for anything so that he doesn't look needy. He hates receiving compliments, hates to make requests or disagree with others because it feels like he is being too dominant. He is worried about offending others. Being one-up is extremely aversive and he avoids it. At the same time he suffers feeling inferior.

Stage 2: Co-Create a Focus and Identify the Core Emotion

Step 5: Identify markers for task work: For the first five or six sessions, the main marker emerged in the form of an attributional split; he would

project that others were critical of him. In session, he would reveal social or school situations in which he would say he was afraid others would see him as weak, different, awkward, a fake, an impostor.

Step 6: Identify underlying core emotion schemes, either adaptive or maladaptive: The core emotion is maladaptive shame, and it is socially activated with other people, not alone. Although he often talks about his fear of rejection, it seems that the fear is actually shame anxiety, fearing he will be dismissed. His fear is related to being exposed as inadequate and feeling humiliated. He takes care to not reveal anything about himself to avoid being judged, exposed, and rejected. His basic organization is that of shame and submissiveness and his fear of rejection was a fear of being found defective and therefore dismissed. The goal through the therapy was to access core adaptive emotions of pride and self-confidence.

Step 7: Identify needs: His core need was to feel worthwhile and likable, as if he had purpose or something to offer.

Step 8: Identify secondary emotions: Secondary emotions that tended to be overgeneralized and thus quite paralyzing. The main emotion was fear, although getting underneath meant accessing maladaptive shame.

Step 9: Identify interruptions or blocks to accessing core emotion schemes:

He avoided emotion most of the time by processing conceptually. He was very guarded in relation to disclosing to the therapist, because he worked so hard to express himself perfectly, but this set up a barrier between him and others as well as the therapist. He also was wary in front of the camera.

Step 10: Identify themes:

a. Self–self relations: I need to be perfect in front of others.
b. Self–other relations: It is better not to let anyone too close so they can't see my flaws. I shouldn't burden others or harm them.

Step 11: Co-construct the case formulation narrative, linking presenting relational and behavioral difficulties to triggering events and underlying emotion schemes:

The therapist helped the client make connections by saying,

> So it seems like your critic monitors and scrutinizes what you say all the time in order to prevent you from saying the wrong thing and being perceived as stupid because this was really embarrassing in the past. This voice is related to perceived "past mistakes." It feels now like that is how you are protecting yourself. When you have allowed yourself to be more free and relaxed, you felt you said the wrong thing and hurt other people and then felt regret. This voice also seems to be connected to not wanting to cause your mother distress when you were growing up, as she seemed fragile or unable to deal with your distress, like when you went to hospital for an illness. This leaves you terrified at the prospect

of being exposed as inadequate (not knowing things, looking awkward); therefore, you make sure by being prepared and by not revealing stuff or talking too much, staying in a shell, or trying to be perfect. Your coping strategy to avoid this fear is to critically monitor yourself at all times so that you are vigilant and avoid mistakes that may expose you. This ends up leaving you feeling awkward, unsure, depressed, and isolated. You also act submissively with people, speaking slowly, never making demands or expressing ideas with confidence, always expressing things hesitantly.

Stage 3: Attend to Process Markers and New Meaning

Step 12: Identify emerging task markers. After many earlier sessions focused on self-criticism through two-chair tasks, different markers emerged for the empty-chair dialogue for unfinished business:

a. Marker: Unfinished business with mother who he felt was overly sensitive and he needed to protect from his distress.
b. Marker: Unfinished business with father who was pressuring and disapproving and did not acknowledge weakness.
c. Marker: Trauma-related unfinished business with childhood bullies.

   Task (for all markers): Empty-chair dialogue for unfinished business. Eventually, we see the emergence of empowered anger in unfinished business with father and bullies.
d. Marker: Mostly occurring in context of the two-chair task or independent of a task, during a session: He intrusively monitors, scrutinizes, second guesses, and judges himself. This process leads him to freeze and remain silent. The main message is, "Don't speak unless you have the perfect thing to say that fits the topic. You'll be rejected or dismissed." Task: Two-chair for self-interruption. In the self-chair he was able to articulate and eventually even briefly say he resents the intrusive monitoring and wants to be relaxed. The self at first feels protected, but sometimes expresses slight signs of dissatisfaction, saying back to interrupting part, "shut up" or "back off."

Step 13: Identify micromarkers

- Micromarker: In the context of unfinished business task with mother, mother has been on the one hand protective but on the other hand stifling, saying, "I am just so worried you are going to make a mistake and fail, do you really think it is a good idea that you try out for the team?" He has expressed a great deal of fear, anguish, and anger in response. At some point, when enacting his mother, he appears critical and fear-mongering, but the therapist notices that he (speaking as his mother) is talking in more subjective terms about her own fear.

- Microformulation: The therapist then moves from encouraging him (as her) to express fear to client, to facilitating him (speaking as his mother) to talk more from her own fears and worries and how it was for her growing up as a child on the prairie and being sheltered and scared.

Step 14: Assess how new meaning influences the reconstruction of new narratives and connects back to presenting problems: He stated that he is more aware of what's going on and is telling himself to relax and that if he was invited it must mean that "I'm not weird." He said he tries to reduce the importance of things, shut down the critical voice to some extent, to be less aware and think less of what he says. "I need to believe they want me there." We talked about what he needs to feel secure in social situations. He came to understand his current anxiety as connected with past experiences of bullying. He wants to put the past behind him and not respond as that younger boy. His new narrative involves a stronger, more secure man in the world.

CASE FORMULATION CHART: COMPLEX TRAUMA

A 32-year-old woman comes to therapy for help with depression, anxiety, and drinking problems (drinking binges approximately once a week, although overall not meeting full criteria for substance dependence).

Stage 1: Unfold the Narrative and Observe the Client's Emotional Processing Style

Step 1: Listen to the presenting problems (relational and behavioral difficulties): My relationships are unstable. I cannot find an intimate partner and be happy in a relationship. I have flashbacks and nightmares. I feel vulnerable in the world. Sometimes I feel depressed and sometimes I feel anxious.

Step 2: Listen for and identify poignancy and painful emotional experience:

- I cannot form close relationships and stay close.
- I am afraid of sexual intimacy and do everything I can to avoid it.
- I am very angry with my mother but I don't feel entitled to express it.
- I don't trust people

Step 3: Attend to and observe the client's emotional processing style:

A. Vocal quality: mainly external initially. Is capable of focusing internally when therapist helps her to do so with empathic-guiding responses.

B. Emotional arousal: initially very low as afraid of emotion and will tend to cut off or dissociate for fear of losing control. When activated in therapy can become somewhat dysregulated such as inconsolable sadness or paralyzing fear. Therapist helps regulate through empathy, acceptance, validation, and compassion.
C. Client experiencing: mostly external at baseline but capable of focusing internally when guided.
D. Emotional productivity
    i. Attending? Has capacity but in natural state, will go in and out of attending.
    ii. Symbolizing? Yes, has capacity but general mode is avoidant.
    iii. Congruence? Incongruent. Will tell stories of terrifying events in matter-of-fact tone.
    iv. Acceptance? Difficulty. In particular, anger is a difficult emotion to access because it is associated with "abuser" and not an emotion self wants to identify with.
    v. Differentiation? Limited capacity as afraid to focus inward as difficult emotions may emerge and be expressed without control.
    vi. Agency? She often feels things "happen to her" as she moves through experience without being aware of emotions and actions. Thus, she is surprised when others react in a strong manner, becomes afraid, and shuts down. As a result, often she doesn't feel in control of emotions.
    vii. Regulation? Both underregulated and overregulated. Overregulated as way of controlling what happens when she does access emotion and becomes underregulated.

Step 4: Unfold the emotion-based narrative/life story (related to attachment and identity): I know I am very angry with my mother but I actually feel numb. When I was 16, I was raped by my uncle, and I did not feel comfortable telling my mother because I was afraid she would deny it or get angry with me. I told my Spanish teacher instead. When my mom found out, she did get angry with me for not telling her, and then she told me it was my fault. Throughout my growing up, I was emotionally neglected. As a teenager, I had to sleep in the same bed as my brothers and they would sexually molest me. When I told my parents, specifically my mother, she did not do anything about it. Sometimes I would try to sleep with my parents, as that was better than being touched by my brothers. I am angry with my both of my parents but perhaps more at my mother. She was not a good role model for me. She did not make sure I was safe and secure. My parents did not make sure to get me my own room, bed, or private space. Now I am afraid to get into an intimate

relationship because I am afraid to be sexually intimate with someone. My last relationship ended because I did not want to become sexually intimate. I regret it, as he treated me very well.

Stage 2: Co-Create a Focus and Identify the Core Emotion

Step 5: Identify markers for task work:

a. Marker: Traumatic experiences have occurred:
   i. Rape when teenager.
   ii. Molestation by brothers. Broken narrative or incoherent memory with respect to specific events.

   Task: Trauma retelling with the goal of the story becoming more integrated and coherent into the overall narrative of her life.

b. Marker: Unfinished business with mother. Angry with mother for not protecting and invalidating her. Task: Empty-chair task with goal of standing up to mother, placing blame for not protecting her where it belongs, and affirming the self.

Step 6: Identify underlying, core emotion schemes, either adaptive or maladaptive: Maladaptive shame and maladaptive fear (overgeneralized). There is also primary core sadness related to her feeling the loss of innocence and not being able to be a "little girl." The goal here is to access adaptive anger, wherein the client says, "I didn't deserve to be treated like that; you were not being a good mother and protecting me as a parent should." The expression of angry self-assertion helps to reduce and shift maladaptive shame, placing blame and responsibility where it belongs and reducing self-blame. This translates to client moving to stance of "it was not me who was wrong, bad, or dirty; rather it was you who did not protect me; you were sick." All of this leads to an increase in an ability to feel entitled to get in touch with needs and express them in relationships.

Step 7: Identify needs: Her core need is for security and has sense that could also give her a stronger sense of self-worth.

Step 8: Identify secondary emotions: Secondary emotions are fear, guilt, and hopelessness. Her secondary anxiety is generally avoidant anxiety for fear of collapse from being overwhelmed by emotions or depression or suicide.

Step 9: Identify interruptions or blocks to accessing core emotion schemes: Don't access the emotions. Numbing self for fear of exposing emotions and becoming "shattered." Overwhelmed by pain. The underlying fear of client is, "I will feel it and it may never stop; I am not sure I am strong enough to bear it."

Step 10: Identify themes:

a. Self–self relations: I feel vulnerable; insecure.
b. Self–other relations: I am afraid to let others close to me, they will betray me, mistreat me, or leave me. Others are not trustworthy and they will always invalidate me. It is better not to let anyone too close.

Step 11: Co-construct the case formulation narrative, linking presenting relational and behavioral difficulties to triggering events and core emotion schemes:

> So you don't let her 'come out' in social situations, work situations, or relationships, and that makes sense, as you are trying to protect her and keep her safe, but that leaves you feeling disconnected and depressed or anxious sometimes. This has been a survival/coping strategy for a long time, so it is important that your "interruptor" keep doing that to make her safe. The risk she takes if she lets you see the light of day is that she will be hurt, it will be painful and you feel like you won't be able to survive. On the other hand, this is a problem for you as the little girl in you wants to be able to see the light of day, to breathe, to connect, be seen heard. And that is an important voice inside of you.

Stage 3: Attend to Process Markers and New Meaning

Step 12: Identify emerging task markers.

a. After empty-chair work resolves in terms of her getting angry and standing up for self to the abusive other, issues of self-worth become more evident and marker of self-criticism emerges. When further explored and prompted, critic says:

> You are nothing, you are a shit. Just stay inside and don't be heard as you will only mess it up. This is the way we have done it for this long so don't even bother trying to come out. You will only be hurt. People will not like you. Staying inside has worked "for us" so far, so just shut up and don't come out.

b. Task: Two-chair work for self-criticism. Therapist says,

> It is hard to accept but this is in fact what you do to yourself. Let's explore this to see how you do it, to see if you might be able to change it, and fight back against this harsh critic. Can you put yourself in chair over here and tell her.

Critic says: "You are worthless." "You are no good."

Step 13: Identify micromarkers

a. Micromarker: In course of empty-chair work with mother, scared "little child" emerges who feels "a lot of pain" and is afraid to come

out, afraid she will not survive. Therapist is not sure whether to further explore the hopelessness and validate and be empathic or to promote a self-soothing mode.

b. Microformulation: Self-soothing task. Therapist switches empty-chair task mid-point and asks her to come over to other chair (replacing mother), and asks an internalized parental figure to soothe and reassure little girl. Therapist says to internalized figure, "She is scared (pointing to self-chair). What can you say to her? How can you reassure her?" Client responds, "Well, I can tell her she is going to be okay and not to worry. I will take care of her." Therapist says, "OK, can you do that now. Tell her, 'it is OK. I will protect you, I will take care of you.'"

Step 14: Assess how new meaning influences the reconstruction of new narratives and connects back to presenting problems: In the context of self-interruptive chair work and resolution toward self-expression, the therapist says,

> So there is a part of you that does want to be seen and wants a 'door' that allows you to come and go, through the wall. And this makes you feel like you could be able to interact in the world, and be seen, and be free to love. So you do need to be heard and free to express yourself and there may be a way to do this, express yourself and get some needs met while at the same time, protect yourself.

CASE FORMULATION CHART: EATING DISORDER

A 22-year-old woman with anorexia nervosa has had previous multiple hospitalizations. She is currently maintaining normal weight (minimally). She was recently released from a residential hospital program. She would like to try to address the eating disorder so as not to have a relapse.

Stage 1: Unfold the Narrative and Observe the Client's Emotional Processing Style

Step 1: Listen to the presenting problems (relational and behavioral difficulties): I would like to live a normal life. I would like to understand why I cannot let go of being thin (below normal weight). I am afraid of relapse. I am afraid that therapy cannot help me. I am afraid nothing can help me.

Step 2: Listen for and identify poignancy and painful emotional experience.

- At fundamental level, I do not feel that I am lovable. My parents love me, but I am not worthy of their love.

- I feel I am too fat. (Client describes feeling she should be thinner even though she sits across from therapist nearly emaciated.) I am gaining weight and I find myself disgusting.
- They say I have distorted vision and that I cannot tell but I look in the mirror and I just see myself as fat.

Step 3: Attend to and observe the client's emotional processing style.

A. Vocal quality: mainly external
B. Emotional arousal: very low; flat and monotone.
C. Client experiencing: very low; relays events and stories in a disengaged manner.
D. Emotional productivity
   i. Attending? Not usually.
   ii. Symbolizing? No, very rarely.
   iii. Congruence? No. Will say feels disgusted with herself and that she deserves to bleed all over, but with no feeling in voice.
   iv. Acceptance? Difficulty. In general, does not like to feel.
   v. Differentiation? No; spends little time reflecting and prefers not to talk about emotions.
   vi. Agency? Yes. Does not want anyone to have any control over emotions, although pretends to have no emotion.
   vii. Regulation? Extremely overregulated.

Step 4: Unfold the emotion-based narrative/life story (related to attachment and identity):

> As long as I can remember, I was obsessed with being thin. As teenagers, my friends and I would weigh ourselves for fun. I was always determined to be the thinnest. I was a cheerleader and a dancer. As a cheerleader, I always strove to be "top girl." That meant I had to be the smallest, thinnest, lightest. Prior to that I was very anxious and as long as I can remember I had obsessive-compulsive symptoms. I remember when I was 3 I had to wear gloves because I didn't want to touch anything. I was afraid of the dirt. My toys had to be neat and perfect. If I walked into a store I would straighten the shelves. My parents are very supportive and they love me, and I feel ashamed that I have put them through hell. I feel distant from my father and, if I am truthful, I am angry that he was not always supportive and was sometimes mean when I was little. He also was not that supportive about my eating disorder, but now he is more understanding. When I was about 5 I had a great deal of separation anxiety from my mother. I could not sleep if she was not in the room with me. Now, I sometimes feel invalidated by her but I never want to say anything bad about her. I have always relied on her for support and I would not dream of being angry with her. Please do not ask me to bring her with me to

the therapy room, as I could not dream of confronting her or having her here as a witness. She cares so much for me. In spite of what I have put her through, she has stuck by me.

Stage 2: Co-Create a Focus and Identify the Core Emotion

Step 5: Identify markers for task work:

Marker: Negative self-evaluation: "You are fat, ugly, and disgusting. You deserve physical, mental, all kinds of pain. You are unlovable. Even your parents who say they love you could not possibly." I deserve nothing.

Task: Two chair for self-criticism. This is the most fundamental task at the beginning.

Step 6: Identify underlying core emotion schemes, either adaptive or maladaptive:

She feels maladaptive shame: I am worthless; "You are right and I am sorry." Eventually, and first evidence of this is only after six sessions and very faint, she accesses tiny grain of adaptive pride and anger: "It hurts when you talk to me like that." By session 45, accesses more adaptive pride/anger, "I don't deserve to be talked to like that. I am worthwhile and I want to live a normal life."

Step 7: Identify needs: Her need is for self-acceptance, self-respect, and self-compassion.

Step 8: Identify secondary emotions: Self-contempt: "You deserve pain, you are worthless, how could anyone ever love you?"

Step 9: Identify interruptions or blocks to accessing core emotion schemes: Very strong blocks to (fear of) accessing all emotions including core emotion schemes. For client with eating disorder, this has become a well-oiled strategy. The client is afraid of feeling the pain of her feelings, particularly her strong self-contempt. She is afraid of losing control. Distracting from emotions is a survival strategy, and this is identified through exploration between client and therapist.

Step 10: Identify themes:

a. Self–self relations: I am not worthwhile.
b. Self–other relations: I am not lovable. Others say they love me but they could not possibly. I am afraid of asserting to mother or father. Afraid I will lose them, but sometimes I am angry with them as I don't think they understand my needs.

Step 11: Co-construct the case formulation narrative linking presenting relational and behavioral difficulties to triggering events and core emotion schemes: It is understandable that you would want to keep restricting your food intake, focusing on your weight, and your body, and not wanting

to feel anything; that is how you have done it all your life, and to change something that has been key to your survival is a great deal to ask. And yet, you are also recognizing that another part of you is a slave to the eating disorder. You talk about how your physical health is suffering and you want that to change. You are seeing that you cannot lead a "normal" life (e.g., go grab a cup of coffee with a friend or eat a piece of pizza in public) and you want to be able to do it. Not focusing on your feelings and needs is to some extent preventing you from moving forward.

Stage 3: Attend to Process Markers and New Meaning

Step 12: Identify emerging task markers.

a. Marker: Unfinished business with mother. This only emerges after 15 sessions because the client is reluctant to talk about her mother. At first she is not willing to do, but eventually reports an incident where her mother is not supportive of her around her eating a piece of chocolate cake and she feels invalidated.
   Task: Empty-chair work with mother. The client puts her in chair and asserts,

   > When you are critical of me, I feel awful. When you spend time with brother's girlfriend, indicates you favor her and are done with me. Fear of getting better and then losing you and this is confirmation that I am worthless.

b. Marker: Unfinished business with father related to feeling he was invalidating, critical, and unsupportive particularly when her eating disorder was most acute.
   Task: Empty-chair work with father.
c. Marker: Emotional self-interruption. [One major marker that emerges in this population is self-interruption.] Here are two contexts where it arises:
   i. General marker: She will say to self, "DON'T laugh, don't enjoy, don't get better, stay sick because everyone will see anything of who you really are, they will leave you." Task: Two-chair task for self-interruption.
   ii. Context of two-chair task for self-criticism, marker for self-interruptive task: In attempts to express anger, stand up to critic, and feel stronger, self-interrupts, shuts down, and tells self don't get better, don't figure things out, because then you will get better and people will leave you.

   Task: Switch to two-chair work for self-interruption.

Step 13: Identify micromarkers.

Micromarker: In context of two-chair task for self-criticism: In critic chair, she is heavily berating herself, saying that she is nothing and deserves only pain and suffering. She moves to the self-experiencing chair and shuts down, saying that she feels nothing. The therapist must formulate whether to move her back to critic chair and encourage or heighten the self-critic or keep her in self-experiencing chair and try to deepen the hurt and shame in spite of client saying she feels nothing.

Microformulation: The therapist decided to keep her in the self-experiencing chair and explore the hurt by reaching in, providing empathic conjectures and attending to her facial expression, saying, "I know you are saying you say nothing but your face says you hurt so much and I imagine it brings an ache in your chest. What is happening inside?"

Step 14: Assess how new meaning influences the reconstruction of new narratives and connects back to presenting problems. Through participation in chair work, the client is able to become aware, at both an experiential and conceptual level, how she keeps herself sick and prevents herself from being able to meet feelings and needs. Together, client and therapist discover how she chastises and threatens herself, thereby denying a voice to the healthy part of her self that wants to feel, experience, and express. In two-chair work, she comes to see how she expresses self-contempt and accesses associated shame. Through the accessing of shame, she finds angry, self-pride, and asserts to critic, saying "stop making me feel bad about myself. I don't deserve it." The critic tries to hold on by saying, "You need me, I have helped you survive this far, you better listen and do as I say, or you will lose everything, you are fat" (shaming her and threatening other people's abandonment, based on her shame). The critical, controlling voice says, "I have protected you and this is how you repay me?" The self-experiencing voice asserts, "I want you to protect me. I want you by my side. I know you have tried to take care of me but I don't like how you have done it." By the end of therapy, therapist and client construct how there is an "eating disorder" voice, saying that she is fat is a way of hanging on and controlling out of fear. She comes to see how that critical, eating disorder voice is holding her back and that she can, in fact, access a stronger voice inside of her that feels like she is worthwhile and she does deserve happiness, and she is strong enough to take care of herself without the critical, controlling voice.

CONCLUSION

Emotion-focused case formulation provides clinicians with an organizing map that guides them through the complex process of formulating a case from beginning to end. Upon meeting with clients and engaging them in

trying to solve their problems or cure what ails them, a strong emotional bond and solid therapeutic alliance is formed, and together client and therapist set out to work. EFT therapists are immediately involved with unfolding presenting problems and begin the dual process of deconstructing the narrative and observing the complex and nuanced emotional processing style of the client. By the end of the first stage, therapists gain a sense of the presenting problems in an emotional and narrative context. Therapists understand the client's problems in the context of an attachment and identity-based narrative that tells the story behind the relational and behavioral difficulties that brought clients to therapy and what they wish to change. Therapists early on begin to attune to and carefully attend to the emotional material in terms of what is painful and poignant for the client. They gain a more complete picture of the client's particular emotional processing style, learn how to classify it, and understand what it may mean about moving forward toward emotional transformation.

Stage 2 continues to follow the client's chronic enduring pain in constructing a picture of the MENSIT: the initial markers, core emotions and needs, the secondary emotions and interruptions that overlay or prevent access to core emotions, and the themes that emerge and coalesce from the work. By the end of the second stage, therapists have a guiding framework around which therapy is organized that has at its core the maladaptive emotion scheme and all its elements. A formulation narrative is formed that ties the presenting relational and behavioral difficulties together with the events that trigger the core emotion schemes that are the source of problems. This narrative framework continues to guide case formulation into the third stage. The final stage is, for the most part, based on moment-by-moment diagnosis of ongoing therapy process and formulation of current client states. In the third stage, new, emergent markers are continuously followed and guide ongoing intervention. Therapists continuously formulate a variety of micromarkers as they present themselves. These micromarkers are essentially choice points that call for microformulations on the part of the therapist about how to best direct the process at a given moment. Formulation in the final stage also involves facilitating the integration of new emotions and meanings that have emerged from the process, and involves assessing in conjunction with clients, how the new information influences the existing or ongoing re-storied narrative themes. New emotions and new narratives are understood in terms of implications and changes in initially presenting relational and behavioral difficulties.

The book has provided a number of in-depth, detailed case examples to illustrate the three stages of case formulation. A chart has been provided that therapists may use to guide their own formulation process. A specific chapter has been devoted to illustrating, in chart form, how case formulation

might occur with cases focused on depression, anxiety, social phobia, complex trauma, and eating disorders as their main presenting problems.

EFT is unique in its emphasis and focus on emotion as the fundamental process that must be targeted and changed. Case formulation has a unique dual focus on emotional process first, but always understood in the context of narrative meaning-making, in an effort to build a picture of the case with the core emotion scheme at the center. Once formulation has coalesced around that which is thematic, a narrative framework is provided which ties the triggering events in the clients' world to the core painful emotion. The case formulation framework that emerges provides a scaffold out of which process formulation continues to occur and guide intervention. This process continues to guide therapy through the process of emotional and narrative transformation. Case formulation thus provides a necessary guiding framework through the complex process of facilitating emotional change in each individual client.

CONCLUSION

Emotion-focused case formulation provides clinicians with an organizing map that guides them through the complex process of formulating a case from beginning to end. A strong emotional bond and solid therapeutic alliance is formed when therapists meet with clients and engage them in the quest to solve their problems—together, client and therapist set out to work. Emotion-focused therapists immediately begin to unfold the client's presenting problems through the dual process of deconstructing the narrative and observing the client's emotional processing style. By the end of the first stage of emotion-focused therapy (EFT) case formulation, therapists understand the client's problems in the context of an attachment- and identity-based narrative that tells the story behind the relational and behavioral difficulties that brought him or her to therapy. They carefully attend to what is painful and poignant in the client's emotional material. They gain a more complete picture of the client's particular emotional processing style, learn how

http://dx.doi.org/10.1037/14523-010
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to classify it, and understand what it may mean for moving forward toward emotional transformation.

Stage 2 continues to follow the client's chronic enduring pain in constructing a picture of the MENSIT: the initial markers, core emotions and needs, the secondary emotions and interruptions that overlay or prevent access to core emotions, and the themes that emerge and coalesce from the work. By the end of the second stage, therapists have a guiding framework for organizing therapy that has at its core the maladaptive emotion scheme and all its elements. A formulation narrative is arrived at that ties the presenting relational and behavioral difficulties to the events that trigger the core emotion schemes that are the source of problems. This narrative framework continues to guide case formulation into Stage 3. The final stage is, for the most part, based on moment-by-moment diagnosis and evaluation of ongoing therapy process and formulation of current client states.

In the third stage, new, emergent markers are continuously followed and guide ongoing intervention. Therapists continuously formulate micromarkers as they present themselves. These micromarkers are choice points at which the therapist makes "microformulations" about how to best direct the process at a given moment. Formulation in the final stage also involves the integration of new emotions and meanings that have emerged from the process and assessing, in conjunction with clients, how the new information influences the existing or ongoing re-storied narrative themes. New emotions and new narratives are understood in terms of their implications for and changes in the relational and behavioral difficulties that brought the client to therapy.

The detailed case examples in this book illustrate the three stages of case formulation. Therapists can use the chart provided in Chapter 9 to guide their own formulation process. The chart illustrates how formulation might occur with in cases in which depression, anxiety, social phobia, complex trauma, and eating disorders are the main presenting problems.

Emotion-focused therapy (EFT) is unique in its focus on emotion as the fundamental process that must be targeted and changed. Case formulation has a unique focus on emotional process first, but it is always understood in the context of narrative meaning-making, in an effort to build a picture of the case with the core emotion scheme at the center. When formulation has coalesced around a theme, a narrative framework is provided that ties the triggering events in the client's world to the core painful emotion. The case formulation framework that emerges supports process formulation and guides intervention throughout the complex process of facilitating emotional change in the individual client.

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