Emotion-Focused Therapy: A summary and overview

Dr Leslie Greenberg

The basic principles of an emotion-focused approach to therapy (EFT) are presented. In this view, people, as well as simply having emotion, also are seen as living in a constant process of making sense of their emotions. Emotion is seen as foundational in the construction of the self and is a key determinant of self–organization and personal meaning is seen as emerging by the self-organization and explication of one's own emotional experience. Optimal adaptation involves an integration of reason and emotion. In EFT, distinctions between different types of emotion provide therapists with a map for differential intervention. Six major empirically supported principles of emotion processing guide therapist interventions and serve as the goals of treatment. A case example illustrates how the principles of EFT helped a patient overcome her core maladaptive fears and mobilize her ability to protect herself.

Emotion-focused treatment was developed as an approach to the practice of psychotherapy grounded in contemporary psychological theories of functioning. A major premise EFT is that emotion is fundamental to the construction of the self and is a key determinant of self-organization. At the most basic level of functioning, emotions are an adaptive form of information-processing and action readiness that orient people to their environment and promote their well being (Greenberg & Safran, 1987; Greenberg & Paivio, 1997; Frijda, 1986).

Emotions are significant because they inform people that an important need, value, or goal may be advanced or harmed in a situation (Frijda, 1986). Emotions, then, are involved in setting goal priorities (Oatley & Jenkins, 1992) and are biologically-based tendencies to act that result from the appraisal of the situation based on these goals, needs, and concerns (Arnold, 1984; Frijda, 1986; Greenberg & Safran, 1986, 1989; Oatley & Jenkins, 1992).

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

The developing cortex added to the emotional brain's in-wired emotional responses the ability to learn and form internal organizations (neural networks) that produced emotional responses to learned signs of what had evoked emotion in a person's own life experience. Those emotional memories and organizations of lived emotional experience were formed into *emotion schemes* (Greenberg et al., 1993; Greenberg & Paivio, 1997, Oatley 1992). By means of these internal organizations or neural programs people react automatically from their emotion systems, not only to inherited cues, such as looming shadows or comforting touch, but also to cues that they had learned were dangerous, like fear at one's father's impatient voice, or life enhancing, like a loved symphony, and these reactions are rapid and without thought. Emotion schemes are organized response- and experience-producing units stored in memory networks. Thus rather than being governed simply by biologically and evolutionarily-based affect motor programs, emotional experience is produced by the synthesis of highly-differentiated structures that have been refined through experience and are bound by culture into emotion schemes (Greenberg,

Rice, & Elliott, 1993; Oatley, 1992; Pascual–Leone, 1991). Emotion schematic processing is the principal target of intervention and therapeutic change in emotion-focused therapy (Greenberg, Rice, & Elliott, 1993; Greenberg & Paivio, 1997).

An emotionally distressing event such as a betrayal or abandonment, at the start results in an emotional reaction. The emotion will fade unless it is "burned" into the memory. The more highly aroused the emotion the more the evoking situation will be remembered (McGaugh, 2003). Then the emotions are connected to memories of the self in the situation and autobiographical memories are formed. As a result the emotional response can be recreated again and again long after the event. For example a memory of a betrayal or something that reminds one of it stimulates an emotional response of anger and hurt.

There are a number of consequences of this reaction. First, the sympathetic nervous system is activated in part via the amygdala each time, setting up a muscular state of readiness often for fight or flight. Second, the activation leads to a heightened state of emotional arousal of the emotion and third to a strengthening of the memory of the traumatic incident. The evolutionary benefit of these effects is the testing and renewal of the defensive system against future violations.

Changes in the emotion schematic memory structures most likely occur through the recently investigated process of memory reconsolidation. The classic view of memory suggest that immediately after learning there is a period of time during which the memory is fragile and labile, but that after sufficient time has passed, the memory is more or less permanent. During this consolidation period, it is possible to disrupt the formation of the memory; once this time window has passed, the memory may be modified or inhibited, but not eliminated. Recently however, there has been renewed "interest in an alternative view of memory suggesting that every time a memory is retrieved, the underlying memory trace is once again labile and fragile – requiring another consolidation period, called *reconsolidation*" (Phelps, 2009, p. 213). This reconsolidation period allows another opportunity to disrupt the memory. Given that maladaptive emotion schematic memories can at times be maladaptive, resulting in such emotions as fear in anxiety disorders and PTSD and shame and sadness in depression the possibility of disrupting a previously acquired emotion schematic memory by blocking reconsolidation may have important clinical implications.

A Dialectical Constructivist View: Integrating Biology and Culture

As well as simply having emotion, people also live in a constant process of making sense of their emotions. An integration of reason and emotion is achieved via an ongoing circular process *of making sense of experience* by symbolizing bodily-felt sensations in awareness and articulating them in language, thereby constructing new experience (Greenberg & Pascual-Leone, 1995, 2001; Greenberg et al 1993; Pascual-Leone, 1991; Guidano, 1991; Mahoney, 1991; Neimeyer & Mahoney, 1995). How emotional experience is symbolized influences the self we experience ourselves to be in the next moment. The self is thus formed at the interface between biology and culture. In an emotion-focused approach, we will argue below that clients need to activate their maladaptive emotion schemes in therapy in order to make them accessible to change by new emotional experience. Furthermore, new narratives that assimilate emotional experience into existing cognitive structures and generate new ones need to be developed. Therapy, thus, involves changing both emotional experience and the narratives in which they are embedded (Greenberg & Angus, 2004).

Emotion Assessment

We propose a system of process diagnoses in which it is important to make distinctions in the therapy session between different types of emotional experiences and expression that require different types of in-session intervention (Greenberg & Paivio, 1997; Greenberg, 2002). *Primary emotions* are the person's most fundamental, direct initial reactions to a situation, such as being sad at a loss. *Secondary emotions* are responses to one's thoughts or feelings rather than to the situation, such as feeling angry in response to feeling hurt or feeling afraid or guilty about feeling angry. In order to access their more primary generators, secondary emotions need to be explored. Although the skills of awareness and understanding apply to most emotions, it is only awareness of primary emotions that provides access to adaptive information that promotes orientation and problem solving. Thus, accessing the healthy anger at unfairness that underlies powerlessness promotes adaptation, while accessing the shame at loss of esteem that underlies rage can promote attachment in place of destructiveness.

The next crucial distinction to be made is between primary states that are adaptive and are accessed for their useful information and primary states that are maladaptive and need to be transformed. *Maladaptive emotions* are those old, familiar feelings that occur repeatedly and do not change. They are feelings, such as a core sense of lonely abandonment, the anxiety of basic insecurity, feelings of wretched worthlessness, or shameful inadequacy that plague one all one's life. These maladaptive feelings neither change in response to changing circumstance nor provide adaptive directions for solving problems when they are experienced. Rather, they just leave the person with symptomatic secondary feelings of hopelessness, helplessness, anxiety or despair. It does not help simply to get in touch with these maladaptive emotions. Instead, they need to be replaced or transformed by access to adaptive emotions that promote problem solving and growth.

Primary emotions need to be accessed for their adaptive information and capacity to organize action, whereas maladaptive emotions need to be accessed and regulated in order to be transformed. Secondary maladaptive emotions need to be reduced by exploring them to access their more primary cognitive or emotional generators. Therefore, emotion focused work involves accessing primary adaptive emotions in order to symbolize their adaptive information and evoking maladaptive emotions in order to make them amenable to change by exposing them to new information and experience. People have to accept what they feel before they can transform the feeling. You have to feel it to heal it!

Even though getting in touch with primary emotion is essential in facilitating emotional change, effective emotional processing involves more than simply activating primary emotional experience. To be productive, primary emotions require a particular manner of processing, which we refer to as being *contactfully or mindfully* aware of the emotion (Auzra, Greenberg & Herman, 2013, Greenberg et al., 2007, Greenberg 2015). In general therapists need to decide if and when to facilitate higher arousal. In the case where therapist and client come to the view that a client's current arousal is not productive, or even harmful, therapist needs to know how to work with the unproductive arousal to help the client achieve more productive emotional processing. Over the last decade we therefore set out to develop a measure to discriminate productive from unproductive emotional processing.

A scale of Client Emotional Productivity (CEP) has been developed and tested. Client Emotional Productivity was defined as: a client experiencing a primary emotion in such a way that a) the useful information inherent in an adaptive emotion can be extracted in the service of problem resolution (the signal feature), or b) a maladaptive emotion is being expressed in a sad way that it shows the potential of being transformed (the transformation feature) (Greenberg, Auszra, Hermann, 2007). In other words, a client should process a primary emotion in such a

manner that, depending on whether the emotion is adaptive or maladaptive either the *utilization or transformation* of the emotion appear possible In our measure contactful awareness is defined by the following seven criteria, all of which have to be more present than not for a client's emotional experience to qualify as productive :1) attending, 2) symbolization, 3) congruence, 4) acceptance, 5) regulation, 6) agency, and 7) differentiation. (Auzra, Greenberg & Herman, 2013). These criteria, which characterize productive emotional process, not only help practitioners to differentiate between therapeutically productive and non-productive emotion processes, but also guide them towards effective intervention by drawing their attention to those dimensions of clients' emotional processing that need to be worked on. The seven elements of a productive manner of emotional processing are attending, symbolization, congruence, regulation, acceptance, agency, and differentiation.

Major Principles of Intervention

EFT intervention is based on two major treatment principles: The Provision of a therapeutic relationship and the Facilitation of therapeutic work (Greenberg et al., 1993). As their ordering implies, the relationship principles come first and receive priority over the task facilitation principles. The overall therapeutic style combines being with doing and following with leading. A person centered approach (Rogers 1959) involves a way of being with patients characterized by entering the clients internal frame of reference, following the clients experience and responding to it empathically. This is combined with a more guiding, process directive Gestalt therapy (Perls, Hefferline & Goodman 1951) style of engaging in experiments to deepen experience.

The relationship is seen as being curative in and of itself. Therapists' empathic attunement to affect helps clients regulate their overwhelming, disorganizing emotions by breaking the sense of isolation and the unbearable aloneness of emotional pain. Over time the interpersonal regulation of affect, becomes internalized into self-soothing and the capacity to regulate inner states (Stern, 1985). When an empathic connection is made with the therapist, affect processing centers in the brain are affected and new possibilities open up for the client. The therapeutic relationship as well as being curative in and of itself also creates an optimal therapeutic environment that promotes the therapeutic work of exploration and creation of new meaning. Another important aspect of a helping relationship is establishing a collaborative alliance on the goals and tasks of therapy. This is essential to developing the experience that *the two of us are working together to overcome the problem*.

The hallmark of EFT however is that in addition to the relationship being seen as curative the therapist also guides clients emotional processing in different ways at different times. In this process certain client in-session states which are markers of underlying affective/cognitive processing problems are seen as offering opportunities for differential interventions best suited to help facilitate productive work on that problem state.

Markers and Tasks

As we have seen 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 affective intervention (Greenberg et al, 1993; Rice & Greenberg, 1984; Greenberg, Elliott & Lietaer, 1994). Client markers indicate not only the type of intervention to use but also the client's current *readiness* to work on this problem. EFT therapists are trained to identify markers of different types of problematic emotional processing problems and to intervene in specific ways that best suit these problems. Each of the tasks has been studied both intensively and extensively and the key

components of a path to resolution and the specific form that resolution takes has been specified. Thus models of the actual process of change act as a map to guide the therapist intervention.

The following main markers and their accompanying interventions have been identified (Greenberg, et al., 1993): 1) *Problematic reactions* expressed through puzzlement about emotional or behavioral responses to particular situations. For example a client saying "on the way to therapy I saw a little puppy dog with long droopy ears and I suddenly felt so sad and I don't know why". Problematic reactions are opportunities for a process of *systematic evocative unfolding*. This form of intervention involves vivid evocation of experience to promote re-experiencing the situation and the reaction to establish the connections between the situation, thoughts, and emotional reactions, to finally arrive at the implicit meaning of the situation that makes sense of the reaction. Resolution involves a new view of self-functioning. 2) An *unclear felt sense* in which the person is on the surface of, or feeling confused and unable to get a clear sense of his/her experience, "I just have this feeling but I don't know what it is" An unclear felt sense calls for *focusing* (Gendlin, 1996) in which the therapist guides clients to approach the embodied aspects of their experience with attention and with curiosity and willingness, to experience them and to put words to their bodily felt sense. A resolution involves a bodily felt shift the creation of new meaning. 3) *Conflict splits* in which one aspect of the self is critical or coercive towards another aspect, for example a woman quickly becomes both hopeless and defeated but also angry in the face of failure in the eyes of her sisters, "I feel inferior to them, Its like "I've failed and, I'm not as good as you". Self-critical splits like this offer an opportunity for *two-chair work*. In this two parts of the self are put into live contact with each other. Thoughts, feelings and needs within each part of the self are explored and communicated in a real dialogue to achieve a softening of the critical voice.

Resolution involves an integration between the different sides of the self. 4) *Self-interruptive splits* arise when one part of the self interrupts or constricts emotional experience and expression, "I can feel the tears coming up but I just tighten and suck them back in, no way am I going to cry". In the *two-chair enactment* the interrupting part of the self is made explicit. Clients become aware of how they interrupt and are guided to enact the ways they do it, be it by physical act (choking or shutting down the voice), metaphorically (caging), etc., or verbally ("shut up, don't feel, be quiet, you can't survive this"), so that they can experience themselves as an agent in the process of shutting down and then can react to and challenge the interruptive part of the self. Resolution involves expression of the previously blocked experience. 5) An *unfinished business* marker involves the statement of a lingering unresolved feeling toward a significant other such as the following said in a highly involved manner, "my father, he was just never there for me. I have never forgiven him, deep down inside I don't think I'm grieving for what I probably didn't have and know I never will have". Unfinished business toward a significant other calls for an *empty-chair intervention*. Using an empty-chair dialogue, clients activate their internal view of a significant other and experience and explore their emotional reactions to the other and make sense of them. Shifts in views of both the other and self occur. Resolution involves holding the other accountable or understanding or forgiving the other. 6) *vulnerability* is a state in which the self feels fragile, deeply ashamed, or insecure, "I just feel like I've got nothing left. I'm finished. It's too much to ask of myself to carry on". Vulnerability calls for *affirming empathic validation*. When a person feels deeply ashamed or insecure about some aspect of his/her experience, above all else, clients need empathic attunement from the therapist who must not only capture the content of what the client is feeling but also note the vitality affects of the client mirroring the tempo rhythm and tone of the experience. In addition the therapists needs to validate and normalize their experience. Resolution involves a strengthened sense of self.

A number of additional markers and interventions such as, trauma and narrative retelling, alliance rupture and repair, self contempt, and compassion, anxious dependence and self-

soothing, high distress and meaning making, and confusion and clearing a space, and more, have been added to the original six markers and tasks identified above (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2002; Greenberg & Watson, 2006).

Principles of Emotional Intervention

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

Awareness

Increasing awareness of emotion is the most fundamental overall goal of treatment. Once people know what they feel they reconnect to their needs and are motivated to meet them. Increased emotional awareness is therapeutic in a variety of ways. Becoming aware of and symbolizing core emotional experience in words provides access both to the adaptive information and the action tendency in the emotion. It is important to note that emotional awareness is not thinking about feeling it involves feeling the feeling in awareness. Only once emotion is felt does its articulation in language become an important component of its awareness.

Clients' ability to articulate what they are experiencing in their inner world is thus a central focus of this treatment. Recently (Lieberman et al. (2004) have shown that naming a feeling in words helps decrease amygdala arousal. EFT therapists work with clients to help approach, tolerate, accept and symbolize their emotions. Acceptance of emotional experience as opposed to its avoidance is the first step in awareness work. Having accepted the emotion rather than avoided it the therapist then helps the client to improve coping. Clients are helped to make sense of what their emotion is telling them, identify the goal/need /concern which it is organizing them to attain and the action tendency provided to do this. Emotion is thus used both to inform and to move.

Therapists model approaching and valuing of emotion by attuning to clients' emotional experience. By empathically responding to clients' stories in an evocative manner emotions are aroused and then clients' attention is guided towards what is emotionally significant in their lives. Over time clients learn to attend inwardly and their awareness of the emotional significance of their self-experience, situations and of others grows. If emotional experience is limited, attending inward is helped by gaining more awareness of the bodily felt experience connected to emotion by the use of focusing and attending to sensory experience.

Emotional Expression

Emotional expression has been shown to be a unique aspect of emotional processing that predicts adjustment to such things as breast cancer (Stanton, Danoff-Burg, Cameron, Bishop, Collins, Kirk, Sworowski, & Twillman, 2000) interpersonal emotional injuries, and trauma (Greenberg & Malcolm 2002; Paivio, Hall, Holowaty, Jellis, & Tran, 2001, Foa & Jaycox, 1999; Paivio, & Nieuwenhuis, 2001). Expressing emotion in therapy does not involve the venting of secondary emotion but rather overcoming avoidance to strongly experience and express previously constricted primary emotions. Expressive coping also may help one attend to and clarify central concerns and serve to promote pursuit of goals.

There can be no universal rule about the effectiveness of arousing emotion or evoking emotional expression and the distinction of the role of expression in therapy, to re-experience and re-work past problematic experience, versus expression in life, needs to be kept clear. The role of arousal and the degree to which it could be useful in therapy and in life depends on what emotion is expressed, about what issue, how it is expressed, by whom, to whom, when and under what conditions, and in what way the emotional expression is followed by other experiences of affect and meaning. Recently Greenberg, Auzra and Hermann (2007) found that it was the manner of processing of aroused emotions, rather than arousal alone that distinguished good from poor outcome cases. They defined productive emotional expression as occurring when a client was contactfully aware of emotion. This form of mindfulness of emotion involved awareness, symbolization, congruence, acceptance, agency regulation and differentiation.

There is a strong human tendency to avoid experiencing and expressing painful emotions. So clients must be encouraged to overcome avoidance and approach painful emotion in sessions by attending to their bodily experience, often in small steps. This may involve changing explicit beliefs like "anger is dangerous" or "men don't cry" governing their avoidance or helping them face their fear of dissolution (Greenberg, & Bolger, 2001). Then clients must allow and tolerate being in live contact with their emotions. These two steps of approach and tolerate are consistent with notions of exposure. There is a long line of evidence on the effectiveness of exposure to previously avoided feelings (Foa & Jaycox, 1998). From the EFT perspective, however, approach, arousal and tolerance of emotional experience is necessary but not sufficient for change. Optimum emotional processing in our view involves the integration of cognition and affect (Greenberg, 2002; Greenberg & Pascual-Leone, 1995; Greenberg & Safran, 1987). Once contact with emotional experience is achieved, clients must also cognitively orient to that experience as information, and explore, reflect on, and make sense of it.

Regulation

The third principle of emotional processing involves the *regulation of emotion*. It is clear that emotional arousal and expression is not always helpful or appropriate in therapy or in life and that, for some clients, training in the capacity for emotional down-regulation must precede or accompany utilization of emotion. For some individuals, psychological disorders and situations emotions are under- or dysregulated (Linehan, 1993) and an important issues in any treatment then are what emotions are to be regulated and how are they to be regulated becomes a central aspects of treatment. Under-regulated emotions that require down regulation generally are either secondary emotions, such as despair and hopelessness, or primary maladaptive emotions such as the shame of being worthless, the anxiety of basic insecurity and panic. Maladaptive emotions of core shame and feelings of shaky vulnerability benefit from regulation in order to create a working distance from these rather than become overwhelmed by them. Emotion needs to be regulated when distress is so high that the emotion no longer informs adaptive action (Pascual-Leone & Greenberg, 2007).

Emotions direct attention to information that seems immediately relevant to maintaining wellbeing or attaining goals. Because attentional capacity is limited, emotions can also divert attention from other information, such as, background information, likely to be relevant in the long run. One of the therapeutic dilemmas is when to regulate by promoting down regulation and when to facilitate emotion approach and possible intensification. In research with adults, suppressing thoughts, especially emotional thoughts, has been shown to produce a rebound effect such that the frequency of those thoughts actually increases (e.g., Wegner, Erber, & Zanakos, 1993). The emotional disengagement strategies of expressive suppression and distraction have been shown to impair memory for emotional events (e.g., Richards & Gross, 2000, 2006). Moreover, emotional disengagement may be particularly difficult for clients who are dysregulated because it presupposes an understanding that deliberately actions like changing thoughts and

goals can lead to changes in emotional experience – an understanding sometimes found to be beyond the capacity of clients early in therapy. In these situations the argument for disengagement is not good.

In other cases however emotional disengagement can facilitate learning and memory, and people can effectively disengage from emotion. A growing body of research with adults also indicates that, under certain circumstances, emotional disengagement can be adaptive (e.g., Coifman, Bonanno, Ray, & Gross, 2007). The first step in helping emotion regulation in the provision of a safe, calming, validating, empathic environment. This helps soothe automatically generated under-regulated distress (Bohart & Greenberg, 1997) and helps strengthen the self. This is followed by the teaching of emotion regulation and distress tolerance (Linehan, 1993) skills involving such things as, identifying triggers, avoiding triggers, identifying and labeling emotions, allowing and tolerating emotions, establishing a working distance, increasing positive emotions, reducing vulnerability to negative emotions, self-soothing, breathing, and distraction. Forms of meditative practice and self-acceptance often are most helpful in achieving a working distance from overwhelming core emotions. The ability to regulate breathing, and to observe ones emotions and let them come and go are important processes to help regulate emotional distress.

Another important aspect of regulation is developing clients' abilities to self-soothe. Emotion can be down-regulated by soothing at a variety of different levels of processing. Physiological soothing involves activation of the parasympathetic nervous system to regulate heart rate, breathing and other sympathetic functions that speed up under stress. At the more deliberate behavioral and cognitive levels, promoting clients' abilities to receive and be compassionate to their emerging painful emotional experience is the first step towards tolerating emotion and self-soothing.

This soothing of emotion can be provided by individuals themselves, reflexively, by an internal agency, or from another person. As we have seen self-soothing involves among other things diaphragmatic breathing, relaxation, development of self-empathy and compassion and self-talk. Soothing also comes interpersonally in the form of empathic attunement to one's affect and through acceptance and validation by another person. Being able to soothe the self develops initially by internalization of the soothing functions of the protective other (Sroufe, 1996; Stern, 1985). Internal security develops by feeling that one exists in the mind and heart of the other, and the security of being able to soothe the self develops by internalization of the soothing functions of the protective other (Schore, 2003; Sroufe, 1996; Stern, 1985). In EFT therapists thus helps clients contain and regulate emotional experience by providing a soothing environment. Over time this is internalized and helps clients develop implicit self-soothing, the ability to regulate feelings automatically without deliberate effort.

Reflection

In addition, to recognizing emotions and symbolizing them in words, promoting further reflection on emotional experience helps people make narrative sense of their experience and promotes it's assimilation into their ongoing self-narratives. What we make of our emotional experience makes us who we are. Reflection helps to create new meaning and develop new *narratives to explain experience* (Greenberg & Pascual-Leone, 1997; Greenberg & Angus, 2004; Goldman, Greenberg, & Pos, 2005, Pennebaker, 1995). Pennebaker (1995) has shown the positive effects of writing about emotional experience on autonomic nervous system activity, immune functioning, and physical and emotional health and concludes that through language, individuals are able to organise, structure and ultimately assimilate both their emotional experiences and the events that may have provoked the emotions.

The meanings of situations that have evoked emotion are made sense of, and patterns in relationships are recognized. The result of this reflection based on aroused emotion is deep experiential self-knowledge. Situations are understood in new ways, experiences are reframed and this leads to new views of self other and world. Developing a new outlook on what is important involves a fundamental change in attitude and these can lead to profound changes. For example reflections on a close to death experience can lead to profound changes in approach to life, like overcoming addictions finding religion, or becoming more consistent.

Transformation

Probably the most important way of dealing with emotion in therapy involves the transformation of *emotion by emotion*. This applies most specifically to transforming primary maladaptive emotions such as fear and shame with other adaptive emotions (Greenberg, 2002). We suggest that maladaptive emotional states are best transformed by undoing them by activating other more adaptive emotional states. Spinoza (1967) was the first to note that emotion is needed to change emotion. He proposed that "An emotion cannot be restrained nor removed unless by an opposed and stronger emotion" (Spinoza, 1967, p. 195). While thinking usually changes thoughts, only feeling can change primary emotions. In EFT an important goal thus is to arrive at maladaptive emotion, not for its good information and motivation, but in order to make it accessible to transformation. In time the co-activation of the more adaptive emotion, along with or in response to the maladaptive emotion, helps transform the maladaptive emotion.

It is important to note that the process of changing emotion with emotion goes beyond ideas of catharsis, completion and letting go, exposure, extinction or habituation, in that the maladaptive feeling is not purged, nor does it simply attenuate by the person feeling it. Rather another feeling is used to transform or undo it. Although dysregulated secondary emotions such as the fear and anxiety in phobias, obsessive compulsiveness and panic may be overcome by exposure, in many situations in therapy, primary maladaptive emotions such as the shame of feeling worthless and the anxiety of basic insecurity are best transformed by other emotions. Thus change in previously avoided primary maladaptive emotions such as core shame or fear of abandonment, is brought about by the activation of an incompatible, more adaptive, experience such as empowering anger and pride or compassion for the self that undoes the old response rather than attenuate it. This involves more than simply feeling or facing the feeling leading it to its diminishment. Rather, for example the withdrawal of primary maladaptive emotion is transformed by activating the approach tendencies in anger or contact/comfort seeking.

Frederickson (2001) has shown that a positive emotion may loosen the hold that a negative emotion has on a person's mind by broadening a person's momentary thought action repertoire. The experience of joy and contentment were found to produce faster cardiovascular recovery from negative emotions than a neutral experience. Frederickson, Mancuso, Branigan & Tugade (2000) found that resilient individuals cope by recruiting positive emotions to undo negative emotional experiences. Thus bad feelings appear to be able to be transformed by happy feelings, not in a deliberate manner, by trying to look on the bright side, or by replacement, but by the evocation of meaningfully embodied alternate experience that undoes the physiology and experience of negative feeling.

This principle applies not only to positive emotions changing negative ones but also to changing maladaptive emotions by activating dialectically opposing adaptive emotions (Greenberg, 2002). Thus, in therapy, maladaptive fear of abandonment or annihilation, once aroused, can be transformed into security by the activation of more empowering, boundary-establishing emotions of adaptive anger or disgust, or by evoking the softer soothing feelings of sadness and need for comfort. Similarly maladaptive anger can be undone by adaptive sadness. Maladaptive shame can be transformed by accessing both anger at violation and self-compassion

and by accessing pride and self worth. Similarly anger is an antidote to hopelessness and helplessness. Thus the tendency to shrink into the ground in shame or collapse in helplessness can be transformed by the thrusting forward tendency in newly accessed anger at violation. Withdrawal emotions from one side of the brain are replaced with approach emotions from another part of the brain or vice-versa (Davidson, 2000). Once the alternate emotion has been accessed it transforms or undoes the original state and a new state is forged. Often a period of regulation or calming of the maladaptive emotion in need of change is needed before the activation of an opposing emotion.

How does the therapist help the client access new emotions to change emotions? A number of ways have been outlined (Greenberg, 2002). Therapists can help the client access new *subdominant* emotions in the present by a variety of means, including shifting attention to different aspects of the situation or to emotions that are currently being expressed but are only 'on the periphery' of a client's awareness; or *focusing on what is needed* and thereby mobilizing a new emotion is a key means of actuating a new emotion (Greenberg, 2002). The newly accessed, alternate feelings are resources in the personality that help change the maladaptive state. For example, bringing out implicit adaptive anger can help change maladaptive fear in a trauma victim. When the tendency to run away in fear is combined with anger's tendency to thrust forward, this leads to a new relational position of holding the abuser accountable for wrongdoing, while seeing oneself as having deserved protection, rather than say feeling guilty and unsafe. It also is essential both to symbolize, explore and differentiate the primary maladaptive emotion, in this case fear, and regulate it by breathing and calming, before cultivating access to the new more adaptive emotion, in this case anger.

Other methods of accessing new emotion involve using enactment and imagery to evoke new emotions, remembering a time an emotion was felt, changing how the client views things, or even the therapist expressing an emotion for the client (Greenberg, 2002). Once accessed, these new emotional resources begin to undo the psycho-affective motor program previously determining the person's mode of processing. New emotional states enable people to challenge the validity of perceptions of self/other connected to maladaptive emotion, weakening its hold on them.

In our view enduring emotional change occurs by generating a new emotional response not through a process of insight, or understanding alone. EFT as we have said works on the basic principle that people must first arrive at a place before they can leave it. Maladaptive emotion schematic memories of past childhood losses and traumas are activated in the therapy session in order to change these by memory reconstruction. Introducing new present experience into currently activated memories of past events has been showing to lead to memory transformation by the assimilation of new material into past memories (Nadel & Bohot 2001, Lane, Ryan, Nadel, Greenberg, 2015). By being activated in the present the old memories are restructured by the new experience of being in the context of a safe relationship and activating more adaptive emotional responses to the old situation and new adult resources and understanding. The memories are reconsolidated in a new way by incorporating these new elements. The past in fact can be changed, at least the memories of it.

Corrective emotional experience

Finally a key way of changing an emotion is to have a new lived experience that changes an old feeling. New lived experience with another provides a corrective emotional experience. Experiences that provide interpersonal soothing, disconfirm pathogenic beliefs or offers new success experience can correct patterns set down in earlier times. Thus an experience in which a client faces shame in a therapeutic context and experiences acceptance, rather than the expected disgust or denigration has the power to change the feeling of shame. Corrective emotional

experiences in EFT occur predominantly in the therapeutic relationship although success experience in the world is also encouraged.

The goal in EFT is for clients, with the help of more favorable circumstances in therapy, to experience mastery in re-experiencing emotions they could not handle in the past. The client then undergoes a corrective emotional experience with the therapist that repairs the traumatic influence of previous relational experiences. Corrective interpersonal emotional experiences occur generally throughout the therapeutic process, whenever the patient experiences the therapist as someone who is attuned to and validates the client's inner world. Therapy offers new opportunities for affect regulation with a helpful other, new self experience through being in contact with the other and being mirrored and through new experiences that promote the activation of alternate adaptive emotion schemes that can potentiate new emergent self-organizations. Overall, the genuine relationship between the patient and the therapist, and its constancy, is a corrective emotional experience.

Additionally specific new emotional experiences with the therapist that supply an undoing of specific patterns of interpersonal experience provide the other form of corrective experience. People's core emotion schemes change by positive interpersonal experience, disconfirming pathogenic ways of being, such as not trusting or feeling controlled or diminished. Clients often disconfirm pathogenic ways of being by actually *testing* them directly in the therapeutic relationship (Weiss & Sampson, 1986). Thus clients who fear abandonment may test to see if the therapist will not abandon them or clients who fear being controlled test limits. If the therapist in the first case is caring and in the second gives freedom, these become corrective emotional experiences that help undo past experience.

Clients in therapy thus can re-experience events differently than they did originally, because they experience the relationship with the therapist in a different way than they experienced the formative relationship, as a child, with caretakers. Now the client can express vulnerability or anger with the therapist without being punished, and can assert without being censured. The undeniable reality of this experience allows clients to experience that they are no longer powerless children facing powerful adults.

Phases of treatment

EFT treatment has been broken into three major phases, each with a set of steps to describe its course over time (Greenberg & Watson 2006). The first phase of bonding and awareness is followed by the middle phase of evoking and exploring. Finally therapy concludes with a transformation phase that involves constructing alternatives through generating new emotions, and reflecting to create new narrative meaning.

Phase 1: Bonding and Awareness. This phase involves four steps: 1) Attending to, empathizing with, and validating the client's feelings and current sense of self 2) Providing a rationale for working with emotion 3) Promoting awareness of internal experience 4) Establishing a collaborative focus. From the first session the therapist holds a therapeutic attitude of empathy and positive regard to help create a safe environment for the later evocation and exploration of emotion. In the early phase of therapy it is necessary to provide clients with a rationale as to how working with emotion will help. This supports clients' collaborating with the aim of working on emotions. For example, the therapist might say: "Emotions tell us what is important to us. It's helpful to feel them and get their message". The therapist also helps the client start approaching, valuing and regulating their emotional experience. The focus of treatment also begins to be established in this early phase. Therapists and clients collaboratively develop an understanding of the person's core pain, and work towards agreement on the underlying determinants (often in the core maladaptive emotion schemes) of presenting symptoms. For example, while working with a

depressed woman who had been a single parent for five years, the therapist, by following her pain, came to focus the client on her underlying maladaptive shame that came from her self contempt for having married a man who had been physically abusive, and for not having left him the first time he hit her.

Phase 2: Evocation and Exploration. This phase involves four steps:

1) Establishing support for emotional experience. 2) Evoke and arouse problematic feelings. 3) Undoing interruptions of emotion. 4) Helping access primary emotions or core maladaptive schemes. During this phase, emotions are evoked, and if necessary, intensified. First however the therapist must ensure there is sufficient internal and external support for evoking painful emotions. Trust, the ability to regulate, sufficient resilience and the capacity to self soothe all are necessary resources before evoking emotion. The goal of the evocation and exploration of emotion is to eventually arrive at the deepest level of core primary emotion. Many techniques can be used to do this, such as empathic evocation, focusing, imagery and gestalt chair dialogues. Once assured of the client's readiness for evoked emotional experiences, EFT therapists, during this phase, help people experience and explore what they feel at their core.

Interruption and avoidance of emotional experience is also worked through in this phase. Therapists focus on the interruptive process itself and help clients become aware of, and experience the cognitive (catastrophic expectations), physiological (stopping breath), emotional (secondary) and behavioral (changing the topic) ways they may be stopping and avoiding feelings i.e.

Therapist: What's happening now? I see you tighten up.
Client: I'm squeezing my stomach and holding my breath to stop my anger.
Therapist: Yeah, do it some more to get a sense of how you do this.

Phase 3: Transformation and Generation of Alternatives. This phase involves three steps: 1) Help generate new emotional responses to transform core maladaptive schemes. 2) Promote reflection to make sense to experience. 3) Validate new feelings and support an emerging sense of self. Having arrived at a core emotion the emphasis shifts to the *construction of alternative ways of responding* emotionally, cognitively and behaviourally. This is done both by accessing new internal resources in the form of adaptive emotional responses and reflecting on these to create new meaning. As clients have new experiences of self they start to create new meanings and self-narratives that reflect a more integrated and stronger sense of self. The therapist acknowledges and validates clients and helps them use their newly found sense of self-validation as a base for action in the world. The therapist and client collaborate on the kinds of actions that could consolidate the change.

It is through the shift into primary emotion and its use as a resource that the deepest change occurs. Thus in some cases change occurs simply because the client accesses adaptive underlying emotions anger such as empowering and reorganises to assert boundaries, or accesses adaptive sadness, grieves a loss and organises 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 provides an alternative way of responding. Action replaces resignation and motivated desire replaces hopelessness.

In many instances however once a core primary emotion is arrived at it is understood to be a complex *maladaptive emotion schematic experience*, rather than simply unexpressed primary adaptive emotions such as sadness or anger. Core schemes that are maladaptive result in feelings such as a core sense of powerlessness, or feeling invisible, or a deep sense of woundedness, of shame, of insecurity, of worthlessness, or of feeling unloved or unlovable. It is these that often are accessed as being at the core of the secondary bad feelings such as despair,

panic, hopelessness or global distress. Primary maladaptive feelings of worthlessness, weakness, or insecurity have to be accessed in order to allow for change. It is only through experience of emotion that emotional distress can be cured. One cannot leave these feelings of worthless or insecurity until one has arrived at them. What is curative is first the ability to symbolise these feelings of worthlessness or weakness and then to access alternate adaptive emotion-based self-schemes. The generation of alternate schemes is based on accessing adaptive feelings and needs that get activated in response to the currently experienced emotional distress. It is the person's response to their own symbolised distress that is adaptive and must be accessed and used as a life giving resource.

The core of EFT practice thus lies in accessing primary adaptive emotions. The goal is to acknowledge and experience previously avoided or non-symbolised primary adaptive emotion and needs. It is not only the experience of primary emotion per se, but the accessing of the needs/goals/concerns and the action tendencies embedded in emotion. Once a core primary emotion is aroused, if it is tolerated, it follows its own course, involving a natural rising and a falling off of intensity. Decrease in intensity allows for reflection. Arousal also leads to associative linking and the activation thereby of many new schemes. Thus it is the combination of arousing, regulating, symbolising, reflecting and accessing new emotions that carries forward the process of change

Case Formulation.

EFT has developed a context sensitive approach to case formulation to help promote the development of a focus for brief treatments (Greenberg & Goldman 2007). Case formulation relies on process diagnosis, development of a focus and theme development rather than person or syndrome diagnosis. In this approach *process is privileged over content, and process diagnosis is privileged over person diagnosis*. In a process-oriented approach to treatment, case formulation is an ongoing process, as sensitive to the moment and the in-session context as it is to an understanding of the person as a case. This is both because of the respectful type of relationship one wishes to maintain and because people are seen as active agents who are in flux constantly creating meaning.

People are dynamic systems entering different self-organisations at different times. The state the person is in at the moment and the current narrative is more determining of their experience and possibility than any conceptualisation of a more enduring pattern, diagnosis or reified view of a core maladaptive belief or self-concept that may be constructed early in treatment. Therefore in a process diagnostic approach there is a continual focus on the client's current state of mind and current cognitive/affective problem states. The therapist's main concern is one of following the client's process and the identification of core pain and markers of current emotional concerns rather than a picture of the persons enduring personality or character or a core pattern.

Case formulation is helpful in facilitating the development of a *focus* and helps fit the therapeutic task to the client's goals thereby aiding in the establishment of a productive working alliance. In formulating a focus the therapist as we have seen attends to a variety of different markers at different levels of client processing as they emerge. Markers guide intervention more than does a diagnosis or even an explicit case formulation. It is the clients presently felt experience that indicates what the difficulty is, and indicates whether problem determinants are currently accessible and amenable to intervention. A collaborative focus and a coherent theme develops from a focus on current experience and exploring particular experiences to their edges within the context of the task focused work at markers, rather than on establishing patterns of experience and behaviour across situations.

In our view, formulations are always co-constructions that emerge from the relationship, rather than being formed by the therapist. Identifying and articulating the problematic cognitive-affective processes underlying and generating symptomatic experience is a collaborative effort between therapist and client and always incorporates identification of the client's chronic enduring pain. The establishment of a problem definition is tantamount to the agreement on treatment goals in the formation of the initial alliance (Bordin, 1994). The establishment of agreement on the determinants of the person's problem helps alliance development in that it implicitly suggests the goal of the treatment is to resolve this issue. Sometimes this agreement is implicit or is so clear that no explicit goals are discussed. Generally however an explicit agreement is established that treatment goals involve addressing the underlying determinants and the connection between the determinants and the presenting problem are discussed.

Sometimes for very fragile clients however it is the establishment of a validating relationship itself that is the goal. For some clients who are unable to focus inward and be aware of their experience, the very ability to attend to their emotions and make sense of them may become the focus of treatment. A focus and a goal for another client might be to acknowledge and stand up to his overly hostile critic, which produces feelings of inadequacy. For another client with low self-esteem the focus and goal might be to become more aware of, and more clearly able to express her feelings and needs. For another dependent client the focus and goal might be to assertively express and resolve her resentment at feeling dominated by her husband. For an anxious client it might be to develop a means of self-soothing and self-support, for another to restructure a deep fear of abandonment and insecurity based on trauma or losses in the past.

An important aspect of the initial alliance also involves that clients perceives the tasks of the treatment as relevant to their goals (Horvath & Greenberg, 1989). The initial tasks that the clients need to perceive as relevant in the treatment are those of disclosure, exploration, and deepening of experience. Once a client is engaged in these, the exploration for a focus begins. The early establishment of a focus and the discussion of determinants or generating conditions of the presenting problem or symptom act only as a broad framework to initially focus exploration.

Any formulation is held very tentatively and is constantly checked with the client for relevance and fit, with clients' moment-to-moment processing in the session remaining the ultimate guide. It is important that therapists' frame their interventions in a manner that is relevant to their clients' goals and objectives and that there is agreement about the behaviors and interactions that are contributing to the client's problems. Formulation and intervention are, in the final analysis, inseparable and they span the entire course of treatment. They also occur constantly at many levels. There is no discrete initial formulation or assessment phase. The therapist, rather gets to know the client over time, but never comes to know definitively what is occurring in the client. Formulation thus never ends.

The following steps have been identified to guide clinicians in the development of case formulations (Greenberg & Watson 2006; Greenberg & Goldman, 2007).

1. Identify the presenting problem.
2. Listen to and explore the client's narrative about the problem
3. Gather information about client's attachment and identity histories and current relationships and concerns
4. Observe and attend to the client's style of processing emotions.
5. Identify and respond to the painful aspects of the client's experiences.
6. Identify markers and when they arise suggest tasks appropriate to resolving problematic processes.
7. Focus on thematic intra-personal and interpersonal processes
8. Attend to clients moment-by-moment processing to guide interventions within tasks.

Initial Steps

The first steps in developing a case formulation involve the identification of the presenting problem, listening to the related narrative, and gathering information regarding attachment and identity histories as it pertains to current relationships. In parallel with the initial steps and throughout the process, therapists attend to the manner in which clients process emotions from moment to moment. This is another hallmark of this approach. Initially, this provides essential information to therapists about what to focus on. As therapy progresses, therapists continue to attend to momentary style of processing to make process diagnoses about how best to intervene to facilitate emotional processing. As therapists build the relationship they begin, right from the first session, to formulate the person's type of global processing style. They note whether the client is emotionally over-regulated or under-regulated, is engaged in conceptual or experiential processing, and note the depth of clients experiencing, the client's vocal quality and the degree of emotional arousal. The therapist assesses whether clients have the capacity to assume a self-focus and are able to turn attention inward to their experience. For this, therapists attend not only to clients' content but also to the manner and style in which they present their experiences. Attention is paid to how clients are presenting their experiences in addition to what they are saying. To aid therapists in reading such paralinguistic cues, they are trained to evaluate vocal quality (Rice and Kerr, 1986) as well as current depth of experiencing (Klein, Mathieu, Gendlin, & Kiesler, 1969) as well as the concreteness, specificity, and vividness of language use and different types of emotional processing.

Four vocal styles relevant to experiential processing have been defined: focused, emotional, limited, and external (Rice & Kerr, 1986). For example, a therapist will notice when a client's voice becomes more focused. This is an indication that the client's attentional energy is turned inwards and the person is attempting to freshly symbolize experience. Alternatively, a highly external voice, that has a pre-monitored quality involving a great deal of attentional energy being deployed outward, may indicate a more rehearsed conceptual style of processing and a lack of spontaneity. While this may initially give an impression of expressiveness, the rhythmic intonation pattern conveys a "talking at" quality. It is unlikely that content being expressed in this voice is freshly experienced. A high degree of external vocal quality suggests that the person does not have a strong propensity to self-focus (Rice & Kerr, 1986). Clients who demonstrate little or no focused or emotional voice are seen as less emotionally accessible and needing further work to help them process internal experiential information. Clients with a high degree of external vocal quality need to be helped to focus inward, whereas those with a high degree of limited vocal quality, indicating wariness, need a safe environment to develop trust in the therapist and allow them to relax.

Another indicator of current capacity for self-focus is client initial depth of experiencing (Klein et al. 1969). The Experiencing scale (EXP) defines clients involvement in inner referents and experience from impersonal (level 1) and superficial (level 2) through externalized or limited references to feelings (level 3) to direct focus on inner experiencing and feelings (level 4), to questioning or propositioning the self about internal feelings and personal experiences (level 5), to experiencing an aspect of self from a new perspective (level 6), to a point where awareness of present feelings are immediately connected to internal processes and exploration is continually expanding (level 7). Momentary formulations, with clients processing at a low level of EXP, suggest facilitating deeper experiencing, sometimes by conjecturing empathically as to what clients are presently experiencing, and at other times, by guiding attention inwards to focus directly on bodily felt experience.

Narrative style whether clients are external, talking about what happened, internal, what it felt like, or reflexive, what it meant, is also attended to with the goal being to encourage a focus on internal experience to promote later reflection (Angus et al., 1999; Greenberg & Angus, 2004).

Noticing the clients' expressive stance, indicating whether clients are observers of their experience, speaking about the self, or expressers, speaking from the self, and whether they are differentiating or global, descriptive or evaluative in their processing is also important. Attention also is paid to vividness of language use, such as the poignancy and aliveness of images and feelings that are conjured up by the material. A high degree of concreteness, specificity, and vividness of language use indicates a strong self-focus and high involvement in working. The therapist also is attending to other micro-markers, such as deflections, rehearsed descriptions, rambling, silence and many other indicators of the person's manner of processing affect. These alert therapists to clients' moment by moment processing so as to enable them to adjust their interventions in order to be maximally responsive to their clients. In summary, formulation at this general level involves evaluations of the nature of current emotional processing style and process diagnoses of how to best facilitate a focus on internal experiencing.

To aid in formulation of momentary states, therapists also distinguish between primary, secondary and instrumental emotional responses (Greenberg & Safran, 1987; Greenberg et al, 1993). In order to formulate successfully EFT therapists also develop *a pain compass*, which acts as an emotional tracking device for following their clients' experience (Greenberg & Watson, 2006). The therapist focuses on the most painful aspects of clients' experience and identifies the client's chronic enduring pain. Pain or other intense affects are the cues that alert the therapist to potentially profitable areas of exploration as they focus on clients' moment-to-moment experience. Painful events provide clues as to the source of important core maladaptive emotion schemes that clients may have formed about themselves and others.

Therapists also observe the types and varieties of coping strategies that clients use to cope with their pain and to modulate their painful emotions and which skills might be lacking. Presence and absence of such strategies as, problem – focused coping, involving ability to think about the problem and ways of solving it, or emotion- focused coping, which involve becoming aware of feelings, ability to tolerate emotions and actively reflect on the meaning and significance of feelings, are noted.

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. Finally in the tasks and throughout therapy, therapists attend to and respond to *clients' moment-by-moment processing* just as they did in early sessions but now to guide their moment-by-moment interventions. The therapist thus attends to micro-markers such as poignancy, vividness of language, interruptions, deflections and many other indicators of the person's manner of processing affect while the tasks are being done. In addition the models of the resolution process for each task described in the research section also guide differential moment-by-moment intervention during tasks.

Summary

Thus, EFT therapists pull together information from multiple levels in working with their clients. The different levels of processing to which therapists listen together constitute a sequence of comprehension. Right from the start therapists attend carefully to clients' moment-by-moment process in the session and to how clients are engaging in the work of processing their emotional experiencing. They also listen to clients' life histories to identify their characteristic ways of being with themselves and others. Therapists listen as well for markers of specific cognitive-affective tasks or problem states and for the client's main underlying problems to emerge. Once a focus has been established and the client and therapist are engaged in working on core themes the focus in on moment-by-moment experience.

While sensitized by theories of determinants of problems or disorders, for example, for depression self-esteem vulnerability via self-criticism and dependence, loss, unresolved anger, powerlessness, shame or guilt, these are seen only as useful tools that provide perspective not as definitive determinants. Thus clients are understood in their own terms and each understanding of the client is held tentatively and is open to reformulation and change as more exploration takes place. Treatment is not driven by a theory of the causes of say, depression or anxiety, but rather by listening, empathy, following the clients process and marker identification; a sense of the determinants are built from the ground up using the client as a constant touchstone for what is true. Treatments therefore are custom made for each person.

While therapists do not direct content from one session to the next, therapists do facilitate a continuing focus on internal themes that consist of underlying painful emotional issues that appear to impede healthy functioning. A focus on the main intra-personal or interpersonal themes that are contributing to clients' pain does emerge over time. For example, in one case, the therapy might focus on feelings of insecurity and worthlessness and encourage their exploration if these seem of core importance. In another, unresolved anger may emerge as a focus. Focused empathic exploration and engagement in tasks often leads clients to important thematic material. We have found that in successful cases, core thematic issues do emerge.

A key aspect of formulation involves helping determine whether a core experience once reached is *primary adaptive emotion*, or a *primary maladaptive emotional experience* generated by a core dysfunctional emotion scheme. Client and therapist together thus decide whether a primary emotion once arrived at is a healthy experience that can be used as a guide. If it seems like the core emotion will enhance their well-being then clients are encouraged to stay with this experience and be guided by the information it provides. If however it appears that being in this emotional state will not enhance clients or their intimate bonds, it is not a place to stay or to be guided by. When people in dialogue with their therapists decide that they cannot trust the feelings at which they have arrived as a source of good information, then the feeling needs to be transformed. Now a means to leave the place they have arrived at must be found.

Case Example

Therapy focused on a client with multiple presenting concerns (including major depression, an anxiety disorder, and interpersonal problems) overcoming her core maladaptive fear by accessing her sadness at loss and anger at violation and mobilizing her current abilities to protect herself. Three major means of accessing new emotions are exemplified in the case example: *shifting attention*, *accessing needs*, and *expressive enactment*. After establishing an empathic bond in the first three sessions, the therapy focused on the client's primary fear of her abusive parents and her fear of her dependence, weakness, and vulnerability. Her frequent expressions of shame and embarrassment in therapy were often mixed with her fear. The client's parents had disciplined her with harsh criticism, ridicule, and physical abuse, and she stated that her greatest pain was that "they never believed in me." She was called stupid, crazy, a whore, and a slut, and she grew up utterly paralyzed in interpersonal relationships. Treatment interventions aimed at having the client become aware of and access her fear and shame in the session by talking about her childhood. Experiencing and reprocessing these emotions led to a strengthening of her sense of self.

One of the client's earliest memories was of her father forcing her and her siblings to watch him drown a litter of kittens. Her father's purpose was to "teach her a lesson about life," and the client believed that he enjoyed it. The client accessed a core self-organization that included her "suppressed scream of horror" from this experience. While the client imaginally relived this scene in session, the therapist *guided her attention* to the expression of disgust in her mouth while she was feeling afraid. The therapist's intervention mobilized the sub-dominant

adaptive emotion of disgust as a resource to begin building a stronger sense of self. Rather than feeling afraid, the client accessed her alternate emotions of disgust and anger, which she actively expressed toward her father in an empty chair therapeutic exercise. She mobilized her *adaptive needs* to not be violated by her father and to be protected by her mother and *expressed* these needs to her parents in the empty chair dialogues. Expression and exploration of her vulnerability (fear and sadness) took place, not to the imagined father, but in the affirming and safe dialogue with the therapist.

In therapy, there were often times of shame mixed with fear. For example, in evoking the shame in the session, the client felt small and insignificant in front of her imagined parents. At first, she was completely unable to imagine facing them or to look them in the eye, and she shrunk away from being the object of their scorn. The shame associated with her father was mixed with fear and disgust at recalling his sexual innuendoes. Imaginary confrontations with the father evoked her fear and her painful memories of childhood beatings, of being told she was bad, and of being aware of nothing but her desperate need to escape. The therapist responded supportively to her overwhelming fear and powerlessness at the time of the incidents and asked how she felt now, as she reflected upon herself as a little kid going through that experience and what she had needed back then. This therapeutic intervention *directed attention* to her internal experience and helped her access and *express* her primary anger at being treated so cruelly. Access to her primary adaptive emotion mobilized her self-protective responses, and she began to stand up for herself saying things to her father, such as "I don't really think I was bad. You are bad." In other words, the client's anger undid her fear, and the therapist supported her newfound sense of power, thus heightening her awareness of her strengths and motivating further assertion and self -validation. The client acknowledged that she was worthy and had *deserved more* than she got from her parents. She began to create a new identity narrative, one in which she was worthy and had unfairly suffered abuse at the hands of cruel parents. She also began to feel that it would be possible to need love and that she was now open to learn to love.

An EFT theory of the affective disorders of depression and anxiety and of eating disorders, which are addictive type of disorders, are given below as examples of the application of the general theory to specific types of disorders. We will look at the key role of affect regulation and maladaptive emotion schemes in these disorders. Given the co-occurrence of anxiety and depression it is clear that there are many overlapping processes in these affective disorders. Eating disorders also often include anxiety and depression. From these descriptions we will see that we are proposing that many disorders stem from the same basic underlying processes – core maladaptive emotion schemes, affect avoidance and problems in affect regulation.

The EFT model of depression and anxiety (Greenberg, Elliott, & Foerster, 1990; Greenberg, Watson, & Lietaer, 1998; Greenberg & Watson 2006) centers on the vulnerability of a disempowered self. Early experiences of abuse, neglect or consistent experiences of being misunderstood can handicap the person's processing of emotional distress, so that it becomes overwhelming and cannot be effectively used as the basis for adaptive responding. Subsequently, loss or failure events trigger core implicit emotion schemes of the self as deeply inadequate, insecure or blameworthy, including secondary reactive and maladaptive emotions, along with related emotion memories. These act to organize experience in terms of vulnerabilities and impoverished coping resources and cause the self to collapse in depression into feeling powerless, trapped, defeated, contemptuous of self, and ashamed and in anxiety into feeling helpless, insecure, worried and avoidance. The person loses access to their sense of mastery and their ability to process their emotional experiences in terms of strengths and resources and to respond in more hopeful, positive ways. Resilience is lost and the person experiences the self as powerless or reprehensible, insecure and helpless that is, as bad or weak.

In the affective disorders generic memories of loss and insecurity come from peoples' experiences of certain feelings earlier in their lives, often from experiences in their formative years. Once activated these emotion-based self-organizations impair peoples' capacity both to process and to regulate their emotional experiences in the present. This manifests as either anxiety or depression dependent upon whether insecurity and helplessness or loss and hopelessness predominate. The goal of therapy is to restore the spontaneity of the self's ability to function, to help access and support the existing resources of the personality to enable these to transform the depressive or anxious self-organization.

Maladaptive Schemes as the Underlying Problem

Depression and anxiety are attempts to cope with the activation of painful affective states that the person feels unable to regulate. Often these affective states emerge in relationships with others. Particularly, states of shame-based worthlessness and anxiety-based insecurity. When these cannot be accepted, processed and regulated a sense of depressive hopelessness and/or anxious helplessness may result. During episodes of anxiety or depression people often do not have access to their core, often painful, affects. They are not in contact with their core maladaptive shame or attachment anxiety, nor with their sadness or anger. They also are not aware of how they avoid these emotions and of the voices in their heads that disclaim their internal experience. Rather than accept their core feelings, they feel globally distressed, lack motivation and cannot get anything done or feel insecure, worried and avoid. They are not aware that their malaise is produced by their inability to discriminate and process their core emotions**.** *Depression and anxiety are clearly affectively based*. The negative views of self, world and future and the behavioral withdrawal that one finds in them are reactions to and results of the avoidance of painful core maladaptive emotions often of fear, shame, lonely, abandonment or anger as well as the result of maladaptive ways of trying to cope with the events that evoke these painful emotions.

Overview of Treatment

Intense feelings of self–contempt for the damaged self, and shame form the core of self-critical depressions. Intense feelings of the core insecurity of being unable to cope with loss or abandonment form the core of dependent depressions (Blatt & Moroudas, 1992). On the other hand catastrophizing anxiety, protective fear and basic insecurity, form the maladaptive affective core of anxiety. Adequate processing of sadness at loss and anger at violation often form the adaptive core of the treatment of both depression and anxiety. Anxiety and helplessness, in addition to shame and hopelessness, are important maladaptive emotion schematic aspects of the insecure self at the core of the affective disorders. In depression the sadness, anxiety and neediness experienced by a childhood sense of loss and deprivation are experienced as evidence of personal inadequacy or in anxiety the inability to be soothed at times of threat confirms the uncontrollability of affect and the environment. Current disappointment, loss, criticisms, rejection, diminishments slights, threats or stress then are experienced as confirmation of inadequacy or of damage and hopelessness or helplessness sets in to produce depression or anxiety. Whatever the antecedents, empowerment, reconnection and soothing appears to be the antidote. Reviving the capacity to feel adaptive anger and sadness and the ability to feel compassion for the self and self-soothe are key affective elements to overcoming depression and anxiety and the powerlessness and insecurity of these disorders. EFT thus focuses on helping clients process their emotional experiencing so that they are able to access primary adaptive emotional responses to situations, such as empowering anger at violation or interpersonally-open sadness at loss.

In EFT, intervention for anxiety or catastrophic expectations involves first "heightening" clients' awareness of what they are doing to themselves to create the secondary anxiety—in this case,

scaring herself. In EFT of GAD clients' agency in the process and awareness of how they contribute to creating their experience of anxiety is highlighted, along with specifying the irrational beliefs or catastrophic expectations that generate the anxiety" (Greenberg & Paivio, 1997). Specifically, their awareness is heightened through the use of a two-chair enactment, whereby the client sits in one chair and expresses the concerns of the "worry critic"; the client also sits in a second chair in order to determine the reaction of the 'self' to these verbalizations (Note: This is similar to a 'self-critical split', except that one side is 'scaring' the other rather than being critical). Another major part of this process is determining the core maladaptive emotion scheme(s) to which anxiety is the secondary response.

Initially, the client had no idea what could be underlying her anxiety, but after two sessions using a two-chair dialogue, critical information emerged, as is often the case her anxiety was coupled with depression. Her feelings of hopelessness emerged when her 'anxiety critic' told her that if she did not do a better job in her academic pursuits that she would fail. For example, in her second session, the critic told her that she has many things to do and that she won't be able to manage. In reaction, she noted that she felt "anxious, like there is no hope of finishing…There is no end in sight.". In session six, the voice told her that other people will notice if she fails and that they will reject her. In response, she felt "very hopeless, like there's nothing I can do about it."

Emotion, especially distressing emotion plays an important role in eating disorders. "Emotional disturbances" have long been recognized as underlying these disorders, and affect has been implicated in triggering eating disorder symptoms (Bruch, 1978; Johnson & Larson, 1982; Wilson & Vitousek, 1999). Use of the eating disorder to manage affect regulation difficulties may result in either underregulation or overregulation of affect. Stereotypical clinical presentation, for example, would include the individual with anorexia nervosa who has highly constricted, impoverished, "overregulated" affect; as well as the individual with bulimia nervosa who may display chaotic and unmodulated affective functioning, and whose symptoms may include other impulsive behaviours in addition to bingeing and purging such as shoplifting, cutting, or substance abuse.

The affect regulation function of the eating disorder is related to a distinctive and pervasive attitude toward emotion among this population (Dolhanty & Greenberg, 2007, 2009). Feelings are intolerable, dangerous, and to be feared, and must be "gotten rid of" or avoided altogether. The eating disorder is a highly effective means of accomplishing this. Starving numbs, bingeing soothes, vomiting provides relief. Attempts at recovery are met with a resurgence of previously avoided feelings that are experienced as being intolerable, the desire to escape them leading to relapse (Federicci, 2004). With the thawing of the emotional self that accompanies increase in weight or decrease in bulimic symptoms, the individual is faced with an onslaught of psychogenic pain that she has no way of managing other than through the eating disorder. The wish for recovery and the logic of knowing what she "should" do are overridden by a desperate sense that "I'd rather die than feel."

Overview of the Treatment

Given that in eating disorder is in the service of avoiding, numbing, or soothing affective dysregulation, it would follow that treatment should involve explicit attending to and accommodating to felt emotion in order to allow its experience and develop proficiency in accepting, modulating, soothing, and transforming it. Emotion-focused therapy promotes in-session experiencing of emotion with the goal of fostering, with the supportive guidance of the therapist, an acceptance of experienced emotion, a capacity and proficiency in regulating emotion and in self-soothing, and a transformation of destructive or "maladaptive" emotions to more healthy alternatives. Individuals experience renewed hope in the possibility that they may alter

and improve their eating disorder by means of working to identify and alter emotion schemes, rather than thinking their only recourse is to keep trying harder to change intransigent eating patterns in the absence of a substitute for managing their distress.

The overriding goal of this approach with eating disorders is to get beyond secondary emotions such as hopelessness or despair which obscure or protect against primary emotions, and to gain access to core maladaptive emotions such as fear and shame. This is done in order to help clients transform their maladaptive emotions and have them gain access to and be guided by their innate, healthy, adaptive emotional experience. This helps them alter dysfunctional behaviour patterns and render the eating disorder unnecessary as a means of coping. This is accomplished by processing the painful and seemingly intractable maladaptive emotions that diminish the self, such as shame, rage, self-loathing, and passive, hopeless despair. "Processing" involves attending to emotion, allowing it, expressing it, symbolizing it through meaning-making, evaluating it vis a vis whether it can be trusted to guide action, and transforming it by access to more adaptive emotions. Processing thus involves heightening awareness of healthy innate emotions and transforming maladaptive ones.

References

Angus, L., Levitt, H., & Hardtke, K. (1999). The narrative processes coding system: research applications and implications for psychotherapy practice. *Journal of Clinical Psychology*, *55*(10), 1255-1270.

Arnold, M. B. (1984). *Feelings and emotions: The Loyola symposium*. Oxford, England: Academic Press.

Auszra L., Greenberg, L. S., & Herrmann, I. (2013). Client emotional productivity: Optimal client in-session emotional processing in experiential therapy. *Psychotherapy research*, *23*, 732-746

Blatt, S., & Maroudas, C. (1992). Convergences among psychoanalytic and cognitive-behavioral theories of depression. *Psychoanalytic Psychology*, *9*(2), 159-161. doi:10.1037/0736-9735.9.2.157

Bohart, A., & Greenberg, L. (Eds.). (1997). *Empathy reconsidered: New directions in theory research and practice*. Washington, DC: APA Press.

Bordin, E. (1994). Theory and research on the therapeutic working alliance: New directions. In A. Horvath & L. Greenberg (Eds.), *The working alliance: Theory, research and practice* (pp. 13-37). New York: Wiley.

Bruch, H. (1978). *The golden cage: The enigma of anorexia nervosa*. Cambridge, MA: Harvard University Press.

Coifman, K. G., Bonanno, G. A., Ray, R., & Gross, J. (2007). Does repression lead to recovery and resilience? Affective-autonomic response discrepancy in bereavement. *Journal of Personality and Social Psychology*, *92*(4), 745-758.

Damasio, A. (1994). *Descartes' error: Emotion, reason, and the human brain*. New York: G.P. Putnam's Sons.

Damasio, A. (1999). *The feeling of what happens*. New York: Harcourt-Brace.

Darwin, C. (1897). *The expression of emotions in man and animals*. New York Philosophical Library (Original work published 1872).

Davidson, R. (2000). Affective style, mood and anxiety disorders: An affective neuroscience approach. In R. Davidson (Ed.), *Anxiety, depression and emotion*. Oxford: Oxford University Press.

Dolhanty, J., & Greenberg, L. S. (2007). Emotion-focused therapy in the treatment of eating disorders. *European Psychotherapy*, *7*(1), 97–116.

Dolhanty, J., & Greenberg, L. S. (2009). Emotion-focused therapy in a case of anorexia nervosa. *Clinical Psychology & Psychotherapy*, *16*(4), 366–382.

Elliott R , Greenberg, L., & Lietaer, G. (2003). Research on experiential psychotherapy. In M.Lambert (Ed.), *Bergin & Garfield's Handbook of Psychotherapy & Behavior Change*. New York: Wiley and Sons.

Elliot, R., Watson, J., Goldman, R. N., & Greenberg, L. S. (2004). *Learning emotion-focused therapy: The process-experiential approach to change*. Washington, DC: American Psychological Association Press.

Federici, A. (2004). *Relapse and recovery in anorexia nervosa: The patients' perspective* (Thesis). Toronto: University of Toronto.

Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 99*(1), 20-35.

Foa, E. B., & Jaycox, L. H. (1999). Cognitive-behavioural theory and treatment of posttraumatic stress disorder. In D. Speigel (Ed.), *Efficacy and cost-effectiveness of psychotherapy* (pp. 23-61). Washington, DC: American Psychiatric Publishing.

Fosha, D. (2000). *The transforming power of affect: A model of accelerated change*. New York: Basic Books.

Frederickson, B. (2001). The role of positive emotions in positive psychology: The broaden-and-build theory of positive emotions. *American Psychologist, 56(3),* 218-226.

Frijda, N. H. (1986). *The emotions*. Cambridge: Cambridge University Press.

Gendlin, E. T. (1996). *Focusing-oriented psychotherapy: A manual of the experiential method*. New York: Guilford Press.

Goldman, R. N., Greenberg, L. S., & Pos, A. E. (2005). Depth of emotional experience and outcome. *Psychotherapy Research, 13*(3), 248-260.

Greenberg, L. S., & Safran, J. D. (1987). Emotion is psychotherapy: Affect, cognition and the process of change. New York: Guilford Press.

Greenberg, L. S., & Johnson, S. (1988). *Emotionally focused couples therapy*. New York: Guilford Press.

Greenberg, L. S., & Safran, J. D. (1989). Emotion in psychotherapy. *American Psychologist, 44,* 19-29.

Greenberg, L. S., Elliott, R. K., Foerster, F. S. (1990). Experiential processes in the psychotherapeutic treatment of depression. In D. C. McCann & Endler, N. S. (Eds.), *Depression: New directions in theory, research, and practice*, (pp. 157-185). Toronto, ON, Canada: Wall & Emerson.

Greenberg, L. S., Rice, L. N., & Elliot, R. (1993). *Facilitating emotional change: The moment by moment process*. New York: Guilford Press.

Greenberg, L. S., Elliott, R., & Lietaer, G. (1994). Research on experiential psychotherapies. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy & behaviour change* (pp. 509-539). New York: Wiley.

Greenberg, L. S., & Pascual-Leone, J. (1995). A dialectical constructivist approach to experiential change. In R. A. Neimeyer & M. J. Mahoney (Eds.), *Constructivism in psychotherapy* (pp. 169-191). Washington, DC: American Psychological Association.

Greenberg, L. S., & Paivio, S. C. (1997). *Working with the emotions in psychotherapy*. New York: Guilford Press.

Greenberg, L. S., & Pascual-Leone, J. (1997). Emotion in the creation of personal meaning. In M. J. Power & C. R. Brewin (Eds.), *The transformation of meaning in psychological therapies: Integrating theory and practice* (pp. 157-173). Hoboken, NJ: John Wiley & Sons.

Greenberg, L. S., Watson, J. C., & Lietaer, G. (Eds.). (1998). *Handbook of experiential psychotherapy*. New York: Guilford Press.

Greenberg, L. S., & Bolger, E. (2001). An emotion-focused approach to the overregulation of emotion and emotional pain. *Journal of Clinical Psychology*, *57*(2), 197-211.

Greenberg, L. S., & Pascual-Leone, J. (2001). A dialectical constructivist view of the creation of personal meaning. *Journal of Constructivist Psychology, 14(3),* 165-186.

Greenberg, L. S. (2002). *Emotion-focused therapy: Coaching clients to work through feelings*. Washington, D.C.: American Psychological Association Press.

Greenberg, L. S., & Malcolm, W. (2002). Resolving unfinished business: Relating process to outcome. *Journal of Consulting and Clinical Psychology*, *70*(2), 406-416.

Greenberg, L. S., & Angus, L. (2004). The contributions of emotion processes to narrative change in psychotherapy: A dialectical constructivist approach. In L. Angus & J. McLeod, *Handbook of narrative psychotherapy: Practice, theory, and research* (pp. 331–349). Thousand Oaks, CA: Sage Publications, Inc.

Greenberg, L. S., & Watson, J. C. (2006). *Emotion-focused therapy for depression*. Washington, DC: American Psychological Association.

Greenberg, L., S., Auszra, L., & Herrmann, I. (2007). The relationship between emotional productivity, emotional arousal and outcome in experiential therapy of depression. *Psychotherapy research*, *2*, 57-66.

Greenberg, L. S., & Goldman, R. (2007). Case formulation in emotion focused therapy. In T. D. Eells (Ed.), *Handbook of psychotherapy case formulation* (pp. 379-412). New York: Guilford Press.

Greenberg, L. S. (2015). *Emotion-focused therapy: Coaching clients to work through their feelings* (Second ed.). Washington, DC: American Psychological Association.

Greenberg, L. S., & Watson, J. (in press). *Emotion-focused therapy of depression*. Washington. DC: American Psychological Association.

Guidano, V. F. (1991). *The self in process*. New York: Guilford Press.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology*, *36*(2), 223-233. doi: 10.1037/0022-0167.36.2.223

Izard, C. E. (1991). *The psychology of emotions*. New York: Plenum Press.

Johnson C., & Larson, R. (1982). Bulimia: An analysis of moods and behavior. *Psychosomatic Medicine*, *44*, 341–351.

Johnson, S., & Greenberg, L. (1985). Differential effects of experiential and problem solving interventions in resolving marital conflict. *Journal of Consulting and Clinical Psychology, 53,* 175-184.

Kabat Zin, J. (1993). *Full catastrophe living*. New York: Delta Press.

Lane, R., Ryan., L., Nadel, L., & Greenberg, L. S. (In press). Memory reconsolidation, emotional arousal and the process of change in psychotherapy: New insights from brain science. *Behavioral and Brain Sciences*.

Klein, M., Mathieu, P., Gendlin, E. J., & Kiesler, D. J. (1969). *The experiencing scale: A research and training manual* (Vol. 1). Madison: Wisconsin Psychiatric Institute.

LeDoux, J. E. (1996). *The emotional brain: The mysterious underpinnings of emotional life*. New York: Simon & Schuster.

Levenson, R. W. (1992). Autonomic nervous system differences among emotions. *Psychological Science 3(1),* 23-27.

Lieberman, M. D., Eisenberger, N. I., Crockett, M. J., Tom, S. M., Pfeifer, J. H., & Way, B. M. (2004). Putting feelings into words: Affect labeling disrupts amygdala activity in response to affective stimuli. *Psychological Science*, *18*, 421-428.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: The Guilford Press.

Mahoney, M. (1991). *Human change processes*. New York: Basic Books.

McGaugh, J. L. (2003). *Memory and emotion: The making of lasting memories*. New York: Columbia University Press.

Nadel, L., & Bohbot, V. (2001). Consolidation of memory. *Hippocampus*, *11*, 56–60.

Neimeyer, R., & Mahoney, M. (1995). *Constructivism in psychotherapy*. Washington, DC: American Psychological Association.

Oatley, K., & Jenkins, J. (1992). Human emotions: Function and dysfunction. *Annual Review of Psychology, 43,* 55-85.

Oatley, K. (1992). *Best laid schemes*. Cambridge: Cambridge University Press.

Pascual-Leone, J. (1991). Emotions, development and psychotherapy: A dialectical constructivist perspective. In J. Safran & L. Greenberg (Eds.), *Emotion, psychotherapy and change* (pp. 302-335). New York: Guilford.

Pascual-Leone, A., & Greenberg, L. S. (2007). Emotional processing in experiential therapy: Why "the only way out is through." Journal of Consulting and Clinical Psychology, 75(6), 875-887. doi: 10.1037/0022-006X.75.6.875

Paivio, S. C., Hall, I. E., Holowaty, K. A. M., Jellis, J. B., & Tran, N. (2001). Imaginal confrontation for resolving child abuse issues. *Psychotherapy Research*, *11,* 433-453.

Paivio, S. C., & Nieuwenhuis, J. A. (2001). Efficacy of emotionally focused therapy for adult survivors of child abuse: A preliminary study. *Journal of Traumatic Stress*, *14*, 115-134.

Pennebaker, J. W. (1990). *Opening up: The healing power of confiding in others*. New York: William Morrow.

Pennebaker, J. W. (1995). Emotion, disclosure, and health: An overview. In J. W. Pennebaker (Ed.), *Emotion, disclosure, and health* (pp. 3-10). Washington, DC: American Psychological Association.

Perls, F., Hefferline, R. F., & Goodman, P. (1951). *Gestalt therapy*. New York: Dell Press.

Phelps, E. A. (2009). The human amygdala and the control of fear. In P. J. Whalen & E. A. Phelps (Eds.), *The human amygdala* (pp. 204-219). New York: Guilford Press.

Rice, L., & Greenberg, L. S. (Eds.). (1984). *Patterns of change: An intensive analysis of psychotherapeutic process*. New York: Gilford Press.

Rice, L. N., & Kerr, G. P. (1986). Measures of client and therapist vocal quality. In L. Greenberg & W. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 73-105). New York: Guilford Press.

Richards, J. M., & Gross, J. J. (2000). Emotion regulation and memory: The cognitive costs of keeping one's cool. *Personality Processes & Individual Differences*, *79*, 410-424.

Richards, J. M., & Gross, J. J. (2006). Personality and emotional memory: How regulating emotion impairs memory for emotional events. *Journal of Research in Personality*, *40*, 631-651.

Rogers, C. R. (1959). A theory of therapy, personality and interpersonal relationships, as developed in the client-centred framework. In S. Koch (Ed.), *Psychology: A study of science* (Vol. 3, pp 184-256). New York: McGraw Hill.

Schore, A. N. (2003). *Affect dysregulation and disorders of the self*. New York: Norton.

Spinoza, B. (1967). *Ethics (Part IV)*. New York: Hafner Publishing Company.

Sroufe, L. A. (1996). *Emotional development: The organization of emotional life in the early years*. New York: Cambridge University Press.

Stanton, A. L., Danoff-Burg, S., Cameron, C. L., Bishop, M., Collins, C. A., Kirk, S. B., Sworowski, L. A., & Twillman, R. (2000). Emotionally expressive coping predicts psychological and physical adjustment to breast cancer. *Journal of Consulting and Clinical Psychology, 68*(5), 875-882. doi: 10.1037/0022-006x.68.5.875

Stern, D. (1985). *The interpersonal world of the infant*. New York: Basic Books.

Van der Kolk, B. A. (1995). The body keeps the score: memory and the evolving psychobiology of posttraumatic stress. *Harvard Review of Psychiatry, 1,* 253-265.

Warwar, N., & Greenberg, L. (1999). *Emotional processing and therapeutic change*. Paper presented at the International Society for Psychotherapy Research Annual Meeting. Braga, Protugal.

Wegner, D. M., Erber, R., & Zanakos, S. (1993). Ironic processes in the mental control of mood and mood-related thought. *Journal of Personality and Social Psychology*, *65*(6), 1093-1104. doi: 10.1037/0022-3514.65.6.1093

Whelton, W. J., & Greenberg, L. S. (2000). The self: A singular multiplicity. In J. C. Muran (Ed.), *Self in relation in the psychotherapy process*. Washington, DC: APA Press.

Wilson, G.T., & Vitousek, K. M. (1999). Self-monitoring in the assessment of eating disorders. *Psychological Assessment*, *11*, 480-489.