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Emotion-Focused Therapy: A Clinical Synthesis

Abstract: A summary of an emotion-focused approach to therapy (EFT) and its research base is presented. In this view, emotion is seen as foundational in the construction of the self and is a key determinant of self-organization. People, as well as simply having emotion, also live in a constant process of making sense of their emotions. 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 shame and basic insecurity in a relatively brief treatment of depression.

Emotion-focused treatment was developed as an empirically informed approach to the practice of psychotherapy grounded in contemporary psychological theories of functioning. Emotion-focused therapy (EFT) was developed by my colleagues and I in the 1980s out of empirical studies of the process of change (1–6) and has developed into one of the recognized evidence-based treatment approaches for depression and marital distress as well as showing promise for trauma, eating disorders, anxiety disorders, and interpersonal problems.

EFTs have been shown to be effective in both individual and couples forms of therapy in a number of randomized clinical trials (7, 8). A manualized form of EFT of depression in which specific emotion activation methods were used within the context of an empathic relationship was shown to be highly effective in treating depression in three separate studies (9–12). In these studies EFT was found to be as effective or more effective than a client-centered (CC) empathic treatment and a cognitive behavioral treatment (CBT). Both the treatments with which it was compared were themselves also found to be highly effective in reducing depression, but EFT was found to be more effective in reducing interpersonal problems than either the CC or CBT treatment, in promoting more change in symptoms than the CC treatment, and highly effective in preventing relapse (77% nonrelapse) (13). EFT also has been found to be effective in treating abuse (14), resolving interpersonal problems, and promoting forgiveness (15, 16). Emotion-focused couple therapy is recognized as one of the most effective approaches in resolving relationship distress (8, 17). EFT also has generated more research than any other treatment approach on the process of change, having demonstrated a relationship between outcome and empathy, the alliance, depth of experiencing, emotional arousal, making sense of aroused emotion, productive processing of emotion, and particular emotions sequences (7, 19, 20).

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Emotion

A major premise of 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 (2, 20–22). Emotions are seen by contemporary emotion theorists as significant because they inform people that an important need, value, or goal may be advanced or harmed in a situation. Emotions, then, are involved in setting goal priorities (23) and are biologically based tendencies to act that result from the appraisal of the

situation based on these goals, needs, and concerns (2, 22).

Emotion is a brain phenomenon vastly different from thought. It has its own neurochemical and physiological basis and is a unique language in which the brain speaks. The limbic system is fundamentally involved in basic emotional responses (24). It governs many of the body's physiological processes and thereby influences physical health, the immune system, and most major body organs. LeDoux (24) found that there are two different paths for producing emotion: the shorter and faster amygdala pathway which sends automatic emergency signals to the brain and body and produces gut responses, and the longer, slower neocortex pathway, which produces emotion mediated by thought. These developed because 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.

EFT suggests that the developing cortex added the ability for complex learning to the emotional brain's in-wired emotional responses. Internal organizations (neural networks) that produced emotional responses to learned signs of what had previously evoked emotion in a person's own life experience were thus formed. Emotional memories of lived emotional experience are seen as being formed into *emotion schemes* (5, 21, 25). 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, such as fear of one's father's impatient voice, or life enhancing, such as a beloved 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 seen as being produced by the synthesis of highly differentiated structures that have been refined through experience and are bound by cultural learning into emotion schemes (5, 26). Emotion schematic processing is the principal source of emotional experience and the target of intervention and therapeutic change in emotion-focused therapy (5, 21).

Emotion schemes are seen as being formed from emotional events such as betrayals or abandonments that result in emotional reactions. The emotion will fade unless it is "burned" into memory. The more highly aroused the emotion the more the experience and the evoking situation will form a memory. An emotion scheme is thus formed by emotions being connected to memories of the self in the situation. As a result, the emotional response can be recreated again and again long after the event. Then a memory of the painful event or a reminder of it stimulates an emotional response.

Changing the emotion schematic memory structures in therapy most likely occurs through the recently investigated process of memory reconsolidation (27, 28). The classic view of memory suggests that immediately after learning there is a period of time during which the memory is fragile and labile, but that after sufficient time has passed, the memory is more or less permanent. During the 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, an alternative view of memory was developed, suggesting that every time a memory is retrieved, the underlying memory trace is once again labile and fragile, requiring another consolidation period, called *reconsolidation*. This reconsolidation period allows another opportunity to disrupt the memory. The possibility of disrupting a previously acquired emotion schematic memory by blocking reconsolidation has important clinical implications.

A DIALECTICAL CONSTRUCTIVIST VIEW: INTEGRATING BIOLOGY AND CULTURE

In addition to 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 (5, 26, 29–33). How emotional experience is symbolized influences what the experience becomes in the next moment. Therapists therefore need to work with both emotion and meaning, making and facilitating change in both emotional experience and the narratives in which they are embedded (34).

EMOTION ASSESSMENT

We have proposed 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 (21, 35). *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 situa-

tion, such as feeling angry in response to feeling hurt or feeling afraid or guilty about feeling angry.

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.

Primary adaptive emotions need to be accessed for their adaptive information and capacity to organize action, whereas maladaptive emotions need to be accessed and regulated to be transformed. Secondary emotions need to be reduced by exploring them to access their more primary cognitive or emotional generators.

Therapy

EFT intervention is based on two major treatment principles: the provision of a therapeutic relationship and the facilitation of therapeutic work (5). The relational style is person-centered (36), which involves a way of being with patients characterized by entering the client's internal frame of reference and empathically following the client's experience. This is combined with a more guiding, process-directive gestalt therapy style (37) of engaging in experiments to deepen experience. The overall therapeutic style thus combines being with doing and following with leading.

The hallmark of EFT is that in addition to providing an empathic relationship 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

A defining feature of EFT is that intervention is *marker guided and process directive*. Research has demonstrated that clients enter specific problematic emotional-processing states that are identifiable by in-session performances that mark underlying affective problems and that these afford opportunities for particular types of affective intervention (5). 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's intervention.

The following main markers and their accompanying interventions have been identified (5).

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 form of intervention that involves vivid *evocation* of experience to promote reexperiencing the situation and the reaction to finally arrive at the implicit meaning of the situation that makes sense of the reaction (5). 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 or her experience: "I just have this feeling, but I don't know what it is." An unclear felt sense calls for *focusing* (38) 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 to the creation of new meaning.
3. *Conflict splits* in which one aspect of the self is critical or coercive toward another aspect. For example, a woman in therapy says, "I feel inferior to them; it's like I've failed and I'm not as good as you." Self-critical splits offer an opportunity for *two-chair work*. In this, two parts of the self are put into live contact by dialoguing with each other. Thoughts, feelings, and needs within each part of the self are explored and communicated in a dialogue to achieve a softening of the critical voice. Resolution involves an integration between sides and self-acceptance.
4. *Self-interruptive splits* in which one part of the self interrupts or constricts emotional experi-

ence 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." *Two-chair enactment* is used to make the interrupting part of the self explicit. Clients are guided to become aware of how they interrupt and to enact the ways they do it, whether 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. They then are invited to react to and challenge the interruptive part of the self. Resolution involves expression of the previously blocked experience.

5. An *unfinished business* marker in which 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 express their unresolved feelings and needs. Shifts in views of both the other and self occur. Resolution involves holding the other accountable or understanding or forgiving the other.
6. *Vulnerability,* 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 or her experience, above all else, that client needs empathic attunement from the therapist who must not only capture the content of what the client is feeling but also note the vitality affects of the client, mirroring the tempo rhythm and tone of the experience. In addition, the therapist needs to validate and normalize the client's experience of vulnerability. Resolution involves the strengthened sense of self that results from empathic attunement to affect.

A number of additional markers and interventions such as trauma and narrative retelling, alliance repair at ruptures, self-compassion at markers of self-contempt, self-soothing at anxious dependence, meaning making at markers of emotional high distress, and clearing a space at markers of confusion, and more, have been added to the original six markers and tasks (12, 39).

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.

Awareness. Increasing awareness of emotion, or naming what one feels, is the most fundamental overall goal of treatment. Lieberman et al. (2004) have shown that naming a feeling in words helps decrease amygdala arousal. Once people know what they feel, they reconnect to their needs and are motivated to meet them. 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 involves feeling the feeling, not talking about it.

EFT therapists help patients approach, accept, tolerate, and symbolize emotions rather than avoid them. Patients are helped to make sense of what their emotion is telling them, identify the goal/need/concern that it is organizing them to attain, and the action tendency provided and to use these to improve coping. Emotion is used both to inform and to move.

Emotional expression. Emotional expression has been shown to be a unique aspect of emotional processing that predicts adjustment to things such as breast cancer (40) interpersonal emotional injuries, and trauma (12, 41, 42). Expressing emotion in therapy does not involve the venting of secondary emotion but rather overcoming avoidance to experience and express previously constricted primary emotions. Expressive coping helps patients attend to and clarify central concerns and promotes pursuit of goals.

There is a strong human tendency to avoid expressing painful emotions. Thus, 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 such as "anger is dangerous" or "men don't cry" governing their avoidance or helping them face their fear of disso-

lution (43, 44). 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 (42). 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 (29, 35). 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 are 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. Emotion needs to be regulated when distress is so high that the emotion no longer informs adaptive action (19).

The first step in helping emotion regulation is the provision of a safe, calming, validating, and empathic environment. Being able to soothe the self develops initially by internalization of the soothing functions of the protective other (45, 46). 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 (45–47). Over time this soothing is internalized, and clients develop implicit self-soothing, the ability to regulate feelings automatically without deliberate effort.

Emotion regulation and distress tolerance (48) skills also need to be taught. Things such 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 improve coping. Forms of meditative practice, which involve observing one's emotions and letting them come and go, breathing, and acceptance are helpful in achieving a working distance from overwhelming core emotions.

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. Another important aspect of regulation is developing clients' abilities to self-soothe. Promoting clients' abilities to receive and be compassionate to their emerging painful emotional experience is the first step toward helping them tolerate emotion and self-soothe followed by relaxation, development of self-compassion, and positive self-talk.

Reflection. In addition to symbolizing emotion in words, reflection on emotional experience helps people make narrative sense of their experience. What we make of our emotional experience makes us who we are. Reflection helps to create new meaning, promotes the assimilation of unprocessed emotion into ongoing narratives, and helps develop new *narratives to explain experience* (25, 49). Pennebaker (50) has shown the positive effects of writing about emotional experience on autonomic nervous system activity, immune functioning, and physical and emotional health and concluded that through language, individuals are able to organize, structure, and ultimately assimilate 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. The *unsayable* is made *sayable*, situations are understood in new ways, and experiences are reframed, leading to new views of self-other and world.

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, shame, and the sadness of being abandoned or alone with other adaptive emotions (35). Maladaptive emotional states are best transformed by undoing them by activating other more adaptive emotional states. Darwin was the first to note that "An emotion cannot be restrained nor removed unless by an opposed and stronger emotion" (51, p 195). Whereas thinking usually changes thoughts, only feeling can change primary emotions. In EFT an important goal therefore is to arrive at maladaptive emotion, not for its good information and motivation, but to make it accessible to transformation. In time, the coactivation of the more adaptive emotion, along with or in response to the maladaptive emotion, helps transform the maladaptive emotion.

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 dysregu-

lated secondary emotions such as the fear and anxiety in phobias, obsessive compulsiveness, and panic may be overcome by mere exposure, 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, is brought about by the activation of an incompatible, adaptive experience, such as empowering anger or self-compassion that undoes the old response rather than attenuates it. This involves more than simply feeling or facing the feeling, leading it to its diminishment. Rather, for example, the withdrawal tendencies of primary maladaptive emotion are transformed by activating the approach tendencies in anger or comfort seeking. Withdrawal emotions from one side of the brain are replaced with approach emotions from another part of the brain or vice versa (52).

Frederickson (53) 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 was found to produce faster cardiovascular recovery from negative emotions than a neutral experience. Resilient individuals have been found to cope by recruiting positive emotions to undo negative emotional experiences (54). Thus, bad feelings can be transformed by happy feelings, not by deliberately trying to look on the bright side, but by the evocation of meaningfully embodied experience that undoes the neurochemistry, physiology, and experience of negative feeling.

This principle applies not only to positive emotions changing negative emotions but also to changing maladaptive emotions by activating dialectically opposing adaptive emotions (6). 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 or the reaching out from contact in sadness. 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 required before the activation of an opposing emotion.

How does the therapist help the client access new emotions to change emotion? A number of ways have been outlined (35). 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; *focusing on what is needed* and thereby mobilizing a new emotion is a key means of activating a new emotion (6). 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 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 expressing an emotion for the client (6). Once accessed, these new emotional resources begin to undo the psychoaffective motor program previously determining the person's mode of processing. New emotional states enable people to challenge the validity of perceptions of self/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 works on the basic principle that people must first arrive at a place before they can leave it. You have to feel it to heal it! Maladaptive emotion schematic memories of past childhood losses and traumas are activated in the therapy session to change these by memory reconstruction. As we have said, introducing new present experience into currently activated memories of past events has been shown to lead to memory reconsolidation by the assimilation of new material into past memories (28). By being activated in the present the old memories are restructured by the new experience of both being in the context of a safe relationship and experiencing

more adaptive emotional responses and new adult understanding to the old situation. The memories are reconsolidated in a new way by incorporating these new elements. The past, in fact, can be changed or at least the memories of it can.

Corrective experience of emotion. Finally, a key way of changing an emotion is to have a new lived experience that changes an old feeling. New lived experience with the therapist provides a corrective emotional experience. Experiences that provide interpersonal soothing, disconfirm pathogenic beliefs, or offer new success 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.

PHASES OF TREATMENT

EFT treatment has been broken into three major phases, each with a set of steps to describe its course over time (12). The first phase involves bonding and emotional awareness, and the middle phase involves evoking and exploring core maladaptive emotion schemes. Therapy concludes with a transformation phase that involves constructing alternatives through generating new emotions and reflecting on aroused emotion to create new narrative meaning.

CASE FORMULATION

EFT has developed a context-sensitive approach to case formulation to help promote the development of a focus (55). Case formulation relies on process diagnosis, development of a focus on underlying determinants, and theme development rather than on person or syndrome diagnosis. In a process-oriented approach to treatment, case formulation is an ongoing process, as sensitive to the moment and the in-session context as it is to an understanding of the person as a case. 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 following the client's process and the identification of *core pain,* which leads to identification of markers of current emotional concerns and accessing the maladaptive schemes underlying the presenting. Painful emotions and markers of different problematic experiential states guide intervention more than a picture of the person's enduring personality or a core pattern. The client's presently felt experience indicates what the difficulty is and indicates whether problem determinants are currently accessible and amenable to intervention.

DIVERSE DISORDERS

EFT theory of both the affective disorders and of eating disorders is discussed briefly below as examples of the application of the general theory to specific types of disorders. We argue that many disorders stem from the same basic underlying processes—core maladaptive emotion schemes, affect avoidance, and problems in affect regulation.

AFFECTIVE DISORDERS

The EFT model of depression and anxiety (12) centers on the vulnerability of a disempowered self. Early experiences of abuse, neglect, or abandonment or consistent experiences of being misunderstood can handicap the person's processing of emotional distress, so that emotion 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, along with related emotion memories plus secondary emotions. The self is thereby organized in terms of vulnerabilities and impoverished coping resources and in depression collapses into feeling powerless, trapped, defeated, contemptuous of self, and ashamed and in anxiety into feeling helpless, insecure, and worried and avoidance. The person loses access to his or her sense of mastery and ability to process the emotional experiences in terms of strengths and resources. Resilience is lost, and the person experiences the self as powerless or reprehensible, insecure, and helpless, that is, as bad or weak.

OVERVIEW OF TREATMENT OF AFFECTIVE DISORDERS

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 (55). 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. Core anxiety and secondary helplessness, in addition to core shame and secondary hopelessness, are important emotions in 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. Whatever the antecedents, empowerment by access to adaptive emotions, reconnection, and soothing seems 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.

EATING DISORDERS

Emotion, especially distressing emotion, plays an important role in eating disorders. 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 behaviors in addition to bingeing and purging such as shoplifting, cutting, or substance abuse.

OVERVIEW OF TREATMENT OF EATING DISORDERS

Given that the eating disorder is in the service of avoiding, numbing, or soothing painful emotion, it follows that treatment should involve explicit attending to and accommodating to felt emotion to allow its experience and develop proficiency in accepting, modulating, soothing, and transforming it. 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.

COMPARISON WITH OTHER TREATMENTS

EFT is itself an integration of client-centered, gestalt, and existential approaches (6). Although it differs from psychodynamic therapy in focusing more on the here and now, it is similar to self-psychology in the attention paid to empathic attunement, and it is dynamically informed, incorporating attachment theory, the importance of interpersonal processes, and repairing alliance ruptures as part of the healing process. It differs from CBT in seeing emotion as more influential in thought and belief production than vice versa and in placing an emphasis on in-session process and change rather than homework and extrasessional change. It is similar to those CBTs that promote exposure to avoided emotion. EFT overlaps with interpersonal therapy in promoting grieving but does not focus on dealing with current maladaptive interpersonal interactions. In fact, EFT views both the maladaptive beliefs of CBT and the current interpersonal difficulties of interpersonal therapy as resulting from maladaptive emotion schemes and proposes that emotional transformation leads to enduring change in both beliefs and interpersonal interactions, which are viewed as symptoms of core painful emotional processes.

CASE PRESENTATION

At the assessment interview, the client, a 39-year-old woman, tearfully reports feeling depressed, saying that she has been depressed most of her life, but that the past year has been particularly bad and that she has not been working and has fallen into a pattern of rarely leaving the house or answering the phone or the door. Her relationships with her family of origin members are difficult and often painful. Her mother is an alcoholic with whom she and her three sisters no longer have contact. Her father is a concentration camp survivor. He has always been emotionally removed from the family and is often perceived as being critical and judgmental. There is a history of physical punishment throughout her childhood.

From the exploration of the first session, the therapist has a sense that throughout her childhood and into her adult life she has often experienced herself as alone and unsupported. She has internalized the critical voice of her parents and often judges herself to be a failure. Within the context of a physically and emotionally abusive past she often felt emotionally unsafe and abandoned.

From the first session the therapist observes that the client is able to focus on her internal experience, particularly in response to empathic responses that

focus her internally. However, she tends to avoid painful and difficult emotions (as do most people). There seems to be an identifiable maladaptive emotional pattern, wherein she moves into states of helplessness and hopelessness whenever she starts to feel primary emotions of sadness or anger and in response to experiencing needs for closeness and acceptance. She also appeared to have internalized her father's self-criticism, seeing herself as a failure. Unfinished business stemming from her early relationship with her father was also evident. She has unresolved resentment and sadness that have affected her own sense of security and self-worth. The goal of the treatment seemed to be to resolve her self-critical conflict split and to resolve her unresolved feelings toward her father.

In session three, with the help of the therapist's empathic attunement she describes not having gotten approval from her father: "I believe I'm a bad person, but deep down inside I don't think I'm a bad person . . . yeah, I'm grieving for what I probably didn't have and know I never will have." The therapist initiates an empty-chair dialogue with her father in this session. In her emotional expression to her imaginary father in the empty chair, she begins to voice the meaning of the painful emotions related to her father. "You destroyed my feelings. You destroyed my life. Not you completely, but you did nothing to nurture me and help me in life. You did nothing at all. You fed me and you clothed me to a certain point. That's about it." The therapist, drawing on her previous narrative replies; "Tell him what it was like to be called a devil and have to go to church every…." She then continued; "It was horrible. You made me feel that I was always bad, I guess when I was a child. I don't believe that now, but when I was a child I felt that I was going to die and I was going to go to hell because I was a bad person."

By the end of session three, the thematic intrapersonal and interpersonal issues on which the therapy will focus have emerged clearly. They are embedded in what the client reports as her most painful experience. First, the client has internalized self-criticism related to issues of failure that emerge in the context of her family relationships. This voice of failure and worthlessness initially was identified as coming from her sisters but clearly has roots in earlier relationships with her parents. This becomes more evident later in therapy. Related to her self-criticism and need for approval is a need for love. Love has been hard to come by in her life. She has learned how to interrupt or avoid acknowledging this need as it has made her feel too vulnerable and alone. She has learned how to be self-reliant, but this independence has had a price as it leaves her feeling hopeless, unsupported, and isolated. This need for love is related to her unfinished business stemming from her early relationship with her father (and her alcoholic mother but her father is more central in her experience). She harbors a great deal of resentment toward her father over his maltreatment of her as a child, and she has a tendency to minimize it as "being slapped was just normal." She has internalized this as a feeling of worthlessness and as being unlovable. These underlying concerns lend themselves very clearly to the emotional processing tasks of both the two-chair dialogue for internal conflict splits and to the empty-chair dialogue for unresolved injuries with a significant other.

In a key dialogue in session 3 she speaks to her father, imagined in front of her in an empty chair and after blaming him for his mistreatment she moves to an expression of primary sadness and anger:

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

Encouraged by the therapist she later tells the image of her father about her fear:

> *C:* I was lonely. I didn't know my father. My father, all I knew you as, was somebody that yelled at me all the time and hit me. That's all—I don't remember you telling me you loved me or that you cared for me or that you thought that I did well in school or anything. All I know you as somebody that I feared.
>
> *T:* Tell him how you were afraid of being hit.
>
> *C:* Yes, and you humiliated me. I was very angry with you because you were always hitting me; you were so mean and I heard Hitler was mean, so I called you Hitler.

Later on in the session, she expresses pain and hurt at her father's inability to make her feel loved: "I guess I keep thinking that yeah, you will never be a parent, that you would pick up the phone and just ask me how I'm doing. It hurts me that you don't love me—yeah—I guess, you know." She ends the session with a recognition that what she had needed was acceptable. "I needed to be hugged once in a while as a child or told that I was OK. I think that's normal."

By accessing both pride and anger and grieving her loss, her core shame is undone (6). She thereby begins to shift her belief that her father's failure to love her was because she was not worth loving. She says to him in the empty chair. "I'm angry at you because you think you were a good father, you have

said that you never hit us and that's the biggest lie on earth, you beat the hell out of us constantly, you never showed any love, you never showed any affection, you never ever acknowledged we were ever there except for us to clean and do things around the house."

In a dialogue with the critic in session 4 her critical voice begins to soften and both her grief over having not been loved and a sense of worth emerge. "Even though Mom and Dad didn't love me or didn't show me any love, it wasn't because I was unlovable; it was just because they were incapable of those emotions. They don't know how to—they still don't know how to love." The client does not experience the hopelessness that had been so predominant in her earlier sessions again.

Later in session 7, the client and the therapist work to identify the way in which the client blocks her feeling of wanting to be loved to protect against the pain of having her needs not met. In session 9 enacting her "interrupter" she says to herself "You're wasting your time feeling bad cause you want them; they are not there. So it's best for you to shut your feelings off and not need them. That's what I do in my life. When people hurt me enough I get to that point where I actually can imagine, I literally cut them out of my life like I did with my mother."

In sessions 7 through 9, the client continues to explore the two different sides to her experience: the critic that attempts to protect her through controlling and shutting off needs and the experiencing self that wants to be loved and accepted. She continues to define and speak from both voices and expresses a range of sadness, anger, and pain/hurt. The hopelessness that was so dominant in the early sessions now is virtually nonexistent. The voice that wants love and acceptance becomes stronger, and the critic softens to express acceptance of this part of her. At the same time she is feeling much better and activation of her negative feelings decrease.

Having processed her anger and her sadness and transformed her shame, she takes a more compassionate and understanding position to her father: *a key empirically demonstrated process of change*. In an empty-chair dialogue with her father in session 10 she says "I understand that you've gone through a lot of pain in your life and probably because of this pain, because of the things you've seen, you've withdrawn. You're afraid to maybe give love the way it should be given and to get too close to anybody because it means you might lose them. You know and I can understand that now, whereas growing up I couldn't understand." She is also able to hold him accountable for the ways that he disappointed and hurt her while also allowing her compassion to be central in the development of a new understanding of his inner struggles.

In talking about the dialogue at the end of the session, the client says "I feel relief that I don't have this anger sitting on my chest anymore." By the end of this 14-session therapy her shame-based core maladaptive belief that "I am not worth loving" has shifted to include the emotional meaning that her father experienced his own pain in his life and that this pain led him to be less available to behave in loving ways toward her or her sisters. Needing to be loved no longer triggers hopelessness, and she is now more able to communicate her needs, to protect herself from feeling inadequate, and to be closer to her sisters.

Conclusion

The effectiveness of short-term EFT for individuals has been demonstrated in several research projects. EFT is an effective treatment for both depression and emotional trauma. EFT activates emotion during treatment to make deep change in automatically functioning emotion schemes that are frequently the sources of problems. EFT combines both following and guiding clients' experiential process, while emphasizing the importance of both relationship and intervention skills.

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