Emotion Focused Therapy - Case conceptualization and treatment: Adults.

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Abstract

This chapter provides a comprehensive overview of emotion focused therapy (EFT). First, the theoretical foundations are presented highlighting the central tenets of the approach, including the therapeutic relationship, clients' experiencing, emotional processing and self-organization. Subsequently, EFT's trans-diagnostic model of case-conceptualization is presented and its application to a number of different client populations including depression, anxiety, trauma, eating disorders, personality disorders couples and families is described.

Keywords: Emotion focused Psychotherapy, humanistic, therapeutic relationship, emotion, depression, complex trauma, anxiety, eating disorders, personality disorders, couples, family therapy, alliance

Introduction

This chapter provides a comprehensive overview of emotion focused therapy (EFT). First the theoretical foundations will be presented highlighting the central tenets of the approach, including the therapeutic relationship, experiencing, emotional processing and the formation of self. This will be followed by an elaboration of the trans-diagnostic model of case-conceptualization as well as its application to a number of different client populations including depression, anxiety, trauma, eating disorders, personality disorders and couples. In conclusion, issues related to diversity and multiculturalism will be discussed briefly.

Theoretical overview

Humanistic and experiential roots

Emotion focused therapy (EFT) is an empirically based treatment approach that has been built on a foundation of process-outcome research conducted from the 1950's to the present. Falling under the umbrella of humanistic and experiential approaches to psychotherapy, EFT resulted from a merger of client-centered, experiential and gestalt psychotherapy theory and practice. Thus, it is rooted in a number of key humanistic principles including emphasizing a phenomenological perspective; the importance of clients' experiencing process as articulated by Carl Rogers (1959) and Eugene Gendlin (1982); a belief in clients' actualizing tendency as a biological imperative enabling the potential for growth; a view of clients as self-reflective agents capable of choice and self-determination; a valuing and respect for the uniqueness of each individual; as well as the importance of interpersonal relationships based on genuineness and authenticity.

One of the first progenitors of the approach, Laura Rice, worked with Carl Rogers and his research team at the Counselling Centre at the University of Chicago. These researchers put clients' and therapists' moment to moment processing under the microscope to understand what made psychotherapy effective. Their close attention to moment by moment interactions between client and therapist would lay the foundation for EFT. Over time this research tradition delineated two core factors that were related effective therapy; the importance of empathically-attuned therapeutic relationships, and the clients' experiencing process (Greenberg, Lietaer & Watson, 1998).

The initial focus of the research was on the therapist's role in the change process, which lead to the articulation of the importance of the therapeutic relationship conditions by Carl Rogers. Rogers, influenced by Jesse Taft, had developed client-centered psychotherapy drawing on the biological principles of organismic growth and development. He determined that human organisms, like other biological organisms, had a natural tendency to grow and thrive under optimal conditions for their development. This capacity to grow and develop was formulated as the actualizing tendency, a fundamental principle in all humanistic approaches including EFT. Rogers (1959) argued that the right conditions to facilitate growth in human organisms was through interpersonal relationships characterized by acceptance, empathy, positive regard and genuineness. In order for the therapeutic relationship conditions to be effective, Rogers (1957) said a number of conditions needed to be met, including the therapist embodying the therapeutic attitudes of empathy, unconditional positive regard and congruence; communicating these to the client; and finally, that the client must be able to receive them.

Over time the researchers began to shift focus from the therapists' role in the interaction to clients' processing, which highlighted the importance of the experiencing process. This

second focus was pioneered by Eugene Gendlin, a philosopher, who began to articulate how people come into contact with their internal bodily felt sense and symbolize it in awareness to access their growth edge. He, like Rogers, saw the therapeutic encounter as an interaction that precipitated change as it unfolded in the moment. As they studied clients' process in therapy, they observed that those for whom it was productive and who successfully resolved issues, attended to an internally felt referent to come to new ways of understanding and being in the world. Gendlin (1982) named this attention to and symbolization of the internally felt referent, experiencing. It was the process of symbolizing inner emerging experience that he saw as the process that indicated that clients were engaged in therapy and as contributing to change. Gendlin was aware that this process was best facilitated in the presence of a responsive, patient and attentive other, who listened carefully to what was shared. He trusted that if clients were directed and supported to continue attending to their bodily felt sense the organismic experiencing process and their actualizing tendency would unfold.

Gendlin (1982) was focused on the whole process of experiencing including the felt flow and shifts along with the live edge of what was felt and emerging into conscious awareness moment by moment. He viewed this process as primary and suggested that change follows when inner experience is attended to, symbolized and carried forward such that experiencing becomes reconstituted freshly or in a new way. This is a constantly evolving and iterative process as people refer to their experiencing process in interaction with others and their environment (Gendlin, 1982). The inner felt referent is complex and provides a highly nuanced feel for the whole of a situation as opposed to a singular emotion or even mix of emotions. To facilitate therapist and clients' access to this process of experiencing, Gendlin (1982) described the process in a series of steps called 'focusing' (1972). This process of symbolizing experience is

what Rogers and Gendlin identified as the live edge that releases the growth potential within the organism. Rogers worked with this process using empathic response modes like reflections, whereas, Gendlin worked with it more directly by more explicitly teaching people how to attend to their inner experience by focusing (1972).

Subsequently, Laura Rice, influenced by Rogers and Gendlin while working with them at the Counselling Centre at the University of Chicago, focused on small shifts in client process and ways that these could be facilitated in client-centred psychotherapy. Rice's work was focused on identifying the mechanisms of change and active ingredients of client-centered therapy. Straddling the work of Rogers and Gendlin, she distinguished the relationship conditions, identified as primary by Rogers, from the task conditions, which focused on specifying therapist and client behaviours during mini change events in the session that contributed to productive engagement and good outcomes (Rice, 1965; 1974; 1984; 1986). Like Rogers, Rice emphasized the role of the actualizing tendency in promoting change, the basis of which was stimulus hunger, which she saw as a primary drive. She proposed that the goal of therapy was to reduce anxiety to enable the organism to explore his/her environment leading to new ways of being and construing the world (Rice, 1984).

In her research, Rice focused on identifying and understanding the resources that clients bring to therapy that contribute to good and poor outcome and how these could be facilitated by therapists using a method of naturalistic observation (Rice, 1992). She developed the client Vocal Quality Scale and the Expressive Stance Measure, to identify various vocal and lexical aspects of clients' speech that differentiated the quality of clients' participation in therapy. These classifications serve as useful guides to clinicians as they respond moment to moment in therapy. Attentive to therapist process that facilitated clients' productive process, she elaborated

the evocative function of the therapist and developed a more differentiated understanding of different empathic response modes. She identified the use of metaphor and vivid evocative language, by both client and therapist, in the change process to facilitate access to clients' experiencing.

Subsequently, she and Leslie Greenberg, who was her doctoral student (Rice & Greenberg, 1984), used Task Analysis to describe and explicated the steps that therapists and clients engage in to resolve specific cognitive-affective problems in client-centered therapy and Gestalt therapy. For example, Rice explicated the steps clients and therapists engaged in to understand intense, problematic reactions in client-centered therapy called *Systematic Evocative Unfolding*, as well as the steps involved in resolving clients' states of intense vulnerability in a session using *empathic affirmation* (Greenberg, Rice & Elliott, 1993). In contrast, Greenberg's work focused on explicating models of specific techniques in Gestalt therapy. Greenberg, working with Rice, used task analysis to model episodes of change and specific techniques in Gestalt therapy, including two-chair dialogues and empty-chair dialogues (L. S. Greenberg, 1977; L. S. Greenberg et al., 1993). The primary objective of this work was to create micro theories of change that would enable therapists to intervene differentially at specific moments in therapy based on client statements or markers to optimize the match between client and therapist resources.

The integration of these programs of research, including the client-centered relationship conditions, evocative-empathy, focusing, and the two Gestalt interventions, along with marker-guided task maps, and emotion theory has grown into emotion focused therapy, initially called process-experiential therapy (EFT-PE – Elliott, Davis & Slatick, 1998; Greenberg, et al., 1993; Rice & Greenberg, 1984; Elliott, Watson, Goldman & Greenberg, 2004) but has come to be

known more commonly as EFT. EFT advocates that therapists attend to clients' moment to moment process and intervene differentially at specific client markers, which are statements that indicate that clients are in a specific problem space, for example, being self-critical, or seeing their reactions as problematic and overly intense, or having difficulty identifying and labeling feelings etc. Today EFT-PE is an empirically supported treatment that is taught around the world (Elliott, et al., 2004;; Greenberg & Watson, 1998; Paivio & Pascual-Leone, 2010; Timulak & McElvaney, 2014; Shahar, Bar-Kalifa & Alon, 2017; Watson, Gordon, Stermac, Steckley, & Kalogerakos, 2003).

Emotion Focused Therapy and the broader Humanistic-Experiential tradition that it is built on have a strong evidence base demonstrating their efficacy, their central putative mechanisms of change, as well as for the utility of central techniques. The efficacy of HEPs broadly has been demonstrated in two large, non-overlapping, meta-analyses (Elliott et al., 2021: d=.73, k[samples]=97, n[clients]=7376; and Elliott et al., 2013: d=96, k=199, n=14206). Within this tradition EFT has shown a trend towards having the largest effect sizes (2021: d=1.31, k=18, n=464, and 2013: d=1.16, k=34,n=1124). In comparative studies, EFT has shown a consistent trend of larger effects than non-HEP therapies (2021: d=.64, k=3, n=202; and 2013: d=.57, k=11, n=183).

Of particular interest is the relative performance of EFT compared to CBT specifically, given the common assumption of CBT's superiority. In a direct comparison for the treatment of depression, both EFT and CBT showed equivalent primary outcomes, but EFT showed greater effects on a secondary outcome of interpersonal problems (Watson et al., 2003). Preliminary analysis of a replication of this study has again shown equivalent effects between EFT and CBT

on primary outcomes at the end of treatment, however EFT had a lower relapse rate after therapy demonstrating greater maintenance of the gains (Vieira, et al. , 2017).

There is also evidence for the role of key putative mechanisms of change posited by HEPs. Meta-analyses have shown that both client Experiencing (r=.19 [equivalent to d=.39], Pascual-Leone & Yeryomenko, 2017) and the Therapeutic Alliance (r=.28 [d=.58], Hovarth et al., 2011) are related to outcome. The central technique of Empathy is also related to outcome (r=.28, [d=.58], Elliott et al., 2018). Together this research shows a consistent picture that EFT and HEPs more broadly are effective, that EFT is at least as effective as other therapies, and that the central mechanisms are related to its efficacy.

Emotion Focused Therapy: Case conceptualization and Treatment

Dialectical constructivism

In EFT change is seen to occur as a result of a dialectical synthesis occurring from the co-construction of new meaning in a dialogue between client and therapist in which the therapist plays an active role in confirming clients' emotional experiences while assisting them to synthesize a new experience of self, based on their strengths and possibilities (Greenberg & J.Pascual-Leone, 1997). The client is seen an active agent constantly organizing or configuring experience and reality into meaningful wholes, with one of the active ingredients of change being the clients' emerging internal experience and the interpersonal support provided by the therapist. Therapists support client's emerging experience and provide an alternative interpersonal encounter that facilitates a reorganization and a reconfiguration of experience within the client. Experiential therapists, subscribing to an inherent growth tendency, evident in all biological processes, view the person's awareness of their organismic experience as providing an important guide towards growth and reorganization.

In EFT, a person's sense of self is seen as constantly evolving moment to moment as aspects of experience coalesce to organize and prioritize experience. Thus, the sense of self is a complex synthesis of many different levels of experience, including physiological, neurological, social and cultural. It is a process of configured experience that is in awareness at any given time. While some configurations may dominate and be activated frequently, other weaker or newer ones can be generated in relationship with others or the environment to transform experience. According to this view the self is constructed as different aspects of experience including the bodily felt sense, higher order conceptual processes, including the symbolization and representation of experience, memories, and dominant narratives are synthesised freshly in different contexts (Greenberg & J.Pascual Leone, 1997)

The essence of dialectics is the splitting of wholes into their constituent parts to reveal their polarities and interrelatedness, thereby making possible the creation of a new structure or framework for experience. A dialectical synthesis requires the separation of opposing sides or views to reveal a new way of seeing or constructing them, just as the act of coming to know or name something transforms both the knower and the known. Dialectical constructivism in EFT is thought to facilitate change on multiple levels, including the synthesis of higher order conceptual processing and emotion, the symbolization and representation of bodily felt experiencing, the synthesis of polarized and hostile parts of the self and the creation of more positive, nurturing and protective behaviours, the reorganization of boundaries between self and other, and the reorganization and integration of new understandings and experiences into dominant narratives (Greenberg, 2019; Greenberg & J. Pascual-Leone, 1995; Watson, 2011)

Emotion Theory

Greenberg expanded the theoretical underpinnings of EFT by grounding it in contemporary emotion theory (Greenberg, 2019; Greenberg and Safran, 1987; Greenberg and Paivio, 1997). According to this view emotion is central to human functioning allowing the organism to orient to its environment and adapt. Emotions enable organisms to process and integrate complex sources of information to guide and prioritize their moment by moment responding. Thus, emotions direct and synthesize experience. They provide an essential compass for survival and mediate human interactions with the environment. Emotions register the impact of the environment on us, tell us what we need, and enable us to communicate with others (Fijda, 1986)

Emotion schemes

Emotions are seen as organizing experience with the formation of emotion schemes representing the integration of a bodily felt sense, its symbolization in awareness, the situation, and the action tendency or need. Leijssen (199) suggested that emotion schemes comprise four elements: perceptual-situational elements, bodily-expressive elements, symbolic-conceptual elements, and motivational-behavioral elements. Each element can be conceived as different constituent parts of experience that are linked together in a network. The term scheme is preferred to schema which has structural connotations whereas the term scheme implies a plan of action and captures the constantly evolving and constructive nature of experience and the sense of self. An emotion scheme is conceived as being in process and constant reconfiguration. Thus, emotion schemes are malleable and open to transformation as new information, bodily felt experience, situations and interactions occur. Typically, emotion schemes are not available to conscious awareness but can be elicited in therapy as people become aware of their bodily felt sense and emotions, symbolize and label them, and recollect situations and memories that are linked with the felt sense along with their behaviours and ways of acting. Leijssen (1998) suggested that optimal

emotional processing often involves the activation all the elements of an emotion scheme. While people have numerous emotion schemes, some may be more dominant than others along with a prevailing sense of self based on the person's lived experience. As a result, emotion schemes are highly idiosyncratic, varying from person to person.

EFT sees difficulties arising from problematic and or maladaptive emotion schemes. The latter are made up of specific autobiographical memories, perceptions, feelings, needs, and actions that are used to interpret different situations. When experience is not processed it can be the source of intense reactions that may be incommensurate with current situations. The primary objective for experiential therapists is to assist clients to access their organismic experience and become aware of how they are blocking or distorting it from awareness so that they can become aware of all aspects of their experience and discover ways of expressing and balancing their needs and feelings with a system of values that they own fully (Elliott et al, 2004; Greenberg & Watson, 2006). Once they are aware of their emotional responses, clients can discriminate which responses are healthy and useful to guide them, and which are maladaptive and need to be changed (Elliott et al, 2004; Greenberg et al, 1993; Greenberg & Paivio, 1997).

In EFT a distinction is made between four different *emotion response types*: primary adaptive emotion, maladaptive emotion, secondary reactive emotion and instrumental emotion. Each of these emotion categories, requires differential intervention. *Primary adaptive emotion* provides information about the impact of environment as perceived through various sensory and perceptual channels and organizes a person to respond in an adaptive fashion to enhance their well-being and survival. For example, feeling sad at loss and seeking comfort or feeling afraid when threatened and seeking to protect oneself, family or community. Some social emotions inform us about our social standing and guide our actions with others. For example, shame

signals that we have breached a social code or acted improperly such that others would condemn and reject us. Feeling shame might prompt us to apologize and atone for our actions or hide from others to demonstrate awareness that one has transgressed social norms and expectations. In contrast to the adaptive nature of primary emotion, the other types of emotional response are less adaptive and more likely to lead to impaired functioning over time. During therapy, primary adaptive emotions need to be accessed as they provide adaptive information to guide functioning (Elliott et al., 2004).

Maladaptive emotional responses originate in dysfunctional, harmful environments that were experienced as negative or injurious and while adaptive in that context they are not as adaptive in other contexts. They reflect an undifferentiated response to current situations that imputes a meaning to the actions of others based on prior negative experiences. For example, a person whose caregiver was emotionally or physically abusive may express anger or freeze in the face of a friendly gesture from a stranger or therapist; or when they feel they are becoming connected or closer to another person. The behaviour of others can become associated with pain and emotions of fear, shame, and sadness as opposed to feelings of warmth, safety and security. Painful experiences in relationship with others can generate alternative neurochemical states, for example, people with borderline processes have been found in some studies to show an elevation of oxytocin linked to levels of distress as opposed to states of comfort and calm with a caring other (Bartz, 2011). In therapy, primary maladaptive emotions need to be accessed in order to be transformed (Greenberg, 2019)

Secondary Reactive Emotions are learned responses to primary emotion in the context where the primary emotion may not be seen as acceptable, valid or legitimate. These emotions are expressed or are activated to hide other more primary adaptive emotions, for example, feeling

angry when sad or feeling shame when you are happy. These secondary emotions prevent the organism from responding optimally in various situations to meet their needs in life enhancing ways. Rather their responses are maladaptive because the primary emotion is disallowed and an alternative emotion expressed so that the resulting action tendency and behaviour does not meet their needs in a satisfying manner. For example, their feelings may be silenced entirely or their actions tendencies may be stifled such that others are confused and unable to respond in ways that would be more satisfying. In therapy, if therapists sense clients are not fully congruent or that the client's emotional response may be more complex than what is being expressed, they may continue to explore client's feelings to access other underlying primary emotions (Elliott et al. 2004).

Instrumental emotions are also acquired through negative experience and interactions with others. They are developed as a way to control and manipulate the experience of others by simulating various emotions and their behavioural manifestations and action tendencies. For example, crying and enacting sadness to extract a reward or make another person feel bad to increase the chances of influencing them. Or acting angry and aggressive to bully people into submission and dominate them. These responses may be deliberate and in awareness but they can also function outside of awareness. Notwithstanding, they do not reflect a person's primary adaptive emotion in a particular context, they are merely enacted expressions of emotion to effect specific outcomes. In therapy, instrumental emotions can be experienced as the client being incongruent and trying to influence the therapist or others in their environment. At these times, therapists reflect what the client is doing and explore their intentions and goals.

Processing organismic experience, and specifically emotions, is important to survival. To do this effectively one must be aware of one's organismic experience and be able to represent it

symbolically in order to know and understand it. Avoiding or distorting organismic experience can be detrimental to one's well-being and survival. Along with processing emotional experience, human beings learn to modulate both their levels of arousal as well as their expression of those feelings to others (Kennedy-Moore & Watson, 1999)

Self-organizations and Identity Formation

During development a portion of experience becomes available to conscious awareness, including emotions and feelings, our interactions with others, how we are treated and perceived, and the judgments we make about ourselves in interaction with our environments. These experiences coalesce to form a sense of self. Stern (1985) posits that in the process of development we acquire a sense of coherence; a capacity to experience, process and regulate emotions; a sense of agency and mastery; as well as a sense of continuity between past, present and future. There is a need to develop a sense of mastery and confidence that one is equipped to face life challenges. Without a sense of confidence in the capacity to survive and thrive, one may feel overwhelmed, discouraged, vulnerable and at risk. A sense of confidence is built in environments that are responsive, providing protection and validation, as well as support for autonomy and differentiation.

Emotion schemes provide the building blocks of self-organizations. At different moments various emotion schemes are synthesized into self-organizations in specific situations resulting in the experience of oneself as vulnerable, confident, shy, efficient, capable, loved, or rejected for example. These various self-organizations can agglomerate to form an enduring sense of self that emerges across different situations and provides a consistency to how people feel and act. They provide a sense of identity comprising beliefs, attitudes and feelings towards the self. These

aspects of self are formed in interaction with our environments and significant others and inform how we relate to ourselves and our experience. During development the responses of others are internalized and used to guide our reactions and behaviours. These self-organizations can be positive providing nurture, support, and guidance along with compassion, acceptance and validation. Alternatively, they may be more negative and manifest as controlling, oppressive, critical, and blaming and/or neglectful, dismissive and annihilating. These internalized attitudes and behaviours, when positive, allow us to process and regulate our emotions and feelings effectively allowing us to flourish. However, when negative, our emotional processing and regulation capacity is reduced leading to more dysfunctional ways of coping (Watson & Greenberg, 2017). **Developing and elaborated understanding of experience through narratives**

A sense of coherence is fostered by the narratives or stories we tell ourselves. Stories form the basis of our self-understanding (Angus & Greenberg, 2011; Watson, Goldman & Greenberg, 2007). By naming and describing experience people come to know and see their environments and their own and others' actions. They are able to see connections between events and to question their own and others' roles to construct alternative ways of seeing and being in the world. Understanding their experience enables them to combine what they perceive in their outer environments with their affective experience to respond effectively to meet their needs. Stories are informed by our memories and life histories. When understanding is disrupted because of challenging or painful life experiences and memories are not consolidated and events not fully processed effectively, stress, anxiety, and confusion can result (Sapolsky, 2004; Schore, 2019). In EFT working with clients' emotions schemes includes helping clients to adequately process their experience and memories in order to facilitate increased understanding and the emergence

of new behaviour and ways of being, including improved emotional processing and regulation.

Differentiation of self and other

The development of a sense of self requires the differentiation of one's own experience from that of others. As organisms mature, they learn to self-regulate and become more self-governing. They balance their need for autonomy with their need for connection to survive and thrive in community with others. An important part of identity formation is the capacity to know what is self and not self and to develop a sense of mastery and confidence in one's ability to navigate one's way through life. These capacities require that people know when to be self-protective and self-reliant or to seek support and rely on others to provide care. These attitudes towards self and other are supported and fostered in EFT. As clients change their negative self-organizations, they begin to relate differently to others. They are encouraged to be more self-compassionate, self-accepting and self-protective and to develop a better balance between the needs of self and the needs of others. In the process of differentiation, they become more responsible for self and more effectively self-governing such that they attend to their needs and try to meet them and better able to attend to the needs of others.

Transdiagnostic case formulation

EFT case conceptualization is transdiagnostic. Case conceptualization is less about symptoms and clients' specific disorders as it is about their moment to moment emotional processing in the session, the quality of their self-organizations, their understanding of their life-histories and the extent to which they are goal directed active agents, with adequate levels of differentiation between self and others. Case conceptualization operates on a number of different levels relying on process diagnoses and theme development. It is an ongoing process that is sensitive both to the in-session contexts in terms of what clients present and to developing an understanding of the

person and their life history. EFT therapists use clients' pain, as revealed in their life stories and in their in-session behaviours, to guide their formulations moment to moment and over the course of treatment. It is clients' pain that directs therapists' attention and highlights core problematic emotion schemes. Therapists listen for markers of clients underlying processing difficulties, including emotional processing, identity formation, understanding of experience and differentiation as they emerge in the moment seeing these as opportunities to offer differential ways of working to facilitate resolution of these problem states and transform emotion schemes. The transformation of emotion schemes opens up new ways of perceiving, experiencing and behaving allowing clients to transform their pain and develop more satisfying ways of being that allow them to thrive.

As they listen to clients' emotion infused narratives, EFT therapists attend to specific client markers, try to identify clients' problematic emotion schemes, listen for unmet core needs, attend to clients' expression of secondary emotions and interruptions to emotional processing, as well as broader themes that reveal clients' more characteristic ways of being in the world. These characteristic ways include the interactions and triggers of pain, their ways of responding and their ways of interacting with others to provide a focus for the treatment (Goldman & Greenberg, 2014). In addition, as they work with their clients, EFT therapists attend to clients' emotional processing trajectory over time attending to their movement from distress, through differentiation and exploration of secondary emotions, through maladaptive emotional states to primary core emotion and life-enhancing needs including self-compassion, self-acceptance and self-protection (Timulak & Pascual-Leone, 2014). The primary focus is to facilitate optimal emotional processing and reorganize self.

Principles of emotional change

Emotional processing is a capacity that is nurtured over the course of development and is essential to survival (Damasio, 1994; 1999; Greenberg 2002; LeDoux, 1996). Blocks to emotional processing are seen to inhibit people's capacity to lead full and satisfying lives. Change comes from processing emotion in new ways and reorganizing the self, resulting in more positive relationships with self and other as well as more elaborated and refreshed narratives. Over the course of treatment clients develop more awareness of their emotional experiencing, learning to tolerate and accept it instead of avoiding and dismissing it. They learn to label and symbolize it to understand it better and express it to others. So, they can acquire the capacity to regulate their levels of organismic arousal and soothe themselves when experiencing overwhelming and distressing emotion. They also acquire the capacity to express their emotions to others in order to better meet their needs and learn to reflect on their emotions to and inform their understanding of themselves and their social contexts and integrate them with their life goals (Greenberg, 2002; Kennedy-Moore & Watson, 1999; Watson & Greenberg, 2017). This work occurs in the context of understanding the impact of clients' attachment histories and life events on their emotional processing and other developmental capacities, with the primary focus being on clients' moment to moment process in the session and working towards a more comprehensive understanding of their client as the work unfolds.

To develop an understanding of clients' emotion schemes and ways of being in the world, EFT therapists listen to clients' life stories paying particular attention to disruptive and injurious attachment histories characterized by trauma, pain, neglect, and loss (Paivio & Pascual-Leone, 2010; Pos & Greenberg, 2012; Watson & Greenberg, 2017; Watson, Goldman & Greenberg, 2006). Clients' attachment histories and the presence of neglect or support and nurture in their

lives has implications for their emotional processing capacity, such that it may be underdeveloped as clients silence painful emotion or learn not to attend or are unable to symbolize it and regulate it effectively. Injurious and difficult attachment histories contribute to the development of negative self-organizations and problematic ways of relating to self and other, and may be accompanied by an impaired understanding of themselves in the world such that some experiences may not have been named or acknowledged and the links between emotions, situations and behaviour unformed, leaving clients feeling vulnerable, lacking confidence and a sense of mastery to engage with others in satisfying ways. Clients with impaired attachment histories are likely to require longer term therapies as they work to develop the capacity to process and regulate their emotions, develop a more elaborated and coherent account of their life stories and understand the links between feelings, behaviour and different situations and contexts, transform their negative self-organizations to become more self-compassionate, self-accepting, and self-protective, and feel more agentic and confident about balancing the needs of self and other.

Stories of painful attachment experiences reveal potential task markers, including unfinished business indicating a need to express the pain and needs that were not met in relationship with significant others who have injured them, which can be facilitated in an empty chair dialogue (Elliott, et al., 2004) Other markers include negative ways of relating to self and their experience that indicate that two-chair dialogues could be used to facilitate contact and transformation of the relationship between parts of the self. When these markers are expressed in the session, EFT therapists may provide a mini-formulation of the issue and suggest the task as a way of transforming negative ways of treating the self or chronic painful feelings about a significant other. In addition, clients may need to work together with their therapists to better

conceptualize their experience and process the links between their experience and their emotions, feelings and behaviours. However, even as EFT therapists become aware of possible markers as they listen to clients' narratives, this information is held tentatively, as they work moment to moment with their clients attending to what is present in the moment as well as from session to session. EFT therapists follow their clients, working at their pace, trusting that they will lead or point in the direction of their pain when they are able to stand it and process it. In this way, EFT therapists affirm and cultivate clients' agency and minimise the power imbalance in the therapeutic relationship.

Treatment

Treatment in EFT focuses on the role of the therapeutic relationship conditions along with collaboration on specific tasks. The client-centered therapeutic attitudes of empathy, unconditional positive regard, acceptance and genuineness are the bedrock of the treatment, with therapists offering different techniques to facilitate clients' access to emotions, and resolve problematic aspects of experience in terms of their self-organizations, shift how they interact with others and refine their understanding of themselves and events.

The Therapeutic Relationship

Following Rogers, EFT therapists are fully present with their clients (Geller & Greenberg, 2012). They are attentive, curious, accepting and fully immersed in their interactions, moment-to-moment, with their clients. They are attentive and without judgment as they try to enter their clients' worlds as they try to see and feel into their experience. They are open and receptive as they try to establish safety so their clients can allow their vulnerability into awareness to process their painful life experiences and transform their negative emotions. This sense of interpersonal safety allows for exploration and diminishes feelings of threat and anxiety.

Porges (2019) polyvagal theory posits that when human organisms feel received and connected to another their brains neuroceive a state of safety that allows them to relax and engage in therapeutic work. Neuroception, a seventh sense posited by Porges, enables organisms to internally sense situations of danger and threat or safety and security. A therapists receptive, open concern as expressed by their vocal and non-verbal behaviour contributes to clients' sense of safety and provides the necessary scaffolding to engage in treatment.

Empathy is an essential aspect of EFT treatment both in terms of the therapists' attitude towards the client but in terms of specific response modes. EFT therapists are empathically attuned to clients' affective states. Tracking and following clients' emotions closely in a session while conveying a deep understanding of the meaning of clients' experience using empathic reflections. Therapists' empathy draws on their cognitive understanding of what it is like to "walk in their clients' shoes" as well as their capacity to resonate to the emotional impact of the events in their clients' lives. The capacity to resonate deeply and to share their understanding of their clients' lived experience contributes to a number of important processes of change. First, it builds the therapeutic relationship by forging a strong working alliance as the therapist communicates an understanding of the clients' struggles and goals and in addition facilitates; second, it contributes to clients' affect regulation in the moment and over time as being seen and understood modulates the intensity of an experience and facilitates the processing of that experience providing direction for future action; third, empathic reflections help clients to deconstruct their world views, identify their assumptions and beliefs about themselves and others and understand how these may be restricting them and inhibiting change. Empathic reflections provide an opportunity for clients to reflect on their experience in order to perceive new ways of viewing it as well as acting in the world; fourth, the experience of being understood by another

without judgment but with concern leads to the internalization of empathy and self-compassion for the self so that all of experience is available to awareness and can be integrated in ways that transform clients' self-organizations and ways of relating to themselves and others.

Unconditional positive regard along with a deep-seated understanding of the clients' moment to moment experience is seen as transformative in EFT. As therapists communicate a positive and sincere valuing of the other just as he or she is without any requirements to be different organismic change is likely to ensue (Gendlin, 1982; Rogers, 1959). Unconditional Positive Regard, is core to client-centered theory (Bozarth, 2001; Freire, 2001), and is a basic underlying condition in EFT as clients become more aware of their feelings, their responses to the world and their self-organizations in the presence of an empathic and accepting other who values the person. Like their client-centered counterparts, EFT therapists are open, receptive, curious, warm and valuing of their clients. They trust that UPR along with clients feeling understood, thus known and seen by the other, will release the clients' potential for growth and reconfiguration.

Trust in the organismic growth tendency is fundamental to the approach with therapists offering the relationship conditions along with different tasks and ways of working to facilitate clients' access to their inner bodily felt sense so that they can symbolize it in awareness. The relational experience of being fully known and accepted by another is viewed as healing allowing clients the space and opportunity to adopt new ways of being and relating to self and other. Clients are seen as complex with hidden dissociated aspects of experience outside of awareness that need to be reclaimed and integrated into the whole. UPR is expressed with empathic response modes that convey validation, understanding, and affirmation. Other response modes demonstrating a more exploratory intent are important to support the clients'

attention to their inner experience so they can symbolize it and know it better bringing it into the light of awareness so as to become more congruent and integrated and facilitate the ongoing flow of experience and being.

Rogers (1957) emphasised that the relationship conditions need to be offered congruently and experienced as sincere for the other conditions to facilitate organismic growth and transformation. It is easy to understand this emphasis as feigned regard or understanding would not likely be experienced as empathic or accepting but rather may be seen as manipulative and shallow. Thus, Rogers underscored the importance of therapists being congruent with their inner experience matching what they are communicating to clients. When offered congruently and genuinely, empathy and UPR can be received and experienced as validating and provide a credible anti-dote to conditions of worth and ways of being that have been hidden or dismissed and silenced in order to guarantee protection, love, acceptance and approval.

EFT therapists make a distinction between genuineness and transparency. Genuineness describes a state of congruence between the therapists' inner feelings about the client and their outer expression. It has been noted that being genuine does not mean that therapists reveal all their feelings to their clients, but rather that they are aware of their feelings and do not pretend or deny them to themselves (Mearns & Cooper, 2005). Lietaer (1993; 2001) distinguishes between inner and outer genuineness. The former refers to the degree to which therapists have conscious access to, and are receptive to the full flow of their own experiencing in the session. This he defines as congruence, in contrast, to outer genuineness or transparency, which refers to more explicit communications by therapists that are revealing about their perceptions, attitudes, and feelings. EFT therapist practice both types of genuineness as they demonstrate their unconditional positive regard for their clients and support the unfolding of their inner process

and share their perceptions about their clients' process, express concern at times when clients are being intensely self-critical and provide psycho-education and suggest different tasks in the session. Transparency is also encouraged to repair ruptures that occur in the session.

The introduction of process direction and tasks in EFT highlights the need for therapists' to be responsive as they attune to their clients, moment to moment in the session. Responsiveness has been characterized as an attitude or a willingness to be flexible and fluid (Watson, in press). EFT therapists are constantly assessing and adjusting to their clients' states of readiness as they suggest tasks and listen empathically to their clients' concerns. They attend to their clients' emotional experience during the session carefully tracking its ebb and flow as they follow and at times direct the process. They continually attend to clients' feedback in order to adjust and modulate their responses to fit their clients' needs moment to moment and find the most fitting response.

In describing therapist responsiveness in EFT, Watson (2021) notes that therapists are aware of balancing the needs and goals of the client with their treatment methods, their moment by moment observations, their place in the treatment trajectory, their assessment of the quality or state of the therapeutic alliance and the interpersonal pulls experienced by therapists in the session. This delicate balancing act is informed by different markers that provide clues about clients' emotional processing capacity, the quality of their self-organizations, their understanding of their history as revealed by the completeness and coherence of their narratives, their attachment histories, as well as their own sense of autonomy and mastery. All this information and possibly more that is beyond conscious awareness (Schore, 2019) informs EFT therapists' responsiveness moment to moment in the session and over the course of treatment (Watson, in press).

Facilitating emotional processing in EFT

Three principles guide emotion focused therapists as they work to facilitate and enhance clients' emotional processing in the session. These include, the awareness, transformation and regulation of emotion (Goldman & Greenberg, 2019; Greenberg, 2004). Emotional awareness requires clients to be aware, tolerate, accept, and symbolize their emotional experience so that they can reflect on it to better understand the impact of events and make sense of their experience. The transformation of emotion occurs with the activation of primary adaptive emotions like self-assertive anger to set boundaries and protect the self from interpersonal injury, or sadness that promotes self-compassion and contact with supportive others rather than withdrawal and self-blame. These change processes are not merely a function of emotional expression although they are facilitated by emotional expression but are a reconfiguration of emotional experience such that the person is more resilient and better able to meet their needs promoting an ongoing cycle of more positive emotions. In addition, the processing of emotion in the context of a genuinely warm, accepting, and empathic other provides an alternative interpersonal experience that facilitates the reconsolidation of emotional memories as well as fundamental changes in emotion schemes as new ways of interacting, feeling and behaving are consolidated.

Regulating emotion can be addressed deliberately or occur automatically as various skills and functions are internalized over time. In the face of overwhelming emotion and intense states of arousal, it can be necessary to coach a client to down-regulate. These intense emotional states can include periods of anxiety, panic, hopelessness and despair. They may be assessed as secondary emotional responses to more painful experience that has been silenced or ignored or they may be maladaptive emotions that developed in dysfunctional and injurious interpersonal environments. The first step in emotion regulation is to symbolically represent the emotion, to

put it into words and label it or represent it in some other way, for example as an image, so that it can be known and understood. This process immediately diminishes the intensity of the experience, modulating it and providing some relief. In addition, EFT therapists work with clients to identify the triggers of their emotions, and teach skills that facilitate greater tolerance and distance from intense feelings, as well as ways of soothing the self to calm intense feeling states and restore equilibrium. Clients may be encouraged to learn how to distract themselves with alternative activities focusing on fun and leisure as well as self-care and creative pursuits. The capacity to self-soothe can be internalized in the presence of an empathic, accepting, warm and sincere other. Additionally, clients can be coached to self-soothe in imaginary dialogues with a vulnerable self or other, or by imagining others who have been experienced as supportive and caring.

Empathic Response Modes

To facilitate emotional processing, EFT therapists work in ways to enhance or facilitate clients' access to their emotions. This is done in a variety of ways. The dominant, baseline way of working in EFT is using empathic reflections as a means of promoting attention and the symbolization of emotional experience in conscious awareness. These types of responses also serve to reveal the sources of clients' pain and allow for an understanding of the clients' history as well as the ways they have developed to cope with adverse life experience. Empathic reflections support clients as the agents in their life stories and serve to validate their perceptions and feelings so they can explore and process their pain in the presence of a genuinely concerned, empathic and valuing other. There are a number of empathic reflections each reflecting a different therapeutic intention including, understanding, affirming, evoking, exploring, conjecturing or refocusing clients experience in the moment. Other techniques that EFT

therapists proffer include focusing, systematic evocative unfolding, and chair dialogues among others (Elliott, et al, 2004). Each of these techniques access emotion in different ways.

Major Tasks

Focusing

Focusing is a technique described and modelled by Gendlin and colleagues (Gendlin, 1982). This technique directs clients' attention inward to their bodily felt experiencing. Clients are encouraged to re-direct their awareness from the outside into their bodily core, including their throat, chest, stomach down through the pelvis and attend to what emerges as they focus on this area of their experience. Clients are also encouraged to be aware of thoughts, gestures, feelings, memories or images that emerge into awareness. Whatever emerges is then symbolized with the client learning to check with whether their representation of their experience fits or not. If it does this is usually accompanied by a small shift, a sense of relief and letting go. If it does not there may be some intensification of the feeling or a sense of something not quite right. Clients are encouraged to stay with the feeling and find the label or representation that fits better with their felt sense. The process of focusing can continue as clients continue to search within and pay attention to what emerges into awareness. This process seems to facilitate right-hemisphere processing and easier access to feelings and emotions than strictly linear and analytical processing. However, at times this process may be challenging if clients are very shut down and have learned to silence their emotional experience and do not know how to process it.

These include, clearing a space; attending inwardly to the felt sense; finding a handle; resonating the handle with the felt sense; asking and receiving; and carrying forward. As a first step Gendlin suggested that clients bring their attention from their outside environment inward to the centre of their bodies, or their torso, the area between their throat and pelvic floor. As they

attend inwardly, they are asked to symbolize or describe what they become aware of, for example, a gesture, a thought, a feeling, a sensation, or an image. After describing what they are aware of the therapist reflects what the client says and asks that they imagine placing it outside themselves. This begins an iterative process whereby the client is directed to attend inwardly again, describe what they become aware of and place it outside. This sequence is repeated until the client feels a sense of quiet with no further images or sensations coming into awareness. They often describe a sense of spaciousness, quiet and calm.

Once clients have cleared a space, the therapist proposes the second step and asks the client to choose one issue or bodily felt sense on which to focus their attention. As clients focus on the issue, they are asked to share what they become aware of and describe it. This is the third step, finding a handle with clients trying to find the label or description that best fits with their bodily experience. Therapists ask that clients check whether the handle fits during the next stage of asking and receiving and proceed to repeat the sequence as clients carry their experience forward.

Systematic evocative unfolding

This is a technique that was developed by Rice (1974; 1984) to help clients process intense emotions that they did not understand or that seemed incommensurate with what had transpired. This technique uses vivid evocation of an episodic memory to bring emotion alive in the session. Rice proposed that therapists encourage their clients to describe the situation in which their problematic reaction occurred using detailed, concrete and specific language almost as if they were playing a movie of the scene. Simultaneously the therapist is tracking the client's feelings and emotions to determine the moment the reaction is triggered. At this point the two can then begin to search for the trigger or stimulus that gave rise to the emotion and begin to process and

explore its meaning leading to a better understanding of the reaction as well as the opportunity to react differently in future.

Two-Chair dialogues

Techniques from Perls' (1969) Gestalt Therapy have been elaborated within EFT (Greenberg, 1984). The primary objective is to resolve two opposing aspects of self that may manifest either as a decisional conflict or as negative ways of relating to self, including being overly critical, self-oppressive and annihilating, self-silencing and neglectful among others (Elliott et al., 2004; Watson & Greenberg, 2006). These negative behaviours are expressed in one chair to activate emotion in the other chair. It is the activation of the primary, vulnerable, painful core feelings in response to the negative voice along with the accompanying need that once expressed can lead to softening and a redirection of the negative behaviour. Here we see that the negative behaviour elicits emotion that facilitates transformation of self and experience.

Empty chair dialogues

Empty chair dialogues, like two-chair dialogues, also emerged from Gestalt therapy and were elaborated by Greenberg and colleagues (Greenberg et al., 1993; Greenberg & Foerster, 1996). Empty chair dialogues use two chairs, but the focus is on a relationship with another as opposed to self. The other is usually significant to the client and has been a source of pain or emotional injury. The purpose is to allow the client to give voice to unexpressed emotion and needs vis a vis the other in order to transform their relationship with the significant other and others more generally. In this process the client is asked to actively imagine and describe a significant other sitting opposite them in another chair. The evocation of the episodic memory of the other using vivid description brings the feelings alive and available for expression. Therapists work with client to access, process and express their feelings to the other. Once these have been expressed

the therapist will ask their clients what they needed or wished they had received from the other. At which point the client can shift into the role of the other to see how they respond. This shifting of change of perspective usually affords the client the opportunity for seeing the self or other in a new light and can facilitate self-assertion to the extent that feelings and needs are being openly expressed. This last step of shifting perspective may not be possible and even contraindicated for clients who have experienced trauma. For these clients it may be more important for them to fully express their pain and their needs within the protective frame of the therapeutic relationship, as they come to terms with the hurt they experienced and learn to protect themselves with assertive anger.

Alliance dialogues and Other tasks

The techniques described above are the essential building blocks of EFT and have provided the structure for other techniques including *alliance repair dialogues*, *self-soothing dialogues* and *narrative expression tasks*. In *alliance rupture dialogues* (Elliott et al., 2004), EFT therapists act quickly to reflect their clients' reluctance, resistance, withdrawal, or hostility and actively listen and validate what their clients are sharing. EFT therapists take ownership of how their behaviour might have caused the client to feel as they do and then they try to realign with their clients' goals and objectives moving away from leading for a while to fall in with their clients' process in the moment. *Self- soothing dialogues* (Sharbanee, Goldman & Greenberg, 2019) can resemble empty chair dialogues where a caring supportive other is imagined in one chair and expresses concern, soothing and care for the client. Alternatively, they can resemble two-chair dialogues with clients actively expressing soothing and care to a smaller vulnerable part of themselves.

The objective in both of these is to activate positive responses to painful experience as opposed to negative ones.

Narrative Markers

Angus and Greenberg (2011) have identified different narrative markers that indicate shifts in the narrative or highlight aspects of clients' life histories. These include markers that indicate problems in clients' stories that indicate clients repeating the same old story, sharing broken stories, empty stories and being engaged in superficial story telling. These problem states highlight aspects of the narrative to which EFT therapists can attend in an attempt to shift the narrative, deepen it or find the anchors and referents for over- and under-regulated emotional states. Other markers in clients' stories may indicate when they are moving from one state to another, for example, developing a competing narrative to a more dominant one, turning attention inward so that the story sounds more inchoate, share episodic memories and engage in reflection about the events and their responses. Other markers indicate changes in clients' narratives, including stories with unexpected outcomes and stories in which a novel understanding or reformulation has occurred. These narrative markers provide EFT therapists with ways to assess their clients' narratives as they work together to facilitate clients' emotional processing capacity and transform their self-organizations.

Micro-Markers

In addition to attending to specific task markers in the session to guide their moment by moment process, EFT therapists attend to micro-markers and markers that reveal their mode of engagement in therapy. EFT therapists do not necessarily start out with an elaborate understanding of clients' life histories as they work in the moment. Rather conceptualization works from the bottom up as therapists attend to how clients process their feelings in the session

and how they relate to themselves. In the session, EFT therapists attend to micro-markers of clients' emotional processing as revealed in their narratives; markers of how clients characteristically relate to themselves and their experience; their mode of engagement in the session; as well as major task markers. Therapists use these to form mini conceptualizations of where their clients are in the moment and to identify possible paths for further exploration.

Micro-markers of clients' emotional processing that are revealed in their narratives, include subtle nuances in content for example shifts in topic or changes in tempo, as well as nuances of meaning that are at the periphery of awareness that if attended to might bring clients into contact with an aspect of experiencing that has remained peripheral. They might experience a feeling more intensely or reconstrue a situation. EFT therapists listen to how the story is being told for example is the client being reflective or sharing rehearsed descriptions indicating that clients are merely recounting what is already known. Alternatively, clients may ramble indicating that they have no clear focus in the session or an experiential question that is directing their explorations. Another important factor is the immediacy of their language use for example whether their descriptions are concrete, vivid and specific such that they are clear and alive for both client and therapist or abstract, general and without specificity indicating an overly distanced stance to their experience. As they listen to clients' narratives, EFT therapists listen for poignancy in clients' language to alert them to painful aspects of experience that clients may want to explore as well the idiosyncratic use of words and phrases that may be filled with personal feelings and meaning. The therapist also attends to whether clients are externally focused or inwardly exploring, representing experience freshly in the moment, as well as engaged in an experiential search to solve specific problems in their lives.

EFT therapists attend to clients' non-verbal behaviours in order to assess their emotional processing capacity moment to moment. These include posture, hand and foot movements, head movements, gaze, and facial expressions. Seeing tears in the eyes; hearing voices break; or seeing clients' slump in defeat, are indicators of organismic experiencing and emotion in the person's current self-organisation. Therapists may reflect these non-verbal behaviours drawing clients' attention to them and opening them up for further elaboration and exploration. They also attend to hesitation or inhibition as clients share their stories, attending to the synchrony and flow in the session to assess how engaged clients are with their experience or how removed or overwhelmed by their feelings.

In order to distinguish maladaptive, instrumental and secondary from primary emotion, therapists attend to whether clients are being congruent in the moment. They might ask themselves the following questions: Does the expression of emotion feel real? Is it intense and accompanied by other non-verbal behaviours that confirm it? Does the emotion fit with what is being shared in terms of the content and the meaning of the experience? To facilitate their awareness of the type of processing activity in which the client is engaged, EFT therapists assess clients' vocal quality as they share their stories as a gage to how they are relating to their inner experience. If clients' voices are *focused* it is likely that they are engaged in exploration and discovering novel aspects of experience, whereas if their vocal tone is *limited* or *externalizing*, then clients' stories are likely to sound rehearsed and not lead to new experiencing. If their vocal quality is limited this may be a sign of anxiety or possibly that the client is too fragile to examine their emotional experience in depth. This is in contrast to when clients' voices are broken by

emotion, indicating that emotional experience is being actively expressed and processed in the moment (Elliott et al, 2004; Rice, & Kerr, 1986).

Clients' Mode of Engagement Markers

These markers provide information about how clients are processing their emotions moment to moment in the session. They inform therapists of the stance that clients have towards their experience, the focus of their attention and the activity in which they are engaged. For example, clients may be analytical and distant from their experience or they may be actively exploring, or actively expressing emotion at any point in time. When clients are engaged productively their attention is directed inward to their organismic experience, including their thoughts, feelings, physical sensation, gestures and sensations. They are actively engaged in exploring, examining and evaluating their experience (Elliott, et al., 2004; Kennedy-Moore & Watson, 1999; Watson & Rennie, 1994). In contrast, less productive engagement is characterised by clients' focus of attention remaining outside on other people and events, or they may be overly conceptual or focused on their physical symptoms and condition. They tend to be more analytical and disengaged from their feelings. Speaking in a rehearsed and flat manner. Experiential modes of engagement include, attending inwardly, and engaging in experiential search, active expression, interpersonal contact with their therapists as well as self-reflection in order to plan and carry changes forward into their lives. All of this work occurs in the context of an accepting, empathic, prizing and genuine therapeutic relationship that contributes to clients' interoceiving feelings (Porges, 2019) of safety in relationship with their therapists in the moment and over time.

Treatment for specific populations

EFT has been adapted and applied to a range of different psychological disorders including depression, anxiety, complex trauma, eating disorders and personality disorders. In addition, it has been adapted and used with individual, families and couples. As mentioned above, EFT is fundamentally a transdiagnostic approach, built predominantly on process diagnosis, rather than syndrome diagnosis. Nevertheless, as the approach has been applied to different presenting syndromes, the conceptualisation of each syndrome has developed along with suggestions for adapting the therapy.

Depression

EFT for depression, an empirically supported treatment (APA Presidential Task Force on Evidence Based Practice, 2006), was adapted by Greenberg and Watson (2006), informed by their research and that of their colleagues (Greenberg & Watson, 1998; Goldman, Greenberg & Angus, 2006; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003). Feelings of low self-worth, depressed affect and a general sense of hopelessness are core to depression. Research has found that adolescents at high risk of developing depression show feelings of inadequacy coupled with lack of support in relation to peers and parents (Harter, 1998). Feelings of inadequacy and lack of support continue to fuel depression in adulthood contributing to core feelings of sadness, disappointment, powerlessness and anger, in addition to feelings of shame and self-blame for failing to garner adequate support and overcome problems in living (Greenberg & Watson, 2006; Salgado, Cunha & Monteiro, 2019). Three major life stressors have been observed to contribute to feelings of depression including, loss, humiliation and entrapment (Kendler, Hettema, Butera Gardner, & Prescott, 2003). Thus, depression occurs when people feel disempowered and lose a sense of mastery.

The EFT treatment formulation for depression highlights two distinct processes dysfunctional emotional processing and negative self-organizations, characterized by a weak or bad sense of self along with feelings of shame and fear. Negative early life experience with few positive experiences interfere with a person's capacity to regulate and soothe emotions and lead to the development of dysfunctional emotion schemes. Such that when feeling overwhelmed by their emotions, depressed clients tend to blame themselves reinforcing their sense of personal inadequacy. This leads to a secondary process whereby their sense of failure leads to feelings of despair, helplessness and hopelessness. They have difficulties regulating affect being unable to soothe themselves, be self-compassionate or self-accepting. In an examination of depressed clients' transcripts Kagan (2003) identified four processes with respect to depression including self-criticism, being shut down, having a lack of direction and feelings of helplessness. Treatment focuses on transforming depressed clients emotional processing capacity as well as their core depressive self-organization. Treatment occurs in three phases, a bonding and awareness phase, an evoking and exploring phase and a transformative phase.

Phase 1

During the bonding and awareness phase therapists focus on developing a safe therapeutic relationship and a trusting relational bond between client and therapist to promote the work of awareness and develop a focus for the treatment. Depressed individuals are often shut down and cut off from the flow of their inner experience. Thus, the initial task is to have them focus inwardly and attend to their bodily felt sense with the goal of accessing the core emotion schemes that are contributing to their depression. Clients are encouraged to attend to and overcome avoidance of and fully acknowledge their painful feelings and negative self-organizations using focusing and empathic affirmation and exploration responses. Once painful

feelings have been acknowledged and negative self-organizations identified clients are ready to move into the second phase of therapy, evoking and exploring.

Phase 2

In the second phase, EFT therapists provide support to clients for being in contact with their feelings; work with their clients to evoke and arouse problematic and painful experience in the session; identify and undo interruptive processes that shut the client down and inhibit access to painful emotion; work with the client to access more primary emotions and needs to transform feelings and behaviours. In this phase the therapist introduces different tasks to vivify and evoke emotion, for example two-chair dialogues to address hopelessness and self-interruption or self-criticism and contempt. During this period, clients' sources of distress in relation to significant others including abandonment, humiliation and criticism are addresses using empty chair dialogues. In addition, therapists continue responding empathically and encourage clients to focus on their inner experience to maintain contact with their inner emotional experience. As clients begin to engage in these tasks EFT therapists work to facilitate task completion and the transformation of clients' emotion schemes.

Phase 3

During the third phase of transformation, therapists work to help clients generate new emotional responses to transform core maladaptive emotion schemes; they encourage reflection on experience to make sense of it and generate new meaning; and provide validation of these new emerging feelings to support a newly emerging sense of self. As clients engage in chair dialogues they begin to recognize and acknowledge the impact of negative self-statements. They become aware of their core primary pain as a result of these self-criticisms and self-interruptions and are encouraged to access core needs implicit in these emotions to protect and support

themselves in the face of these negative self-statements. This begins the process of transformation. Clients are encouraged to access new emotional responses of self-compassion, self-assertion, and self-acceptance to overcome feelings of shame, hopelessness, inadequacy and despair. The emergence of new needs leads to the establishment of new goals providing a sense of direction and more positive feelings of self- worth. They acquire new ways of supporting the self and regain feelings of resiliency and mastery. The therapist supports the development of these internal strengths and sense of competence to combat negative self-organizations and core maladaptive emotion schemes along with clients' capacities to self-soothe. New meaning is generated by reflecting on experience to make sense of it and construct new narratives incorporating the changes into the client's sense of identity. The transformations become consolidated in a new story of resilience and feeling empowered. Therapists validate clients' emerging more confident, assertive and accepting sense of self and help them to link it to their lives outside therapy fostering a sense of agency.

More chronic and severe depression is often characterized by clients having more impaired emotional processing capacity, more negative self-organizations with minimal if any positive ways of treating themselves and their experience, less coherent narratives with little self-understanding as well as poor boundaries and impaired differentiation of self and other. Clients with these difficulties show greater levels of self-contempt and a lack of positive life experiences and memories. Initially in treatment these clients may have difficulties becoming aware of and symbolizing their feelings and emotions. This requires their therapists to work with clients to gain access to their inner experience working relationally with them using empathic responding and focusing. In this process they also begin to foster new positive introjects as clients develop self-compassion, and the capacity to set boundaries with others and be more self-protective.

Anxiety

EFT has developed formulations for on two anxiety disorders, generalized anxiety (GAD) and social anxiety. Some of the processes underlying these two diagnoses are similar and others are more distinct.

Generalized Anxiety Disorder (GAD)

Development and etiology

The formulation of EFT for GAD has been developed by Watson, Greenberg, Timulak and colleagues (Watson & Greenberg, 2017; Watson, Timulak & Greenberg, 2019). Repeated exposure to painful, threatening and negative life events without adequate protection, support, soothing and nurture compromises a person's capacity to adequately process and regulate their emotions as well as the formation of their self-identity and contribute to the development of GAD. Negative and painful life experiences including interpersonal injuries as a result of neglect and abandonment as well as rejection, intense criticism, invalidation, bullying and overly intrusive interactions can contribute to a wounded and vulnerable sense of self that is core to GAD. People with GAD struggle to self-soothe and adequately protect themselves in interactions with others. They feel a personal sense of responsibility for their own well-being and are reluctant and unable to rely on and trust others to support and protect them such that they remain vigilant and sensitive to threats in their environments.

Repeated feelings of threat, fear and vulnerability overload the system and interrupt the adequate processing of situations as well as bodily felt experience. Thus, they are unable to adequately process and regulate their emotions and develop negative self-organizations characterized by a sense of the self as vulnerable and at risk as well as wounded and defective. They experience intense feelings of shame as well as feeling alone, unacceptable and inadequate.

Given high levels of arousal memories and painful events and stimuli are not adequately encoded which results in experience not being accurately symbolized in conscious awareness (Porges, 2019). Under threatening conditions, the organism is unable to adequately process stimuli. Thus, their understanding of events and their environments is negatively impacted with triggers and stimuli being overly generalized and non-specific. From an EFT perspective, the core features underlying GAD are impaired emotional processing and regulation capacity, a negative self-organization, impaired understanding and an impoverished narrative as well as a compromised sense of agency and mastery.

Treatment Process

To treat GAD, EFT therapists focus on working with their clients to more effectively process their emotions of fear, sadness, and shame to develop more adaptive emotion schemes and ways of dealing with distress as well as greater self-acceptance, self-compassion and self-protection. As with other conditions or disorders, treatment for GAD starts with developing a safe therapeutic relationship that requires the therapists to be present and curious about the clients' experience. First, the therapist cultivates a stance of empathic attunement in order to remain in touch with the clients' experience and effectively track it during the session to facilitate clients' emotional processing and understanding of their experience. Second, EFT therapists work to establish a secure and trusting bond with their clients. It is essential for clients with GAD that they experience their therapists as empathic, genuine, and accepting in order to counteract their feelings of being inadequate and unacceptable. Third, EFT therapists work to develop collaboration on the goals and tasks of therapy providing rationales and psycho-education about how they can work together to address the problems clients are bringing into therapy.

Phase 1: Strengthening client's vulnerable sense of self

Effectively working in this way begins to strengthen the client's vulnerable sense of self including building trust in their perceptions of events as well as their own bodily felt sense and emotions. They develop more coherent and elaborated life stories to make sense of their experience and acquire a sense of agency and greater confidence in their ability to cope. As they internalize their therapists' attitudes, they become more accepting of their subjective experience and become more supportive, compassionate and protective of themselves. Clients learn to process their emotional experience as they attend inwardly and represent it in words. This process provides the opportunity to reflect on it and modulate their levels of arousal as they reflect and express it as well as develop new ways of expressing and regulating their feelings. EFT therapists work with their clients to cultivate a working distance from their emotions that enable them to process it productively becoming neither overwhelmed or overly distant from their inner experience. Emotion dysregulation is seen as a result of failures in the dyadic regulation of affect and the capacity to down-regulate the autonomic nervous system. Thus, a major goal of the treatment is to develop the capacity to regulate and self-soothe distress and feelings of anxiety automatically.

Phase 2: Working with negative self-organizations

Working with negative self-organizations is a second major focus of treatment. Clients with GAD tend to dismiss, block, silence and reject their perceptions and feelings. They often experience shame around feelings and needs and blame themselves when things go wrong. These behaviours lead to worry as they seek to ward off feelings of sadness, shame and inadequacy. Two chair dialogues are used to address feelings of shame and blame as well as other negative ways clients have for interrupting and blocking their feelings. The goal of two-

chair dialogues is to facilitate clients' awareness of the negative behaviours, expectations and evaluations and to represent their emotional and organismic experience in awareness so that they can be more self-compassionate and self-protective. These processes are further supported with empty-chair dialogues to resolve emotional injuries with significant others. These tasks facilitate the full expression of feelings that were silenced and blocked and effectively address attachment injuries with significant others. These dialogues support clients' in differentiating from others and more effectively meeting their needs in relationships with others.

Phase 3: Developing self-soothing strategies

Finally, clients are encouraged and supported to develop effective self-soothing strategies as they become more compassionate to their emerging painful experience. As clients internalize their therapists' attitudes, they become more accepting of their experience and feel more entitled to their feelings and needs. In addition, EFT therapists work with their clients to develop more explicit self-soothing strategies to down-regulate their autonomic nervous system. These self-soothing exercises include "Clearing a Space" and self-soothing dialogues in which a compassionate part of self and or an imagined other provide validation, compassion and protection to a fearful, vulnerable and inadequate part of self. These transformations are consolidated into new narratives of self and provide the foundation for improved emotional processing and regulations capacities as well as more positive self-organizations.

Social Anxiety Disorder (SAD)

Development and Etiology

The adaptation of EFT for social anxiety, has been led by Robert Elliott and Ben Shahar's research teams (Elliott, 2013; Elliott & Shahar, 2017, 2019; Shahar et al., 2017). There are two key elements that seem to contribute to the development of Social Anxiety disorder, according to

Elliott and Shahar (2019). The first is a history of *social degradation* in which the person experiences degrading events that imply that they are defective. This could be repeated criticism, expressions of contempt, social humiliation, or forms of degrading physical, sexual or emotional abuse. These degradation events are internalised as evidence of the defectiveness of the self, leading to the development of a core emotion scheme of shame. The second key contributor is the *absence of social support* or protection during the experience of degradation. If significant others who should have been protective, don't act to stop degrading events, this can be seen as a tacit validation of the degradation. The absence of support can therefore function as a magnifier of the degradation, leading people to see the absence of support as further interpersonal proof that are deserving of such treatment.

Core emotion schemes of shame and self-criticism

The resulting core emotion scheme of shame, which represents the self as defective, is the central element in the etiology of Social Anxiety. The development of the shame scheme, is accompanied by an introjected self-critic, which functions to maintain the shame through harsh criticisms (e.g., "you're disgusting", "you're stupid"). These criticisms often capture key messages explicit or implied by the degradation, and effectively repeats the voices of harmful others. Thus, the introjected critic maintains the experience of degradation long after the original degrading events have ended.

Secondary Anxiety Processes

A secondary anxiety process subsequently develops over the core shame scheme, in the form of a vigilance process called a Coach/Critic/Guard by Elliott (Elliott, 2013; Elliott & Shahar, 2019). This vigilance process functions to protect the self, by monitoring the environment for signs of further degradation, or for risks of the defective self being exposed. The

vigilance process can involve tracking other peoples' reactions, including their facial expressions and body language for any sign of negative response. It can also take the form of rumination when it applies to rehearsing past and future social encounters. It is this vigilance process that then leads to the shaky experience of anxiety. Together these two emotional processes, vigilance and anxiety over self-criticism and shame, are the essential components of the etiology of social anxiety. The vigilance process causes frequent experiences of anxiety, which when it gets too much to cope with, can lead to being emotionally overwhelmed or dysregulated. When anxiety becomes overwhelming, a flee or freeze reaction may be activated. The latter, is otherwise referred to as a self-interruption in the EFT literature (see Greenberg et al. 93).

Treatment Process

Elliott and Shahar (2019) recommend structuring the work over a series of phases. Beginning initially with the anxiety producing vigilance process, then working with the shame inducing self-critical processes, before finally working towards the historical origins of degradation memories and unfinished business. This is consistent with EFT's prioritization of using process diagnoses to guide treatment, it is important to be sensitive and not rush towards deeper work before clients are ready, given the population's fear of self-exposure.

Phase 1: Alliance building and initial exploration.

More than some other presentations, developing a working alliance is important and very difficult with SAD. Clients' inherent social vigilance makes it easy for alliance problems to develop, and the socially exposing nature of therapy that requires one to reveal oneself to another is particularly the kind of situation that socially anxious people most want to avoid. These factors make it important for the therapist to adopt a stance that is fundamentally non-threatening and, while interested, also sensitive to not coming across as too intrusive, scrutinising or critical. In

some cases, some self-disclosure can be helpful to building the working alliance. In addition, some clients will be specifically anxious about unstructured social situations, and exploratory non-directive therapy is exactly that. This makes it more important to provide structure through the use more psycho-education including explanation and descriptions of the therapy process prior to internal exploration than is sometimes necessary with other populations. In this initial phase, the therapist also works to begin to symbolise the client's experience and imbed it in a narrative of their life story. This becomes the center of a co-constructed case-formulation.

Phase 2. Anxiety Processes

To begin working with the anxiety processes, it can be useful to start with a specific example of a socially anxious situation. This situation can then be replayed in a manner similar to Systematic Evocative Unfolding and other reprocessing tasks (Elliott et al., 2004; Rice & Sapiera, 1984).Through this unfolding, the manner and content of the vigilance process can be elicited which forms the basis of working on the anxiety split. The anxiety split can then be structured with the vigilance process in one chair, and the anxious experiencer in the other. When enacting the vigilance, it can be useful to not only track the content of the vigilance ("look at their reaction, they might not like it") but also the manner, which can be racing, frantic, or electrifying. This is key to accessing the experience of anxiety in the other chair, which provides both a sense of agency over generating the anxiety, and also the motivation for the vigilance to soften. It is also important to note that the anxiety can easily overflow into a dysregulated freeze/dissociation state, or a panicky flee state. EFT therapists carefully track this response and are actively responsive to co-regulate it with their clients.

Phase 3. Shame Process

Underneath the anxiety and vigilance, lies self-criticism and contempt. This can also be worked with in a two-chair dialogue, similar to how it is worked with in Depression and in EFT generally (see Greenberg et al. 1993). The critical process can be located in one chair, and enact the criticisms of the self (e.g., "you're too fat/stupid/ugly"), which evokes the shame in the experiencing part in the other chair. As with the anxiety split, this helps them to gain a sense of agency over the process, and the shame also in turn elicits the assertive and protective anger to combat the criticism.

Phase 4. Developmental Origins

Following the softening of the criticism, clients are then able to work on the developmental origins of the shame scheme, through accessing and re-experiencing the memories of degradation, and the unfinished business with significant others who either perpetrated the humiliation, or witnessed and allowed it to happen. Elliott and Shahar (2019) noted that these memories involve both a vulnerable sense of exposure of the shameful self, and also frequently a sense of abandonment stemming from feeling shunned or rejected by their family or social group. The access and expression of these painful feelings can lead to, and be undone by clients accessing assertive anger towards the perpetrators, and a sense of self-compassion for the self.

Phase 5. Consolidation.

Finally, it is often necessary to once more rework the secondary anxiety and avoidance processes after clients' memories of degradation and abandonment have been processed. This helps to consolidate the change, and break the more habitual aspects of the avoidance behaviours, as well as carry forward the newly accessed desire for contact with others that arises. It is important to help the client carry the new internal states into new ways of acting in life.

Complex Trauma

The application of EFT to complex trauma is based primarily on the work of Sandra Paivio and her research team, and is discussed most thoroughly in the text by Paivio and Pascual-Leone (2010). C*omplex* trauma, which is sometimes called a type 2 trauma, refers to repeated traumatic incidents, particularly during critical early developmental periods, and often perpetrated by people that should have been a source of security, such as care-givers and family members. The specifics of the trauma could be varied, and consist of sexual abuse, violence, emotional verbal abuse such as humiliation, or neglect. Part of the complexity of these scenarios is the relational component, where a key relationship is both the source of danger or abuse, and is also still an attachment figure that should be a source of safety.

Complex trauma can be contrasted with single incident traumas, or type 1 traumas, that arise from single incident accidents (e.g., witnessing a car crash) or violence (e.g., a mugging); typically not perpetrated by a developmentally significant relationship figure. Working with single incidents tends to require heavy use of reprocessing tasks, such as Trauma Retelling and Meaning Protest. These will not be elaborated here, instead the interested reader is referred to Elliott et al (2004) for discussion of these tasks and to Elliott et al (1998) for an overview of trauma that includes the type 1 presentation.

Theory of dysfunction

Core Emotion Schemes of Fear & Shame.

The development of complex trauma difficulties stems from repeated traumatic incidents which lead to the development of core fear and/or shame emotion schemes. The experience of being repeatedly violated can lead people to develop a core sense of fear-based vulnerability. In addition, since the abuse is perpetuated by a significant other it also often leads the victim to a

shame-based sense of being broken or deserving of abuse. Peoples' sense of self is highly dependent on how they are treated by early caregivers. Therefore, the experience of being abused can lead people to internalise the interpersonal signal that they deserve to be abused, resulting in a core sense of shame. In addition, since a child is dependent on their attachment figures for survival, it can feel dangerous to express anger at the abuse out of fear of losing the relationship. By blaming themselves instead of the caregiver, the child is able to maintain the important connection to the attachment figure. Both the interpersonal signal of being worthy of abuse and the danger in being angry, can add to a strong tendency for self-blame instead of blaming the perpetrator for the abuse.

Emotional Avoidance & Dissociation

In healthy development, children usually learn to regulate their emotions through having them symbolised and reflected back by their caregivers. This emotion regulation function is typically not available when the caregivers are a source of the painful feelings. This leads to a general sense of emotional dysregulation, with a tendency towards hyperaroused states that the person has difficulty making sense of. This high aroused emotion is an internal signal that something is very wrong that has yet to be made sense of or responded to.

In addition, since there is often no other way to cope with the painful feelings of fear and shame, people will typically emotionally numb or partially dissociate in order to protect themselves. This is the essentially a strong version of the *self-interruptive* process, or the 'freeze' response. Together this leaves people with conflicting impulses, with one part of the self, needing to process and make sense of the traumas, and another part of the self-interrupting and avoiding it to keep emotionally safe. This conflict leads to the alternation between states of numbing dissociation, and then periods of intrusive memories and hyperarousal.

Relationship Problems

The fear, shame and emotional avoidance can also contribute to difficulties in relationships. This core sense of fear can manifest as difficulty in trusting others, and shame can also contribute to a fear of rejection and hence prevent and interfere with intimacy. Shame can also manifest as difficulty asserting personal boundaries, as clients feel undeserving of good treatment.

Emotional avoidance can also make it hard to know what one feels, adding to the difficulty of expressing vulnerable feelings that is required for intimacy and connection with others. The limited awareness of one's own emotional experience can also manifest as a limited ability to empathise with others' experiences, making it harder to both disclose their own feelings or to respond to feelings of others.

Treatment process

The treatment procedures follow the standard EFT treatment guidelines, with a focus on the Empty Chair dialogue, given that the complex trauma is essentially a marker of Unfinished Business with significant others. On top of the already described treatment principles, several aspects of EFT were given increased emphasis when working with complex trauma in order to account for the greater fear of emotion and fear of confrontation that arises around engaging in the empty chair work with abusive others. These points of emphasis are fundamentally around scaffolding the degree of emotional arousal. This scaffolding is done through providing an empathic relationship using empathic reflections, the rationale for the empty chair technique, and through breaking contact with the image of the other when engaged in empty chair dialogues.

Establishing a strong empathic relationship and rationale

The first point of emphasis is the need for a strong empathic relationship in order to engage in the trauma memories. Following the application of EFT for shorter term therapies, Paivio and Pascual Leone (2010), recommend not starting the Empty Chair work until at least session 4, and to spend the initial period building the empathic relationship, and setting the rationale for engaging in the UFB. Support for this proviso has been provided by research from Paivio's lab that showed that the quality of therapist empathy early in treatment predicted clients' subsequent engagement in the empty chair dialogue (Mlotek, 2013).

Staggering the evocativeness of the Empty Chair

The second point of emphasis is to stagger the evocativeness of the empty chair work to ensure that you're working within the person's window of tolerance. This can be done by initially focusing on a less threatening other. For example, empty chair work can begin with a neglectful other that failed to protect the person from the abuse, rather than the primary abuser. This provides a chance to begin to work with the trauma memories, and to help the person feel entitled to their anger and needs without directly confronting the abuser. It can be important to encourage the client to choose with whom they would prefer to work initially to enhance their sense of control over the process.

In addition, when working with an abuser it can be important to not express feelings of vulnerability to the abuser. Hence, when beginning to access the feelings of fear and vulnerability from memories of abuse, it is useful to encourage the person to temporarily break contact with the imagined other in the empty chair and express these vulnerable feelings to the therapist instead. Contact with the imagined other in the empty chair can be reengaged when clients have accessed assertive anger and can be encouraged to express it to the other to assert boundaries and protect self.

Alternative to the Empty Chair technique

For some clients the empty chair technique may be too evocative, even with the aforementioned adjustments. For these clients it is may be necessary to use Empathic Exploration without imaginal contact with the abusers in an empty chair dialogue. With empathic exploration, the focus remains on the traumatic material, and is guided by the sequences outlined in the task analytic model of empty chair work (L. S. Greenberg & Foerster, 1996). The only difference in the process is that the trauma is processed in interaction with the therapist instead of in imaginal contact with the abuser. This shift makes the process substantially less evocative, and was the selected method for 20% of the clients in the research trials conducted by Paivio (2001). The less evocative approach resulted in less drop outs from therapy, 7% compared with 20% using empty chair dialogues (Paivio et al., 2010).

While Empathic Exploration was shown to be successful as an alternative treatment approach, clinicians are encouraged not to abandon the empty chair technique too readily. Research has shown that the quality of contact with the imagined other in the empty chair predicted change over that predicted by the alliance (Paivio et al., 2001) and clients consistently identified the initial Empty Chair dialogue as one of the most helpful parts of treatment (Holowaty & Paivio, 2012). This suggests the importance of the empty chair technique when possible.

Focus on Self-processes and Emotional Avoidance

A final point of emphasis when working Complex Trauma was the need to spend time working with negative self-treatment and emotional avoidance, prior to being able to resolve the unfinished business. The extent of the fear of emotion, and the extent of the shame often involved in the abuse, means that it’s important to spend time on these self-related processes by

working with the shame in self-critical two-chair dialogues, and on the emotional avoidance with self-interruption work, and not exclusively focus on the relationship with the abusive other.

Personality Disorders

The section on Personality Disorder draws on the work of Alberta Pos and her colleagues (Pos, 2014; Pos & Greenberg, 2012; Pos & Paolone, 2019). In terms of conceptualising personality difficulties, these issues are seen as representing more severe polarisation of normally occurring processes, including the capacity to process and regulate emotion, the formation of self-organizations and the differentiation of self and other rather than as separate discrete phenomenon. This section will cover personality disorders generally, although there are various subtypes. The variations of subtypes of personality disorders reflect the different dominant self-organisations that are found in the other non-personality diagnoses. So, an avoidant personality disorder can be considered as a more severe split of the same essential self-critical shame-based organisation as found in social anxiety. In a similar way, one of the key features associated with the borderline personality diagnosis, is the difficulty in attachment relationships, which is similar to the attachment basis of GAD. However, there is a more negative self-organization in borderline personality disorder as well as increased reactivity to interpersonal processes and severely impaired differentiation of self and other. Borderline clients fluctuate between self-silencing and self-sacrificing behaviours to wall off from others to prevent being hurt. Therefore, personality problems are similar to, but also different from the other diagnostic categories. The essential difference is the need to consider the increased severity of the processes. The severity covers the increased polarisation in the negative vs. positive ways that clients treat their experience, and the increased reactivity to interpersonal processes. This

presents challenges in engaging in empty chair dialogues, current interpersonal relationships, and the therapeutic alliance.

Development of Personality Disorder Processes

The development of personality-disorder processes is essentially the same developmental trajectory as described for complex trauma. That is, early developmental experiences of not having fundamental needs met, especially by primary caregivers, leads to the development of core emotion schemes of shame, worthlessness, lonely-abandonment and/or fear. These emotion schemes are maintained through negative self-treatment, and lead to relationship problems, emotional dysregulation, and alexithymia. Finally, the emotional lability that is seen in borderline clients can also manifest in the use of maladaptive emotional regulation strategies such as self-harm, substance use and impulsive behaviours.

Given this developmental etiology is essentially the same as complex trauma and GAD, they are not considered as discreet phenomena. Rather various markers are differentially prominent in different cases presenting with different diagnoses. Complex Trauma is largely defined by the marker of Unfinished Business, and the treatment is focused predominantly on the UFB model of resolution. In contrast, most of the diagnostic criteria for personality diagnoses reflect other key markers including markers related to negative self-organizations self-related difficulties (self-criticism, lack of identity markers related to impaired differentiation of self and other leading to current relationship difficulties, markers related to difficulties with emotional processing including emotion lability and impulsive/risk taking behaviours. Different diagnoses partly reflect which markers tend to be most prominent in a given case as well the extent of impairment in each developmental capacity. It is possible that there is a tendency to consider acts of commission (e.g., sexual or violent abuse) as more obvious traumas, and hence categorise

them as such. Whereas acts of omission, such as chronic invalidation or neglect as seen in GAD and PD are less obvious and therefore may be less likely to be identified as 'traumas', however these developmental experiences can pose intense challenges for the developing organism.

Therapy Process

Problems with standard two-chair dialogue

The adaptations of EFT for personality disorders, have focused primarily on adapting the two-chair dialogue for negative self-evaluative splits. Pos and Colleagues (Pos & Greenberg, 2012; Pos & Paolone, 2019) identified several ways that use of the two-chair task is challenged when working with clients diagnosed with PD, which led to several alterations to practice. Usually in the two-chair dialogues, the negative self-treatment and experiencing self are separated in two chairs and the negative self-treatment is activated in order to access and intensify the experience of emotional pain in the other chair. The emotional pain becomes the motivating force or the antidote that leads to push-back in the form of expressing pride in the self or assertive anger at being treated badly, which leads to a softening in the critical or negative chair, thereby defusing the negative self-treatment.

The process can falter in a few ways with clients diagnosed with PD. The first is the possibility of them becoming emotionally overwhelmed and shutting down. In some cases, the extent of the emotional arousal that arises from activating harsh, negative self-treatment can be beyond the person's capacity to regulate their emotions, overwhelming them and causing a strong self-interruption response. The second, is that people become deeply locked into a polarized self-organisation, where they completely identify with one side of the split. They can be locked into a self-critical or self-silencing stance, and be unable to alternate from this position. Alternately, people can be locked in a state of deep shame or worthlessness when faced

with the criticism, and collapse. Finally, some people can find the process confusing and struggle to balance the two aspects of themselves. This can be experienced as a struggle to know which aspect of themselves was the 'good' one that should be sided with, rather than experiencing it as a transient live conflict in the moment.

These issues can be a sign that the person doesn't yet have either the emotional regulation capacity necessary to handle the emotional activation as in GAD. Or that they do not have sufficient reflective capacity and understanding of self and other to hold awareness of the two sides of the split simultaneously, as is necessary to achieve integration between the parts.

Adjustments to the Two-chair Technique

In response to these difficulties, it is important to adjust the therapy to provide greater scaffolding to foster better emotion regulation capacities in the moment as well as the capacity to reflect on and process their experiences. To facilitate these processes, two adjustments can be made for the two-chair dialogue.

Internal Couples Therapy. The first adjustment is to conceptualize the intra-psychic split as an internal couple, and follow the *cycle de-escalation* stage of EFT for couples. In this version of the chair dialogue, rather than focusing on accessing and intensifying the pain, the focus is on reflecting and tracing the interactional cycle between the parts of the self. By maintaining a cycle perspective, it is easier for the person to understand the effects of negative self-treatment and their ways of regulating emotions without becoming overwhelmed by them. An important aspect of de-escalating the cycle view is that both sides of the self are validated, which helps to reduce the polarisation between the parts. The process then uses psycho-education to describe the structure, saying "the more that you do this, the more they do that", which helps seed the futility of the positions and encourages an internal de-escalation and begins to build

greater cohesion in terms of the clients' self-organizations and sense of identity as well as their understanding of themselves. An example of the therapist mirroring the process is, "the more you [critic], criticise him, the more he collapses into his shame, and then he struggles to do what he needs to. And for you [experiencer], the more that you collapse, and fail to do, the more he tries to berate you into action".

Chair-work by proxy. The second way in which EFT therapists can scaffold the chair work, including unfinished business dialogues is for the therapist to express the emotions in chair-dialogues on behalf of the person. This enables the client to be less aroused and overwhelmed as their feelings are less evoked, and facilitates a more reflective state as they witness the expressions of emotion by their therapist. This also models the expression of emotion for the client and shows how emotions can be owned and expressed adaptively. One important point of working in this manner, is to invite the person to collaborate in directing the dialogue as it progresses to ensure that the expressions fit for them, so that they feel actively engaged and a begin to assume ownership of their emotional expression moving forward.

Eating Disorders

The application of EFT to eating disorders began with Joanne Dolhanty and Les Greenberg's adaptation of the individual and group variants of EFT to eating disorder presentations (Dolhanty & Greenberg, 2007, 2009; Wnuk et al., 2015). This was subsequently expanded into a family therapy model in collaboration with Adele Lafrance (Dolhanty & Lafrance, 2019; Lafrance et al., 2020; Lafrance-Robinson et al., 2015). We will outline the individual approach here. For further discussion of the family approach see Dolhanty & Lafrance (2019) and Lafrance et al. (2020).

Development and Etiology

As with other presentations, at the center of eating disorder etiology are the primary maladaptive emotion schemes, that develop from histories of not having essential needs met, especially by primary givers. Essentially, disordered eating symptomatology is seen as way of controlling painful emotion. This view of emotion as central to eating disorders is consistent with long standing clinical observations (e.g., Bruch, 1979), and the theory that restrictive eating behaviour functions as a means of controlling emotion is widely accepted (Prefit et al., 2019; Treasure, 2012). Across the eating disorders there has been noted a general difficulty with alexithymia - a difficulty identifying and describing emotions and internal experience (Westwood, Kerr-Gaffney, Stahl & Tchanturia, 2017). This general difficulty with emotions leaves people with little ability to effectively process their experience in other ways.

When emotion schemes of shame, worthlessness or being unloveable are activated, the person focuses or displaces the resulting negative emotion onto the body as a harsh judgement of their weight and shape. This provides an alternative focus for the painful emotion that provides a sense of personal control as the body can be modified through restricted eating. The success at controlling eating behaviour and weight can become a source of pride that helps fend off the underlying emotional pain. Restrictive eating also makes hunger the predominant aspect of a person’s experience, effectively numbing out the less bearable painful core emotions. Other eating and compensatory behaviours can also function in a similar emotion regulation manner. Binge episodes can function to soothe activated affect, and the guilt of bingeing can also be counterbalanced by purges or excessive exercise. The relative balance of these different regulation strategies, and the relative outcome on weight reflect the various eating disorder diagnostic categories.

Therapy Process: Individual EFT and Eating Disorders

In the following section we describe adjustments to the emotional processing work that can be required within this population. However, it's important to note that engaging in any emotional processing requires that weight has been stabilised sufficiently first, so that the person has the capacity for processing.

Working with Alexithymia

One of the main difficulties in working with extremely alexithymic clients is that they struggle to identify their experience, and therefore often don't respond readily to focusing interventions which require accessing and symbolising experience. Hence, it is important in these cases to be prepared to slow down the work, and to be prepared to deal with the clients' uncertainty about their experience. As when working with other clients whose emotional processing is silenced and shut down, there may be a greater need for therapists to use empathic conjectures. It can also be useful to try to elaborate when clients say "I don't know what I feel", using empathic conjectures and empathic exploration of specific feeling states. For example: "So you say you're not feeling? Sort of vague or not clear maybe? Or more like shut down?". These types of therapist responses can lead to exploration of the interruptive, silencing and 'shut down' process. The use of empathic conjectures can also assist clients to access and articulate painful emotional states that are being blocked. For example, "So you don't really know how you feel about that. But I could imagine I would feel sort of overlooked or almost invisible if that was me; does that fit for you?".

Two-chair dialogues with an 'Anorexic Voice'

A second consideration with eating disorders, especially the more restricted anorexic presentations, is the strongly dominant and ego-syntonic nature of the 'anorexic voice'. The anorexic-critical voice is usually simultaneously harshly critical of the self, and also very proud

of its' own restrictive control over eating. The client is highly identified with this voice. Due to the dominant and proud nature of the anorexic voice, attempts to distract from it or dispute it can provoke strongly negative reactions. Hence, it is necessary to hear it out and fully understand it. Two chair dialogues are an effective way to achieve this, while also making space for acknowledgement of the damage it causes.

Couples Therapy

EFT has also been adapted for couples. This modality was initially developed by Leslie Greenberg and Susan Johnson (Greenberg & Johnson, 1986, 1988). Susan Johnson was Leslie Greenberg's doctoral student, and her doctoral thesis provided the original evidence base for the model, evaluating the outcome and the process of change. They continued to develop the model together for around 10 years, before deciding to work separately, and continuing to develop it independently of each other. This has led to two variants of EFT for couples, each with a slightly different emphasis with Johnson emphasising attachment theory and Greenberg emphasising emotion theory. However, in practice they are both more similar than different, and both still draw from the same basic understanding of couples' distress and the techniques outlined in the original presentations of the model (Greenberg and Johnson, 1986, 1988). For further elaboration of EFT for couples see Greenberg and Goldman (2008) and Greenberg and Johnson, 1988).

Working with Diverse Populations

A central tenet of EFT and other humanistic and experiential psychotherapies is to empower individuals as they deal with challenging life events and experiences. Levitt, Whelton and Iwakabe (2019) discuss ways of adapting EFT for use with multicultural and diverse populations. They advocate for therapists to be self-aware and to recognize the variety of rules

and practices that govern communication and behaviour in different cultures. In working with diverse populations there is a commitment to responsibly navigate the power dynamics that emerge in therapy by respecting and seeing clients as the experts of their lived experience. This includes not only their feelings and emotions abut also their perceptions and interactions with others and the world at large. EFT therapists are willing to continually adjust to take account of their clients' experiences both within and outside the session. Fuertes, et al.. (2006) suggests that this should include an in-depth understanding of clients' specific location within society includes sensitivity to issues of race, oppression, socio-economic status, gender, sex, religion, as well as other socio-political forces. While there is a recognition that understanding and attending to one's organismic experience can contribute to one's capacity to thrive and experience enhanced well-being, EFT therapists are aware of needing to distance form their agendas if these are at odds with their clients' perspectives and situations. EFT therapists attempt to be responsive to their clients concerns and are sensitive to client's deference as they work to ensure that clients are being authentic in the moment being true to themselves and their own lived experience.

Possible disconnections between clients and therapists are discussed openly with the use of alliance dialogues where EFT therapists are careful to assume responsibility for moments of disconnect and to privilege their clients experience as they work with them to get back on track (Elliott, et al., 2004; Watson & Greenberg, 1998). Thus, EFT therapists are expected to be self-aware of their own identity and its impact on people from diverse groups. To navigate these differences, EFT therapists cultivate humility, openness, and sensitivity to the concerns of others. They interrogate their assumptions and ways of looking at the world in order to fully respect and value the uniqueness and complexity of each individual. When discrepancies arise, they are able to put their thinking aside and work towards a better understanding of their clients to

explore their lived experience in order to collaborate effectively to realize their clients' goals.

Conclusion

EFT developed from an in-depth exploration and examination of psychotherapy process and outcomes and continues to evolve to more effectively support clients' growth and development over the life-span. In this chapter we have presented a broad overview of EFT for individuals encompassing its historical roots, theory and fundamental assumptions, and treatment conceptualizations for depression, anxiety, complex trauma, personality disorders and eating disorders. The approach has been adapted for different modalities including models of therapy to work with individuals, couples and families. It is an evolving approach that provides an alternative to other ways of working with clients presenting with a variety of issues based on a moment to moment process model focusing on their emotional processing and self-development.

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