

# emotion-focused therapy

robert  
elliott 5

Emotion-focused therapy (EFT), also known as process-experiential therapy, integrates active therapeutic methods from gestalt and other humanistic therapies within the frame of a person-centred relationship (Greenberg, Rice & Elliott, 1993; Elliott, Watson, Goldman & Greenberg, 2004). In essence, EFT benefits from the creative tension between the person-centred emphasis on creating a genuinely empathic and prizing therapeutic relationship (Rogers, 1961) and the active, task-focused process-guiding style of gestalt therapy (Perls, 1969) and focusing (Gendlin, 1981), among others. In addition, EFT updates these experiential, process-oriented therapies by incorporating contemporary emotion theory and affective neuroscience, dialectical constructivism (to be described later), and contemporary attachment theory. In this chapter, I review the current status of EFT, summarising its history, theory, practice, and outcome evidence.

## A brief history of emotion-focused therapy within the person-centred and experiential approaches

The tribes of the person-centred and experiential (PCE) therapies nation began to divide themselves in the late 1950s when Rogers and Gendlin began to look more closely at the client side of the famous 'process equation'. This shift in attention from therapist facilitating conditions to in-depth study of the client's process led first to the Walker-Rablen-Rogers Process Scale (1960), subsequently to the Client Experiencing Scale (Klein, Mathieu-Coughlan & Kiesler, 1986), and eventually to the practice of focusing (Gendlin, 1981). This phase of the development of the PCE approach came to be called 'experiential' and resulted in a separation from those therapists who continued to put the primary emphasis on the therapist relational conditions of accurate empathy, unconditional positive regard, and genuineness. Originally referred to as 'non-directive' and then as 'client-centred', this relational branch later became known as the 'person-centred approach' as it broadened beyond individual therapy to include encounter groups, large groupwork, and, in Rogers' final years, peace-making (Kirschenbaum, 2007).

Laura Rice had been a student of Rogers in the 1950s; after Rogers left Chicago she stayed on at the Counseling Center, which

**Greenberg, LS, Rice, LN & Elliott, R (1993)** *Facilitating Emotional Change: The moment-by-moment process*. New York: Guilford Press.

**Elliott, R, Watson, JC, Goldman, RN & Greenberg, LS (2004)** *Learning Emotion-Focused Therapy: The process-experiential approach to change*. Washington, DC: American Psychological Association.

**Rogers, CR (1961)** *On Becoming a Person*. Boston: Houghton Mifflin.

**Perls, FS (1969)** *Gestalt Therapy Verbatim*. Moab, UT: Real People Press.

**Gendlin, ET (1981)** *Focusing* (2nd edn). New York: Bantam Books. This book is currently available in the '25th Anniversary edition', published in 2003 by Rider Books.

**Walker, AM, Rablen, RA, & Rogers, CR (1960)** Development of a scale to measure process changes in psychotherapy. *Journal of Clinical Psychology*, 16, 79-85.

**Klein, MH, Mathieu-Coughlan, P & Kiesler, DJ (1986)** The Experiencing Scales. In L Greenberg & W Pinsof (eds) *The Psychotherapeutic Process* (pp 21-71). New York: Guilford Press.

### Note

The Experiencing Scale and supporting materials can be found at:

<[www.experiential-researchers.org/instruments/exp\\_scale/exp\\_scale\\_main.html](http://www.experiential-researchers.org/instruments/exp_scale/exp_scale_main.html)>

**Kirschenbaum, H (2007)** *The Life and Work of Carl Rogers*. Ross-on-Wye: PCCS Books.

**Wexler, DA & Rice, LN (1974)** *Innovations in Client-Centered Therapy*. New York: Wiley.

**Bohart, AC & Tallman, K (1999)** *How Clients Make Therapy Work: The process of active self-healing*. Washington, DC: American Psychological Association.

**Rice, LN & Saperia, EP (1984)** Task analysis and the resolution of problematic reactions. In LN Rice & LS Greenberg (eds) *Patterns of Change* (pp 29-66). New York: Guilford Press.

**Greenberg, LS (1977)** A task analytic approach to the events of psychotherapy. (Dissertation, York University.) *Dissertation Abstracts International*, 37B, 4647. (Available from National Library of Canada, Ottawa K1A 0N4; order no. 26,630.)

**Rice, LN & Greenberg, L (1984)** (eds) *Patterns of Change*. New York: Guilford Press.

**Gendlin, ET (1981)** *Focusing* (2nd edn). New York: Bantam Books. This book is currently available in the '25th Anniversary edition', published in 2003 by Rider Books.

she directed for a time. While there, she and Wexler continued the focus on client process, emphasising client information processing and drawing on early cognitive science (Wexler & Rice, 1974). In the late 1960s and early 1970s she carried out a series of studies broadening the investigation of client processes to examine client stylistic variables like expressiveness and vocal quality, as well as beginning to look at the evocative function of the therapist, through the use of metaphor and vocal expressiveness.

In the meantime, beginning around 1970 and in collaboration with her student Leslie Greenberg, Rice had adapted the method of task analysis from cognitive science knowledge elicitation methods developed to study 'expert systems' in order to study how clients use therapy to solve their personal, cognitive-affective problems, foreshadowing later work by Bohart and Tallman (1999) on the client as the active agent in therapy. Using recordings from the Chicago Counseling Center, Rice first studied how clients use a process of careful re-experiencing to resolve the task of making sense out of a puzzling personal overreaction. This became the first EFT task to be mapped: *evocative unfolding for a problematic reaction point* (Rice & Saperia, 1984).

In parallel, as proof of concept for therapeutic task analysis, Greenberg agreed to study gestalt therapy to see what client tasks could be identified and studied there (Greenberg, 1977). He identified the task of resolving internal conflicts using the gestalt therapy technique of two-chair work, in which the client enacted the two conflicting aspects of self, usually a critic ('topdog') and a part that was being criticised or pressured to do something ('underdog'): *two-chair work for conflict splits*. In the late 1970s and early 1980s Rice and Greenberg carried out a series of studies on these two tasks; eventually, this research was written up in their chapters in *Patterns of Change* (1984).

In 1985 I joined them to develop an experiential therapy for depression that integrated unfolding and two-chair work within a fundamentally person-centred relationship. To their experience with person-centred therapy and gestalt therapies, I brought my background as a therapy micro-process researcher studying therapist response modes and client in-session experiences, along with my interest in Gendlin's (1981) focusing method. The first thing we did was to develop the set of six therapeutic principles that are the basis of EFT today; these provided the starting point for everything else (see Table 1 for their current wording). Then, as I applied the approach to a population of clinically depressed clients, we began to develop and integrate models of additional tasks: empty-chair work for unfinished business, two-chair enactment for self-interruption, experiential focusing for an unclear

**Table 1****Basic Principles of Emotion-Focused Therapy** Adapted from Elliott, Watson, Goldman & Greenberg (2004)**A. Relationship Principles:** Facilitate safe, productive relationship:

1. *Empathic Attunement:* Enter, track clients' immediate and evolving experiencing
2. *Therapeutic Bond:* Actively offer accepting, empathic presence to clients
3. *Task Collaboration:* Facilitate mutual involvement in goals and tasks of therapy

**B. Task Principles:** Facilitate work on specific therapeutic tasks:

4. *Process Differentiation:* Offer clients opportunities to work in different ways at different times, according to the current task they are engaged in
5. *Task Completion/Emotional Change:* Help clients resolve key therapeutic tasks in order to facilitate reorganisation of core maladaptive (no longer useful) emotion schemes
6. *Self-development:* Help clients differentiate and access new experiencing, inner strength or resources, agency or self-empowerment

felt sense, and empathic affirmation for vulnerability. We named it the process-experiential (PE) approach, to distinguish it from Gendlin's (1973) and Mahrer's (1983) versions of experiential therapy and because the therapy is process-oriented (Greenberg et al., 1993).

In its early years, the process-experiential approach was controversial and its place among the tribes of the PCE nation was questioned by some. For example, John Shlien (personal communication, July 1994) once told me that he thought it would be better for the person-centred approach 'to die a noble death' than to come under the influence of 'people like you'. Even more than focusing, the process-experiential approach was the object of suspicion among classical non-directive therapists such as Brodley (1990), who felt that proposing things like two-chair work for conflict splits violated the client's autonomy and the principle of unconditional positive regard. As process-experiential therapy proponents, we argued that the traditional person-centred facilitative conditions were necessary and might be sufficient, but were not 'efficient', an argument that we thought was clever but which was not received particularly well by many at the time.

Over the years, after its original somewhat shaky emergence in the PCE world, the PE approach has evolved: first, it changed its name, or rather added the name that is more commonly used today: emotion-focused therapy. In the late 1980s Les Greenberg and Suzanne Johnson (1988) had developed an approach to working with couples that integrated experiential and systemic therapy. They named this approach 'emotionally focused therapy for couples' in order to distinguish it from the behavioural marital therapy popular at the time. Process-experiential therapy had always had a major focus on emotion and made use of important emerging work on

**Elliott, R, Watson, JC, Goldman, RN & Greenberg, LS (2004)** *Learning Emotion-Focused Therapy*. Washington, DC: APA.

**Gendlin, ET (1973)** Experiential psychotherapy. In RJ Corsini (ed) *Current Psychotherapies* (2nd edn, pp 317-52). Itasca, IL: Peacock.

**Mahrer, AR (1983)** *Experiential Psychotherapy: Basic practices* New York: Brunner/Mazel.

**Greenberg, LS, Rice, LN, & Elliott, R (1993)** *Facilitating Emotional Change: The moment-by-moment process* New York: Guilford Press.

**Brodley, BT (1990)** Client-centered and experiential: Two different therapies. In G Liettaer, J Rombauts, & R Van Balen (eds) *Client-Centered and Experiential Psychotherapy in the Nineties* (pp 87-107).

Leuven, Belgium: Leuven University Press. Reprinted in Moon, KA, Witty, M, Grant, B & Rice, B (2011) (eds) *Practicing Client-Centered Therapy: Selected writings of Barbara Temaner Brodley*. Ross-on-Wye: PCCS Books.

**Greenberg, LS & Johnson, SM (1988)** *Emotionally Focused Therapy for Couples* New York: Guilford Press.

**Greenberg, LS & Safran, JD (1987)** *Emotion in Psychotherapy*. New York: Guilford Press.

**Greenberg, LS (2004)** Being and doing: Person-centeredness, process guidance and differential treatment. *Person-Centered & Experiential Psychotherapies*, 3, 52-64.

**Elliott, R, Watson, JC, Goldman, RN, & Greenberg, LS (2004)** *Learning Emotion-Focused Therapy: The process-experiential approach to change*. Washington, DC: American Psychological Association.

**Pascual-Leone, A & Greenberg, LS (2007)** Emotional processing in experiential therapy: Why 'the only way out is through'. *Journal of Consulting & Clinical Psychology*, 75, 875-87.

#### Note

Of course, the term 'emotion-focused therapy' at the same time obscured our roots and situatedness within the person-centred and experiential therapy tradition and did nothing to allay the fears of folks like Shlien, who had been inclined to distrust our intentions from the beginning. However, we took these criticisms as challenges, and during this time period there was a parallel development of articulations of the PE/EFT formulations of relational and interpersonal processes of empathic exploration generally and the tension or dance in EFT between relational and task processes, between 'being' and 'doing'.

**Elliott, R, Watson, JC, Goldman, RN, & Greenberg, LS (2004)** *Learning Emotion-Focused Therapy: The process-experiential approach to change*. Washington, DC: American Psychological Association.

human emotions (Greenberg & Safran, 1987). Thus, over the course of the 1990s and early 2000s, it began to make sense to adopt the broader term 'emotion-focused therapy'. For one thing, by this time we had been able to elaborate the therapy's underlying emotion theory to the point where it provided a rich guiding account of psychological function, dysfunction and change, culminating in the articulation of a set of principles of emotional change (Greenberg, 2004) and models of the emotional deepening process (Elliott et al., 2004; Pascual-Leone & Greenberg, 2007). These emotion change principles and unifying models ran across the different therapeutic tasks (e.g., systematic evocative unfolding for problematic reactions, two-chair work for conflict splits, empty-chair work for unfinished business) and offered an elegant integration of the many tasks and subprocesses. In addition, it became clear that 'emotion-focused therapy' was a more comprehensible and broadly intuitively appealing term than 'process-experiential'.

### Distinctive features of emotion-focused therapy

What are the distinguishing features of emotion-focused therapy as it has developed today? A useful place to start an explication of EFT is by laying out six of its defining characteristics (Elliott et al., 2004):

1. EFT is a *neo-humanistic* therapy: It is based on a set of key values, deriving from the tradition of humanistic psychology but is reinterpreted in light of contemporary emotion theory, attachment theory, and dialectical constructivism (see pp. 112–13). These values include:
  - a. *Experiencing*: Immediate experiencing is the basis of human thought, feeling and action.
  - b. *Agency/Self-determination*: Human beings are fundamentally free to choose what to do and how to construct their worlds.
  - c. *Wholeness*: People are greater than the sum of their parts, and cannot be understood by attending only to single aspects.
  - d. *Pluralism/Equality*: Differences within and between people should be recognised, tolerated and even prized.
  - e. *Presence/Authenticity*: People function best and are best helped through authentic, person-to-person relationships.
  - f. *Growth*: People have a natural tendency toward psychological growth and development that continues throughout the life span.

2. As noted earlier, the major contemporary foundation of EFT is an evolving *emotion theory* (Greenberg & Safran, 1987, 1989; Greenberg & Paivio, 1997; Pascual-Leone & Greenberg, 2007), which holds that emotion is fundamentally adaptive in nature, helping the person to process complex situational information rapidly and automatically in order to produce action appropriate for meeting important organismic needs (e.g., self-protection, support). Specifically, EFT makes use of three key emotion-theoretical concepts: emotion schemes, emotion response sequences, and emotion regulation, to be detailed later in the theory section of this chapter.
3. Essential to its practice, EFT is based on a *person-centered but process-guiding relational stance*. The therapist *follows* the track of the client's internal experience as it evolves from moment to moment, trying to remain very empathically attuned to the client's immediate inner experience, and communicating this. Fundamentally, the therapist tries to follow the client's experience because the therapist recognises that the client is human in the same way that the therapist is: another existing human being, an authentic source of experience, an active agent trying to make meaning, to accomplish goals and to reach out to others. The therapist prizes the client's initiative and attempts to help the client make sense of his or her situation or resolve problems.

At the same time, however, the therapist also offers active guidance of the therapeutic *process*. This does not mean lecturing the client, giving advice, or controlling or manipulating the client. It also does not mean doing the client's work for them, or trying to fix the client's problems, or trying to enlighten them. The therapist is an experiential guide who knows something about the shape and feel of various experiences and also about emotional processes. EFT is often referred to as 'process directive', but 'process guiding' is actually a better phrase to describe how the therapist acts. The therapist's responses continually offer the client opportunities to work with experience, what Sachse (1992) referred to as 'processing proposals'.

To say that the therapist follows and guides at the same time sounds like a contradiction, but EFT therapists see it instead as a *dialectic* or creative tension between two vitally important aspects of therapy. Following without guiding can result in therapy getting stuck and going in circles, with the client getting lost in the same ways that they usually do. Guiding without following is ineffective and counter-productive, undermining attempts to help the client develop as an empowered, self-organising person. Thus, in EFT the therapist

**Greenberg, LS & Safran, JD (1987)**  
*Emotion in Psychotherapy*. New York: Guilford Press.

**Greenberg, LS & Safran, JD (1989)**  
Emotion in psychotherapy. *American Psychologist*, 44, 19-68.

**Greenberg, LS & Paivio, S (1997)**  
*Working with Emotions in Psychotherapy*. New York: Guilford Press.

**Pascual-Leone, A & Greenberg, LS (2007)** Emotional processing in experiential therapy: Why 'the only way out is through'. *Journal of Consulting & Clinical Psychology*, 75, 875-87.

**Sachse, R (1992)** Differential effects of processing proposals and content references on the explication process of clients with different starting conditions. *Psychotherapy Research*, 2, 235-51.

tries to integrate following and guiding, so that the distinction disappears, analogous to a dance in which each partner responds to the other by alternately following and leading. The ideal is an easy sense of co-exploration.

4. Most concretely, EFT is marked by a distinctive *therapist empathic exploration response style*, generally apparent simply from listening to a few minutes of the therapy. Typically, this style makes use of *exploratory reflections*, as in this short example:

C: I just want enough of who I used to be, so that I could live like a human being.

T: It's almost like, 'I don't feel like a human being right now. I feel like some kind of something else, that's not human.' Is that what it feels like?

*Exploratory questions* are also important, such as, 'What does it feel like inside right now?'; 'What are you experiencing as you say that?'; or even 'Where is the [sadness/anxiety] in your body?' Empathic exploration responses are active, engaged, and often evocative or expressive, but at the same time typically tentative, and sometimes even deliberately inarticulate, as they try to model and promote client self-exploration of immediate felt experiencing.

5. EFT is *marker-guided*, characterised by clear descriptions of in-session therapeutic *markers* and *tasks*. Markers are in-session behaviours that signal that the client is ready to work on a particular problem. An example is a *self-critical split* marker in which one part of the person (a *critic*) is criticising another part (an *experiencer*). Tasks involve immediate within-session goals, such as resolving the conflict inherent in a self-critical split. EFT also describes particular therapeutic methods for helping clients resolve tasks. For example, if the therapeutic alliance is developed enough the therapist might suggest that the client take turns speaking as the critic and the experiencer, moving back and forth between two chairs (*two-chair dialogue*). The therapist listens for the client to present task markers, then offers interventions to match the tasks that emerge. Using the 'following' and 'guiding' language, the therapist first *follows* the tasks presented by the client in the form of markers, then *guides* the client by offering potentially productive ways of working on these tasks.
6. EFT is an *empirically supported psychotherapy*. It is based on a 35-year-old programme of psychotherapy process and outcome research. This began with adapting research on

#### Note

In an era of increasing demands for brief, effective treatments and criticism of humanistic/experiential psychotherapies (HEPs) for lack of theory and empirical support, EFT appears to offer a viable development of the humanistic and person-centred traditions, while at the same time appealing to therapists from other traditions. The continuing efforts described here, in theory development, research, training, and extension to new client populations, are part of a larger effort to help re-establish HEPs as empirically supported and generally respected psychotherapies for the 21st century.

cognitive problem-solving to develop and test micro-process models of the steps clients typically go through to resolve key therapeutic tasks such as internal conflicts or puzzling personal reactions. There followed research on therapist response modes and client within-session helpful experiences. For the past 20 years, the focus of much of this research has been on outcome research, complemented by process-outcome prediction studies, qualitative research and case studies (reviewed in Elliott, Greenberg & Lietaer, 2004).

## Emotion-focused therapy theory

I turn now to the theory of EFT, which attempts to update the theory of humanistic-experiential psychotherapy (HEP) particularly in the light of contemporary emotion theory and dialectical constructivism.

### *Emotion theory*

Contemporary emotion theory (Elliott, Watson et al., 2004) holds that emotion is fundamentally adaptive in nature. Emotion helps the organism to process rich incoming situational information in a rapid, automatic manner, in order to produce action appropriate for meeting important organismic needs (e.g., self-protection, connection, exploration). In addition to making emotion a central therapeutic concern, EFT uses three sets of concepts in its theory of function and dysfunction: emotion schemes, emotion response types, and emotion regulation.

*Emotion schemes* provide an implicit, constantly evolving higher-order organisation for experience, but are not available to awareness until activated or reflected upon (Greenberg & Paivio, 1997). They are idiosyncratic and highly variable, both across people and within the same person over time, requiring individualised and flexible assessment via therapist empathic attunement and client self-exploration. Although emotion schemes serve as the basis of self-organisation, they are not static entities; they are instead continually synthesised in the person's moment-to-moment experience (Greenberg & Pascual Leone, 1997). Emotion schemes consist of component elements linked together in a network, with the activation of single elements spreading to other elements. What are these component elements? It is useful in practice to distinguish five types of schematic component (adapted from Cornell, 1996; by way of Leijssen, 1996). These elements are:

- a. The *experienced emotion* organises all of the other elements around a particular emotion and its felt quality (e.g., intense fear of being severely physically harmed). The person may

### Note

Readers wanting to see some of the history of EFT research are directed to, for a recent summary:

**Elliott, R, Greenberg, LS & Lietaer, G (2004)** Research on experiential psychotherapies. In MJ Lambert (ed) *Bergin & Garfield's Handbook of Psychotherapy and Behavior Change* (5th edn, pp 493-539). New York: Wiley.

**Elliott, R, Watson, JC, Goldman, RN, & Greenberg, LS (2004)** *Learning Emotion-Focused Therapy: The process-experiential approach to change*. Washington, DC: American Psychological Association.

### Note

EFT seems to appeal to humanistic-experiential therapists who are interested in the transformative power of emotion or who share humanistic values of focusing on people's internal resources and strengths. At the same time, it offers a bridge into humanistic psychotherapy for CBT and psychodynamic practitioners: CBT therapists like EFT's systematic formulations and effectiveness data, while psychodynamic therapists like its depth.

**Greenberg, LS & Paivio, S (1997)** *Working with Emotions in Psychotherapy*. New York: Guilford Press.

**Greenberg, LS & Pascual-Leone, J (1997)** Emotion in the creation of personal meaning. In M Power & C Brewin (eds) *The Transformation of Meaning in Psychological Therapies* (pp 157-74). Chichester: John Wiley & Sons.

**Cornell, AW (1996)** *The Focusing Guide's Manual*. Berkeley, CA: Focusing Resources.

**Leijssen, M (1996)** Characteristics of a healing inner relationship. In R Hutterer, G Pawlowsky, PF Schmid & R Stipsits (eds) *Client-Centered and Experiential Psychotherapy: A paradigm in motion* (pp 427-38). Frankfurt am Main: Peter Lang.

- be fully aware of their experienced emotion or only partially or slightly aware of it.
- b. *Perceptual/situational* elements represent the person's past or current external environments and include immediate awareness of the current situation and episodic memories of past situations and events. For example, a client's perception of her mother's darkened living room might remind her of a previous trauma, activating fears of being attacked again.
  - c. *Bodily/expressive* elements represent the emotion through the body, including both immediate sensations within the body (e.g., a round, knotted feeling in the gut accompanied by feelings like electrical impulses in arms and legs) and bodily expression of the emotion (e.g., a fearful facial expression and nervous laughter).
  - d. *Symbolic/conceptual* elements are verbal or visual representations of the emotion, produced through reflective self-awareness of the other elements. Symbolic representations can be verbal ('I could be attacked again at any moment') or visual (an image of an attacker bursting through the glass window). They can be descriptive labels or metaphors for the emotion ('the fear is like a thing'), the situation ('It's a trap'), one's body ('shaking like a leaf'), or possible actions ('I've got to get out of here').
  - e. *Motivational/behavioural* elements are activated by the emotion scheme and represent it in the form of associated desires, needs, wishes, intentions or actions (e.g., the wish to be safe from attack or attempts to ignore the fear).

**Leijssen, M (1996)** Characteristics of a healing inner relationship. In R Hutterer, G Pawlowsky, PF Schmid & R Stipsits (eds) *Client-Centered and Experiential Psychotherapy: A paradigm in motion* (pp 427-38). Frankfurt am Main: Peter Lang.

As Leijssen (1996) has shown, the therapeutic implication of this framework is that optimal emotional processing involves all of these schematic elements. Particular difficulties occur when the person neglects one or more types of elements. In addition, difficulties in emotion processing can also occur when emotion schemes are activated in the wrong situations. In EFT, the therapist helps clients reflect on, understand, and re-evaluate their emotion schemes, through careful empathic listening and evocative or expressive work.

**Elliott, R, Watson, JC, Goldman, RN, & Greenberg, LS (2004)** *Learning Emotion-Focused Therapy: The process-experiential approach to change*. Washington, DC: American Psychological Association.

*Emotion response types.* However, not all emotional expression is the same, and so different kinds of emotion response require differential therapist responses (Elliott et al., 2004). Assessing these different emotion processes requires close empathic attunement to the nuances of the client's expression and to the perceived situation in which the emotion emerged. Four types of emotion response are distinguished in EFT:

First, *primary adaptive* emotion responses are the ones most likely to have helped our evolutionary ancestors deal usefully with a given situation. They are thus our first, natural reactions to the current situation that would help us take appropriate action. For example, if a person is being violated by someone, anger is an adaptive response, because it helps the person to take assertive action to end the violation; fear signals immediate, overwhelming danger that needs to be avoided or escaped; sadness indicates loss and motivates the need for connection; and so on. We have these forms of rapid, automatic responding because they helped our ancestors to survive.

Second, *maladaptive* emotion responses are also initial, direct reactions to situations; however, they involve overlearned responses, based on previous, often traumatic, experiences. For example, a client with borderline processes may have learned when she was growing up that offered caring was usually followed by physical or sexual abuse. As a result, the therapist's empathy and caring are responded to with anger, as a potential violation: The client's angry response is understandable and needs to be met with empathy and compassion, but is not useful to the client in their immediate situation.

Third, in *secondary reactive* emotion responses, the person reacts to his or her initial primary adaptive or maladaptive emotional response, so that it is replaced with a secondary emotion. For example, a client who encounters danger and begins to feel fear may become angry with himself or herself for being afraid or may become angry at the danger, even when angry behaviour increases the danger.

Finally, *instrumental* emotion responses are strategic displays of an emotion for their intended effect on others, such as getting them to pay attention to us, to go along with something we want them to do for us, to approve of us, or perhaps most often just not to disapprove of us. Common examples include 'crocodile tears' (instrumental sadness), 'crying wolf' (instrumental fear), and bullying (instrumental anger).

Assessing these four types of emotion response requires close empathic attunement to the nuances of the client's expression of the emotion and the perceived situation in which the emotion emerged. In EFT each type of emotion response is worked with differently (Greenberg, 2004; Greenberg & Paivio, 1997): that is, primary adaptive emotions are accessed and more fully allowed; secondary reactive emotions require empathic exploration in order

#### Note

Here the word 'primary' simply means 'first'.

#### Note

Here, 'maladaptive' simply means the response is no longer useful, because it doesn't fit the current situation.

#### Note

Here, 'secondary' simply means 'second' – a different emotion occurred first.

#### Note

Here, 'instrumental' means that the emotion is used like a tool or instrument.

**Greenberg, LS (2004)** Being and doing: Person-centeredness, process guidance and differential treatment. *Person-Centered & Experiential Psychotherapies*, 3, 52-64.

**Greenberg, LS & Paivio, S (1997)** *Working with Emotions in Psychotherapy*. New York: Guilford Press.

**Note**

'Subdominant' refers to another primary emotion that was present all along but in the background, often at the person's edge of awareness.

**Elliott, R, Watson, JC, Goldman, RN, & Greenberg, LS (2004)** *Learning Emotion-Focused Therapy: The process-experiential approach to change*. Washington, DC: American Psychological Association.

**Kennedy-Moore, E & Watson, JC (1999)** *Expressing Emotion: Myths, realities, and therapeutic strategies*. New York: Guilford Press.

**Paivio, SC & Greenberg, LS (2001)** Introduction to special issue on treating emotion regulation problems in psychotherapy. *Journal of Clinical Psychology*, 57, 153-5.

**Note**

'Neo-Piagetian' refers to a group of developmental psychologists, starting with Juan Pascual-Leone, who have attempted to refine and improve the theories of Swiss psychologist Jean Piaget.

to discover the underlying primary emotions that preceded them; and instrumental emotions are explored interpersonally in the therapeutic relationship to identify and address their interpersonal function or intended impact. The most challenging to work with are primary maladaptive emotion responses, which are accessed, explored and deepened to help the client identify core unmet existential needs (e.g., for validation or safety) that cross-link to subdominant implicit primary adaptive emotions (connective sadness or protective anger).

*Emotion regulation.* The third set of key emotion theory concepts involves emotion regulation, the ability of the person to tolerate, be aware of, put into words, and use emotions adaptively, in order to regulate distress and to effectively pursue needs and goals (Elliott et al., 2004). People's emotion regulation capacities are recognised as being strongly affected by their early attachment experiences and include both being able to soothe one's own anxiety and emotional pain as well as adjusting the general level of emotional arousal in order to function adaptively. Effective emotion regulation requires the ability *both* to access and to heighten emotion; and also to contain or moderate emotion, depending on the task at hand, whether it be trying to get oneself going in the morning or to psych oneself up for a presentation, or, on the other hand, to calm one's nerves before a test or to unwind after a stressful day.

In EFT, the inability to regulate one's emotions is a general form of difficulty. Emotion regulation difficulties include problems of both under-arousal and over-arousal. If you are *over-aroused* for the task you are trying to accomplish, you will become disorganised or even paralysed, and will be unable to accomplish what you set out to do. You will be rattled and forget what you meant to say; and when your therapist asks you to talk to your grandfather in the empty chair, you will feel overwhelmed and your heart may start to pound. Alternatively, if you are *under-aroused*, you will be inefficient, slow, and will not put out your best performance. Your oral presentation will be boring, or you will fall asleep reading a bedtime story to your son. In short, when people are under-aroused, they are not able to access the emotion schemes they need to guide their actions, and their behaviour will lack direction and focus. Moreover, people often alternate between the two, particularly when dealing with traumatic or painful experiences (Kennedy-Moore & Watson, 1999; Paivio & Greenberg, 2001).

***Dialectical constructivism***

EFT is based on a dialectical constructivist epistemology and theory of self and the change process. This is a pluralist, neo-Piagetian perspective, in which the process of knowing changes

both the knower and the known, in which therapy changes both the client and the therapist, and in which the self is viewed as a process made up of various elements continuously interacting to produce experience and action (Greenberg & Pascual Leone, 1997). The multiple interacting self-processes often take the form of emotion schemes, which parallel related concepts such as 'configurations' (Mearns & Thorne, 2007), or 'voices' (Stiles, 1999). For EFT, the 'I' is an agent self-aspect or self-narrating voice that constructs a coherent story of the self by integrating different aspects of experience in a given situation; however, this voice has no special status as an executive self. Of particular importance for EFT are two sets of voices that can be referred to broadly as 'internal' and 'external,' or as 'experiential' and 'conceptual' (Elliott & Greenberg, 1997).

A dialectically constructive change process starts with clear separation between the different self-processes, emotion schemes or configurations, especially between the internal or experiential and the external or conceptual processes, some dominant or salient, others implicit or unacknowledged. Next, the therapist helps the client to bring the different aspects into direct contact with each other so that discords and harmonies can be heard. By accessing emerging or implicit inner aspects and helping these interact with the more obvious aspects, an internal dialogue is created. If this dialogue is successful, some form of newness will be generated, in the form of new experiences and restructuring of existing emotion schemes. This dialectic process can be seen most clearly in EFT's use of two-chair dialogue for conflict splits. However, interaction between different aspects of the client runs through most EFT tasks and provides a general change process (Elliott & Greenberg, 1997). As is true for all dialectically constructive processes, the precise nature of the new experiences and emotion scheme changes is impossible to predict in advance, although it should be understandable in retrospect (cf. Gendlin, 1996). Moreover, when successful, this process leads to change in both aspects or voices; that is, both assimilation and accommodation will occur. Importantly, the therapist can only facilitate such a process, but cannot know or direct the specific nature of the change that takes place as a result.

### The practice of emotion-focused therapy

The basis of EFT practice is the set of six therapeutic principles described earlier (see Table 1, p. 105). Practice in EFT is also described at two further complementary sets of concepts: *experiential response modes*, which occur at the level of individual

**Greenberg, LS & Pascual-Leone, J (1997)** Emotion in the creation of personal meaning. In M Power & C Brewin (eds) *The Transformation of Meaning in Psychological Therapies* (pp 157-74). Chichester: John Wiley & Sons.

**Mearns, D & Thorne, B (2007)** *Person-Centred Counselling in Action* (3rd edn). London: Sage.

**Stiles, WB (1999)** Signs and voices in psychotherapy. *Psychotherapy Research*, 9, 1-21.

**Elliott, R & Greenberg, LS (1997)** Multiple voices in process-experiential therapy: Dialogues between aspects of the self. *Journal of Psychotherapy Integration*, 7, 225-39.

**Gendlin, GT (1996)** *Focusing-Oriented Psychotherapy: A manual of the experiential method*. New York: Guilford Press.

therapist responses, and *therapeutic tasks*, which encompass substantial portions of therapy sessions centred on a particular kind of therapeutic work, such as two-chair work for conflict splits.

### ***Experiential response modes***

It is useful to describe what therapists do in terms of therapeutic speech acts or response modes. Here are some of the key therapist experiential response modes used in EFT (Elliott et al., 2004):

**Elliott, R, Watson, JC, Goldman, RN, & Greenberg, LS (2004)** *Learning Emotion-Focused Therapy: The process-experiential approach to change*. Washington, DC: American Psychological Association.

1. *Empathic understanding*. Consistent with its person-centred heritage, the bedrock of therapist responding in EFT is empathic reflection and following, using responses that try to communicate understanding of the client's message, including simple reflections and brief acknowledgements or minimal encouragers ('Uh-huh's'). For example, when Beth, one of our clients with severe crime-related post-trauma difficulties, said about her inability to do things on her own,

C: I mean that's the biggest grief, that's my biggest sadness.

her therapist reflected with:

T: That's what you grieve for, the loss of independence.

2. *Empathic exploration responses*. The most characteristic EFT response, however, is empathic exploration. These responses simultaneously communicate understanding and help clients move toward the unclear or emerging edges of their experience. Empathic exploration responses take many different forms, including evocative and open-edge reflections, exploratory questions, 'fit' questions (to check understanding), and empathic conjectures. Here is a brief excerpt illustrating empathic exploration responses, taken from a two-chair self-soothing work between Beth's strong pre-victimisation self and her weak post-victimisation self:

C: I just want enough of who I used to be, so that I could live like a human being.

T: 'I don't feel like a human being right now. I feel like some kind of something else that's not human.' [first person *evocative reflection* spoken as the post-victimisation self]

C: Just like a paranoid little, girl, ya know.

T: It's like what you want from that part is some of the courage. Is that right? [*empathic conjecture*, intended to offer Beth a chance to turn her attention back to her current, post-victimisation self; followed by a '*fit*' question to assess accuracy]

A little later, the therapist offers a response with two *exploratory questions*, addressed to the lost, pre-victimisation self, in order to help the client to access this part of herself:

T: What's that like? What do you feel in that part?

C: Happy. [laughs softly]

3. *Process guiding*. The difference between non-directive person-centered therapy and EFT is most apparent in the use of a variety of process guiding responses used in EFT to facilitate productive client experiencing. Although EFT therapists do not suggest possible solutions to client life problems, they sometimes offer process suggestions, proposing in a non-imposing way that the client try engaging in particular in-session activities, such as turning attention inside or saying something to an imagined person or self-aspect in the other chair. EFT therapists also sometimes provide experiential teaching, giving orienting information about the nature of therapy or of emotional experience, or they offer gentle support, orienting suggestions or encouragement for working on the task at hand (task structuring responses). At other times, they may tentatively formulate a process or self-aspect for the client in EFT terms ('critic', 'unfinished business'), again in the service of work on the current therapeutic task. Finally, at the end of the session EFT therapists may offer awareness homework, encouraging them to continue work from the session on their own. Many of these are illustrated in this sample of process guiding responses used to help the client Beth to grieve and re-access her lost, pre-victimisation 'strong self':

T: [early in session; *process suggestion* about her discouragement at not overcoming her fears:] Can you stay with that hurt and sadness for a minute, and just feel what that's about and what that's like?

T: [later in session; *experiential teaching* about a potentially useful therapeutic strategy:] One way to try to work with the grief is to put that part of you that you've lost in the chair and talk to her. There are other ways but that is one way that occurs to me.

T: [introducing chair work; *task structuring*; points to 'other' chair:] So there's the 'normal' Beth.

Later, a *refocusing* response is used to redirect the client after a sidetrack:

C: Whenever we needed to drive somewhere, I drove. When we needed to get something, I got it.

T: So this is the strong Beth, and somehow, you're gone, you went away.

Finally, near the end of the session, the therapist helps the client reintegrate her lost, pre-victimisation self, using a series of *process suggestions*, in this exchange:

T: [Gently:] Can you go over and *be* the strong part?

C: I would but I wouldn't know how.

T: Tell her, 'I'd like you to have that strength.'

C: I'd like you to have my strength.

T: What's that feel like? [*exploratory question*]

C: Like a, like a mom.

### Note about content directives

In EFT, therapist responses such as interpretation, extra-therapy advisement, expert reassurance, and disagreement are avoided or minimised. These responses compromise empathic attunement, collaboration and particularly growth/choice principles of EFT, and are generally irrelevant, ineffective, and interfere with client experiential work. Nevertheless, occasionally such non-experiential responses may be useful, for example, for helping clients manage suicidal experiences. In addition, at times, a content directive response will rise up in the therapist's consciousness to the extent that the effort of suppressing it would interfere with their empathic attunement. In these cases, the therapist offers the content directive response briefly and tentatively, as a disclosure of a personal experience. E.g.:

T: As I sit here, part of me is a bit worried for you, and wants to ask you if your husband's life insurance is paid up. Does that feel like something that would be useful for you to do ... or not?

There is an art to gently offering such responses, and then emotionally detaching from the directive response in order to re-engage with the client's experience.

4. *Experiential presence*. In EFT, therapist empathic attunement, prizing, genuineness and collaborativeness are largely communicated through the therapist's genuine presence or manner of being with the client. Although the specific configuration of therapist paralinguistic and non-verbal behaviours, including silence, vocal quality, posture and expression varies among therapists, there is a distinctive, easily recognised EFT style: for example, when offering process guiding, the therapist typically uses a gentle, prizing voice (and sometimes humour), while empathic exploration responses often have a tentative, pondering quality. Presence is also indicated by direct eye contact at moments of connection between client and therapist.

Therapist *process* and *personal disclosures* are really explicit forms of experiential presence, in that they are commonly used to communicate relationship attitudes. For example, the therapist began the first session of Beth's therapy with a process disclosure of excitement:

T: ... So I'm excited about giving it [the therapy] a try.

In the fifth session, he used another process disclosure to frame an empathic conjecture in helping her explore her crime-related fear:

T: You know it reminds me of, you know, those creepy old science fiction horror movies about things that take possession of people.

### *EFT tasks*

EFT integrates a variety of different experiential tasks, drawn from person-centered-experiential, gestalt, and existential therapy traditions. These tasks all include three elements: (1) a *marker* of a client problem state signalling the client's wish to work on a

particular experiential task; (2) a desired *resolution* or end state; and (3) a *task sequence* of actions carried out by client and therapist in working on the task (Greenberg, 1984). We find it useful to divide EFT tasks into various groupings based on their most distinctive change processes: empathy, therapeutic relationship, experiencing, reprocessing, and enactment (see Table 2 overleaf for the current list of EFT tasks; see Elliott et al., 2004, for more detail).

### *Empathy-based tasks*

These tasks derive from person-centred practice and provide the foundation for EFT.

1. *Empathic exploration of problem-relevant experiences* is the baseline task because the therapist begins each session with it, because the markers for other tasks typically emerge from empathic exploration, and because client and therapist return to this task when they pause or complete their work on one of the other tasks. In a sense, any experience which captures the client's attention in the session is an *exploration marker* and can be empathically explored or differentiated, especially when it is incomplete, fuzzy, undifferentiated or global, and even when it is expressed only in external terms. For example, in session 5, Beth stated:

I mean it [my fear] controls my life, every, step of my life, every action and every thing.

Beth's 'it' provided the marker for an extensive, branching exploration of her experience of her trauma-related fear as a 'thing'. The therapist offered Beth a variety of exploratory questions to help her explore different aspects of this emotion scheme, such as 'What kind of thing is it?' and 'Where is it in your body?' The therapist balanced these process guiding responses with evocative reflections (e.g., 'So the fear is like a thing that comes upon you.')

Empathic exploration tasks can be said to be partially resolved if they lead to a marker for another therapeutic task (e.g., *unfinished business*); a greater degree of resolution occurs if the client is able to achieve a substantial differentiation of their experience. A complete resolution of this task requires some form of experienced shift in the targeted experience. In the 'fear as a thing' example, Beth later reported that it was helpful that:

I placed the center of my fears in my gut. They were more abstract and therefore more uncontrollable before. It gave me a definite 'thing' to overcome rather than external, all encompassing overwhelming fear.

**Greenberg, LS (1984)** Task analysis: The general approach. In LN Rice & LS Greenberg (eds) *Patterns of Change* (pp 124-48). New York: Guilford Press.

**Elliott, R, Watson, JC, Goldman, RN, & Greenberg, LS (2004)** *Learning Emotion-Focused Therapy: The process-experiential approach to change*. Washington, DC: American Psychological Association.

<b>Table 2. Emotion-Focused Therapy Tasks: Markers, Interventions and End States (2011 version)</b>		
<b>Task Marker</b>	<b>Process</b>	<b>End State</b>
<b>A. Empathy-Based Tasks</b>		
<b>Problem-Relevant Experience</b> (e.g., interesting, troubling, intense, puzzling)	<b>Empathic Exploration</b>	Clear marker, or new meaning explicated
<b>Vulnerability</b> (painful emotion related to self)	<b>Empathic Affirmation</b>	Self-affirmation (feels understood, hopeful, stronger)
<b>B. Relational Tasks</b>		
<b>Beginning of Therapy</b>	<b>Alliance Formation</b>	Productive working environment
<b>Therapy Complaint or Withdrawal Difficulty</b> (questioning goals or tasks; persistent avoidance of relationship or work)	<b>Alliance Dialogue</b> (each explores own role in difficulty)	Alliance repair (stronger therapeutic bond or investment in therapy; greater self-understanding)
<b>C. Experiencing Tasks</b>		
<b>Unclear Feeling</b> (vague, external or abstract)	<b>Experiential Focusing</b>	Symbolization of felt sense; sense of easing (feeling shift); readiness to apply outside of therapy (carrying forward)
<b>Attentional Focus Difficulty</b> (e.g., confused, overwhelmed, blank)	<b>Clearing a Space</b>	Therapeutic focus; ability to work productively with experiencing (working distance)
<b>D. Reprocessing Tasks [Situational-Perceptual]</b>		
<b>Difficult/Traumatic Experiences</b> (narrative pressure to tell painful life stories)	<b>Trauma Retelling</b>	Relief, validation, restoration of narrative gaps, understanding of broader meaning
<b>Problematic Reaction Point</b> (puzzling over-reaction to specific situation)	<b>Systematic Evocative Unfolding</b>	New view of self in-the-world-functioning
<b>Meaning Protest</b> (life event violates cherished belief)	<b>Meaning Creation Work</b>	Revision of cherished belief
<b>E. Enactment Tasks [Action Tendency]</b>		
<b>Self-Evaluative Split</b> (self-criticism, tornness)	<b>Two-Chair Dialogue</b>	Self-acceptance, integration
<b>Self-Interruption Split</b> (blocked feelings, resignation)	<b>Two-Chair Enactment</b>	Self-expression, empowerment
<b>Unfinished Business</b> (lingering bad feeling re: significant other)	<b>Empty-Chair Work</b>	Let go of resentments, unmet needs re: other; affirm self; understand or hold other accountable
<b>Stuck, Disregulated Anguish</b>	<b>Compassionate Self-Soothing</b>	Emotional/bodily relief, self-empowerment

2. *Empathic affirmation* is offered when clients present a *vulnerability marker*, indicating the emergence of general, self-related emotional pain. The client reluctantly confesses to the therapist, often for the first time, that he or she is struggling with powerful feelings of personal shame, unworthiness, vulnerability, despair or hopelessness. The sense is that the client is experiencing a pervasive, painful feeling and has run out of resources. Vulnerability markers are relatively common in work with traumatised clients (Elliott et al., 1998), and are also found in depression. When vulnerability emerges in the course of working on some other task, it takes priority.

In emotional vulnerability, the client's need is to face and admit to another person an intense, feared aspect of self that had been previously kept hidden. The therapist's task is to offer a non-intrusive empathic presence, accepting and prizing whatever the client is experiencing, allowing the client to descend into his or her pain, despair or humiliation as far as he or she cares to go. The therapist does not push for inner exploration, and, indeed, does not try to 'do' anything with the client's experience, except understand and accept it. When the therapist follows and affirms the client's experience in this way, it helps to heighten the vulnerability to the point where the client hits bottom, before beginning spontaneously to turn back toward hope. It is very important, but also very difficult, for the therapist to maintain the faith that the client's innate growth tendencies will enable him or her to come back from this process. Resolution consists of enhanced client self-acceptance and wholeness, together with decreased sense of isolation and increased self-direction.

### *Relational tasks*

These emphasise the relational strand of the PCE therapy tradition and involve the development and repair of a safe working relationship between client and therapist, in which change is believed to emerge directly from a therapeutic relationship characterised by empathic attunement, prizing, genuineness and collaboration. These two tasks take priority over all others because they make other kinds of work possible.

3. *Alliance formation* is the first task of therapy, working with the client to establish mutual trust and a safe environment so that clients can engage in experiencing and exploring more painful experiences (Elliott et al., 2004). Alliance formation unfolds through several successive stages, culminating with the achievement of a productive working relationship.

In EFT the starting principle is 'contact before contract',

**Elliott, R, Davis, K & Slatick, E (1998)**

Process-experiential therapy for post-traumatic stress difficulties. In L Greenberg, G Lietaer, & J Watson, *Handbook of Experiential Psychotherapy* (pp 249-71). New York: Guilford Press.

**Elliott, R, Watson, JC, Goldman, RN, & Greenberg, LS (2004)** *Learning Emotion-Focused Therapy: The process-experiential approach to change*. Washington, DC: American Psychological Association.

wherein EFT therapists begin therapy by being emotionally present and highly empathically attuned, which promotes client experiencing and feelings of safety within the therapeutic environment. Next, the therapist works actively with the client to establish a specific focus for therapy by paying close attention to the significance of events and experiences in their clients' lives and how these might be contributing to their symptoms and current distress. In particular, they use their clients' emotional responses as a compass to direct them where to focus attention.

It is also important for clients and therapists to establish shared agreement on therapeutic goals (what to work on) and tasks (how to go about working) early in therapy, so that the client is prepared to self-disclose and focus on self. In order to do this, it may be useful for therapists to inform clients explicitly about the nature of the relationship and the tasks and goals of therapy, including the role of emotion in the change process, and to reflect the client's main difficulties, interrupted life projects, and main therapeutic foci back to them.

4. *Alliance dialogue* takes place when the client expresses some form of *complaint or difficulty* about therapy, for example:

- I feel stuck, like I'm not progressing anymore, or maybe even going backwards.
- I have the feeling that you are getting tired of me complaining all the time.
- I know you're not supposed to give advice, but I really think I need someone to tell me what to do about these fear attacks I keep having.

Therapeutic errors, empathic failures and mismatches between client expectations and treatment are inevitable in any therapy, and warrant immediate attention and the suspension of other therapeutic tasks. These difficulties result in disappointment and sometimes anger on the part of the client. In addition, this task is particularly relevant to work with clients who have histories of abuse or other forms of victimisation; such persons routinely perceive the therapist as just another potential victimiser. It is therefore very important that therapists listen carefully for and respond to *therapy complaint* markers.

The therapist begins alliance dialogue work by offering solid empathic reflection of the potential difficulty, trying to capture it as accurately and thoroughly as possible. The therapist suggests to the client that it is important to discuss the difficulty in order to understand what is going on, including what the therapist may be doing to bring about the problem. The difficulty is presented as a shared responsibility for client

and therapist to work on together. The therapist models and fosters this process by genuinely considering and disclosing their own possible role in it. In this way, the client is encouraged to examine their part in the difficulty as well, and the client and therapist explore what is at stake for the client in the difficulty, as well as how it might be resolved between them. Resolution consists, at minimum, of client and therapist together arriving at an understanding of the sources of the problem; full resolution entails greater self-understanding and renewed enthusiasm for the therapy.

### *Experiencing tasks*

Experiencing tasks are aimed at helping clients develop access to and symbolise their emotionally tinged experiences. They include clearing a space and experiential focusing, which derive from the work of focusing-oriented therapists, including Gendlin (1996), Cornell (1996), and Leijssen (1996).

5. *Experiential focusing* has been described by Gendlin (1981, 1996) and others as a general task for helping clients deepen their experiencing. For example, the client may be experiencing emotional distancing in the session, in the form of speaking in an intellectual or externalising manner, talking around in circles without getting to what is important to him or her. When this occurs, the therapist can gently interrupt the client, as in this hypothetical but typical example:

T1: I wonder, as you are talking, what are you experiencing?

C1: I'm not sure, I'm just going on [talking].

T2: I wonder if we could try something here? (C: nods) Can you take a minute, maybe slow down ... and see if you can look inside ... Ask yourself, 'what's going on with me right now?' and see what comes to you.

As focusing progresses the client shifts to internal self-exploration. Resolution involves developing an accurately labelled felt sense, accompanied by an experienced sense of easing or relief and a direction for carrying this 'felt shift' into life outside the therapy session.

6. *Clearing a space*. If the client feels overwhelmed by multiple worries or by strongly painful experiences (e.g., trauma memories), the therapist can help the client by using the clearing a space process from focusing (Gendlin, 1996). That is, the therapist helps the client mentally set aside each of his or her problems, generating a safe, clear internal space. Here, resolution involves the attainment and full appreciation of the

**Gendlin, GT (1996)** *Focusing-Oriented Psychotherapy: A manual of the experiential method*. New York: Guilford Press.

**Cornell, AW (1996)** *The Focusing Guide's Manual*. Berkeley, CA: Focusing Resources.

**Leijssen, M (1996)** Characteristics of a healing inner relationship. In R Hutterer, G Pawlowsky, PF Schmid & R Stipsits (eds) *Client-Centered and Experiential Psychotherapy: A paradigm in motion* (pp 427-38). Frankfurt am Main: Peter Lang.

**Gendlin, ET (1981)** *Focusing* (2nd edn). New York: Bantam Books. This book is currently available in the '25th Anniversary edition', published in 2003 by Rider Books.

**Gendlin, GT (1996)** *Focusing-Oriented Psychotherapy: A manual of the experiential method*. New York: Guilford Press.

imagined safe space. Resolution occurs when the client attains a sense of an internal, clear safe space.

### *Reprocessing tasks*

These are tasks in which clients present some form of problematic experience that has happened to them outside of therapy. They reflect the person-centred and existential heritage of EFT. The therapist helps the client examine the experience closely in order to make sense of it and to create new meaning about it in the broader context of their life.

7. *Trauma retelling of difficult or traumatic experiences* is common in EFT for post-trauma difficulties. While telling stories of difficult or traumatic experiences is usually painful, people typically have a strong need to tell others about such experiences. The *narrative marker* is an indication that the client is experiencing some internal pressure to tell their story (e.g., ‘When I was robbed, there was nothing I could do to stop them!’). Often, it is useful for the therapist to encourage the client to ‘Tell me the story of \_\_\_\_\_ in as much detail as you feel safe giving’. This also signals the therapist’s willingness to ‘hear the client through their pain’ (Egendorf, 1995).

A resolved retelling is a relatively complete narrative experienced by the client as making sense, with a clear point or overall meaning in the broad context of their life. Resolved retellings may also be marked by an indication from the client that he or she has developed a greater awareness or understanding of something in the story. For example, as Beth retold her post-victimisation story near the end of her therapy, she began to see her debilitating fear as not just the result of her victimisation, but more about lowered self-esteem from having since set aside her own needs in order to please her boyfriend. This finally helped her to understand and reverse the puzzling downward spiral of increasing fear that had brought her into therapy.

8. *Systematic evocative unfolding* is used for *problematic reaction points*, or instances in which the client is puzzled by an overreaction they had to a specific situation (Elliott et al., 2004; Greenberg et al., 1993). This task is particularly relevant to clients who experience sudden episodes of unwanted emotion, including post-traumatic flashbacks, panic or anxiety attacks, anger outbursts, impulsive acts, or episodes of strong emotion dysregulation. Unfolding tasks resemble retelling tasks in that both involve helping the client elaborate narratives with immediacy and vividness, but unfoldings are driven by

**Egendorf, A (1995)** Hearing people through their pain. *Journal of Traumatic Stress, 8*, 5-28.

**Elliott, R, Watson, JC, Goldman, RN, & Greenberg, LS (2004)** *Learning Emotion-Focused Therapy: The process-experiential approach to change*. Washington, DC: American Psychological Association.

**Greenberg, LS, Rice, LN, & Elliott, R (1993)** *Facilitating Emotional Change: The moment-by-moment process*. New York: Guilford Press.

curiosity or puzzlement (they are like a mystery story), while retellings are driven by the need to share distress or emotional pain (they are like a history).

When the client presents a problematic reaction point, the therapist suggests that the client take them through the puzzling episode, including what led up to it, and exactly what it was that the client reacted to. The therapist helps the client alternately explore both the perceived situation and their inner emotional reaction in the situation. As the client imaginably re-enters the situation, he or she commonly re-experiences the reaction, while the therapist begins by encouraging the client in an experiential search for the exact instant of the reaction and its trigger. As with the other tasks, resolution is a matter of degree; at a minimum, resolution involves reaching an understanding of the reason for the puzzling reaction; this is referred to as a 'meaning bridge'. However, the meaning bridge is usually just the beginning of a self-reflection process in which the client examines and symbolises important self-related emotion schemes and explores alternative ways of viewing self. Full resolution involves a clear shift in view of self, together with a sense of empowerment to make life changes consistent with the new view.

9. *Meaning creation work* involves a *meaning protest* against a life event. Clarke (1989) described the meaning protest marker as the expression of strong emotion and confusion or puzzlement about a painful life event, in conjunction with description of a challenged cherished belief. Meaning protests often involve loss, disappointment or other life crises, and so meaning creation work is particularly appropriate with post-trauma, grief or chronic illness. This task involves helping clients in states of high emotional arousal to capture their experience in words and images that symbolise and begin to contain their emotional experience. Therapist interventions that facilitate this task attempt to help the client clarify and symbolise the the cherished belief (e.g., bad things don't happen to good people), the discrepant experience (a trauma or other painful life event), and the discrepancy between belief and experience. The client and therapist work together to accomplish this, typically using metaphors that capture aspects of the meaning crisis in words and images.

As this work progresses, client and therapist explore the cherished belief, including its basis and continued tenability. However, the therapist does not challenge the cherished belief, or call it 'dysfunctional'; instead, the belief is accepted and understood, while being held up for reflection. In full resolution,

Clarke, KM (1989) Creation of meaning: An emotional processing task in psychotherapy. *Psychotherapy*, 26, 139-48.

**Labott, S, Elliott, R & Eason, P (1992)** 'If you love someone, you don't hurt them': A comprehensive process analysis of a weeping event in psychotherapy. *Psychiatry*, 55, 49-62.

the client modifies some aspect of the cherished belief, symbolises this change, and considers new behaviour. For example, in Labott, Elliott and Eason (1992), a depressed client wept intensely as she accessed her disappointment and anger with her alcoholic father for hitting her as a child; in exploring her reaction, she discovered that his behaviour had violated her cherished belief that 'if you love someone, you don't hurt them'. Through examining this belief and her experience, she concluded that her father hadn't really loved her and that his behaviour was not really her fault. Finally, she realised that she needed to work on issues of trust in her marital relationship.

### *Active expression tasks*

The last set of EFT tasks come out of gestalt and psychodrama traditions and ask the client to enact a conversation between aspects of self or between self and others. These tasks are used to allow clients to evoke, access and change disowned or externally attributed aspects of self; and they are particularly useful for helping clients change how they act toward themselves (e.g., moving from self-attacking to self-supporting). These active, highly evocative tasks generally require a strong therapeutic alliance and thus are rarely attempted before session three or four.

**Greenberg, LS (1979)** Resolving splits: The two-chair technique. *Psychotherapy: Theory, Research & Practice*, 16, 316-24.

10. *Two-chair dialogues* are used when the client presents some form of *conflict split* marker (Greenberg, 1979). While some conflicts are easily recognised, others are not:

- **Decisional conflict:** client feels torn between two alternative courses of action (e.g., to end a relationship or not).
- **Coaching split:** client tries to encourage self to do or feel something; here, the conflict is between coach and self aspects of the person.
- **Self-criticism split:** client criticises self; this is seen as a conflict between critic and self aspects.
- **Attribution split:** client describes what they perceive as an overreaction to a perceived critical or controlling other person or situation; this is understood as a conflict between the self aspect and the client's own critic or coach aspect, projected onto the other person or situation.

In addition, 'anxiety splits' and 'depression splits' are common forms of split found in anxious or depressed clients. For example, trauma victims often present anxiety splits which play off a weak self against the client's perception of a fear-inducing situation (e.g., driving on the motorway) to which

the client over-reacts. Clearly, the conflict split marker is the broadest, most complex of all the EFT task markers!

The therapist initiates two-chair dialogue by suggesting that the client move back and forth between two chairs, each representing one self-aspect, in order to enact the internal conversation between the two parts. In the case of an attributional split, the client is asked to enact the other or the external situation. For example, a traumatised client with a fear of driving on the motorway can be asked to 'be' the motorway and 'show how you scare [the client]'. This gives the client the opportunity to identify with and re-own the powerful, scarifying part of the self. This re-owning provides a partial resolution, while a full resolution would require some kind of mutual understanding and accommodation between the fearful self and the fear-inducing aspect, with the fearful self elaborating its fear emotion scheme and needs, and the fear-inducing aspect softening its stance toward the self-aspect.

11. *Two-chair enactment for self-interruption* markers are relevant for addressing immediate within-session episodes of emotional avoidance or distancing, which indicate self-interruption (Elliott et al., 2004). Depressed, anxious and traumatised clients often suffer from an underlying emotional processing split between emotional/experiencing and intellectual/distancing aspects of self. These processing splits result in emotional blocking or stuckness. Self-interruptions are most readily recognised when the client begins to feel or do something (e.g., express anger) in the session, then stops him- or herself, often with some kind of non-verbal action (e.g., squeezing back tears) or reported physical sensation (e.g., headache). However, self-interruptions are also indicated by statements of resignation, numbness, or stuckness, or reports of feeling weighted down.

Work on this task begins by asking the client to enact the process of self-interruption. In a two-chair enactment, the therapist directs the client's attention to the interruption, suggesting an experiment by asking them to 'show how you stop yourself from feeling [e.g., anger]'. The intervention aims to help the client to bring the automatic avoiding aspect of self into awareness and under deliberate control; this in turn helps the client become aware of the previously interrupted emotion, so that it can be expressed in an appropriate, adaptive manner. Minimal resolution involves expression of the interrupted emotion, with more complete resolution requiring expression of underlying needs and self-empowerment.

**Elliott, R, Watson, JC, Goldman, RN,  
& Greenberg, LS (2004) *Learning  
Emotion-Focused Therapy: The process-  
experiential approach to change.*  
Washington, DC: American  
Psychological Association.**

**Note**

Research by Paivio and Greenberg (1995) supports the effectiveness of empty-chair work for helping client resolve trauma-related issues, and it is also used extensively with depression (e.g. Greenberg & Watson, 2005), especially with clients whose depression is characterised by interpersonal loss issues. See also Andy Hill's section on Counselling for Depression, pp 223-32.

Paivio, SC & Greenberg, LS (1995) Resolving 'unfinished business': Efficacy of experiential therapy using empty chair dialogue. *Journal of Consulting and Clinical Psychology*, 63, 419-25.

Greenberg, LS & Watson, JC (2005) *Emotion-Focused Therapy for Depression*. Washington, DC: American Psychological Association Press.

**Watson, J, Goldman, R, Greenberg, LS & Fox, A (July, 2012) *Working with Self-Soothing for Anxiety in EFT***. Paper presented at the conference of the World Association for Person-Centered and Experiential Psychotherapy and Counseling, Antwerp, Belgium.

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

In this task, the therapist suggests that the client imagine the other in the empty chair and express unexpressed or unresolved feelings toward them. Where appropriate, the therapist sometimes suggests that the client also take the role of the other and speak to the self. At a minimum, resolution consists of expressing the unmet needs to the other; full resolution requiring restructuring of unmet needs, a shift toward a more positive view of self, and a more differentiated view of the other.

Empty-chair work is highly evocative and emotionally arousing. If the client is already in a highly emotional state, they are likely to feel overwhelmed even by the suggestion to speak to the other in the empty chair. Therefore, when emotional arousal is high to start with, it is preferable to use the meaning creation task described earlier, because it helps the client to symbolise and contain painful emotion. In general in empty-chair work, the therapist needs to maintain constant empathic attunement to the client's level of emotional arousal and whether the client feels safe enough with the therapist to undertake or continue with this task.

13. *Compassionate self-soothing* is the most recently developed EFT task (Watson et al., 2012) and is used when the client experiences *stuck/disregulated anguish*, typically in the face of a powerful existential need (e.g., for love or validation) that has not or cannot be met by others. Compassion is the opposite of self-criticism; expressing compassion toward oneself is a way of changing painful emotions (e.g., shame, fear, sadness) by internally confronting them with a different emotion. In this task, the therapist first helps the client deepen their sense of anguish so that they can access their core existential pain and express the unmet need associated with it. Then, the therapist offers a two-chair process to the client in which they enact providing what is needed (e.g., validation, support, protection) to themselves. This can be done either directly or

with the needy part symbolised as child or close friend experiencing the same things that the client is. The comforting aspect is represented either as a strong, nurturing aspect of self or as an idealised parental figure.

## Practical implementation of EFT

### *Modality*

EFT is generally carried out in an individual format, however, under different names ('focused expressive therapy', 'emotionally focused therapy') and with somewhat different emphases, EFT has been used successfully in a group modality (Daldrup, Beutler, Engle & Greenberg, 1988) and extensively in a conjoint format (e.g., Greenberg & Johnson, 1988; Johnson, 2004).

### *Appropriate clients*

EFT is most appropriate for use in outpatient settings with clients experiencing mild-to-moderate levels of clinical distress and symptoms (Elliott et al., 2004). Some clients seem to enter therapy with processing styles that allow them to engage almost immediately in the mindful attending, experiential search and active expression modes of engagement so critical to this approach. These clients quickly respond to empathic interventions by turning inward and exploring, suggesting some predisposition on their part. Such clients may have a variety of diagnoses and problems, including adjustment reactions, depression, post-trauma difficulties, anxiety, low self-esteem, internal conflicts, emotional injuries and difficulties with others.

In our experience, some clients do have trouble exploring the edges of their own experience. It's important to EFT to creatively adapt therapy to the range of clients with various processing styles. For instance, some clients seem to be persistently focused on external factors such as unsupportive others and seem oblivious to the therapist's efforts to help them look inside. Other clients enter therapy seeking expert advice. These clients can experience the therapist's failure to give advice or interpretations as unempathic and an arbitrary withholding of help. For these clients, the EFT therapist helps them gradually increase their ability to turn their attention inward by consistent empathic exploration of inner experience and by explaining the purpose of this sort of work. In addition, process guiding tasks such as focusing and empty-chair work may be useful. Finally, with such clients, the therapist is always ready to engage in relationship dialogue regarding EFT tasks and activities.

**Daldrup, R, Beutler, L, Engle, D & Greenberg, LS (1988)** *Focused Expressive Therapy: Freeing the overcontrolled patient*. London: Cassell.

**Greenberg, LS & Johnson, SM (1988)** *Emotionally Focused Therapy for Couples*. New York: Guilford Press.

**Johnson, SM (2004)** *The Practice of Emotionally Focused Marital Therapy: Creating connection* (2nd edn). Philadelphia, PA: Brunner-Mazel.

**Elliott, R, Watson, JC, Goldman, RN, & Greenberg, LS (2004)** *Learning Emotion-Focused Therapy: The process-experiential approach to change*. Washington, DC: American Psychological Association.

**Greenberg, LS & Watson, JC (2005)** *Emotion-Focused Therapy for Depression*. Washington, DC: American Psychological Association Press.

**Paivio, SC & Pascual-Leone, A (2010)** *Emotion-Focused Therapy for Complex Trauma*. Washington, DC: APA.

**Elliott, R (in press)** Person-centered-experiential psychotherapy for anxiety difficulties: Theory, research and practice. *Person-Centered & Experiential Psychotherapies*

**Elliott, R, Watson, JC, Goldman, RN, & Greenberg, LS (2004)** *Learning Emotion-Focused Therapy: The process-experiential approach to change*. Washington, DC: American Psychological Association.

#### Note

Ideally, therapists learning EFT will have previously learned PCT. If not, the initial phase of EFT training focuses on the PCT facilitative skills of accurate empathy, unconditional positive regard, and genuineness, since training in the more active tasks e.g. chair work, rely heavily on PCT skills. EFT training often begins with the less process-guiding tasks of focusing, evocative unfolding, and meaning creation, and increasingly shifts to the different forms of chair work. Training in each task typically begins with didactic instruction and training in recognising markers, followed by modelling and experiential workshop training in both client and therapist roles. Trainees are then closely supervised with actual clients. To be certified as an EFT therapist they must complete about 120 hours of formal training and supervision in EFT tasks, and successfully apply a range of EFT tasks in at least 30 sessions with at least two different clients.

### *Session length and frequency*

In EFT the standard session length and frequency of 50–60 minutes once a week is typical. In order to maintain continuity, sessions generally occur on a weekly basis, particularly in the main working phase. Nevertheless, the therapist is flexible and allows for client self-determination within the limits imposed by scheduling. Particularly as therapy progresses, it makes sense to offer the client the option of less frequent sessions, including monthly ‘maintenance’ sessions after the main work of therapy has been completed.

EFT is appropriate as either a brief or long-term therapy, although the relationship elements appear to play a larger role in the longer therapies needed for clients suffering from chronic personality or interpersonal difficulties. As a brief therapy, EFT emphasises task interventions, and there are standard protocols for clients presenting with depression (Greenberg & Watson, 2005), complex trauma (Paivio & Pascual-Leone, 2010), and most recently social and generalised anxiety (Elliott, in press). In open-ended work, a good practice is to ask the client at the beginning of therapy how many sessions they feel are needed, and to review progress and goals every ten sessions or so. As much as external constraints allow, the client is encouraged to judge when they are ready to end therapy.

### *Training and supervision*

Learning EFT presents trainees with substantial demands in that they are asked to learn general theories of function, dysfunction, and the change process, along with sets of therapy principles, therapist response modes, and therapy tasks and their variations. Elliott et al. (2004) describe a multifaceted training program to promote the development of these therapist capacities. The training consists of the following components:

- Trainee selection and self-selection for basic experiential capacities and interests
- Safe, supportive but stimulating training context
- Cognitive/didactic learning, including lectures and readings
- Observation of examples/modelling
- Supervised practice in therapist role, including focus on both technique and personal development
- Direct experience in client role, in order to experience the effects of task interventions
- Reflexivity, supported by self-observation/evaluation, client feedback, and participation in continuing treatment development

## Research – Selected outcome data on EFT

Based on the 2008 meta-analytic data set of Elliott et al. (in press), the outcome of individual EFT has been the subject of at least 18 separate studies with various clinical populations, involving a total of 344 clients. The client populations fall into four clusters:

- Major depression (e.g., Goldman et al., 2006; Greenberg & Watson, 1998)
- Abuse, trauma, and other unresolved interpersonal relationships (e.g., Greenberg, Warwar & Malcolm, 2008; Paivio & Nieuwenhuis, 2001)
- Decisional conflicts (e.g., Clarke & Greenberg, 1986)
- Mixed or other problems (e.g., Klein & Elliott, 2006)

All the available studies (above is a selection of the most accessible) give data from over 300 clients across studies. The data show very large amounts of client change over the course of therapy, even more than the large pre–post changes generally found for person-centred or other humanistic therapies. Seven of the studies compared EFT to CBT or psychoeducation, generally for interpersonal-relational problems (including trauma). These studies show a consistent advantage for EFT over the other therapies. Finally, the two York (Canada) depression studies (Greenberg & Watson, 1998; Goldman et al., 2006) found EFT to be more effective for depression than PCT.

This shows that EFT appears to be a promising approach to therapy, especially for depression and trauma/relational/interpersonal problems; however, more research is needed to document its effects with a broader range of client populations. In particular, several EFT researchers are currently conducting studies on the effectiveness of EFT with anxiety difficulties, including generalised anxiety and social anxiety. Recently, for example, my colleagues and I have reported promising initial results comparing PCT and EFT to each other and to published CBT outcome benchmarks (Elliott, in press), while Timulak and McElvaney (2012) have reported large pre–post effects in an open clinical trial of EFT for generalised anxiety difficulties.

**Elliott, R, Watson, J, Greenberg, LS, Timulak, L & Freire, E (in press)** Research on humanistic-experiential psychotherapies. In MJ Lambert (ed) *Bergin & Garfield's Handbook of Psychotherapy and Behavior Change* (6th edn). New York: Wiley.

**Goldman, RN, Greenberg, LS & Angus, L (2006)** The effects of adding emotion-focused interventions to the client-centered relationship conditions in the treatment of depression. *Psychotherapy Research, 16*, 537-49.

**Greenberg, LS, & Watson, J (1998)** Experiential therapy of depression: Differential effects of client-centered relationship conditions and active experiential interventions. *Psychotherapy Research, 8*, 210-24.

**Greenberg, LJ, Warwar, SH, & Malcolm, WM (2008)** Differential effects of emotion-focused therapy and psychoeducation in facilitating forgiveness and letting go of emotional injuries. *Journal of Counseling Psychology, 55*, 185-96.

**Paivio, SC & Nieuwenhuis, JA (2001)** Efficacy of emotion-focused therapy for adult survivors of child abuse: A preliminary study. *Journal of Traumatic Stress, 14*, 115-34.

**Clarke, KM & Greenberg, LS (1986)** Differential effects of the gestalt two-chair intervention and problem solving in resolving decisional conflict. *Journal of Counseling Psychology, 33*, 11-15.

**Klein, MJ & Elliott, R (2006)** Client accounts of personal change in process-experiential psychotherapy: A methodologically pluralistic approach. *Psychotherapy Research, 16*, 91-105.

See overleaf for a note on the York depression studies and the remainder of the references.

**Note**

The York depression studies are controversial: the results of the two studies had to be combined in order for the benefit for EFT over PCT to show up; also they can be criticised as having been influenced by researcher allegiance. On the other hand, the therapists were carefully trained and supervised in both PCT and EFT, and were also monitored for treatment adherence, including empathy.

**Elliott, R (in press)** Person-centered-experiential psychotherapy for anxiety difficulties: Theory, research and practice. *Person-Centered & Experiential Psychotherapies*

**Timulak, L, & McElvaney, J (July 2012)** *Emotion-Focused Therapy for Generalised Anxiety Disorder*. Paper presented at conference of the World Association for Person-Centered and Experiential Psychotherapy and Counseling, Antwerp, Belgium.

**Resources****Key books**

Elliott, R, Watson, JC, Goldman, RN & Greenberg, LS (2004) *Learning Emotion-Focused Therapy: The process-experiential approach to change*. Washington, DC: American Psychological Association.

Greenberg, LS & Watson, JC (2005) *Emotion-Focused Therapy for Depression*. Washington, DC: APA.

Paivio, SC & Pascual-Leone, A (2010) *Emotion-Focused Therapy for Complex Trauma*. Washington, DC: APA.

Greenberg, LS, Rice, LN & Elliott, R (1993) *Facilitating Emotional Change: The moment-by-moment process*. New York: Guilford Press.

Watson, J, Goldman, RN & Greenberg, LS (2007) *Case Studies in Emotion-Focused Therapy for Depression*. Washington, DC: APA.

**Videos**

*Emotion-Focused Therapy Over Time* (Les Greenberg, 6 sessions, with voice-over commentary. APA, 2008) <[www.apa.org](http://www.apa.org)>

*Emotion-Focused Therapy for Depression* (Les Greenberg, 2 sessions; APA, 2006) <[www.apa.org](http://www.apa.org)>

**EFT for couples**

Greenberg, LS & Goldman, RN (2008) *Emotion-Focused Couples Therapy: The dynamics of emotion, love, and power*. Washington, DC: APA.

Johnson, SM (2004) *The Practice of Emotionally Focused Marital Therapy: Creating connection* (2nd edn). Philadelphia, PA: Brunner-Mazel.

**Websites**

<[www.iseft.org](http://www.iseft.org)> [Website for International Society for Emotion-Focused Therapy]

<[www.process-experiential.org](http://www.process-experiential.org)> [*Learning EFT* book website]

<[www.emotionfocusedclinic.org](http://www.emotionfocusedclinic.org)> [Les Greenberg's website]

<[www.eft.ca](http://www.eft.ca)> [Sue Johnson's website]

**Useful research tools**

(available at <<http://experiential-researchers.org/instruments.html>>

Helpful Aspects of Therapy Form

Change Interview

Therapist Experiential Session Form