An Introduction to Emotion-Focused Therapy

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Basics of EFT

Focus on emotion as organizing principle and key to transformation, high dose of empathic attunement
Focus on relational presence and fostering the therapeutic alliance
Focus on collaboration between T & C and agreement of goals & tasks in therapy
Strong focus on process differentiation: differential empathy, specific markers & tasks as a means to explore, evoke and transform emotions.
Experiential re-formulation of client’s problems according to the theory of emotion: EFT case formulation
Evidence-based
“Changing emotion with emotion”

Emotion-Focused Therapy

- aka Proces-Experiential psychotherapy
- Leslie Greenberg, Laura Rice, Robert Elliott, Jeanne Watson, Ronda Goldman, Sandra Paivio & Antonio Pascual-Leone
- Integration of:
  - Person-centered & Experiential Psychotherapy
  - Empathy, Genuineness & Acceptance (Rogers)
  - Focusing (Gendlin)
  - Existential therapy
  - Interpersonal therapy
  - Gestalttherapy (Perls)
  - Emotion theories

Emotions are fundamentally adaptive

1. We construct our reality highly based on emotion
2. Emotions are a source of idiosyncratic information, they tell us what is important for us.
3. Emotions help us to survive, they trigger efficient, automatic reflexes in important situations.
4. Emotions give us a sense of identity, they integrate our experiences and give them meaning.
5. Emotions prepare us for action: emotions generate wishes/needs, and they tell us what we need to do.

“Every feeling has a need, every need has a direction for action”
3 problems with emotional processing

1. Sometimes we are too close or too distant to our emotions → emotion regulation
2. Sometimes we get stuck in emotions because we miss an important piece of it → emotion schemes
3. Sometimes the most important emotion gets covered up by other emotions → different sorts of emotional responses

Emotion regulation: how to smell the soup

Adaptive Strategies for Moderating Emotion

<table>
<thead>
<tr>
<th>Strategy/Route</th>
<th>Examples of Therapeutic Work or Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Support client’s strategies</td>
<td>Ask what client does for self</td>
</tr>
<tr>
<td>2. Controlled expression of emotion</td>
<td>Offer client opportunity to safely and carefully experience/express emotions</td>
</tr>
<tr>
<td>3. Seek support and understanding from others</td>
<td>Offer genuine empathic understanding and unconditional positive regard</td>
</tr>
<tr>
<td>4. Symbolize emotion in words or images</td>
<td>Empathic exploration; Focusing; creative arts methods</td>
</tr>
<tr>
<td>5. Use language/imagery to contain or distance</td>
<td>Use packaging rather than evocative reflections; reflect using “it” or “something”; help client attain useful working distance; Clearing a Space</td>
</tr>
<tr>
<td>6. Self-soothing/self-compassion, relaxing, self-comforting, self-supporting, self-caring</td>
<td>Empathic Affirmation; prizing voice; offer Self-Soothing task; suggest pleasant or self-soothing activities</td>
</tr>
<tr>
<td>7. Regain psychological contact (for overwhelmed or dissociated states)</td>
<td>Pre-therapy; Mindfulness suggestions: “Take a breath”; “Put your feet on the floor”; “Look at me”; “Pay attention to what you sense around you”</td>
</tr>
</tbody>
</table>

Adaptive Strategies for Accessing Emotion

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Examples of Therapeutic Work or Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate level of arousal in order to create safety</td>
<td>Make a safe Space for attending to emotions</td>
</tr>
<tr>
<td>Attend to emotion-related bodily sensations</td>
<td>Focusing</td>
</tr>
<tr>
<td>Remember previous emotion episodes</td>
<td>Systematic Evocative Unfolding; Trauma retelling</td>
</tr>
<tr>
<td>Encounter vivid emotion triggers</td>
<td>From client or therapist; words or images</td>
</tr>
<tr>
<td>Enact emotion expression and action tendencies</td>
<td>Unfolding, Meaning Creation</td>
</tr>
</tbody>
</table>
Emotion Schemes

Pre-experiential mode of client’s engagement

Emotion Response Types

Forms of Emotion Response

1. Primary Adaptive Emotion Responses:
   Unlearned, direct response to situation

- Finding the Most Useful Emotion that Got Covered up by a Different, Less Useful Emotion
- Controversy: Does anger expression help or hurt?
- It depends on what kind of anger

- rationalising
- externalising
- impulsive
- somatising

Situation
- e.g., violation

Primary Emotion
- e.g., anger

Adaptive Action
- e.g., defend self
2. Maladaptive Emotion Responses:
Learned, direct response to situation: SOS

3. Secondary Reactive Emotion Responses:
Adaptive emotion obscured by a self- or externally-focused reaction to the primary emotion

4. Instrumental Emotion Responses:
Emotion displayed for its intended effect, independent of actual emotional experience

“You have to arrive at an emotion, before you can leave it”
Universal Human Emotions in their Adaptive Forms (from Greenberg & Paivio, 1997)

<table>
<thead>
<tr>
<th>Situation</th>
<th>Emotion</th>
<th>Adaptive Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violation, attack on self, family or possessions</td>
<td>Anger</td>
<td>Assert, protect, defend self</td>
</tr>
<tr>
<td>Loss, separation</td>
<td>Sadness</td>
<td>Seek connection, support (e.g., crying)</td>
</tr>
<tr>
<td>Psychological injury</td>
<td>Emotional pain</td>
<td>Withdraw into self</td>
</tr>
<tr>
<td>Danger</td>
<td>Fear</td>
<td>Freeze, monitor, flee</td>
</tr>
<tr>
<td>Exposure as having acted inappropriately</td>
<td>Shame</td>
<td>Correct or hide impropriety to protect social standing, connection with others</td>
</tr>
<tr>
<td>Harming a valued other</td>
<td>Guilt</td>
<td>Repair the damage, apologise</td>
</tr>
<tr>
<td>Offensive, dirty, indigestible object or person</td>
<td>Disgust, contempt</td>
<td>Expel or avoid object or person</td>
</tr>
<tr>
<td>Change, novel stimuli</td>
<td>Surprise, interest, curiosity, excitement</td>
<td>Attend, approach, explore, engage</td>
</tr>
<tr>
<td>Suffering of a vulnerable other</td>
<td>Compassion</td>
<td>Offer support, validation, soothing</td>
</tr>
<tr>
<td>Achievement of goal, task, need or connection</td>
<td>Happiness, joy</td>
<td>Friendly interaction, future seeking of similar situations</td>
</tr>
<tr>
<td>Highly valued other</td>
<td>Love, affection, caring</td>
<td>Contact, express positive regard; strengthen attachment bonds</td>
</tr>
</tbody>
</table>

A short story about emotions

Therapeutic Tasks in EFT

- What is a therapeutic task?
- From research on human problem-solving
  - Research method: Task Analysis
  - Clients bring specific immediate issues or emotional tasks to sessions
### Elements of EFT Tasks

- **Marker**: observable sign that client may be ready to work on a problem
- **Client steps to resolution**: Measured by 6-point Degree of resolution scale
- **Therapist responses**: What therapist can do to help client resolve
- **Resolution state**: What resolution looks like

### EFT Task Map - 2015

#### A. Interpersonal/Relational Markers:

1. **Begins therapy**
2. **Alliance Difficulty**: (a) Confrontation: Client expresses or implies complaint or dissatisfaction about nature or progress of therapy, or therapeutic relationship; (b) Withdrawal: Client disengages from therapy process

#### A. Interpersonal/Relational Markers, cont.:

3. **Vulnerability**: Client expresses distress over strong negative self-related feelings (usually with hopelessness & sense of isolation)
4. **Contact Disturbance**: Immediate in-session state takes client out of psychological contact with therapist (hearing voices, dissociation, panic, narrowly focused interest)

#### EFT Task Map - 2015

<table>
<thead>
<tr>
<th>Marker</th>
<th>Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Interpersonal/Relational Markers:</strong></td>
<td></td>
</tr>
<tr>
<td>1. Begins therapy</td>
<td><strong>Alliance Formation</strong></td>
</tr>
<tr>
<td>2. <strong>Alliance Difficulty</strong>: (a) Confrontation</td>
<td><strong>Relational Dialog</strong></td>
</tr>
<tr>
<td>3. <strong>Vulnerability</strong>: Client expresses distress over strong negative self-related feelings (usually with hopelessness &amp; sense of isolation)</td>
<td><strong>Empathic Affirmation</strong></td>
</tr>
<tr>
<td>4. <strong>Contact Disturbance</strong>: Immediate in-session state takes client out of psychological contact with therapist (hearing voices, dissociation, panic, narrowly focused interest)</td>
<td><strong>Contact Work (Pre-therapy)</strong></td>
</tr>
</tbody>
</table>
### B. Experiencing Markers:

1. **Unclear Feeling:**
   - (a) Vague/nagging concern
   - (b) Global, abstract, superficial, or externalized mode of engagement

2. **Attentional Focus Difficulty:**
   - (a) Overwhelmed by multiple worries or one big worry
   - (b) Stuck/blank: Unable to find a session focus

### C. Reprocessing Markers:

1. **Narrative pressure:** Client refers to a traumatic/painful experience about which a story wants to be told (e.g., traumatic event, disrupted life story, nightmare)

2. **Problematic Reaction Point:** Client describes unexpected, puzzling personal reaction (behavior, emotion reaction)

3. **Meaning Protest:** Client describes a life event discrepant with a cherished belief, in an emotionally aroused state

### D. Introject Markers:

1. **Conflict Split:** Client describes a conflict between two aspects of self, in which one aspect of self is (a) critical (self-criticism split), (b) coercive toward (coaching & decisional splits), or (c) blocks another aspect (self-interruption split).

   - Two Chair Work (self aspects)

2. **Attribution Split:** Client describes general over-reaction to others, in which other(s) are experienced as (a) critical of, (b) coercive toward, (c) blocking of the self; or (d) generating an intense interpersonal “allergy”

   - Two Chair Work (w Others as self aspect)

### D. Introject Markers, cont:

3. **Unfinished Business/Unresolved Relationships:** Client blames, complains, or expresses hurt or longing in relation to a significant other

   - Empty Chair Work

   - Alternative: Speaking Your Truth

4. **Anguish with inability to regulate:** Expresses strong emotional pain in presence of severe self-criticism or lack of connection/support, and is not helped by therapist empathic affirmation

   - Self-Soothing Work
Two Chairwork for Conflict Splits

A. Conflict Split Marker
1. Two wishes or action tendencies
2. Description of contradiction, conflict between
3. Expression of struggle, coercion

Prototypical Split = Decisional conflict

Alternative Forms:
1. Self-criticism
2. Coaching splits (self-coercion)
3. Self-interruption (internal blocking)
4. Attribution splits (externalized; over-reaction to others)

Self-Evaluation Splits: Task Resolution Scale
1. Marker/Task Initiation: Client describes internal conflict in which one aspect of self is critical of, or coercive toward, another aspect.
2. Entry: Clearly expresses criticisms, expectations, or "shoulds" to self in concrete, specific manner.
3. Collapse/Deepening: Experiencing chair agrees with critic ("collapses"); primary underlying feelings/needs begin to emerge in response to the criticisms. Critic differentiates values/standards.
4. Emerging Shift: Clearly expresses needs and wants associated with a newly experienced feeling.
5. Softening: Genuinely accepts own feelings and needs. May show compassion, concern and respect for self.
6. Negotiation: Clear understanding of how various feelings, needs and wishes may be accommodated and

Model of Resolution of Self Criticism

Self Critical Marker

Role Play Critic

Hard criticism

Specific criticisms

Values standards

Softening

Role play Experiencer

Affective reaction

Differentiated feelings

Emerging experiences

Wants and needs

Secondary Maladaptive Adaptive

Negotiation

Integration

Two Chairwork: Facilitating Therapist Responses
1: Identify client marker (including pre-marker work). Elicit client collaboration in task
2: Structure (set up) experiment. Create separation & contact. Promote owning of experience. Intensify client arousal
3: Access and differentiate underlying feelings in the experiencing self (including collapsed self process). Differentiate values and standards in the critical aspect. Follow deepening forms of the conflict. Facilitate identifying with, expressing, or acting on organismic need. Bring contact to an appropriate close (= closure/ending experiment w/o resolution)
4: Facilitate emergence of new organismic feelings Create a meaning perspective (= processing)
5: Facilitate softening in critic (into fear or compassion)
6: Facilitate negotiation between aspects of self re: practical compromises
Illustration Two-chair dialogue with Les Greenberg

**What studies do we have?**

1. **Pre-post studies**
   - "Open clinic trials" & effectiveness studies:
   - Addresses question of whether clients change over therapy
   - 191 studies; 203 research samples
   - 14,235 clients
2. **Controlled studies**
   - vs. waitlist or nontreatment conditions
   - Addresses question of therapy causes change
   - 63 research samples; 60 studies, including 31 RCTs
   - 2,144 clients; 1,958 controls
3. **Comparative studies**
   - vs. non-PCE therapies (e.g., CBT, treatment as usual)
   - Addresses question of whether which therapies are most effective
   - 135 comparisons; 105 research samples; 100 studies; 91 RCTs
   - 6,097 clients

**Is EFT evidence-based?**

**Main Reference:**


**Inclusion Criteria**

- Exhaustive search: attempt to find all existing studies:
- Therapy must be labeled as Client-/Person-centred, (Process-)Experiential, Focusing, or Gestalt; or described explicitly as empathic and/or centering on client experience
- 2+ sessions
- 5+ clients
- Adults or adolescents (12+ years)
- Effect size (Cohen’s d) must be calculable
### Type of PCE Therapy

<table>
<thead>
<tr>
<th>(Pre-post effects)</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person-Centred Therapy (PCT)</td>
<td>82</td>
<td>40%</td>
</tr>
<tr>
<td>Supportive-Nondirective (SNT)</td>
<td>33</td>
<td>17%</td>
</tr>
<tr>
<td>Emotion-Focused Therapy (EFT)</td>
<td>34</td>
<td>17%</td>
</tr>
<tr>
<td>Other experiential (e.g., Gestalt, Psychodrama)</td>
<td>43</td>
<td>21%</td>
</tr>
<tr>
<td>Supportive-expressive (Existential)</td>
<td>10</td>
<td>5%</td>
</tr>
</tbody>
</table>

### What is an Effect Size (ES)?

Change E.S. = \( \frac{m_{\text{pre}} - m_{\text{post}}}{sd_{(pooled)}} \)

- This stuff is **algebra** …
- That means when you use letters to stand for numbers
- The letters are called "variables", because they vary…
- This is useful because we can use them to stand for lots of different numbers
- Change ES = Pre-post Effect size
- M = mean/average of pre or post scores
- SD = averaged ("pooled") standard deviation

### Interpreting Effect Sizes (SD units)

- LARGE
  - 1.0
  - 0.9
- MEDIUM
  - 0.8
  - 0.7
  - 0.6
- SMALL
  - 0.5
  - 0.4
  - 0.3
  - 0.2
  - 0.1
  - 0.0

### Pre-post studies

- "Open clinic trials" & effectiveness studies;
- Addresses question of whether clients change over therapy
- 191 studies; 203 research samples
- 14,235 clients
### Overall Pre-Post Effect Sizes: first line of evidence

<table>
<thead>
<tr>
<th>ASSESSMENT POINT</th>
<th>N</th>
<th>Mean ES</th>
<th>Standard error of mean ES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post</td>
<td>185</td>
<td>.95</td>
<td>.05</td>
</tr>
<tr>
<td>Early Follow-up (&lt; 12 months)</td>
<td>77</td>
<td>1.05</td>
<td>.07</td>
</tr>
<tr>
<td>Late Follow-up (12+ months)</td>
<td>52</td>
<td>1.11</td>
<td>.09</td>
</tr>
<tr>
<td>Overall: Unweighted</td>
<td>199</td>
<td>.96</td>
<td>.04</td>
</tr>
<tr>
<td>Weighted</td>
<td>199</td>
<td>.93</td>
<td>.04</td>
</tr>
</tbody>
</table>

*Standard error of mean = how dodgy the mean ES is; the smaller the better!*

### Interpreting Effect Sizes:

After PCE, average (=50%) Person => better off than 84% of People were before PCE

### Controlled & Comparative Study Analyses: second line of evidence

- Calculate difference in pre-post ES between:
  - PCE therapy, and
  - No-treatment control or non-PCE treatment

### Are PCE Therapies More Effective than no therapy?

- Also: Do PCE therapies cause clients to change?
- Better: Do clients use PCE therapies to cause themselves to change?
### Controlled Effect Sizes (vs. waitlist or untreated clients)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean ES</th>
<th>Standard error of mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Untreated clients</td>
<td>53</td>
<td>.19</td>
<td>.04</td>
</tr>
<tr>
<td>pre-post ES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Controlled:</td>
<td>62</td>
<td>.81</td>
<td>.08</td>
</tr>
<tr>
<td>Unweighted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weighted by N</td>
<td>62</td>
<td>.76</td>
<td>.06</td>
</tr>
<tr>
<td>Weighted, RCTs only</td>
<td>31</td>
<td>.76</td>
<td>.10</td>
</tr>
</tbody>
</table>

### Interpreting Effect Sizes (SD units)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td></td>
<td>1.0</td>
</tr>
<tr>
<td>LARGE</td>
<td>.9</td>
</tr>
<tr>
<td></td>
<td>.8</td>
</tr>
<tr>
<td>MEDIUM</td>
<td>.7</td>
</tr>
<tr>
<td></td>
<td>.6</td>
</tr>
<tr>
<td>SMALL</td>
<td>.5</td>
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<td></td>
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<td>.3</td>
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<td>.2</td>
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<td></td>
<td>.1</td>
</tr>
<tr>
<td></td>
<td>.0</td>
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</table>

### Are Other Therapies more Effective than PCE Therapies?

- Which therapies are most effective?
- Note: Most people in our culture assume that CBT is more effective than other therapies, include PCE therapies.
- Is this true or is it a myth?

### Equivalence Analyses

<table>
<thead>
<tr>
<th>Comparison</th>
<th>N</th>
<th>Mean Comp ES</th>
<th>Stand err of mean</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCE vs. non-PCE</td>
<td>135</td>
<td>0.01</td>
<td>0.03</td>
<td>Equivalent</td>
</tr>
<tr>
<td>PCE vs. non-CBT</td>
<td>59</td>
<td>0.17</td>
<td>0.05</td>
<td>Trivially better</td>
</tr>
<tr>
<td>PCE vs. CBT</td>
<td>76</td>
<td>-0.13</td>
<td>0.04</td>
<td>Trivially worse</td>
</tr>
<tr>
<td>SNT vs. CBT</td>
<td>37</td>
<td>-0.27</td>
<td>0.07</td>
<td>Equivocally worse</td>
</tr>
<tr>
<td>PCT vs. CBT</td>
<td>22</td>
<td>-0.06</td>
<td>0.02</td>
<td>Equivalent</td>
</tr>
<tr>
<td>EFT vs. CBT</td>
<td>6</td>
<td>0.53</td>
<td>0.2</td>
<td>Better</td>
</tr>
<tr>
<td>Other Exp. vs. CBT</td>
<td>10</td>
<td>-0.17</td>
<td>0.1</td>
<td>Trivially worse</td>
</tr>
</tbody>
</table>
What is “Supportive-Nondirective” Therapy (SNT)?

- Supportive/Nondirective:
  - 87% studies carried out by CBT Researchers (negative researcher allegiance; 40/46)
  - 65% explicitly labelled as “controls” (30/46)
  - 52% involve non bona fide therapies (24/46)
  - 76% of researchers are North American (35/46)
  - 61% involve depressed or anxious clients (28/46)

Researcher Allegiance (RA)

- Tendency to find results that support your approach or orientation
- Consistent finding:
  - E.g., Luborsky et al., (1999) RA predicts results at $r = .86$
  - Applies to drug research also
- Many possible explanations, e.g.:
  - Using non bona fide versions of therapies
  - Suppressing negative results
  - Researcher/therapist enthusiasm

Controlling for Researcher Allegiance (RA) Effects

- Strong, statistically-significant RA effect in comparative treatment studies ("horse races")

  => Ran analyses controlling for RA
  - Regression analysis: Used RA to predict Comparative ES, calculated residual scores
  - Ran analyses again, using residuals (what RA didn’t predict)

What Client Problems Do PCEPs do Best and Worst With?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Pre-Post</th>
<th>Controlled</th>
<th>Comparative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Mean ES</td>
<td>n</td>
</tr>
<tr>
<td>Relationship/Interpersonal/Trauma</td>
<td>23</td>
<td>1.27(+)</td>
<td>11</td>
</tr>
<tr>
<td>Depression</td>
<td>34</td>
<td>1.23(+)</td>
<td>8</td>
</tr>
<tr>
<td>Psychosis</td>
<td>6</td>
<td>1.08</td>
<td>0</td>
</tr>
<tr>
<td>Medical/Physical</td>
<td>25</td>
<td>.57(-)</td>
<td>6</td>
</tr>
<tr>
<td>Habit/Substance misuse</td>
<td>13</td>
<td>.65(-)</td>
<td>2</td>
</tr>
<tr>
<td>Anxiety</td>
<td>20</td>
<td>.94</td>
<td>4</td>
</tr>
<tr>
<td>Total Sample</td>
<td>201</td>
<td>.93</td>
<td>62</td>
</tr>
</tbody>
</table>
Main Conclusion:

Previous versions of meta-analysis replicated with an independent sample of new, recent studies:

Person-centred/ experiential therapies appear to be effective.

Summary of General Results: More Comparative Effects

- Pure PCT appears to be statistically equivalent in effectiveness to CBT (ES: -.09sd)
  - Even without controlling for researcher allegiance
- Emotion-Focused Therapy for individuals or couples appears to be more effective when compared to CBT (ES: .35)
  - But this may be due to researcher allegiance (sample too small)

What about Specific Client Problems? - 1

- Five client problem areas with bodies of literature:
  - Depression: PCE generally effective; strongest evidence for:
    - EFT
    - PCT for peri-natal depression
  - Trauma and Abuse: EFT has strong evidence
  - Couples problems: EFT-Couples has very strong evidence

What about Specific Client Problems? - 2

- Anxiety: CBT appears to be better than “nondirective-supportive” therapy
  - Virtually no research on PCT and EFT
  - But: EFT for Social Anxiety (Elliott) and Generalised Anxiety (Timulak)
- Severe, Chronic Dysfunctions: promising emerging evidence
  - Schizophrenia, severe personality difficulties
- Health-Related Problems: promising emerging evidence for chronic, life-threatening medical conditions
  - Eg. cancer, HIV-positive
  - “Supportive-Expressive therapy”: Yalom/existential
Where from here: Key Texts

- Paivio & Pascual-Leone, 2010: *Emotion-Focused Therapy for Complex Trauma*