Emotion-Focused Therapy

I. Musings & Some Things to Know about Psychotherapy

1. Psychotherapy in the Context of Evolution: Humankind has evolved to the point where the development of our intellectual and emotional capacities (frontal lobes, language centers, and limbic system) have advanced us so far that we are able to contemplate (self-consciousness) our own existence and place in the world leading us to consider what is the purpose of life. But this advancement is far from perfect. Thus there are genetic and biological deviations and disturbances, problematic developmental and leaning experiences, mostly in childhood, and existential concerns about the meaning of life that lead to psychological and physiological disturbances.
2. Psychotherapy and Medical Psychiatry are attempts to correct those disturbances. In the broadest and best sense consciousness is attempting to right itself in the context of everyday life, the universe, and the understanding of the meaning of life—practical to existential to spiritual/metaphysical. The alone mind is trying to find its way into a greater union; the part uniting with the whole.
3. One definition of psychotherapy is, "An interpersonal process designed to bring about modifications of feelings, cognitions, attitudes and behavior which have proved troublesome to the person seeking help from a trained professional (Strupp)."
4. Psychotherapy Theories and Practice: About 500 hundred psychotherapies can be listed but most stem from a few major traditions. Only a small number of psychotherapies have been scientifically evaluated. For their efficacy/effectiveness. Most approaches have forms of Individual, Family & Couples, Group & Organizational). Major traditions: Psychodynamic (Originals--Freud, Jung and Adler; 4 major schools--Freudian, Ego, Object Relations & Self), Cognitive-Behavioral (Cognitive, Behavioral--Operant & Classical conditioning, Dialectical), and Humanistic (covered below). Like the 3 great cooking traditions—French, Italian & Chinese—psychodynamic, behavioral and Humanistic have spawned a multitude of approaches.
5. Some of the subdivisions within these approaches are: Person-Centered, Gestalt, Existential, Emotion-focused, Biological/Psychopharmacological (ECT, TMS, Drugs), Strategic, Systemic, Structural, Solution-focused, Feminist, Constructivist, Narrative, Interpersonal, Expressive & Experiential, Hypnotherapy, EMDR, Mindfulness, Eclectic, Integrative/Holistic to just name a few.
6. The question to be answered regarding psychotherapy is, "What works, for whom, under what conditions." One has to consider, the therapist and the therapist's role, the client and what they bring personally as well as the support of the world around them, the kind of problem to be addressed and sometimes the diagnosis, the type and form of therapy/intervention offered, the time and frequency available, the match between the therapist and client, the therapeutic and working relationship, the readiness/motivation/stage of change, racial/cultural factors, and ongoing awareness of meeting client's needs and flexibility to change.

II. Understanding EFT for TLT: Theory & Treatment Process

1. Review of EFT Theory and Therapy Process:
    a. Historical development: Fritz Perls (Gestalt), Carl Rogers (Person-Centered), Irving Yalom, Rollo May, Victor Frankl (Existential), Leslie Greenberg, Susan Johnson, Robert Elliott, Rhonda Goldman, Sandra Paivio, Antionio Pascual-Leone, Jeremy Safran, Jennie Watson, Laura Rice (Process-Experiential & EFT)
    b. Focus is on the crucial role of emotional *experience* as the gateway into the impact of emotion on perception, thoughts, somatic reactions, and behavior.
    c. Constructive reason and emotion must to work together to produce optimal results.
    d. In working with emotions, needed is:
        i. A theory of emotion and the self.
        ii. A system for or way of accessing emotions.
        iii. A set of principles describing emotional change.
    e. Why focus on emotions?
        i. Emotion is information.
        ii. Emotion is a prime motivator of behavior.
        iii. Emotion is our primary signaling system.
        iv. Emotion is the basis for attachment (fear/anxiety regulated by closeness & security) & identity (anything from shame to pride and is regulated by sense of agency, assertion, prediction/control, & degree of validation). Also, interest/joy/affection/love are regulated by degree of attraction to & liking others.
        v. Emotion is often feared and avoided which lead to difficulties.
        vi. Emotional reactions are a learned phenomenon, often through early experiences and play an important role in internal and external behavioral reactions.
        vii. Emotions are therefore changeable and not immutable (i.e., memory reconsolidation research).
    f. Nature of emotions
        i. Emotions have a neurological primacy.
        ii. Emotions can occur outside of awareness.
        iii. Emotions precede (is faster than) thinking and language and are based direct knowing (experience).
        iv. With development, emotions become fused with cognition.
        v. The brain has two languages: symbolic/conceptual and sensory/bodily felt.
        vi. The "self" speaks mot powerfully in the language of emotion—especially in regard to basic physiological needs, safety & security, attainment of loving relationships, building self-esteem, and expression of innate and developed potentials.
    g. Function of emotions
        i. Tells us when something is wrong or when our needs not being met (provides motivation)
        ii. Emotions are our primary meaning system constantly giving us information about what we deem important.

iii. Emotions are a primary signaling system to others and ourselves about how we feel—the seeking pleasure and avoidance of pain.
iv. Emotions provide us with "action tendencies," meaning they shape the choice of behavioral responses tailored to achieve a personally meaningful end.
v. Emotions identify problems to be solved and rapidly communicate that there are problems to be solved.
vi. Emotions are biologically adaptive to survival.
vii. Emotions are fundamental to the construction of the sense of oneself—the feeling of what happens.

h. Learning how to regulate or manage our emotions is an important adaptation/motive in order to optimally survive and interact with the world around us, especially others.
i. Emotions enhance the motivation for:
   i. Fight or flight or freeze
   ii. Bonding when comforted by or attracted to another.
   iii. Taking action.
   iv. Amplifying our goal-directed behavior—even fostering or creating goals.
   v. Engaging in appropriate and proportioned responses, b/c without the direction emotions provide there would be fear without fleeing danger (harm avoidance); excitement without seeking a mate (bond/connection); empathy without caring or compassion for others (attachment); anger without defending oneself (boundaries); pride without gaining recognition (identity).
j. Major premise of EFT is that emotion is fundamental to the construction of the self and is the key determinant of self-organization or having a coherent sense of oneself—what is called the Dialectical Construction of the Self:
   i. We have emotions and the ability to reflect on emotions
   ii. Having emotions is automatic, without awareness or language and guides growth us by telling us whether good/bad as related to relevance, novelty, threat, violation, loss, noxious, achieving goals
   iii. Evaluating then is a reflective process, mostly in language, consciously on the output of having emotion and thus if can or should follow what emotion is telling us—if can trust our feelings, rely on them, want what we want and this is where we are responsible to choose and where agency resides.
   iv. Both streams above feed conscious experience and constantly interact with each other and with the world around us in a kind of dialogue that constructs meaning for us (a dialectical construction).
   v. Emotions provide the building blocks to self-organize but is influenced by culture/experience and organizes into schemes based on the emotions experienced in situations
   vi. What this means is that these parts of us connect with each other and work out some meaningful solutions—one that is co-constructed.
   vii. Emotion schemes are the primary generators of conscious experience

viii. When these experiences are put into language, they create understanding which is formed into beliefs and then narratives which are told stories formed from the lived story of our experience.
ix. Remember though experience is not formed from a single scheme but the synthesis of multiple schemes which configure to produce response with the help of other mental operations (attention; executive processes)
x. A person is organized by the dialectical synthesis of co-activated schemes into one of many possible self-organizations (possible me's). It produces "the feeling of what happens," the bodily felt-sense of oneself, the gut-feeling.
xi. The self is then this complex process of what emerges from the dialectical interaction of the many components to create a coherence that explains human knowing.
xii. In EFT we work with the dialectic, moment-by-moment implicit and explicit experience. We make the implicit explicit and help the participants reflect, articulate, organize, and construct a coherent narrative by integrating emotion and reason, head and heart.
xiii. We discover and create experience to generate new meaning. We weigh up the contradictory information and resolve them into a coherent whole that is "us." In this process we both create and discover ourselves, who we are, what we feel, and the world we choose to live in. What we make of experience makes us who we are—it determines the self we are about to become and the narrative we form about us.

k. Emotion Schematic Processing: Experiences are generated by Emotion Schemes (programs or apps). They are triggered automatically. Will not change by thinking alone. Make it safe. Access emotion scheme by arousing emotional experience. Generate new emotional experiences. Support emergence of adaptive emotion.

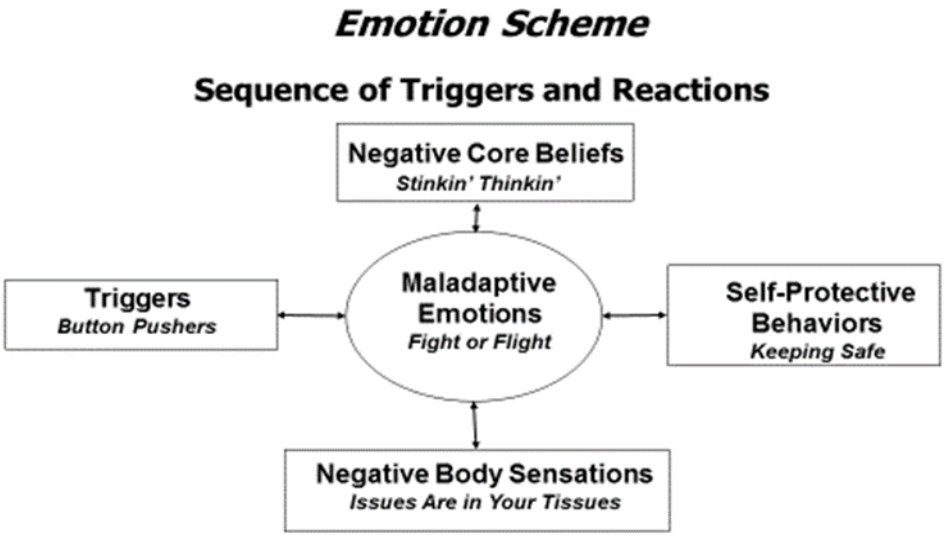


Figure 1. A hypothesized internal emotional memory structure that synthesizes psychological elements into a coherent self-organization and is the primary generator of experience.

l. Problems arise when one become incapable of managing one's emotions
   i. Down- and up-regulation (self-soothing and feeling feelings)
m. Types of Emotions (varied):
   i. Primary adaptive- normal fear in the face of danger. Contains information about needs and adaptive actions.
   ii. Primary maladaptive- fear when shown love. Explore for the maladaptive meaning that elicit them so that meaning can be understood and transformed into new meaning that support adaptive emotion in the situation instead of maladaptive.
   iii. Secondary or self-protective—anger when really scared. Needs to be explored for their self-protective purpose. Resolve the beliefs that interrupt the primary emotion. Eventually the primary emotions underlying them need to be discovered for their information.
   iv. Instrumental- acting angry to get what you want. Requires examination and awareness concerning the manipulative function so that the desired goals can be achieved in more adaptive ways
n. Role of Attachment Theory (Bowlby; Ainsworth): Why important? Reflections of the expectations and beliefs people have formed about themselves and their close relationships. One develops a set of rules and assumptions about relationships in general. Impacts how attachment functions in relationship dynamics and impacts relationship outcomes.
   i. Secure attachment: Will explore freely while the other is present, typically engages with strangers, often visibly upset when the other departs, and is generally happy to see the other return. Parents who consistently respond to their child's needs will create securely attached children who are certain their parents

will be responsive to their needs and communications. Securely attached adults tend to have positive views of themselves, their partners and their relationships. They feel comfortable with intimacy and independence, balancing the two.

ii. Anxious-resistant (anxious-preoccupied or ambivalent) insecure attachment: typically explores little and often wary of strangers, Ambivalent/Resistant strategy is a response to unpredictably responsive caregiving, and the displays of anger or helplessness towards the caregiver— a strategy for maintaining the availability of the other by preemptively taking control of the interaction. Children with abusive childhood experiences were more likely to develop ambivalent attachments, and difficulties in maintaining intimate relationships as adults. Anxious-preoccupied adults seek high levels of intimacy, approval and responsiveness from partners, becoming overly dependent. They tend to be less trusting, have less positive views about themselves and their partners, and may exhibit high levels of emotional expressiveness, worry and impulsiveness in their relationships. They sometimes value intimacy to such an extent that they become overly dependent on their partners.

iii. Anxious-avoidant (dismissive-avoidant) insecure attachment: avoid or ignore the other showing little emotion when the other departs or returns. Will not explore very much regardless of who is there—a mask for distress. Allows one to maintain a conditional proximity with the other, close enough to maintain protection, but distant enough to avoid rebuff. It direct attention away from the unfulfilled desire for closeness with the other. Dismissive-avoidant adults desire a high level of independence, often appearing to avoid attachment altogether. They view themselves as self-sufficient, invulnerable to attachment feelings and not needing close relationships. They tend to suppress their feelings, dealing with rejection by distancing themselves from partners of whom they often have a poor opinion.

iv. Disorganized/disoriented (fearful avoidant) attachment: Indicates a disruption or flooding of the attachment system, and includes overt displays of fear; contradictory behaviors or affects occurring simultaneously or sequentially; stereotypic, asymmetric, misdirected or jerky movements; or freezing and apparent dissociation. Mothers of these children suffered major losses or other trauma shortly before or after the birth of the infant and reacted by becoming severely depressed. Unresolved loss in the mother tended to be associated with disorganized attachment in their infant primarily when they had also experienced an unresolved trauma in their life prior to the loss. Fearful-avoidant adults have mixed feelings about close relationships, both desiring and feeling uncomfortable with emotional closeness. They tend to mistrust their partners and view themselves as unworthy. Like dismissive-avoidant adults, fearful-avoidant adults tend to seek less intimacy, suppressing their feelings.

v.

Security-based strategy of affect regulation

		Self-esteem (thoughts about self)	
		Positive	**Negative**
Sociability (thoughts about others)	**Positive**	Secure	Anxious–preoccupied
	Negative	Dismissive–avoidant	Fearful–avoidant

vi. Withdrawers often feel: rejected, inadequate, afraid of failure, overwhelmed, numb or frozen, afraid or scared, not wanted or desired, and judged or criticized.

vii. Pursuers often feel: hurt, alone, not wanted, invisible, isolated or disconnected, not important, abandoned, or desperate.

2. EFT approach to case formulation:
   a. Follow the client's core pain
   b. Using this as a guide to the development of a focus on underlying determinants that are generating the presenting concerns.
   c. Clients' presenting problems, or symptomatic distress, are seen as manifestations of underlying emotion-schematic processing difficulties.
   d. The client's core painful experiences are articulated as such feelings as a deep fear of abandonment or a shame-based sense of unworthiness.
   e. The essence of formulation involves following the client's most painful or poignant experience and using this to guide toward the core emotion scheme.
   f. In addition, markers of in-session problematic states are identified to light the way for the best interventions to help gain access to the maladaptive core scheme.
   g. When assessing what is going on emotionally, look for:
      i. Narrative is interrupted by strong affect: Focus on the emotional response, especially in the body. Make if safe for them to share.
      ii. Affect is conspicuous by its absence: Explore lack of engagement in the personal experience being related. What is the significance of what is missing?
      iii. Personal Landmark Story: Focus on and explore story in detail. Uncover the real meaning for the participant. Label the story in understandable terms about what is unresolved. Validate primary and secondary emotions.
      iv. Interactional Landmark: What are the emotional difficulties as expressed in problems in relationship(s).
      v. Position Taken: What position(s) have they taken about themselves and what justifies their emotions to themselves. How do others react to their position?
      vi. Contact Comfort: How do they respond to emotional contact with themselves and with others? Do they exist from contact? Are they comfortable with contact, receive as well as give?
   h. In formulating a focus, one attends to a variety of different in-session markers. Markers are client statements or behaviors that alert you to various aspects of clients'

current self-organization that offer opportunities for specific types of intervention that will help lead to underlying determinants of the presenting problem. It is the presently felt experience that indicates what the difficulty is, and indicates whether problem determinants are currently accessible and amenable to intervention. The focus is always subject to change and to development, and process diagnosis of problem-states always acts as a major means of focusing work. Interventions at markers all work to access core emotions schemes. The markers are entry points into the underlying self-organizations involved in a client's difficulties.

i. EFT is an empirically validated, evidenced-based model of therapy for a number of difficulties for depression, anxiety, couple's therapy, interpersonal difficulties, eating disorders, posttraumatic distress, emotional injuries, and adjustment difficulties.
j. EFT Integrates relationship factors & task factors leading to reflection on aroused emotion to create new meaning.
k. Creative tension between TOCs of genuine empathy and acceptance or prizing and the more active, task-focused, process-guiding style of engagement that promotes deeper experiencing.
l. A collaborative effort: the working relationship—agreement (implicit or explicit) on goals and means to goals. Balance leading and following
m. Coach skills: validation (their experience is their experience, reflection (non-verbal and verbal, incongruences), and reframing (shift focus, redirect but only post validation).
n. Consider: how emotionally reactive are they, what is the strength of their attachment, degree of openness, willingness to engage, and ability to trust?
o. Three phases of work: (1) bonding and emotional awareness, (2) evoking and exploring maladaptive emotion patterns, and (3) emotion transformation
p. Seven steps in working with participants:
    i. Create collaborative relationship & help become aware of emotions—what is their agenda based on homework, what A&M already know, what the participant tells you about their goals/needs/wants. This builds the alliance.
    ii. Coach on how to accept and allow emotional experience. Legitimize responses and validate.
    iii. Aid in putting feelings into words. Reflect emotional experience. Expand the emotional experience by open questions to focus on what is the stimulus, the body response, the action the emotion calls for, and the desire/want/need embedded in the emotion.
    iv. Help become aware of and clarify emotional reactions and if these feeling are primary emotions—how do they construct their experience and interactions. Sort out unclear of marginalized elements. Heighten experience with enactments, images, metaphors, repeat phrases, or images.
    v. Together evaluate if emotions are healthy (constructive) or unhealthy (destructive).

vi. Assist discovery of healthy emotional responses and reorganize experience so they can reorganize responses and develop new experience and meaning. Can conjecture new approaches.
vii. Teach how to challenge unhealthy/destructive thoughts (core negative beliefs) and emotions & to transform them based on healthy primary emotions and needs by:
    1. Restructured interaction: engage participant to help them slow down, track, reflect and replay interactions and then reframe the enactment (shift the meaning).
    2. Choreograph Change: Enact the position they have taken and then enact new responses. Clarify the negative patterns. Create a new dialogue and new position that contains positive emotional responses.
    3. Emotional engagement: start small and work your way up. Remember insight is not enough but when cognitions are "hot" and emotional work done then is the time to develop new meanings that have a deeper poignancy.
    4. Softening: Can they now soften their emotional reactions towards themselves and others who have harmed them (forgiveness)? Can they now have a new dialogue with themselves and/or the other? Can they demonstrate a more secure attachment by healthier engagement where needs are expressed and new emotions shared?
    5. Rifts or Impasses: Repair if necessary and perceived or felt betrayal of trust or abandonment and associated pain by acknowledgement and appropriate acceptance of responsibility. Express regret. What do they need at this point to move forward? Make it safe again and show how repairs can happen

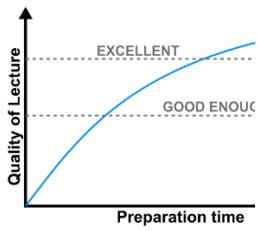
q. EFT is a person-centered approach that works within the participant's internal frame of reference and empathically follows their experience. You as the coach also guides the participant's ability to process emotion in a variety of experiential ways via engaging the emotion, transforming it and creating new meaning.
r. Look for the participant's various states of being that are markers of underlying affective and cognitive problems (see attached case conceptualization notes), then intervene in ways best suited to the participant.
s. Six Main Markers for Work:
    i. Problem Markers: expressed through confusion about emotional responses— "I saw a clown at the circus, and I began to feel sad and lonely."
    ii. Unclear Felt-Sense: unable to make sense of an emotional experience— "I have a feeling, and I don't know how to describe it."
    iii. Conflict Splits: part of the self is critical or coercive towards the other— "I feel inferior to everyone else at work."
    iv. Self-Interruptive Splits: part of the self constricts or interrupts the other— "I could feel the tears burning in my eyes, but I forced myself to hold them back."
    v. Unfinished Business: statements about unresolved feelings toward other(s)— "My mom was never around when I was growing up, and I still feel angry about it."
    vi. Vulnerability: feels fragile or ashamed— "If I have a bad day, it's too much to push myself to carry on."

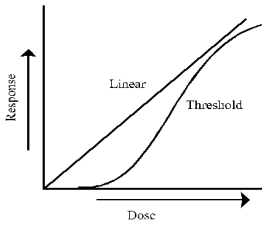
t. A map of differential interventions follows Six Major Principles of Emotion—guide the interventions intended to help participants achieve their goals:
    i. Emotional Awareness: increasing awareness of emotion, or naming what one feels, is the most fundamental goal. Help the participant approach, accept, & tolerate emotions rather than avoid them. Help them make sense of what their emotion is telling them. Identify the need/concern which is organizing them to attain or achieve what is wanted. Identify the action tendency "provided" as well as how to use these emotions to improve coping.
    ii. Emotional Expression: an aspect of emotional processing that predicts adjustment to various types of conflicts. Helps one attend to and clarify central concerns and promotes pursuit of goals. There is a tendency to avoid expressing painful emotions so the participant must be encouraged to overcome avoidance and approach that which is painful
    iii. Emotional Regulation: When distress is so high, emotion no longer informs adaptive action and needs to be down-regulated. First step if the provision of a safe, calming, validating, and empathic environment as well as being able to self-soothe—may have to learn it from you first. Sometimes have to learn to identify and avoid certain triggers, identify and label emotions, or establish a working distance.
    iv. Emotional Reflection: Help participant reflect on emotional experience by creating a narrative of it—what one makes of their emotional experience makes us who we are. Reflection creates new meaning, promotes assimilation of unprocessed emotion into an ongoing narrative and to develop a new narrative to explain experience.
    v. Emotional Transformation: Here one transform emotion with emotion such as when primary maladaptive emotion like fear, shame, and sadness of say being abandoned is transformed by other adaptive emotions. Accessing or mobilizing new emotions can include shifting attention to different aspects of the situation, or to emotions on the periphery of awareness, focusing on what is needed.
    vi. Corrective Emotional Experience: Another way to change an emotion is to have a new lived experience that changes the old feeling which is corrective in itself. Restructures key interactions
u. Critique considerations:
    i. To be successful one must see the importance of expressing emotions and attachment issues
    ii. The major focus is on emotions and may miss other arenas
    iii. Requires sticking with it for a period of time
    iv. Must be able to regulate emotion otherwise will not be able to access painful emotions
    v. Learning emotional expression does not directly translate into behavior—need practice
    vi. Expression of secondary emotions is not enough; need to access adaptive primary emotions

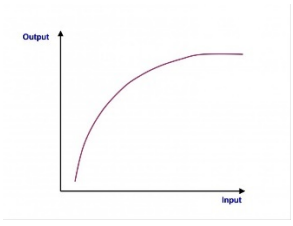
3. Other Aspects of TLT Relevant to Know
    a. A&M work with the staff to develop specific plans to work effectively with particular participants.
    b. A&M work with the Staff to in a general way to improve overall performance—here we focus on your overall knowledge, objectivity, & skills.
    c. A&M work with the Steering Committee and Staff to resolve specific problems related to the running of the program.
    d. A&M work with themselves and the Steering Committee, especially the Program Administer & Program coordinator to enhance their skills and knowledge to be more effective with regard to program development, implementation, and evaluation.

II. General Psychotherapy & Psychological Research Applicable to TLT

1. Psychotherapy research: General conclusions:
    a. Psychotherapy works: the average therapy client is better off than 80% of those need therapy but went untreated. The size of psychotherapy's effect is about equal to that achieved by medical and educational interventions in their respective fields.
    b. One type of therapy does not appear to be consistently superior to any other type of therapy across different types of disorders/problems (the Dodo Bird effect)
    c. This suggests that positive changes may not be due to any unique or specific technique but instead to factors that different therapies share in common (known as Common Factors—emotional expression, positive relationship meaning empathy, genuineness & caring, behavioral regulation such as self-soothing, psychoeducation meaning cognitive learning & mastery)
    d. There is a relationship between treatment length and outcome.
        i. Longer duration of treatment is associated with better outcome.
        ii. But positive outcome appears to level off after 26 sessions to where 75% of clients show measurable improvement.
        iii. Better outcome increases to 85% after 52 sessions. This is called a dose-dependent relationship. In this case, it is also known as the curve of diminishing returns.







    e. Good evidence shows that depression responds to 16 sessions of CBT, but good evidence also shows that people who have only had 16 sessions have only a 25% chance of being well one year later, while those getting maintenance therapy are more likely to avoid a relapse (would insurance like to pay for longer sessions or maintenance therapy or give you sessions enough just to improve and then drop you

since relapse is high with fewer sessions—give examples from A&M's home insurance).

f. Phase Model of Therapy:
    i. Benefits of treatment vary depending on the number of sessions.
    ii. Treatment can be placed in three stages related to the length of treatment:
        1. Remoralization: initial feelings of hopelessness and desperation generally respond quickly within the first sew sessions measured by well-being).
        2. Remediation: the presenting symptoms usually find relief by 16 sessions (measured by symptom reduction).
        3. Rehabilitation: the troublesome, maladaptive and habitual patterns begin to be unlearned and corresponding new way of dealing with the former troublesome aspects of life are established in a more permanent way. The number of sessions to achieve these goals depends on the type, severity, and extent of difficulties (measured by life functioning).
        4. Reformation: (added by AF) a transformation of one's life is begun in earnest concluding with the formation of a transfigured life—a change in the personal sense of the meaning and purpose of one's life (measured by self-actualization—Kurt Goldstein's term for the realization of one's full potential, expression of one's creativity, quest for spiritual enlightenment, pursuit of knowledge, and the desire to give to society. No end date.

2. Psychological Research related to TLT
    a. Diverse populations:
        i. Ethnic matching of therapist and client seems to have only a small, nonsignificant, positive effect on number of sessions attended.
        ii. Ethnic and cultural minorities are more likely to terminate treatment prematurely than whites. African Americans had highest drop-out then Whites and Hispanics about equal, and Asians the lowest.
        iii. Preference for ethnically similar therapists affected by client's ethnic identity, level of acculturation, gender, trust of whites. People with strong commitment to their culture more likely to prefer ethnically similar therapist.
        iv. For many culturally diverse groups, factors such as therapist education and similarity in values and worldview are more important than similarity in terms of race, ethnicity, or culture.
        v. Older adults may respond more slowly to treatment than younger.
        vi. In a national survey, 20.5% of women and 7% of men said they had been physically assaulted by a current or former intimate partner.
    b. Partner Abuse
        i. Women more likely to assaulted when they are younger, heterosexual, American Indian/Alaska Native followed by African American, and in families with yearly incomes less than $10,000.
        ii. Family income is the best single predictor of cessation of battering with low income the most likely to continue violence.

iii. Goals on intervention are: safety, building self-esteem, sense of empowerment & control.
iv. Be careful about vicarious traumatization or when triggered because of own abuse history.
v. May need referral.
vi. Women will stay on abusive relationships when: committed to the relationship, attached to the relationship, desirous of "saving" the relationship, been in it for an extended period of time, economically dependent, believe that the batterer will change, or fear that the batterer will retaliate at the woman or the children.

c. Some Miscellaneous Clinical Issues:
   i. Standardization of approach.
      1. Is it better to have a manualized and standardized approach or a completely open approach to treatment that relies on clinical judgment as to what is needed?
      2. A standardized approach specifies theoretical underpinnings, treatment goals, therapeutic guidelines & strategies, along with concrete examples about how to work, and ways to assess what is going on.
      3. May oversimplify the treatment process.

d. Does TLT add anything beyond the common factors to most therapeutic approaches.
e. How much change should focus on changing the environment of the participant (alloplastic interventions) so it better adjusts to the participant (accommodation), and how much does the participant need to change (autoplastic interventions) so as to better function effectively within the environment (assimilation).
f. Therapist (peer-coach) distress: personal distress can potentially decrease the quality of work
   i. suicidal statements the most distressing client behavior
   ii. lack of therapeutic success the most stressful part of work
   iii. confidentiality issues the most encountered ethical issue
g. Characteristics of diverse populations:
   i. African Americans: worldview emphasizes interconnectedness and group welfare over the individual; family includes nuclear, extended and others outside biology but connected—church may be part of the extended family; roles within the family are flexible; men and women relationship tend toward egalitarian; adults and children may adopt multiple roles. Useful to discuss client's reaction to you as a different racial/ethnic background early on.
   ii. Asian American: know country of origin and acculturation status; greater emphasis on family/community than individual; more of a hierarchical family structure & traditional gender roles; emphasis on harmony, interdependence, mutual loyalty, and obligation in relationships; value restraint of strong emotions, avoid shame. Directive, goal oriented approach preferred. May see you as the expert and authority so you may need to foster participation regarding goals and solutions. Prefer a more formal interaction respecting status and conversational distance. Note role of shame and obligation. Strong adherence to prescribed roles & responsibilities. Modesty

and self-deprecation not necessarily signs of low self-esteem. Establish credibility and competence early by disclosing your experience. Show immediate & meaningful benefit. Emotional issues may show up as somatic complaints. Prefer focus on behavior than emotions. Note role of individual within the family and how change in the individual may impact family.

iii. Hispanic/Latino Americans: emphasize family over individual welfare; allegiance to family; interdependence seen as healthy and necessary; value connectedness and sharing; discussion of intimate details with strangers unacceptable; problems should be handled in the family; concrete & tangible approach to life, control of life events often attributable to luck, supernatural forces, or acts of god. Important role of "familismo," however "personalismo" must be emphasized except early on when "formalismo" is preferred. Families tend to be patriarchal and sex roles inflexible. Parent-child bond may be more important than husband-wife bond. Differences in degree of acculturation within a family is often a source of individual and family problems. Religious and spiritual factors are important. Emotional issues may show up as somatic complaints.

iv. Sexual Minorities (LGBTQ): youth who identify as non-heterosexual more likely to experience depression, anxiety, substance abuse, and higher risk of suicidality—probably not due to sexual orientation but to prejudice and discrimination. Tends to lead to social withdrawal & isolation. Also, can lead to internalized homophobia—acceptance of society's negative evaluation and incorporate this into a negative self-concept which leads to low self-esteem, self-doubt or self-hatred, sense of powerlessness, denial of one's sexual orientation, and self-destructive behavior. Research supports that "Coming Out" to family/friends disclosing one's sexual orientation may have negative consequences but also has beneficial effects leading to higher self-esteem and positive affectivity, lower anxiety, reduced anonymous socializing, and lower levels of psychological distress.

h. Cultural Competence:

i. Three competences (Sue & Sue):

1. Awareness: own assumptions, values, and beliefs stemming from one's cultural heritage that may be detrimental to another cultural group
2. Knowledge: understand the worldview of other culturally diversity clients—their history, experiences and values including the impact of oppression.
3. Skills: able to use interventions appropriate to culturally different clients that are a better fit and not automatically use same particulars for everyone. Recognize limitations.

ii. Two processes are critical: Credibility & Giving

1. Credibility: perception that the therapist is an expert and is trustworthy. Credibility is affected by ascribed and achieved status—the latter, in part, by ability to demonstrate adequate cultural knowledge.
2. Giving: perception that one has received something worthwhile and substantial from treatment. Has beneficial effects on degree of involvement and motivation—e.g., a skill or a "normalization."

i. Acculturation: degree to which a member of a culturally diverse group accepts and adheres to the values, attitudes, & behaviors of own group and the dominant majority group. Acculturation status described in terms of four categories (Berry). Identity needs to be interpreted in terms of cultural significance.
   i. Integration: can maintain own minority culture and still incorporate many aspects of the dominant culture—aka biculturalism.
   ii. Assimilation: accepts the majority culture and relinquishes own culture.
   iii. Separation: withdraws from dominant culture and accepts own culture.
   iv. Marginalization: does not identify with own culture or with dominant culture.

(Editorial): We can be myopic in terms of our understanding others and what has molded them, not seeing the role of culture in so many ways. Sometimes the difficult issue/decision clinically is seeing what really needs to change. Do we help the participant change him/herself, the negative ideas they may have incorporated from the majority/minority culture, or both? What does a person become "identified" with in a way that makes them negative within themselves, even if they have justification? Think about the idea of accountability and responsibility as I have presented it, and then deciding what should be the locus of change?
In the end it has to land with the person him/herself, but change may be aimed at the internal perceptual, emotional, cognitive or behavioral aspects and /or at leaning to feel empowered enough to deal with the negative parts of the impacting culture around one and/or make the attempts to foster change in others views/behavior and the larger environment system around oneself—personally to politically, local to large scale.

j.

3. Psychotherapy Research on EFT:
   a. From a research perspective, the processes that have been shown to predict good outcome in EFT can be summarized as: Making narrative sense of moderately aroused emotions that are deeply experienced and reflected on in the context of an empathically attuned relationship with a good working alliance. This involves approaching rather than avoiding emotions, as well as accepting, tolerating, regulating and symbolizing emotion in awareness.
   b. Other processes shown to predict outcome are: Processing aroused emotion in a mindfully aware manner, and changing emotion with emotion, by moving from secondary to primary emotion, and from maladaptive to primary adaptive emotions. In the latter, emotion transformation sequence, the client moves from high distress (anxiety, hopelessness, despair) through maladaptive emotions such as fear of isolation and shame of inadequacy, to acknowledging unmet needs and feeling deserving of them. Accessing primary maladaptive emotions leads to the healing adaptive emotions such as assertive anger at invalidation, self-compassion towards one's own suffering and grief at what has been lost or was missing.
   a. Awareness, arousal and expression of emotion relates to good outcome.

i. Process research has shown that immediate experiencing is related to outcome.
ii. Session emotional intensity is a strong predictor of outcome.
iii. Evoking affect and bringing troublesome feelings into awareness correlates with good outcome.
iv. Higher levels of physiological arousal during exposure to what is anxiety provoking is beneficial.
v. Arousal of emotional memory is important for change.
vi. Good moments in therapy are characterized by emotional arousal and expression, but more to it—see below.
vii. Anger expression can be particularly helpful—if done right—see below.

b. Arousal or catharsis (venting) or reason alone is not enough for enduring change.
i. Venting only works only works for some people with certain concerns.
ii. Growing consensus that activation of emotional experience, its symbolization in experience, and its expression are important for therapeutic change.
iii. There are hypothesized implicit emotional "meaning-structures": (the emotion scheme) that operate in the construction of experience. These "structures" are triggered by particular internal or external cues, integrate data from cognition, emotions, and sensory experience automatically, and influence or motivate action/behavior.
iv. To change these emotional meaning-structures, reason alone is not enough, but must be accessed by activating the emotional experience they produce and the emotion needs to be processed.
v. Aroused emotion needs to be processed to make sense of it. How? By activating the emotional experience of interest, then symbolizing emotion (in language), which bring the emotions to a level awareness, where the source of the arousal is clarified, and the emotion made sense of in new ways so as to break the cycle of automatic maladaptive emotional processes.

c. Exactly how do these meaning-structure change or get restructured?
i. First one must note that not all processing of emotions is the same.
ii. Need to differentiate productive and nonproductive emotional experience.
iii. Effective or productive processing of emotions, one that leads to change in the meaning-structure, is facilitated by a state of mind in which sensations, thoughts, and feelings are directly and intimately experienced in awareness (Teasdale).
iv. Remember emotions are not just disruptive; they are viewed as a primary meaning system, holding crucial adaptive information relevant for human survival and well-being—usually by undoing them with more adaptive emotions that hold constructive information that can be used to problem solve and create new meaning.
v. The processing of emotional experience is means to experience live contact and access it in language and full consciousness—symbolized, explored, reflected upon, made sense of, and restructured when necessary. Allowing one to accept them, be moved by them, informed by them, and transformed when necessary b/c they a maladaptive.

vi. These meaning-structures containing emotional experience need to be activated to access its information and to make it amenable to new input, and to create or alter meaning of experience as well as access alternate adaptive emotions.

4. A way to measure the level of someone's emotional experience.
   i. Awareness or consciousness of own emotion can be "measured" by ratings on a 7-point scale. Carl Roger's idea of seven stages of client experiencing was operationalized into a "process scale," which attempts to measure the extent that one was remote from or engaged with their own experiencing.

   ii. *The Experiencing Scale* (Gene Gendlin):
   Level 1: Client talks about external events in impersonal, detached or journalistic way.
   Level 2: Client talks about external events with behavioral or intellectual self-description, self-as-object style, in an interested personal manner suggesting self-participation.
   Level 3: Client now talks about personal reactions to external events, limited self-descriptions, and some reports of feelings appear in reaction to events. Manner is reactive and emotionally involved.
   Level 4: The majority of communication is of feelings and personal experiences told from the internal and personal perspective. Manner is self-descriptive and associative.
   Level 5: Problems and propositions about the self and experiences are explored and worked through, feelings elaborated and searched.
   Level 6: Synthesis of readily accessible feeling and experiences occurs. Feelings vividly expressed, experienced in an affirmative and conclusive manner.
   Level 7: Full and easy presentation of experience, all elements confidently integrated. Manner is expansive, illuminating, confident and buoyant

5. Is emotional expression (venting) productive? Yes, and no. When is it a sign of coping and when a sign of distress or a working through of that distress? It depends? When is the expression of emotion regulated, under-regulated, over-regulated? Different types of emotional processing have to be taken into account. Venting (anger or crying) thus emerges as a marginally useful and incomplete theory of explaining when emotional expression is productive.
6. Expression of negative emotions is only adaptive when it leads to some kind of distress resolution. The effectiveness of aroused and expressed emotions "depends on what the emotion is, how it is expressed, by whom, to whom, when, under what conditions, what the underlying therapeutic issue is, how the expression in followed up and all the panoply of relevant circumstantial detail" (Whelton, 2004, p. 60). This supports that how individuals process emotions and other information prior to expression is more important than whether they express at all. It should be noted that the expression of emotions may signal distress rather than indicative of the process of change and resolution.

7. If the expression of emotion itself isn't necessarily beneficial, then what determines whether it is?
    i. A description of external experiences that is vivid, concrete and imagistic language is associated with productive processing. While some research touts the interpersonal benefit of these descriptions, there is considerable support for the idea that it can have beneficial intrapersonal consequences and represent a productive processing activity.
8. If optimal emotional processing is more than simply activating and expressing emotional experience, then what is defined as productive and unproductive emotional arousal? If it is not so much the frequency of higher levels of expressed emotional arousal over the course of treatment that is important but the productivity of high aroused emotional expression that is a better predictor of positive outcome, what needs to be included?
    i. Some degree of arousal is important—just remember that degree of arousal of expressed emotion is too general to be a valid predictor of productive emotional experience. Still, both increase in degree of arousal of expressed emotion and increase in depth of experiencing from the beginning to key episodes in the working phase of treatment have been found to predict outcome.
    ii. Certain ways of processing activated emotion matter.
    iii. Exploration of the significance and personal meaning of emotional experience is vital.
    iv. Other factors to consider in the processing of emotions: individual differences such as cultural views of emotion, type of problem, diagnosis, degree of alexithymia, circumstantial concerns, type of emotional response (primary, secondary, instrumental).
    v. Productivity is defined as:
        a. The expressed emotion is primary (the first and fundamental emotional response. Remember primary emotions can also be adaptive or maladaptive, the latter may not be productive. One also needs to grasp culture and context to make the determination), not secondary (a reaction to a primary emotion or thought—shame about anger. Can also be fused emotions such as anger and sadness. Also, can be global and undifferentiated like feeling bad or upset) or instrumental (an emotion to achieve an aim—sadness to solicit pity).
        b. The emotion is expressed in the present—outwardly, vocally, facially, & posturally. Further, the account is subjective, not objective, the lived not the told story; it is about personal associations and feelings, and less about events or actions.
        c. The client in in a mindful state meaning it is "owned" and therefore the client experiences him/herself as an agent rather than a victim of feelings.
        d. The emotion is not overwhelming
        e. There is a fluidity in the process of emotional experience rather than blocked.
        f. The emotion is on a therapeutically relevant theme.

g. Productive emotions that are primary and adaptive match the situation (fear in a dangerous situation) and fit the appraisal (feels abandoned and expresses sadness vs rage). The action fits identity, attachment goals, and concerns of the person (sadness leads to reaching out for comfort rather than blame; anger to assertion rather than withdrawal.
h. Maladaptive may be productive if the person is mindful of the emotion, can symbolize it in awareness rather than being confused, or can take responsibility and is willing to work with it rather than feel like a victim.
i. Maladaptive emotions are not productive if the person is overwhelmed, lost contact with the therapist, is not able to extract the informational value, has little control over the expression and action it produces, is blocked or stuck meaning there is a lack of progress in the manner of processing (the emotion is not tolerated, regulated, or accepted better), or there is no differentiation of emotional awareness (the emotion does not develop into a more complex feeling or meaning or is not elaborated into a sequence of other feelings and meanings).

vi. Productivity of emotional arousal is more important than emotional arousal alone. As an example, clients high in emotional productivity could have anywhere from low to high expressed arousal and did better than low productive client regardless of whether they had high or low arousal. In fact, poorer outcome client had 1.5 times more highly aroused emotion.
vii. The mere expression of emotion is not sufficient in reducing distress. There is common agreement that for emotional arousal to be beneficial in the change process certain conditions need to be satisfied, such as a good alliance, and that arousal needs to be combined with cognitive processing of the emotion. The type of emotion and the manner in which the activated emotion is processed are both important—the meaning-structure and how it is processed matter, not just arousal.
viii. The quality of emotional expression regardless of degree of expressed arousal as well as the quality of more highly aroused expressed emotion seem to be crucial in the change process.

9. Depth or level of experiencing relates to outcome, especially when combined with reflection on aroused experience.
10. Increases in level of experiencing from early to late sessions relate to stronger outcome.
11. Higher emotional arousal at mid-treatment coupled with reflection on aroused emotion and deeper emotional processing late in therapy predicted good outcome—arousal and meaning construction are both important.
12. EFT appears to work by enhancing a particular type of emotional processing: helping clients experience, then accept, and finally make sense of emotions.
13. Ability to process emotions early not as critical as ability to acquire ability over course of treatment. The alliance contributes to the ability to process emotions.
14. Moderate to high level of arousal seems to best predict outcome as long as high levels are not too long or too often. Minimal arousal predicts poor outcome.

15. Activation of emotion and new information incompatible with the emotion is necessary for the emotion to change (memory reconsolidation).
16. A focus on experiencing is related to outcome—meaning a sense of ongoing awareness that includes perceiving, sensing, feeling, thinking, and wanting/intending.
17. Emotional disclosure provides a structure for emotional events by translating experience into words. It is through language that emotional experience is organized and assimilated.
18. Emotional arousal is particularly important to the resolution of unfinished business.
19. Higher productive arousal and deeper level of experiencing distinguish good from poor outcomes.
20. Outcomes of experiential psychotherapy often show the presence of self-compassion and vulnerability, in addition to healthier emotional experience, empowerment, resilience, greater self-awareness, mastery of symptoms, improved interpersonal functioning, and insight.
21. When negative outcomes occur, they are related to non-resolution of problems, feeling overwhelmed, being harmed by therapist, disappointment by not being understood, fear of changing, and a consequent increase in emotional restriction preventing change.
22. Clients pursue two aims: development of personal meaning for themselves and monitoring of the therapist. Interventions were evaluated by clients in terms of compatibility with their own plans and ways of working.
23. Clients are differential to therapists—tend not confront therapists—and preferred to tolerate shortcomings rather than confront.
24. Empathic skills play a central role in fostering positive outcome defined as insight and self-understanding.
25. Client follow their own agenda, so if there is mis-attunement from misunderstanding or in the relationship, it threatens the therapeutic work and it may not be pointed out.
26. Looking at helpful and hindering events in therapy revealed:
    ii. Helpful events: the importance of: (1) creating safety and how fragile it is, (2) the therapist skill in facilitating an empathic experiential processing which helps the client bear emotional pain, bring about new awareness, and a new sense of personal power, (3) skillful clarification, (4) guidance, (5) compassionate presence, (6) interpersonal affirmation, and (7) awareness-promoting communication of empathic understanding.
    iii. Hindering events: degree of (1) client's sense of vulnerability, and (2) therapist personal level of anxiety.
27. Important was also degree of connection sensed on a human level, awareness of own needs, support offered, and credit to the therapist to bring out avoided experiences.
28. In order of importance is empathy, positive regard or caring/prizing, and genuineness/congruence.
29. Strongest predictors of outcome are empathy and the working alliance (agreement on goals and means to goals)

30. Relationship conditions are predictive of wide range of outcome—positive regard, unconditionality, empathy and congruence.
31. Perhaps these are important because they lead to self-empathy.
32. Empathy is related improved attachment style.
33. Unprocessed emotion means high arousal and low meaningfulness
34. Task analysis of emotional processing = movement through global distress of fear, shame or aggressive anger to articulation of needs and negative self-evaluations to assertive anger, self-soothing, and processing of hurt and grief all predicted positive outcome and found that emotions emerged in a predictable and sequential manner.
35. Processing of emotion needs to be productive meaning in contact with and aware of presently activated emotion.
36. Helpful factors in 3 categories: stimulation and deepening of self-exploration, focusing on and exploring more deeply, and intensively living through and experiencing fully.
37. Therapist statements high in experiencing influenced client level of experiencing
38. Good outcome clients shifted to internal, emotion-focused and reflexive narratives.