

# Change processes in therapy: Case studies in Process- Experiential / Emotion-Focused Therapy

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## Summary

The research presented in this thesis investigated in-therapy experiences and treatment effects for four depressed young women counselled with Process-Experiential/Emotion-Focused Therapy (PE-EFT). PE-EFT, an evidenced-based, manualised, therapy developed by Greenberg, Elliott and Rice in the mid 80s, emphasises the quality of the client-therapist relationship and offers efficient techniques to assist clients to deal with emotional experience in the present moment. This study was designed to investigate change processes and help reduce the research-practice gap. It used multiple sources of qualitative and quantitative evidence including established quantitative instruments, assessment of the client's perspective, using Change Interviews, and careful observation of work with the four young women in twelve-counselling sessions in a naturalistic setting. The expanded single case design took an interpretive approach to examining client change and its causes, seeking client and therapist viewpoints. The participatory and collaborative approach to the collection of data and the documentation of the young women's experiences was in line with the person-centred values underpinning PE-EFT. A thematic analysis of the qualitative data elicited propositions about the changes that occurred as a result of therapy from the four young women's perspectives. The clinical significance of these changes was also examined. In general, the young women reported in their Change Interviews that there was a decrease in their presenting symptoms. They also described improvement in their interpersonal relationships, increased inner awareness, improved emotion regulation, decrease in confusion and more compassion and acceptance for self and other. Analyses of these data suggested these changes resulted from the combination of an emphatically attuned working alliance *and* the PE-EFT therapeutic tasks. A key to the task success was the facilitation of the *felt-shifts* in experience when the emotion scheme was successfully activated and reprocessed. This research adds to the growing understanding of what happens in therapy.

## **Statement of Authorship**

Except where reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis submitted for the award of any other degree or diploma.

No other person's work has been used without due acknowledgement in the main text of the thesis.

The thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

All research procedures reported in this thesis were approved by the Faculty Human Ethics Committee FHEC06 / 206.

Signed: \_\_\_\_\_ Melissa Harte

Date: \_\_\_\_\_

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## Chapter One • Introduction

This thesis reports on an investigation into the process and effects of Process-Experiential/Emotion-Focused Therapy (PE-EFT). The case focused research design provided an opportunity for four young women to express their judgments of, and reactions to, the therapeutic process and changes during their therapeutic journeys.

This study incorporates *change-process* research because such research concerns itself with explaining both *how* and *why* change occurs in therapy (Elliott, Greenberg, & Leitaer, 2004; Elliott, Slatick, & Urman, 2001). Identifying, describing, explaining and predicting the effects of the processes that bring about therapeutic change over the course of therapy provides useful understandings to the therapist in the field. The emphasis is on studying the *process of change* where both beginning and endpoints are taken into account, as well as the events between these points (Elliott et al., 2001).

Such change-process research has the potential to transcend the dichotomy between process and outcome (Greenberg, 1986). For, while extensive literature exists on psychotherapy research into the effectiveness of particular therapeutic modalities, using quantitative methodology as an investigative tool, these randomised control trials and meta-analyses have not illuminated the dynamic processes of what happens *within* therapy (McLeod, 2003a). The study of psychotherapeutic *process* however offers a means to address such questions despite the in-session phenomena investigated being highly complex and elusive (Cooper, Watson, & Holldampf, 2010).

Qualitative change-process research is already providing us with a more thorough overall understanding of *how* change occurs within sessions and over the course of therapy and we now know more about the therapeutic process (Elliott et al., 2001). We know that the working alliance is an important change factor (see Norcross, 2010 for a review). Particular techniques or interventions have been shown to have an influence on stimulating change (Elliott, Watson, Goldman, & Greenberg, 2004). Research has also provided evidence that emotional processing has a direct relationship with good outcomes (Pos, Greenberg, Goldman, & Korman, 2003). In addition, depth of in-session client *experiencing* has been posited as an important change factor (Gendlin, 1962, 1981, 1996; Rogers, 1951, 1957, 1961). Nevertheless,

there is still a need to know more about *what* happens within the therapy hour from the perspective of client and therapist and *how* change is precipitated or facilitated (Elliott, 1995a, 2007; Elliott, Greenberg et al., 2004).

Whilst there has been an emphasis in research on establishing evidence-based practices through quantitative outcome studies, it seems clinicians in the field tend to ignore the published research literature and are frustrated when significant practice relevant questions are not addressed (Morrow-Bradley & Elliott, 1986; Wedding, 2011). This divergence, known as the *research-practice gap* (Morrow-Bradley & Elliott, 1986; Wedding, 2011), has its roots in models where technique and observation are emphasised over relationship and lived experience, resulting in a fundamental alienation between practice and research. One important purpose of outcome research should be to inform the practising clinicians about effective therapeutic treatments (Morrow-Bradley & Elliott, 1986). Controlled research is limited if it fails to meet the more basic criterion of having clinical value (Goldfield & Wolfe, 1998). Although both researchers and clinicians are presumably dedicated to the development and implementation of effective intervention procedures, there needs to be more collaboration between researchers and clinicians (Elliott & Zucconi, 2005, 2006, 2010; Morrow-Bradley & Elliott, 1986; Wedding, 2011).

Despite prolific research into the effectiveness of counselling and psychotherapy, the gap between clinical research and counselling and psychotherapy practice continues to exist. This research-practice gap has resulted in a near disenfranchisement of many forms of therapy, including person-centred/experiential, psychodynamic and systems approaches, all of which are currently underrepresented on lists of empirically-supported or evidence-based treatments (Bohart, O'Hara, & Leitner, 1998; Elliott, 2007; Elliott & Zucconi, 2010; Roth & Fonagy, 2004). Because therapies that are experiential and emotion-focused have been under-investigated, calls from the person-centred and experiential therapies' communities (e.g. WAPCEPC<sup>1</sup>) have challenged practitioners and researchers to develop research

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1 The World Association for Person-Centered and Experiential Psychotherapy and Counseling (WAPCEPC), provides a worldwide forum for practitioners and scholars working within the person-centered and the experiential paradigms, fosters the exchange of research, theory and practice across language groups and cultures, supports and encourages scientific study as well as improvement of practice in the field of psychotherapy and counseling, promotes person centered



methods that emphasise both process and outcome in order to investigate these modalities (Elliott et al., 2001; Elliott & Zucconi, 2006). What is needed is not so much evidence-based practice but *practice-based evidence* driven by research-practitioner initiatives (Barkham & Mellor-Clark, 2000). Investigating non-Cognitive Behavioural therapies demonstrates to practitioners and the consumer that there are alternative evidence-based practices (Elliott, 2001b).

For efficacy research to be genuinely authoritative a *mixed method* approach should ideally be employed (Dattilio, Edwards, & Fishman, 2010). The focus on client-therapist based research and respect for the experience of the client, therapist and researcher are developments in the field of psychotherapy research that have been guided by the intent to produce research that psychotherapists can adopt and apply (see Elliott & Zucconi, 2006). Case-based methods, in the form of systematic case-studies or case-based process research, have been particularly recommended, including the case study of a particular client within a RCT, as a way of making the results more meaningful to, and influential for, practitioners (Stewart & Chambless, 2010). Well-written case studies appear to offer a unique means of providing clinical knowledge that can directly inform practice.

The present investigation uses the systematic case study design, which is becoming increasingly recognised as a credible and useful method for understanding the happenings within a therapy session, with the potential to contribute knowledge and understanding that is highly relevant to counselling practice (Goldman, Watson, & Greenberg, 2011; McLeod & Elliott, 2011; Watson, Goldman, & Greenberg, 2011). Case studies make this vital contribution to building an evidence base for counselling and psychotherapy theory and practice by providing a methodologically pluralistic approach to accumulating knowledge about processes and outcomes of therapy (McLeod & Elliott, 2011). The advantage of the case study methodology is that it is an empirical inquiry that investigates a contemporary phenomenon in depth and within its real life context and honours the client's lived experience (Schneider, 1999; Yin, 2009). Systematic case studies are also a method of change-process research (Elliott &

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and experiential perspectives and stimulates cooperation and dialogue with other psychotherapeutic orientations (<http://www.pce-world.org/>).

Zucconi, 2005, 2006) and are well suited to describing and making sense of the processes of change (McLeod, 2003b).

## **This Research**

Process-Experiential/Emotion-Focused Therapy (PE-EFT) was the therapy chosen for investigation in this study because it represents a current expression of the contemporary humanistic-experiential tradition in psychotherapy and is an alternative evidence-based practice. PE-EFT is part of a suite of experiential therapies that include Person-Centred Therapy, Gestalt Therapy, Focusing-Oriented Psychotherapy, Psychodrama, Existential Psychotherapy, Expressive/Arts Therapies, Accelerated Experiential Dynamic Therapy, Coherence Therapy, and Hakomi. The model was developed by Les Greenberg, Robert Elliott and Laura Rice in the early 1980s (see Greenberg, Rice, & Elliott, 1993) and emphasises the quality of the client-therapist relationship while offering techniques to assist clients to deal with emotional experience in the present moment. PE-EFT has attracted quite significant research efforts (see Elliott, Greenberg et al., 2004 for a review) and has been listed by the APA as an empirically supported treatment (EST) for depression (American Psychological Association, n.d.). PE-EFT has been shown to be equivalent to CBT in dealing with disorders involving emotional dysfunction, such as depression (see Elliott, Greenberg et al., 2004). In addition, given PE-EFT's focus on emotions, this therapy has also been shown to be effective in dealing with other disorders involving emotional dysfunction such as anxiety (Elliott et al., 2009), trauma (Paivio & Nieuwenhuis, 2001; Paivio & Pascual-Leone, 2010), borderline personality disorder (Warwar, Links, Greenberg, & Bergmans, 2008) and eating disorders (Dolhanty & Greenberg, 2007, 2009).

PE-EFT was developed from research on therapy process and outcome and continues to evolve through active research programs that refine existing therapeutic tasks, add new ones and apply PE-EFT to new treatment populations (Elliott & Greenberg, 2007). The model has been manualised in the text by Elliott, Watson, Goldman, and Greenberg, (2004) *Learning emotion focused therapy: The process experiential approach to change*. The *task-focused* interventions at identifiable

readiness *markers*<sup>2</sup> constitute a useful strategy for helping clients to resolve specific therapeutic issues (Greenberg et al., 1993).

The choice of client population for this study was influenced by an appeal by Elliott, Slatick, and Urman (2001) who called for a focus on specific client groups (e.g. young people) and by Greenberg and Watson (2006) who described depression as one of the most highly prevalent and incapacitating psychological disorders in our society. According to the World Health Organisation report (2001) depression is not only considered the most prevalent mental health problem in the West but has placed an enormous burden on society. Although depression can affect individuals at any stage of life, there is an increasing prevalence of depression during adolescence and young adulthood (World Health Organization, 2001). Depression has links with health risks, including tobacco use, illicit drug use, alcohol misuse and dependence, eating disorder and obesity (Commonwealth of Australia, 1999). Suicide remains one of the common and avoidable outcomes of depression and is the leading cause of death for young adults (World Health Organization, 2001). People suffering from depressive disorders have a risk of suicide 30 times that of the general population, and it is most prevalent in the 15-34 year-old age group (Commonwealth of Australia, 1999). Women experience higher rates of depressive episodes than men (Australian Bureau of Statistics, 2008).

In general adult populations have been studied extensively but there has been little research investigating issues associated with young people, specifically young women. Depression has been targeted by diverse therapeutic approaches and studied extensively in psychotherapy research but not with young women. Specifically, there has been no research investigating depression in young women being counselled using PE-EFT as the treatment modality.

The framework suggested by Elliott and Zucconi (2006, 2010) as necessary and sufficient for successful practice-based therapy research was chosen because of the emphasis on making the research relevant to the actual practice of therapy (see Chapter 5 on Methodology). The *choice of* inexpensive and easy-to-use instruments and measures was also guided by Elliott and Zucconi, (2005, 2010). Multiple sources

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2 Markers are in-session client statements or behaviours that indicate a client's specific underlying emotional processing difficulty and the client's potential *readiness* for a particular kind of therapeutic exploration or intervention (Elliott, Watson et al., 2004; Greenberg et al., 1993).

of evidence were chosen because no single measure can capture all elements of the sought-for change during therapy (Kazdin, 1999, 2003). A participatory and collaborative approach to the collection of data and the documentation of the young women's experiences was an important aspect of this research, in line with the person-centred values underpinning this therapy.

The focus of the study was to investigate the process of change that occurred within the therapeutic journey and the links between process and outcome, by using established instruments and careful observation of work with four young women in a research-based but naturalistic setting. Central to this study were the clients' perceptions of the therapeutic effectiveness, together with the clients' perceptions of what, in both the therapy and their broader lives, may have contributed to their recovery.

## **The Researcher's Lens**

My thesis arises from my professional contexts as a counselling psychologist employing Process-Experiential/Emotion-Focused Therapy (PE-EFT) and as a higher degree research student studying for a professional doctorate in psychology. As a practising therapist, I am aware of the movement not only to find empirical evidence for the efficacy of psychotherapeutic treatments but also to understand the process of change and the elements contributing to change processes. My study grew out of a desire to add to that knowledge of change processes empirical findings specifically related to PE-EFT.

Having personally experienced the transformative quality within my PE-EFT training as the client in the triad work, I became acutely aware of the healing potential made possible through the working alliance and the use of appropriate techniques to facilitate change at a core level. When I took on the task of finding a research topic it became obvious to me that the PE-EFT model would be the therapeutic modality I would investigate. I was drawn to the idea of conducting my research *in-mode*, using the underlying person-centred principles found within the PE-EFT therapeutic approach and applying them to how I interacted with, and collected the data from, the young women who were my research participants. As this endeavour became very

important to me I needed to find a design/methodology that complemented the PE-EFT foundational values. While I had originally intended to contribute to the international research by conducting a small outcome study, the scale of my research was limited by the resources available to me. I explored various options and decided to focus on the *process of change* from the client's perspective and to investigate process as well as outcome employing a pragmatic case study methodology (Fishman, 1999, 2004, 2005). I became keenly interested in investigating the process of change that occurred within the therapeutic journey and the links between process and outcome.

I was also driven by another objective in that I wanted to contribute to the closing of the practice-research gap by providing insight into the clinical therapeutic interventions of PE-EFT within this practice-research framework. I sought to be consistent with the flexible research protocol and framework presented by Elliott and Zucconi in (2006, 2010) for guiding individual and collaborative international research into the effectiveness of person-centred and experiential psychotherapies. This framework also recommended systematic case studies as an alternative to positivist outcome research.

As the therapist/researcher, I hoped to be able to reflect critically on the PE-EFT therapeutic approach that appeals to me because of its view of human nature, its embrace of research, its transformational potential, its techniques and its emphasis on the role of emotions in therapeutic change. We need to know more about the processes that occur within PE-EFT. I have attempted to investigate some of those processes by combining qualitative and quantitative measures within a case study design in an attempt to understand client and therapist experiences of PE-EFT. I was particularly interested in identifying aspects of this therapy that precipitated or facilitated positive change for four depressed young women.

## Summary

This study has investigated change-processes in therapy using a mix of qualitative and quantitative methods. This thesis aimed to understand the intricacies of change processes and not specifically how the tasks of PE-EFT implement change. I aimed to

investigate what worked (from both client and counsellor perspectives) for four depressed young women counselled with PE-EFT in a naturalistic counselling setting. I have utilised an expanded single case design that takes an interpretive approach to examining client change and its causes. This design aimed to discover both client and therapist understandings of the research questions for this study, which were:

1. What (if any) changes occurred in the client's presenting problems during and after a course of Process-Experiential/Emotion-Focused psychotherapy?
2. What evidence is there for concluding that therapy was responsible for the changes?
3. Which processes in therapy might have been responsible for the changes?
4. What alternative explanations are there for the changes?

## Chapter Two • Change in Psychotherapy

### Overview of Chapter

This study draws on a number of different areas of relevant psychotherapy research and practice, and therefore this literature review divides these into distinct chapters. In this chapter I briefly summarise the evidence that experiential therapies are not only efficacious but equivalent to other evidence based treatments, before reviewing some of the current understandings of *change* in counselling and psychotherapy, and the role systematic case studies are now taking in counselling and psychotherapy research. I also discuss *change-process* research. Chapter 3 details the development of the integrated model of PE-EFT. Chapter 4 highlights the impact of depression on young people and the lack of research in the area together with presenting current research using PE-EFT for depression for adults.

### Efficacy of Experiential Psychotherapies

While Cognitive Behaviour Therapy (CBT) has been long been recognised as efficacious (see APA website, American Psychological Association, n.d.), a substantial body of research data supports the effectiveness/efficacy of what have been termed *experiential* therapies (see Elliott, Greenberg, & Leitaer, 2004; Greenberg, Watson, & Lietaer, 1998). Originally referred to as *humanistic* therapies, experiential therapies include: Rogers' person-centred therapy (Rogers, 1961), Gendlin's focusing-oriented approach (Gendlin, 1996), Gestalt therapy (Perls, Hefferline, & Goodman, 1951), and existential therapy (Yalom, 1980). Although these approaches vary somewhat in technique and conception, they share a number of distinctive theoretical assumptions. The most central of these are that the therapeutic relationship is potentially curative and the promotion of in-therapy experiencing essential (Elliott, Greenberg et al., 2004). Process-Experiential/Emotion-Focused Therapy (PE-EFT) is one current expression of this contemporary humanistic-experiential tradition in psychotherapy.

An early meta-analysis by Greenberg, Elliott and Lietaer (1994) was the first to focus on person-centred and experiential therapies. They included in the analysis all outcome studies of experiential, humanistic or *supportive* therapies (those using empathy or exploration of the client's experiencing) published between 1978 and 1992 for which it was possible to calculate an effect size. The analysts calculated pre- and post changes for thirty-seven outcome studies involving 1,272 clients. Experiential therapies were found to be efficacious. The average pre-post effect size (*ES*) for this sample of studies is 1.20 ( a large effect size). The analysts also considered the question of whether the experiential therapies were as effective as non-experiential therapies and concluded that the answer was "yes," experiential therapies were considered as effective as other forms of treatment. Further results published in 1996, supported the earlier analyses: "outcomes for experiential/client-centred treatments were statistically equivalent to nonexperiential treatments generally... and specifically to cognitive-behavioural interventions... client-centred / experiential and cognitive-behavioral treatments appear to be statistically equivalent in effectiveness..." (Elliott, 1996, p. 125). The equivalence analysis showed the average difference in *ES* experiential and non-experiential therapies was .04, a difference not significantly different from zero but significantly different from .4 which met the definition of equivalence (Elliott, Stiles, & Shapiro, 1993). This later meta-analysis also controlled for researcher allegiance, a well known effect that suggests almost all the variance in outcome comparative studies can be accounted for by the theoretical orientation of the investigators (Elliott & Freire, 2010). When researcher allegiance was statistically removed from the comparative effects all the comparisons were statistically equivalent (Elliott, 1996).

Elliott's more recent analyses (2001b; Elliott, Greenberg et al., 2004) further expanded the meta-analysis and once again CBT was found to be statistically equivalent to person-centred and experiential therapies with a mean comparative *ES* = -.16. Elliott et al. (2004) were also interested to determine whether the more process-directive approaches such as PE-EFT or Gestalt were more effective than the less process-directive approaches. Five studies compared these directly and the mean comparative effect size significantly favoured the process-directive therapies.



Of particular interest in this analysis was the inclusion of particular client problems or diagnoses (Elliott, Greenberg et al., 2004). For example, (PE-) EFT was identified as having enough research support to be considered “efficacious” according the Empirically Supported Treatment criteria (Chambless & Hollon, 1998) for depression which earned it the right to be listed on the APA EST website (American Psychological Association, n.d.). In addition, EFT for effects of childhood abuse, post trauma difficulties and work with couples were classified as “specific and efficacious.” EFT for anxiety, anger and aggression treatments, major personality disorders, life adjustment in schizophrenia and various health-related problems was considered “possibly efficacious” (Elliott, Greenberg et al., 2004).

Preliminary conclusions of the most recent version of the ongoing meta-analysis were included in a chapter by Elliott and Freire (2010) in the book *Person-centred and experiential therapies work: A review of the research on counselling, psychotherapy and related practice*. The results of this analysis confirm the effectiveness of experiential and person centred therapies by providing multiple lines of evidence. A much larger sample of 186 outcome studies, amounting to more than 14,000 clients, was included in the analysis ( $ES = 1.01$ ). Six conclusions were presented by Elliott and Freire (2010). See Table 2.1. In this recent analysis, person-centred and experiential therapies were shown to be as effective as or more effective than CBT. PE-EFT for individuals or couples actually appeared to be more effective than CBT ( $ES = .35$ ). Elliott and Freire (2010) were so surprised by these striking results that they reclassified the entire data set from scratch and still obtained the same results.

Elliott and Freire (2010) recommended that since person-centred and experiential therapies are empirically supported by multiple lines of scientific evidence, the lists of empirically supported treatments should be updated, enabling clients access to these efficacious therapies through the various mental health settings and allowing them to be paid for by health funds.

Table 2.1. Conclusions derived from Elliott and Freire (2010) meta-analysis.

Conclusions	
1	Person-centred and experiential therapies are associated with large pre- and post- client change. ( $ES = 1.01$ )
2	Clients' large post-therapy change gains are maintained over early and late follow-ups. ( $ES = .99$ immediately after therapy vs. 1-12 for follow-ups less than a year after therapy.)
3	Clients in person-centred and experiential therapies show large gains ( $ES = .78$ ) relative to clients who receive no therapy ( $ES = .19$ ).
4	Person-centred and experiential therapies are clinically and statistically equivalent to other therapies. (weighted comparative $ES = .00$ ).
5	Broadly defined person-centred and experiential therapies might be trivially worse than CBT. ( $ES = -.18$ ). However this small effect disappeared when the theoretical orientation of the researcher was controlled for. ( $ES = -.06$ ).
6	So-called "supportive" therapies have worse outcomes than CBT but other kinds of person-centred and experiential therapies are as effective as or more effective than CBT. ( $ES = -.09$ ).

Source: Elliott and Freire (2010).

## Models of Change

The concept of *change* has many facets and can be defined as the act or process of making or becoming different; the result of altering or modifying; a transformation or transition from one state, condition, or phase to another; to undergo transformation, transition, or substitution; a new experience, becoming new, something different (see Farlex, 2011; Oxford University Press, 2011). Interestingly, positive change or change in the direction of the client's goals is assumed to be the most favourable outcome of counselling and psychotherapy but how and what causes change is still disputed. This section reviews some key theoretical perspectives on change and discusses particular elements that are considered necessary for change.

### **Rogers: A process conception of psychotherapeutic change.**

In 1957, Rogers published his seminal article describing the necessary and sufficient conditions for therapeutic change (see Table 2.2). Essentially, he held that change

occurs where the therapist holds deep respect for, and has full acceptance of, the client and that this attention encourages the client's recognition of their own core integrity. The therapist's consideration for the client needs to be communicated in such a way that the client perceives the therapist as understanding them (Rogers, 1957). Rogers further elaborated his theory in his book *On becoming a person* (Rogers, 1961), and argued that the primary motivation in all human behaviour is *actualisation* of a person's potential. Dysfunction was seen as being caused by incongruence between self-concept and experience that renders the person anxious. According to Rogers (1961), within the authentic, safe therapeutic relationship, clients can allow problematic aspects to come into awareness through freely *experiencing* the basic datum of their sensory and visceral reactions. Experiencing can be defined as the "result of attention to and awareness of the ongoing flow in the body" (p. 146, Greenberg, 2011). The feeling of acceptance and respect from the therapist assists in reducing their tension and fear. Rogers underlined the person-to-person nature of the interaction in therapy, where not only the phenomenological world of the client but also the therapist's state of being are of crucial significance (Thorne, 2007).

Table 2.2. The necessary and sufficient conditions of therapeutic change according to Rogers.

<b>Conditions necessary for therapeutic change</b>	
1	Two persons are in psychological contact
2	The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious
3	The second person, whom we shall term the therapist, is congruent or integrated in the relationship
4	The therapist experiences unconditional positive regard for the client
5	The therapist experiences an empathic understanding of the client's internal frame of reference and endeavours to communicate this experience to the client
6	The communication to the client of the therapist's empathic understanding and unconditional positive regard is achieved at least to a minimal degree

Source: Rogers (1957, p. 96).

Client- or person-centred therapy aims to facilitate a process whereby the client comes to a self-view without self-deception or distortion. In this process the experiencing of *feeling* in a session is really a “discovery of unknown elements of self” (Rogers, 1961, p. 111) assisting a client to “become what he is... (Rogers, 1961, p. 113). The person who emerges is open to experience, trusts themselves as able to take appropriate action, make decisions and take responsibility for self and others, and develops an internal locus of evaluation.

Rogers elaborated his theory or process of change by looking for elements that would characterise change (see Rogers, 1961). He listened to hours of recorded therapy sessions as he endeavoured to capture the process of change. He was intrigued when clients came closer to their feelings and symbolised their experience by searching for a precise word or phrase to describe those feelings accurately. He appreciated “moments of movement – moments where it appears that change actually occurs” (Rogers, 1961, p. 130). This investigation resulted in a seven stage process model of change (see Rogers, 1961). Essentially the process of change involves a movement from a point of fixity to a flowing experience where new experiencing is managed with immediacy.

In a 1987 interview with Michelle Baldwin, Carl Rogers stated, “I do use myself... I include my intuition and the essence of myself... I also include my caring, and my ability to really listen acceptingly...” (M. Baldwin, 1987b, p. 45-46). Rogers saw therapy as a process of self-exploration through to empowerment and recognised it was most effective when the therapist focused on the process of therapy and not the outcome. He considered people to have a positive and constructive inner core and said “the best therapy sometimes leads to a dimension that is spiritual... in interpersonal relationships power and energy get released, which transcends what we thought was involved... surrendering yourself to the process, certain things happen” (M. Baldwin, 1987b, p. 50).

### **Gendlin’s account of change.**

Eugene Gendlin, a student of Rogers, developed an account of psychotherapy in which like Rogers he viewed *experiencing* as the basic level of psychological phenomenon and experiential awareness as essential to healthy living (Gendlin, 1962).

Gendlin's process view of functioning involved an increased focus on experiencing and saw *felt meaning* interacting with verbal symbols to produce explicit meaning. Blocking experiencing or an inadequate manner of experiencing was viewed as the cause of dysfunction. Gendlin's (1996) style of psychotherapy involved directing clients' attention to their present experience and this then influenced their physiological responses and meaning creation. He termed this process *focusing*. Focusing involves checking words against experience and finding a *fit* that generated the feeling of certainty.

Gendlin conducted outcome and process research that found that when the client was able to come into contact with immediate experiencing within the session, this was correlated with measures of success. This success was not related to what clients discussed, but rather to the manner of the *process* of that immediate experiencing within the session (Gendlin, Jenney, & Shlien, 1960). Gendlin further showed that those clients who naturally slowed down their talk, became less articulate and began to grope for words to describe their experience in the moment were found to have successful outcomes at the end of therapy (Gendlin, 1962, 1981, 1996; Weiser Cornell, 1996). These successful therapy clients also mentioned body sensations they were experiencing in the session. Gendlin (1981) described these special kind of internal sensations as vague, hard-to-describe body awareness or *felt-sense*. When Gendlin (1981) referred to felt-sense, he included the body sensation and the emotion, although the emotion was not explicit and the felt-sense of a situation contained more than the emotion. Automatic emotional responding and tacit meaning making may give rise to a felt-sense but if it is not the centre of awareness it is ignored (Greenberg, 2011). Gendlin argued against venting and catharsis and deemed that this body awareness or felt-sense made all the difference between unsuccessful and successful therapy. He was determined to find out how to teach this skill to all clients.

Thus, experiential *focusing* was developed in the late 1960s as a way of helping clients access their experience by having them attend to their bodily felt-sense (Gendlin, 1981, 1996). Through the different stages of *clearing the space*, attending to, and symbolising their felt-sense, clients are encouraged to form a trusting relationship with themselves (Weiser Cornell, 1996). Therapists are encouraged to listen actively through *attunement* (advanced empathy) and to *stay with* the internal experience of

their clients. Choosing to reflect present feeling in those inarticulate moments can assist the client to stay with, and explore, their experience rather than moving into self-analysis or criticism (Weiser Cornell, 1996). Making the implicit explicit was the process goal of therapy.

Gendlin's model has a dual intention. Attending to the immediately felt sense of experience combined with empathic understanding leads to *deepening* that experience. The integration between the feeling process and the attention brought to it generates a specifiable felt-sense and symbolising it enables a *carrying forward* to some sort of action. The therapist's task is to carry the client's experiencing forward and to remain in-touch experientially with what is occurring in their client (Mathieu-Coughlin & Klein, 1984). The skilful facilitation of process encourages exploration of the edge of the client's awareness of their experience. Deepening of that experience as it occurs in the present moment can potentially lead to new understanding and change (Gendlin, 1996; Weiser Cornell, 1996). A full resolution manifesting as a result of a *felt-shift* leads to new thoughts, awarenesses and feelings (Gendlin, 1981).

### **Psychotherapy dose-effect model of change.**

According to Bloom (2001) there is no greater question than knowing when enough psychotherapy has been done, a concept referred to as *therapeutic sufficiency*. Termination can indicate, not that all conflict has been fully and permanently resolved, but that significant psychological work has been done that permits the client to manage on their own. In contrast to Roger's theory of change, where the client not only sets the pace of therapy but also the duration, the notion of a *dosage-effect* model has emerged where *effect* is the probability of recovery and *dose* is measured by the number of therapy sessions (see Beutler, Clarkin, & Bonger, 2000; Kopta, Howard, Lowry, & Beutler, 1994). In addition, the construct of *clinically significant change* has become widely used in psychotherapeutic research to measure and validate therapeutic change. Clinical significance can be calculated by the demonstration that post-treatment clients who were initially assessed to have high levels of psychological distress are no longer distinguishable from (or are within the range of) normative well-functioning non-clinical individuals (Kazdin, 1999, 2003).

Government bodies and insurance companies across the developed world, frequently limit the number of counselling and psychotherapy sessions to clients. It has been suggested that the purpose of such rationing is not only to save costs but also to enable more individuals to obtain treatment and reduce waiting-lists for those treatments (see Harnett, O'Donovan, & Lambert, 2010). Such limits vary greatly from country to country. With the Medicare initiative in Australia in 2006, clients diagnosed with mental illness referred by a general practitioner were able to receive up to 12 sessions with a psychologist per calendar year. A further 6 sessions was made possible under exceptional circumstances. However, in 2011, the Australian Federal Government cut the number of sessions to a total of ten per calendar year. According to Harnett et al. (2010) such session limits arise without public discussion or consultation with health professionals.

Howard and his colleagues identified a three-phase model of psychotherapy that identified sequential progression in improvement in subjectively experienced well-being, reduction in symptomatology, and enhancement in life functioning (Howard, Kopta, Krause, & Orlinsky, 1986). The authors referred to these stages as remoralization, remediation, and rehabilitation. In the first stage a sense of hope and optimism was fostered, usually within six sessions. Change in hope and optimism, was necessary to activate the second phase of change, symptom relief or remediation. Within twenty-five sessions most clients had a reduction in symptoms, and by fifty-four sessions 80% of clients experienced significant symptom relief. The third phase of change, enduring personality changes or rehabilitation, appeared most relevant for only a relatively small portion of clients. Individuals with enduring interpersonal and personality disturbances required long-term interventions and these were only successful when changes had occurred in the early stages of therapy (Howard et al, 1986).

The study conducted by Kopta, Howard, Lowry, and Beutler (1994) analysed data across sixty-two symptoms for 685 outpatients (18 years and older) in individual therapy at five mental health centres. The participants underwent time-unlimited therapy, usually once a week. The presented findings indicated that 50% of clients achieved significant clinical change within eleven sessions and 75% of clients achieved significant clinical change after 58 sessions (Kopta et al., 1994).

A study by S. A. Baldwin, Berkeljon, Atkins, Olsen, and Nielsen, (2009) compared dose-effect and good-enough level models of change in 4,676 psychotherapy clients, ages 17 to 60 ( $M = 22.3$ ,  $SD = 3.7$ ) who received individual psychotherapy in naturalistic settings. Data was drawn from an archival dataset of therapy outcomes at a large university counselling centre. Clients attended 6.46 sessions on average ( $SD = 4.14$ ). Treatment outcome was assessed by the Outcome Questionnaire-45 (Lambert et al., 2004). The results indicated that clients rate of change varied as a function of the total dose; small doses of treatment related to fast rates of change whereas large doses of treatment were related to slow rates of change. Clients change at different rates and thus need different doses of treatment (S. A. Baldwin et al., 2009). Total dose had a nonlinear relationship with the likelihood of clinically significant change. Fixing dose does not reflect the clinical reality because people generally stay in therapy until they get better. Given the variability in rates of change, it appears that time limits for treatment uniform to all patients would not adequately serve clients' needs (S. A. Baldwin et al., 2009). Limitations of this study included (1) only a single outcome variable was used, (2) specific treatment/s delivered to each client was not known (a common limitation of naturalistic settings), (3) clients were from a university counselling centre, (4) information as to why clients terminated was unknown and (5) diagnostic information was drawn from therapist's impressions and not from structured clinical interviews (S. A. Baldwin et al., 2009).

Another piece of research supporting the dose model was presented by Analise O'Donovan from Griffith University during the 2009 conference of the Australian Area Group of the Society for Psychotherapy Research. An investigation she and her team conducted on therapy outcomes for 125 clients of student counselling services aimed to ascertain how many sessions it took for those clients suffering from psychiatric illness to return to a normal state of functioning or reliably improve (Harnett et al., 2010). The outcome measure used was the Outcome Questionnaire-45 (Lambert et al., 2004). Using survival analysis it was estimated that it would take about 8 sessions for 50% of clients to show reliable improvement and 21 sessions for about 85% to meet this criterion. Recovery took more treatment, with 50% of clients estimated to recover after 14 sessions and 70% requiring 23.



The authors conclude that the present funding by the Australian Government for the number of sessions for clients entering psychological treatments is much less than is necessary to show a benefit. These estimates are fairly consistent with estimates from research conducted in the USA that indicate that 50% of clients attain clinically significant change after 11 to 18 sessions (Anderson & Lambert, 2001; Hansen, Lambert, & Forman, 2002; Kadera, Lambert, & Andrews, 1996; Kopta et al., 1994). Harnett et al. (2010) argue that the limited Medicare sessions available for distressed clients fall far short of the number necessary for most clients to receive substantial benefit and suggest it would be more reasonable to allow 20 to 25 session per calendar year. Recommendations by both S. A. Baldwin et al. (2009) and Harnett et al. (2010) suggested that client progress be routinely monitored so that clients who respond rapidly will depart therapy with fewer sessions offsetting the cost of providing more sessions to clients who respond more slowly. A considerable limitation for both the study conducted by S. A. Baldwin et al. (2009) and the investigation by Harnett et al. (2010) was that the issue of maintenance of improvement was not addressed. The relationship between number of sessions for successful outcome and maintenance of improvement is an important consideration that requires active investigation so that government bodies and insurance companies can be fully informed.

However in contrast to the above findings there is growing evidence that planned focused single-session psychotherapy is equivalent to both brief and long-term therapies (see Bloom, 2001), and sufficient for some clients. Bloom (2001) conducted a review of the clinical and research literature of single-session psychotherapy and reported that overall between one-third and one-half of randomly selected clients seen in single-session psychotherapy stated they had been sufficiently helped in the one session. He also suggested that the basic reason for the equivalence is not that long-term therapy is limited in effectiveness but that the single-session work yields remarkable results. Client motivation is high as is willingness to change, thus creating a context where rapid change is possible. Single-session therapy has been practised from a wide variety of theoretical perspectives with no one orientation shown to be more effective than another (Bloom, 2001).

### **The common factors model of change.**

An alternative to the medical model (exemplified by the empirically supported treatments or ESTs movement) is the *common factors* model. This proposes that there exists a set of factors that are common to all (or most) therapies and that these common factors are responsible for psychotherapeutic benefits rather than the ingredients specific to particular theories (Duncan & Miller, 2000; Greenberg & Watson, 2006; Hubble, Duncan, & Miller, 1999). These common factors include establishing a therapeutic alliance, setting treatment goals and empathetic listening, all factors which are deemed essential but not unique to any one form of therapy (Duncan, Miller, Wampold, & Hubble, 2010; Wampold, 2001).

Lambert (1986, 1992) following an extensive review of outcome research identified four therapeutic factors and estimated their percentagewise contribution to outcome (see Figure 2.1) He suggested the percentages were “an illustration of what empirical studies suggest about psychotherapy outcome” (Lambert, 1992, p. 96). According to Lambert (1992) the outcome research base from which this proposed partition was derived was extensive, diverse, spanned decades and dealt with a large number of adult disorders studied through a variety of research designs. However, Lambert used no statistical procedures to derive the percentages and admits “the percentages that appear... [are] somewhat more precise than is perhaps warranted” (Lambert, 1992, p. 98). Aside from its uncertain derivation, another of its limitations is that it assumes that these proportions will be relatively similar across different forms of psychological distress which might not actually be the case (Cooper, 2008). Also, it tells us very little about the specific factors that might contribute to therapeutic change.

Hubble, Duncan, Miller, and Wampold (2010) suggested that outcome is related to the potency of the common factors working together. These authors suggested that the apportionment of the Lambert percentages could render the components of the common factors model as discrete elements and therefore potentially allow them to be operationalised individually. Hubble et al. (2010) further explained that the common factors are not invariant but are “interdependent, fluid and dynamic” (p. 34), and the components exert “their benefits through their joint and inseparable emergence over the course of therapy” (p.35). In addition, Wampold (2010) stated common factors cannot be experimentally manipulated in the same manner as specific ingredients as

common factors are intertwined with each other and with specific ones. The role and degree of the influence of any one factor are dependent on the context: who is involved; what takes place between therapist and client; when and where the therapeutic interaction occurs; and ultimately, from whose point of view these matters are considered (Hubble et al., 2010). Any treatment involves specific components but the manner in which they unfold depends on the interaction between the therapist and the client (Hubble et al., 2010).

Despite offering only an estimate and questionable percentages, the four elements in Figure 2.1 together with some additions and revisions in the conceptualisation of the factors responsible for change have been accepted as useful ways to consider the relative contributions of specific and non-specific factors (Duncan et al., 2010; Hubble et al., 1999). I will now discuss briefly several common factors.

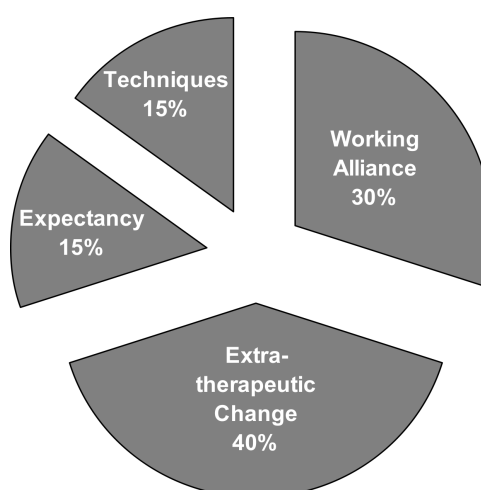


Figure 2.1. Percentage of improvement in psychotherapy patients as a function of therapeutic factors.

Source: Lambert (1992).

### **Client factors in therapeutic change.**

As defined by Cooper (2008), client factors are “those that exist within the person of the client” (p. 62) and are stable ways of being, identifiable outside the therapeutic environment that are more than the client’s values or beliefs or immediate feelings.

These *extra-therapeutic factors* are considered to explain much of the success or failure of the therapy (Asay & Lambert, 1999; Hubble et al., 1999; Lambert, 1992).

Bohart and Tallman (1999) hypothesised that the primary determinant of therapeutic outcome is the degree to which clients can make use of the therapeutic resources available to them. Orlinsky, Ronnestad, and Willutzki (2004b) claimed that a client's openness, motivation, active involvement, collaborative and cooperative attitudes are important determinants of positive outcome. They also stated that the client's level of *resistance* to therapeutic processes is a strong predictor of poorer outcome.. Tallman and Bohart (1999) referred to the client's capacity for self-healing as the "most potent common factor in psychotherapy" (p. 91). Duncan and Miller view that client as the *Hero* (Duncan & Miller, 2000; Duncan, Miller, & Sparks, 2004; Tallman & Bohart, 1999) but in the research the client has been rarely mentioned or recognised as the instigator of change. Tallman and Bohart (1999) believe the equivalence found for different therapies "occurs because the client's abilities to use whatever is offered surpass any differences that might exist in techniques or approaches" (p. 95). They explained that the reasons that different approaches to psychotherapy work equally well is that each allows clients the opportunity to work through and resolve their problems by utilising and individualising what each approach provides.

*Expectancy* factors include hope and the placebo effect. Lambert (1992) suggested that these factors are important because they carry with them the strong expectation that the client will in fact be helped. Clients who agree with the rationale of a therapeutic approach are likely to experience an increase in agency and in their determination to improve that further reinforces efforts to succeed (Snyder, Michael, & Cheavens, 1999). Therapist expectancies may also play a significant role in therapy outcome.. Therapists who have confidence in, and mastery of, their chosen method may enhance their client's belief in the potential for healing. The resulting hope, in turn, is predictive of more favourable therapeutic outcomes. Clients who have relatively realistic expectations about what will happen in therapy tend to get the most out of it (Cooper, 2008).

Snyder et al. (1999) reported that research has shown that a substantial portion of client improvement occurs within the first three to four weeks of psychological

treatment and suggested that this is possibly attributable to the expectancy-hope-placebo factor. The placebo effect for a control group or no-treatment group has played a confusing role in the assessment of outcome research. It was believed that the placebo, like its medical counterpart, offered a psychologically inert condition. However, a significant percentage of participants experienced meaningful change (not as much as the treatment group) when allocated to a placebo control position (Snyder et al., 1999).

Interestingly, if we were to include the expectancy-hope-placebo factors, which are also client features, then a larger percentage of the outcome variance is attributable to the client. In addition, the therapeutic relationship is as much created by the client as it is by the therapist and so further adds to the significant contribution brought to therapy by the client.

#### **Model and technique factors in change.**

A *model* in therapy is defined by Ogles, Anderson, and Lunnen (1999) as a collection of beliefs or unifying theory about what is needed to bring about change with a particular client in a particular treatment context. Cooper (2008) defined a therapeutic *technique* as a well-defined procedure implemented to accomplish a particular task or goal, as distinct from a therapeutic skill. Traditionally, the techniques are what makes a particular therapeutic approach unique. Indeed, Lambert (1986) defined therapeutic techniques as “those factors unique to specific therapies” (p. 25). Specific interventions have been enthusiastically studied because of practitioners’ allegiance, but results have been equivocal (Asay & Lambert, 1999).

In a study by Carey et al. (2007) clients, when asked what they found helpful, reported specific technical interventions as valuable. It is possible certain clients may find certain techniques or interventions to be more effective or beneficial than others. However, Bohart and Tallman (1999) reported different findings that when clients were asked about helpful aspects of therapy, non-technical factors were said to be more beneficial. Wampold (2001) examined further evidence that many of the common factors are related to outcome. The working alliance (see section below) has been repeatedly shown to be one of the best predictors of outcome regardless of the techniques employed (Bachelor & Horvath, 1999; Duncan et al., 2010). In addition,

research designs either adding particular techniques to form a therapy (additive designs) or removing them (dismantling designs) rarely result in a difference to overall outcomes (Ahn & Wampold, 2001). Hubble et al. (1999) suggested that models and techniques provide therapists with replicable and structured ways for developing and practising values, attitudes and behaviours consistent with the core ingredients of an effective therapy. The role of techniques is to enhance the potency of the common factors. Cooper (2008) made the point that techniques are what therapists *do* but there is no clear distinctive boundary between applied techniques and therapeutic processes that are relational skills, such as self-disclosure. Cooper (2008) also argued that non-CBT approaches may be more helpful for those clients who have internalised their difficulties where CBT approaches may be more useful for those who have externalised their problems and are able to apply practical solutions to their lives.

According to Wampold (2001), the uniform efficacy of bona fide treatments, provides indirect evidence that specific ingredients are not responsible for the benefits of psychotherapy. He reviewed research designed particularly to detect the presence of specific factors and found that the evidence indicated that, at most, specific ingredients account for only 1% of the variance in outcomes. The results of studies using component designs, placebo control groups, mediating constructs and moderating constructs consistently failed to find evidence for specificity (see Wampold, 2001 for details).

Thus an interesting paradox has emerged, where the evidence based-practice movement places great emphasis on *treatments*, yet the evidence suggests that in fact the type of treatment accounts for very little of the variability in outcomes (Asay & Lambert, 1999; Lambert, 1992; Wampold, 2001). Clearly, the EST movement ignores aspects of treatment that are valued by psychologists and clients and that have been shown to account for some variability in outcomes, such as variation among psychologists, the relationship and other common factors (Wampold & Bhati, 2004).

Cooper (2010) raised concerns that if we allow generalised research evidence to govern how we relate to clients we may impose particular techniques or interventions on individual clients that may be unhelpful or potentially harmful. According to Cooper (2010) it may be more important to tailor our interventions to meet the

requirements of our clients because there is growing evidence that different kinds of therapy benefit different clients.

Despite the common factors model being widely accepted, the debate continues over whether one technique is significantly different from, and more effective than, another. Consequently, at this stage of the understanding of what produces change in therapy, Ogles, Anderson, & Lunnen (1999) state that the most that can be concluded about the role of techniques is that they contribute to positive treatment outcomes. Specific techniques may enhance change, depending on the client population. This fact, however, does not contradict the evidence regarding the significant role of the other common factors – client, relationship, placebo, hope and expectancy. Rather it suggests that unique or special variables may at times be important as well (Lambert & Bergin, 1994).

### **The working alliance and client change.**

Bordin (1979) wrote “I propose that the working alliance between the person who seeks change and the one who offers to be a change agent is one of the keys, if not *the* key, to the change process” (p. 252). The working alliance, also referred to as the therapeutic alliance or bond, can be defined in many ways but Horvath and Bedi (2002) usefully define it as: “the quality and strength of the collaborative relationship between therapist and client in therapy” (p. 41). This is inclusive of mutual trust, caring and respect, together with a consensus about the goals of therapy and how those goals might be achieved. There is potentially an enthusiastic sense of partnership, commitment and engagement with therapy as a consciously purposeful endeavour (Horvath & Bedi, 2002).

Researchers have repeatedly found that a positive alliance is one of the best predictors of outcome (see Norcross, 2010) and is identified as a *robust* common factor (Duncan et al., 2010; Hubble et al., 1999). The components that make up the working alliance include elements found in a variety of therapies regardless of the therapist’s orientation, especially the therapeutic relationship itself, which ideally comprises empathy, warmth, acceptance, encouragement, trust, and safety. The “necessary and sufficient conditions”, suggested by Rogers (1957) as essential for personality change, are accurate empathy, unconditional positive regard and

congruence. These conditions are considered by virtually all therapy orientations as significant for progress in psychotherapy and fundamental in the formation of a working alliance (Asay & Lambert, 1999; Lambert, 1992). Except for what the client brings to therapy, these variables are probably responsible for most of the gains resulting from psychotherapy interventions (Asay & Lambert, 1999; Bachelor & Horvath, 1999; S. A. Baldwin, Wampold, & Imel, 2007; Bohart, Elliott, Greenberg, & Watson, 2002; Cooper, 2008; Horvath & Bedi, 2002; Lambert & Bergin, 1994; Norcross, 2010).

Within the humanistic model of therapy, the goal is not to provide treatment for psychopathologic conditions but to develop a relationship that provides an optimal environment for a person to reflect on their life difficulties. The therapy should involve a co-constructive dialogue with the client, with the therapist offering “exquisitely sensitive differential responding in the moment” (Bohart, O’Hara, & Leitner, 1998, p. 145).

An early review by Elliott and James (1989) indicated that clients do not emphasise the effectiveness of techniques or models, but primarily attribute the effectiveness of their treatment to the relationship with their therapists. According to Norcross (2010) “psychotherapy is an intensely relational and affective pursuit” (p. 116), and despite psychotherapy research looking past the interpersonal experience of the client, clients themselves continue to report the relationship as vital to successful therapy.

In 2001, after a four year investigation, the APA Division 29 Task Force published conclusions and recommendations about the therapeutic relationship (Ackerman et al., 2001; Norcross, 2001). The Task Force had two specific objectives: to identify elements of effective therapeutic relationships and to identify what works for particular clients. The reviews and subsequent series of meta-analyses were based on the results of empirical research, both quantitative and rigorous qualitative studies, linking the relationship element to psychotherapy outcome (see Table 2.3).



Table 2.3. Conclusions and recommendations of the Division 29 Task Force about the therapeutic relationship.

<b>Degree of effectiveness</b>	<b>Factor</b>	<b>Definition</b>
Demonstrably Effective	Therapeutic (working) Alliance	Quality and strength of collaborative relationship between client and therapist as distinct from the whole therapeutic relationship
	Empathy	“Therapist’s sensitive ability and willingness to understand client’s thoughts, feelings and struggles from their point of view” (p. 98, Rogers, 1957)
	Goal Consensus and Collaboration	Therapist-client agreement on treatment goals and expectations Mutual involvement of participants in the helping relationship
Promising and Probably Effective	Positive Regard	The therapist quality is characterised as warm acceptance of the clients’ experience without conditions
	Congruence	The therapist’s personal integration in the relationship
	Genuineness	The therapist’s capacity to communicate his or her personhood to clients as appropriate
	Feedback	Descriptive and evaluative information provided to clients from therapists about clients’ behaviour or the effects of that behaviour
	Repair of Alliance Ruptures	Tension or breakdown in the collaborative relationship is addressed and mended
	Self-Disclosure	Therapists’ statements and behaviours that reveal something personal
	Management of Countertransference	A therapist’s acting out countertransference hinders psychotherapy but effectively managing it aids process of therapy
	Quality of Relational Interpretations	Therapist interventions that attempt to bring material that was previously out of awareness to conscious awareness

Source: Ackerman et al. (2001); Norcross (2010).

One of the conclusions of the Task Force was that “the therapy relationship... makes substantial and consistent contributions to psychotherapy outcome independent of the specific type of treatment” (Ackerman et al., 2001, p. 495). In addition, adapting or tailoring the therapeutic relationship to specific client needs and characteristics may enhance the effectiveness of therapy. Essentially the Task Force recommended that therapists “simultaneously use what works. Avoid what does not... nurture the therapeutic relationship” (Norcross, 2010, p.134).

Interestingly, the Task Force:

...unanimously acknowledged the deep synergy between techniques and the relationship. They constantly shape and inform each other... The relationship does not exist apart from what the therapist does in terms of technique, and we cannot imagine any techniques that would not have some relational impact... (Norcross, 2001, p. 349)

Further, Norcross (2010) claimed that “to remove the interpersonal from the instrumental may be acceptable in research, but it is a fatal flaw when the aim is to extrapolate research results to clinical practice” (p. 132). According to Bohart et al. (1998) the therapist is the treatment of choice, not the therapy. A therapist’s orientation is a personal way of implementing the interpersonal presence. What is considered most useful is *how real* the therapist is in relation to the client and how flexible her adjustment is to the emerging flow of interaction between therapist and client.

Notwithstanding that it is widely acknowledged that the working alliance plays an important role in outcomes what is debated is the actual amount of variance that can be contributed to this factor. Cooper (2010) questioned Lambert’s apportionment of 30% of the variance in outcome to the working alliance, citing Beutler et al. (2004) who concluded the portion might be somewhere between 7-17%. Wampold (2001) used meta-analysis to identify the fact that the working alliance contributed only 5% to the variance of outcome. Cooper (2010) argued that just because relational factors are connected to outcome, that doesn’t prove they caused it. He also asserted that the working relationship is not something a therapist provides for the client but

something that emerges from the client-therapist interaction. Cooper (2010) challenged Rogers' (1957) hypothesis by stating that "certain relational conditions are not necessary (though they may be sufficient) for therapeutic personality development to occur" (p. 188).

In Process-Experiential/Emotion-Focused therapy (PE-EFT) the first task is to develop a safe working alliance (Elliott, Watson, Goldman, & Greenberg, 2004). Such a therapeutic relationship is considered inherently curative and the Rogerian attitudes of empathy, unconditional positive regard and genuineness (Rogers, 1957) are understood as central change-producing aspects (Greenberg, Rice, & Elliott, 1993). Rice (1983) proposed that the working alliance serves two functions. First, it promotes growth by helping clients to understand and accept themselves. Second, it assists clients to develop trust in the therapist and in the therapeutic process so the client can engage in the often difficult work of self-exploration and active expression. Whilst the first function is considered vital in PE-EFT, the task-facilitative function of the working alliance is emphasised (Watson & Greenberg, 1998). A safe empathic working environment is considered essential when introducing and facilitating the active interventions or tasks of PE-EFT that are utilised to promote clients' change processes (Greenberg et al., 1993).

PE-EFT theory recognises that clients are active agents in their exploration of their inner world and are fundamental to the establishment of a collaborative working alliance. The "clients are experts on their own experiences, and therapists are experts at facilitating different types of exploration" (Elliott, Watson et al., 2004, p. 142). Alliance difficulties or ruptures are considered opportunities for both client and therapist to interact genuinely with each other (Watson & Greenberg, 1998). Reluctance is seen as a therapeutic opportunity to understand how clients feel about the process of therapy and to assess their readiness to participate wholeheartedly in therapy. Interpersonal repair work is particularly important with clients who have extensive or severe histories of trauma or abuse, including those with borderline processes (Elliott, Watson et al., 2004). Genuine and authentic therapists, in their relationships with their clients, may be challenged to offer honest disclosure of their own experiencing in relation to their client. Clarifying how each person's behaviour affects another can be beneficial to the client's interpersonal growth, especially when

there is an understanding of the potential impact that such a transparent disclosure might have (Elliott, Watson et al., 2004). Therapists are encouraged to be responsive to the different needs of the client at different times.

## **Therapist Effects on Client Change**

Historically, research has overlooked the provider of the therapeutic interventions, the therapist (Goldfield & Wolfe, 1998; Wampold & Bhati, 2004). Wampold (2006) found that analyses of clinical trials rarely examine the degree to which therapists were responsible for the benefits of treatment. This leaves unanswered the question of whether some therapists consistently produce better outcomes than others, regardless of type of psychotherapy. A significant proportion of the variability in outcomes in clinical trial research can be attributable to therapists within treatments even when therapists have been selected for their skill and adherence to treatment protocols (Kim, Wampold, & Bolt, 2006). Similarly, in naturalistic settings some therapists are more effective than others regardless of the therapy (Lutz, Leon, Martinovich, Lyons, & Stiles, 2007; Wampold & Brown, 2005). S.A. Baldwin, Wampold, and Imel (2007) found that therapists who formed better alliances also had better outcomes. Thus, a client who has difficulty forming relationships has a better outcome with a therapist who can form a better alliance. Effective therapists foster hope by providing their clients coherent and relevant explanations of their difficulties and delivering treatments consistent with such explanations (S. A. Baldwin et al., 2007). A strong alliance will increase the likelihood that clients will agree with their therapists on the tasks and goals of therapy, and this has been shown to affect outcome (Wampold, Imel, Bhati, & Johnson, 2006). Some theorists have conjectured that clients are largely responsible for the alliance, but the study conducted by S. A. Baldwin et al. (2007) did not corroborate this.

## Clients' Perspectives Accessed through Case Studies

Elliott (2007) encouraged person-centred therapists to engage more intensively in research that investigates the general effects with specific client groups through randomised control trials (RCTs). However, he also warned that vital evidence can be missed when looking purely at outcome data, and described randomised controlled trials of psychotherapy as “*causally empty*... they provide conditions under which inferences can be reasonably be made but provide no method for truly understanding the specific nature of the causal relationship” (Elliott, 2001a, p.316). According to McLeod, (2010) “*what causes what*” in therapy cannot be understood by results obtained by RCT alone. Interestingly, psychological interventions tested in RTCs were developed over years in clinical settings through systematic observations and application of different kinds of interventions within cases (Dattilio, Edwards, & Fishman, 2010). Examining specific effects with specific clients through systematic case studies could make a contribution to the network of evidence and ideas that constitute counselling and psychotherapy research literature (McLeod, 2010). Investigating what clients find helpful or transformative moments in therapy are other areas Elliott (2007) proposed as important for investigation.

Rogers and Dymond (1954) pointed out that different conclusions on process and outcome could be reached depending on whether the perspective of the client, the therapist or an observer was considered. Most research has relied either on the therapist or on external observer perspectives (McLeod, 2003a). Fewer studies have investigated the client's experience of counselling (Eells, 2007; Gordon, 2000; McLeod, 1990) and attempts to understand the nature of therapy have generally overlooked the client's view (see Gordon, 2000). Research involving the client has often used standardised questionnaires or rating scales, which filtered the client's experience through categories and dimensions imposed by the researcher (McLeod, 2003c). More recently, however, another important strand of process research has emerged investigating clients' experiences of therapy (Gordon, 2000; McLeod, 2003a).

The main aim in process research studies has been to create a representation, through an account of the client's experience, of what the therapy was like from their

point of view. However, the investigation of client experience can be a complex matter. For instance, Elliott and Zucconi (2006, 2010) recommend integrating client, counsellor and observer perspectives in a single version. Conversely, Rennie (1990) has constructed a rationale for concentrating solely on the experience of the client. Gordon (2000) stated that researchers need to acknowledge that the clients they observe are responsible agents capable of constructing and managing their world. Eells (2007) described the individual as the “unit of interest and the unit of analysis” (p. 34). Understanding people in the client role in this way offers an alternative to viewing the client as a passive recipient of the therapist’s interventions.

This type of inquiry can take the form of systematic descriptive case studies. According to Greenberg and Newman (1996) “...description should be seen as a discovery process” (p.435) and has the potential to offer an invaluable insight into client experience. (See Chapter 5 on Methodology for more detail on case study research criteria). Interestingly, Fishman (1999) envisaged a new direction for psychology’s journals.

Instead of today’s journals filled with “theory-driven” group studies, the field would have journals filled with systematic, comprehensive case studies. These case studies could then be organised into a computerised database by various categories. Practitioners working with the problems and goals and contexts of a particular case situation could then access those case studies in the database that best matched the target situation and employ those studies for suggestions or guidelines for addressing the target case. Researchers and theorists would conduct comparative analysis across specific types of cases to yield pragmatically focused generalisations about what interventions work to accomplish certain types of goals in specific kinds of case situations. (p. 20)

Pragmatic Case Studies in Psychotherapy (PCSP), an internet web-based journal launched by Fishman (2005), is a peer-reviewed, open-access journal and database, intended to provide innovative, quantitative and qualitative knowledge about

psychotherapy process and outcome for both researchers and practitioners. The case-study manuscripts are organised in terms of common headings in order to facilitate comparison among cases and can accommodate a wide array of different theoretical approaches, from the highly manualised treatment models to the more individualised therapy models (Fishman, 2005). However, these headings still follow a medical model to some extent and are not consistent with the values underpinning person-centred approaches.

Systematic case studies are becoming more recognised as making a vital contribution to the development of an evidence base for counselling and psychotherapy theory and practice (McLeod & Elliott, 2011). Stephen, Elliott, and Macleod (2011) acknowledge that systematic case-study research heralds a new movement in counselling and psychotherapy research. McLeod (2010) suggested that case studies are a flexible method of inquiry that have the potential to contribute to shared professional and scientific knowledge, to enable clients and practitioners to get an understanding of what actually happens in therapy and to provide an opportunity for practitioners to reflect on their practice. He claimed that case study reports contribute to research, theory building, training, organisational and political change, marketing and public awareness. Case studies have immediate appeal to clinicians and when presented in a narrative format can give insight into how a particular treatment actually works (Stewart & Chambless, 2010). For example, using a hermeneutic single case efficacy design, a mixed case study method for evaluating therapy efficacy in single cases Elliott (2001a, 2002b) identified specific change processes. Paul, a 49 year old man with depression was counselled at the Centre for the Study of Experiential Therapy, by a second year clinical psychology student using PE-EFT. Paul showed change in his long-standing problems of ten years, especially in his unresolved loss/grief issues. In his Change Interview (Elliott, Slatick, & Urman, 2001) Paul attributed most of his change was as a result of therapy. The therapist's main contributions, as reported by Paul were to keep him focused on difficult issues, and to help his grieving while patiently persisting in facilitating his process over 39 sessions. Paul's description and the hermeneutic analysis provided "a plausible account of the chain of events from cause (therapy) to effect outcome" (Elliott, 2002b, p. 17).

A second such case by Elliott and seven of his colleagues (2009) illustrated the application of an adjudicated form of hermeneutic single-case efficacy design. George was a 61-year-old European-American male diagnosed with panic and bridge phobia attended 23 sessions of individual PE-EFT. George listed four improvements as the result of his therapy; he could now cross bridges, had a better relationship with his wife, was more tolerant of difficulties and setbacks, and was less afraid of flying. In this study, affirmative and sceptic teams of researchers developed opposing arguments regarding whether the client changed over therapy and whether therapy was responsible for these changes. Three judges representing different theoretical orientations then assessed data and arguments, rendering judgments in favour of the affirmative side. Each of the three judges agreed strongly that George had changed and further agreed, although with somewhat less certainty, that therapy was at least partly responsible for the client's change. They agree that the therapeutic relationship played a central role in the change process. However, they disagreed about what other processes were operating, with the two non-experiential judges attributing George's change to processes not specific to PE-EFT (Elliott et al., 2009).

Stewart and Chambless (2010) suggested that when publishing RCT data the editors of journals should include a case study of a particular client within the trial thus making the RCT results more meaningful to, and influential for, practitioners. Because RTCs provide little information about the mechanisms of how therapy works, Dattilio et al. (2010) suggest that for efficacy research to be genuinely authoritative a *mixed method* approach should be employed. These methods need to include case-based methods in the form of systematic case-studies or case-based process research. Different research methodologies offer unique types of evidence and the information from one method can illuminate interpretations from other methods (Dattilio et al., 2010). Well-written case studies offer a unique means of providing clinical knowledge that can directly inform practice.

The pragmatic case study proposed by Fishman (1999) has been designed to address the limitations of traditional clinical cases studies by encouraging the researcher to gather as much data as possible and write up the case in a standard format. Each case is then rigorously peer reviewed and published alongside two or three expert commentaries this enabling the reader to arrive at their own



interpretation of the case. Very recently, Pragmatic Case Studies in Psychotherapy (PCSP) published a series of case studies in its online journal incorporating an Individual Case-Comparison (ICC) method that was described as a promising approach for bridging the research-practice gap (Fishman, 2011). This method consisted of systematically comparing good-outcome and poor-outcome cases that have both been drawn from a successful RCT treatment condition. The methodology included a mixed methods model that integrated group-based, quantitative results with the case-based results of systematic and contextualized narrative case studies. Both types of knowledge were considered as complementary.

A comparison of two clients, taken from a RCT for Emotion-Focused Therapy (EFT) for depression were presented (Fishman, 2011). A poor-outcome client “Tom” (Watson, Goldman, & Greenberg, 2011) was compared with a good-outcome client “Eloise” (Goldman, Watson, & Greenberg, 2011). The aim of such a comparison was to provide an opportunity to investigate holistically and in detail the individual and interactive roles of a variety of factors that affect outcome for each client (Fishman, 2011). One of the main factors attributed to Tom’s limited success was that treatment was not long enough. At session 16 he was only beginning to show signs of improvement, he was sceptical therapy could help him, he had a limited support network and he was deeply ashamed that a major life project had been criticised and dismissed.

On the other hand, Eloise attended ten sessions and by session 7 her depression score on the BDI was 1. She attributed the decrease in her depressive symptomatology to therapy. A strong working alliance in conjunction with the PE-EFT tasks was used to address specific emotional processing problems. This good-outcome case study, provided support that identified the way that PE-EFT treatment set processes of change in motion and how these changes led to the remission of Eloise’s depression (Fishman, 2011; Goldman et al., 2011).

## **Change Process Research**

This study belongs to the field of process research, particularly *change-process research*, and is designed to contribute to understanding processes of client change

during Process-Experiential/Emotion-Focused Therapy (PE-EFT). Process research has developed over the last 25 years to investigate what happens in therapy and why not all clients improve (Cooper, 2008, 2010; Elliott, 2010a; McLeod, 2003a). According to Elliott (2010a) there have been four major types of change process research developed but this chapter will focus particularly on the *significant events approach* which includes the *task analysis* of Rice and Greenberg (1984) and the *helpful events* of Elliott (1984).

The process of counselling is concerned with *change*, and attempts to create positive change for the client by the actions and intentions of the client and therapist in collaboration (McLeod, 2003c). *Change-process research* is distinct from outcome and process research, because it concerns itself with explaining both *how* and *why* change occurs in therapy (Elliott, Greenberg, & Leitaer, 2004; Elliott, Slatick, & Urman, 2001). According to Greenberg (1986) change process research has the potential to transcend the dichotomy between process and outcome. Identifying, describing, explaining and predicting the effects of the processes that bring about therapeutic change over the course of therapy has the potential to provide useful understandings to the therapist in-the-field. Put simply, in studying the process of change, both beginning and endpoints are taken into account, as well as the events between these points (Elliott et al., 2001; Greenberg, 1986). The research focus can be from the perspective of the client or therapist or through the eyes of an observer or researcher (Elliott, 1991; McLeod, 2003c). According to Elliott (2010a) change process research “is the study of the processes by which change occurs in psychotherapy and is a necessary complement to randomised control trials and other forms of efficacy research” (p. 123) because it offers several strategies for investigating and evaluating client change. These range from process-outcome investigations to asking clients to describe the aspects of their therapy that helped them change.

During 1940 and 1945 Rogers and his colleagues at the University of Ohio were the first to audio-record therapy sessions and the first to study process in a systematic way (Rogers, 1942, 1951, 1961). They looked at the way clients made reference to *self* at different points in the therapy in addition to the *directiveness* of the therapist. The results of these investigations culminated in two key papers, on the *necessary and*

*sufficient conditions* of therapeutic change (see Rogers, 1957) and the process of change in therapy (see Rogers, 1961).

According to Elliott (2010a) there are now four predominant change process research designs. The three basic designs are the quantitative *process-outcome* design, the qualitative *helpful factors* design, and the *microanalytic sequential process* design. A more complex mixed genre design is the *significant events* approach, which includes task analysis and comprehensive process analysis that integrate the first three designs.

### **The quantitative process-outcome design.**

The commonly used quantitative process-outcome design has generated several thousand separate findings that have measured various dimensions from client, therapist and observer perspectives. This design tests key processes from one or more therapy sessions to predict post-therapy outcome (Elliott, 2010a). The therapeutic alliance for example has been studied the most. A meta-analysis conducted by Martin, Garske, and Davis (2000) indicated that the overall relationship of therapeutic alliance with outcome is moderate, but consistent, regardless of many of the variables that have been posited to influence this relationship. Technique variables have also been researched extensively but with mixed results (see Orlinsky, Ronnestad, & Willutzki, 2004a). Therapist empathy, considered one of the most consistent predictors of therapy outcome, was found in a meta-analysis ( $n = 190$ ) by Bohart, Elliott, Greenberg, and Watson (2002) to have a mean weighted effect size of .32. This is considered a relatively small proportion of the variance and is not consistent with Roger's (1957) hypothesis that the relational conditions are necessary and sufficient for client change. Despite this type of change process research being widely used there are a number of limitations (see Elliott, 2010a), the most obvious being that, because only input and output are looked at, everything in between, such as the within session moment-by-moment change events, is ignored.

### **The qualitative helpful aspects factors design.**

Qualitative research is an excellent way to investigate change-processes in therapy (Elliott, 2010a; Elliott et al., 2001; Hill, 2006; Hill & Corbett, 1993; Lutz & Hill, 2009). Such research has the potential to contribute to the further development of clinical

practice because it can discover and/or construct useful understandings of how therapy works. Asking clients what they find helpful or unhelpful in their therapy has become an increasingly popular and important method of change process research. Elliott (2010a) refers to two main types. Firstly, collecting a qualitative overview of their therapy experience can be obtained by interviewing clients. The *Change Interview* developed by Elliott in 1996 provides a semi-structured interview to ascertain changes that have occurred from the client's point of view, to record attributions regarding what, inside or outside of therapy, brought about the changes and enquire into the helpful or hindering aspects of the therapeutic experience (Elliott et al., 2001). A study by Levitt, Butler, and Hill (2006) interviewed clients who had completed psychotherapy about the significant experiences and moments they recalled within their sessions. These interviews were analysed using grounded theory (Strauss & Corbin, 1990, 1998), creating a hierarchy of six cluster categories that represent what clients found important in therapy. Significantly, clients in this study spoke of their therapeutic relationship more than any other factor and emphasized the importance of the experience of care within that relationship (Levitt et al., 2006). This finding is supported by meta-analyses that indicate that relational and contextual factors contribute more to change than do specific interventions (Wampold, 2001).

Another way to establish helpful aspects of therapy in change process research is by the use of a post-session questionnaire such as the *Helpful Aspects of Therapy* (HAT) form (Llewlyn, 1988). This frequently employed questionnaire is useful for collecting information about helpful events in therapy for further analysis. Clients are asked to describe an important experience that happened in the session they had just completed and explain why it had been helpful/unhelpful (Llewlyn, 1988). Such enquiries can complement rich qualitative accounts of change processes in single-case research designs (Elliott et al., 2009; Macleod, Elliott, & Rodgers, 2012) or can be used in systematic qualitative analysis methods, such as grounded theory (see Elliott, 2010a; Strauss & Corbin, 1990, 1998). Whilst it may seem obvious and an easy task to ask the client what was helpful, people's judgments about causes of events may often be wrong and could be misattributed to therapy instead of their own efforts outside of therapy or life events, or clients may not be able to explain the changes they are experiencing. However, in spite of these limitations, the clients are best placed to

inform us about what worked for them and what didn't, thus providing us with one line of evidence (Elliott, 2010a). Combining qualitative helpful factors research with single-case methods, which evaluate the validity of the clients' self-report, is posited by Elliott (2010a) as an "intriguing possibility" (p. 127). He further states that he sees qualitative research of this type as useful in developing the theories of how change occurs in therapy, though not so much for the testing those theories.

### **Microanalytic sequential process design.**

A far less common form of change process research involves the investigation of the turn by turn in-session interaction between client and therapist. The question of "what client processes are triggered by what therapist responses under what conditions" (Elliott, 2010a, p. 128) is the focus of this design. A small number of process variables are investigated, such as studying the person-centred expectation that therapist empathy facilitates deeper client experiencing. Despite being difficult and time consuming, this sequential process research, Elliott (2010a) suggests, is capable of providing the basis for strong causal inferences about important therapeutic change processes.

### **Significant events approach.**

The significant events design is a more complex framework and mixes qualitative and quantitative data collections (Elliott, 2010a) with the aim of informing theory. Several researchers have argued for examining process without preconceived notions about what one expects to find (Elliott, 1984; Hill, 1990). Where the Rogerian studies were informed by theory, *events* studies were largely non-theoretical and assisted in providing descriptions of *change events*. In this approach researchers attempt to observe sessions and describe and analyse what they observe with the aim of developing theories. For example, Elliott (1984) found that the path to client insight progressed from the client being blocked and indirectly requesting help, to a therapist interpretation, to mild client agreement and finally to client insight.

Task analysis (see next section), adapted in 1984 from cognitive science by Rice and Greenberg (see Greenberg, 2007; Pascual-Leone, Greenberg, & Pascual-Leone, 2009), along with comprehensive process analysis (Elliott, 1984, 1993; Elliott &

Shapiro, 1992) are examples of the significant events design. The focus is on important moments in therapy and incorporates helpful factors methods. Such methods range from identifying significant events using methods such as the self-report, HAT form (Llewlyn, 1988), to reviewing sessions using observational methods (Greenberg, 2007), to using recordings of sessions and procedures such as Brief Structured Recall to access participants' internal experiences of significant events (Elliott, 1984; Elliott & Shapiro, 1992). A combination of methods may be employed. Once one or more events have been identified, sequential process methods are used to develop a description of what happened, usually by tracking multiple parallel aspects, and to build theory (Elliott, 2010a). Finally, significant events studies generally attempt to link within session processes to post session and post therapy outcomes by looking at the connections between in-session process and outcome.

The highly flexible significant events research operates at a level that is close to practice, and is useful for explicating therapist implicit knowledge and translating findings into clinical microtheories (Rice & Greenberg, 1984). Despite being used to study a variety of types of events or therapies, significant events research is technically demanding and highly time consuming (Elliott, 2010a), although it may be well suited to single-case or small-sample student research projects. Elliott (2010a) also suggests significant events research may be useful in understanding whole therapies.

Comprehensive process analysis (Elliott, 1984; Elliott & Shapiro, 1992) works inductively and can produce complex, clinically-sophisticated understandings of change processes by analysing significant events. Elliott and Shapiro (1992) saw "significant events as a window into the process of change... significant events represent important general therapeutic factors but in more concentrated form" (p.164). Although Elliott (1993) has argued for letting the "data speak for themselves," he also saw value in explicating what is implicit or tacit, and in exploring participants' varying perceptions of situations. Interestingly, Simons (2009) warned that the "data do not speak for themselves" (p. 118) as there is only interpretation and it is clearly the researcher who makes sense of the data. The researcher tells the story by selecting and recording the data and subsequently making meaning of it. However, Bohart, Tallman, Byock, and Mackrill (2011) argue that with a sufficiently rich case record, observers/jurors can plausibly draw conclusions as to whether a person changed in

psychotherapy and what in therapy contributed to that change. In addition, inferences can be drawn about what processes in therapy plausibly seemed to have helped, and what the complexities of the change process look like (Bohart et al., 2011). In a similar vein, Stephen and Elliott (2011) present a means of *testing the evidence* by using an adjudicated process as a way of addressing the criticism of researcher bias.

### **Task Analysis and the Development of PE-EFT**

*Task analysis* is a method used to discover and validate how clients successfully resolve affective-cognitive emotional issues within therapy, and to validate these discoveries by illuminating the steps in successful completion of a *task* (Greenberg, 2007; Rice & Greenberg, 1984). “Task analysis uses pluralistic methods and engages in a variety of different types of studies, including intensive observation, model building, measurement construction, and testing hypotheses and works in the context of both discovery and justification to investigate how people change in psychotherapy” (Greenberg, 2007, p. 15). After a failed attempt to develop a *sequential* analytic approach for psychotherapeutic change Rice and Greenberg (1984) decided to study change by applying a *task analytic* method. The measures they had employed did not adequately capture some of the important phenomena of therapeutic change they observed and so they employed a more intensive, observational method and developed a context-sensitive events approach (Greenberg, 2007). They conceptualised that certain discernible recurring *events* in therapy possess a high probability of effecting change. Each event consists of an interactional sequence between the client and therapist that has a beginning, an end and a particular structure that gives it meaning. The therapist follows an implicit or explicit guideline or *marker* which takes the form of “*when* the client did this *then* the therapist did that...” (Greenberg, 1984b, p. 138). The presence of such a marker indicates to the therapist that some affective issue needs to be resolved by the client. Many of the potent events in therapy signalled by these markers, possess task-like characteristics. A distinctive feature of task analysis has been the rigorous focus on the experience of the client in context (McLeod, 2003a). “The client is the one in whom change takes place; the therapist’s job is to facilitate the process of client change” (Rice & Greenberg, 1984, p. 23). Task analysis thus evolved out of an event-based approach to

psychotherapy process research that emphasised the importance of studying process in context (Greenberg, 2007; Rice & Greenberg, 1984).

The steps of task analysis (see Error: Reference source not found) include a discovery-orientated phase and validation-orientated phase (see Greenberg, 2007). The first phase aims to build models but emphasises working within the context of discovery and uses both rational and empirical analysis to observe and categorise performance. The second phase works within the context of justification through empiricism and emphasises validation, hypothesis testing, group design, and statistical model validation to relate process to outcome (Greenberg, 2007).

Table 2.4. Steps of Task Analysis.

Phase	Step description
Discovery	<ol style="list-style-type: none"> <li>1. Specify the task</li> <li>2. Explicate clinician's cognitive map</li> <li>3. Specify the task environment</li> <li>4. Construct rational model</li> <li>5. Conduct empirical analyses <ol style="list-style-type: none"> <li>a. Discern essential steps</li> <li>b. Develop criteria for objective measurement</li> </ol> </li> <li>6. Synthesize a rational empirical model <ol style="list-style-type: none"> <li>a. Construct the first model</li> <li>b. Reiterate empirical analysis and model refinement</li> </ol> </li> <li>7. Explain the model: theoretical analysis</li> </ol>
Validation	<ol style="list-style-type: none"> <li>8. Validation of the components of the model</li> <li>9. Relating process to outcome</li> </ol>

Source: Greenberg (2007).

Rice (1974) working within the person-centred framework identified the first type of *change event*. This involved the therapist offering an evocative response to a client who experienced a problematic reaction to a situation. The evocative response was an attempt to focus on a single incident and for the client to re-experience it as concretely as possible. This enabled the client to experience the event more fully and to allow it to unfold rather than repackage it (Rice, 1974). Intensive task analysis, undertaken on



the change event of the problematic reaction, yielded a model for *systematic evocative unfolding* that included the stages that facilitated resolution (Rice, 1984).

In 1975, whilst at York University conducting research for his doctoral dissertation, Greenberg identified a second type of *change event* (as cited in Greenberg, Rice, & Elliott, 1993). This involved the resolution of an intrapsychic split within the client by means of a two-chair dialogue taken from Gestalt therapy. A split is described as an in-therapy statement between two aspects of self (Greenberg et al., 1993). Greenberg conducted an intensive task analysis of the processes involved within this change event revealed that conflict resolution occurred when the previously *harsh critic* softened its stance toward the side that expressed the *experiencing self* (Greenberg, 1984a; Greenberg & Webster, 1982). Further analyses produced a model of intrapsychic conflict resolution with the two-chair dialogue that composed of six resolution components, three for each side. The harsh critic in successful dialogues was found to go through a sequence of blaming the self, then expressing its standards and values and finally softening. The experiencing self was found to be able to express its feelings and then its needs. In successful discourses a final negotiation between the two sides resulted in an integration of the two sides.

“The identification of problematic reactions and splits as markers of affective problems requiring specific types of intervention was the first step in developing a more differentiated approach to experientially orientated intervention” (Greenberg et al., 1993, p. 8). Thus, results from numerous task analyses assisted in documenting the client markers and therapist facilitating responses that are offered as opportunities within the co-construction of therapeutic change (Elliott et al., 2001). Intensive change-process research conducted by Greenberg, Rice and Elliott led to the eventual development of the therapeutic model of Process-Experiential/Emotion-Focused Therapy (PE-EFT), demonstrating how such research can contribute to the construction of an effective, research-informed approach to therapy (Elliott, 2010a; Greenberg et al., 1993).

The PE-EFT developers were able to identify the interventions that were indicated when a client presented with a particular issue or marker. Generally the process took the form “*when* the client does this, *then* the therapist should do that *in order* to help the client achieve such-and-such a positive effect” (Elliott et al., 2001, p. 105). The task

analytic investigations indicated that empty-chair work (Greenberg & Foerster, 1996; Greenberg & Malcolm, 2002) is indicated when a client wishes to resolve unfinished business with a significant other, or two-chair dialogue (Greenberg, 1979, 1992; Greenberg & Webster, 1982) is suggested when a client presents with a self-evaluative split, or systematic evocative unfolding is the recommended task for resolution of a problematic reaction (Rice, 1984). In addition, the research conducted by Greenberg, Rice and Elliott also illustrated the ways in which the Rogerian core conditions of empathy, acceptance and congruence were shown to be essential elements within longer task sequences.

When evaluating change processes, Elliott (1995a) suggested asking clients to quantify helpful factors on a post-treatment questionnaire, or to write descriptions of what was most helpful within each session. Elliott (2002b) proposed that two types of information are necessary to make a convincing case that therapy caused a reported change: “(a) other evidence that the change occurred (corroboration); and (b) plausible ruling out of alternative possible causes” (p.3). He further suggested that, when utilising a discovery-orientated qualitative inquiry into the process of change within therapy, researchers use quantitative measures to identify and verify significant events as well as analyse rich descriptions qualitatively. Research undertaken by Greenberg, Elliott and colleagues found the gap between research and practice called for a form of research on client-therapist processes that illuminated the therapeutic relationship and emotion theory. This research focused on client experiences of therapy.

Elliott (1995a) stated that evaluating therapy process in clinical settings can be undertaken by taking good process notes, using periodic relationship measures and outcome assessments which can then be put into a narrative case study. The resultant case study can be checked by an independent rater to address issues of bias. Timulak (2008) described the intensive or systematic case study as “a special form of descriptive psychotherapy process research... [that] can be considered a mixture of process and outcome studies” (p. 142). Elliott et al. (2001) also recommend a broad range of options for qualitative data collection and analysis in psychotherapy change process research. For example, data taken from the Change Interview (Elliott et al., 2001) and the Helpful Aspects of Therapy form (Llewlyn, 1988) for a particular *fear-*

*thing* event experienced by client named Rachael were analysed by the task analysis method (Greenberg, 2007; Rice & Greenberg, 1984) to yield an undifferentiated experience marker for Empathic Exploration (Elliott et al., 2001). The application of multiple research methods to the same research question or data, known as *triangulation*, allows strengthening of research rigour (Patton, 1990). The different approaches can corroborate, enrich or qualify each other and offer different levels of analysis in therapy, making possible a much richer overall understanding of how change occurs in therapy (Elliott et al., 2001). My investigation adds to the process research knowledge for a particular client group by exploring client experiences both qualitatively and quantitatively and combines this with therapist perspectives.

## **In Summary**

The more we use generalised research evidence to determine how we relate to clients the more we may miss what is important to our clients. According to Cooper (2010) different clients change in different ways, and therapists' being open to many frameworks and working collaboratively with the clients may enhance the outcome. Person-centred and experiential theorists suggest that, ideally, we need to tailor our practices to each client. Working within a person-centred framework, paying particular attention to the therapeutic alliance, including therapist and client factors, is suggested by theorists and supported by research as sufficient for client change. A research project with a person-centred focus might investigate the perspectives of both the client and the therapist/researcher, thus presenting not only a client-centred exploration but a truly person-centred endeavour. The philosophies underlying the PE-EFT model enable the PE-EFT practitioner to remain flexible enough to work collaboratively with each client and yet provide an evidence-based structure.

Change processes in therapy: Case studies in Process-Experiential / Emotion-Focused Therapy

## Chapter Three • PE-EFT: An Integrated Model

### Introduction

The research conducted by Greenberg, Rice and Elliot resulted in the development of Process-Experiential/Emotion-Focused Therapy (PE-EFT), the intervention used in this study. These researchers have been influential in establishing strategies for studying the ways therapeutic process leads to client change. The theory underpinning PE-EFT offers a framework for understanding client change in therapy and will be the theory consulted to assist with the interpretation of the findings of this study. Because of the foundational role of PE-EFT in the present research, this chapter reviews its development in some detail.

### Significant Influences that Underpin PE-EFT

The history of the practice of Process-Experiential/Emotion-Focused Therapy (PE-EFT) has its roots in the humanistic, client-centred, existential and Gestalt approaches (Greenberg, Watson, & Lietaer, 1998). Despite undergoing a number of iterations since its development, this experientially-orientated psychotherapy contains an emphasis on the importance of two fundamental principles. First, a genuine, empathically confirming therapeutic relationship is seen as facilitative of change in a client, and curative in its own right. Second, *deepening* the client's *experiencing* within the therapy sessions is understood as a vital component of sustainable client change. The client's experiencing in session involves the examination and representation of his or her internal worldviews, including feelings, perceptions, goals, values and constructs (Greenberg et al., 1993; Watson, Greenberg, & Lietaer, 1998). Methods that stimulate or activate emotional experience are used within the context of the empathetic facilitative relationship. People are viewed as meaning-creating, symbolising agents, whose subjective experience is an essential aspect of their humanness. I will briefly review the influences on PE-EFT of the therapeutic

approaches integrated into this model that are relevant for an understanding of change processes in therapy.

### **Influence of Carl Rogers and the person-centred approach to therapy.**

Rogers believed that people had the potential within themselves for self-understanding, and the capacity to alter their behaviour (Rogers, 1961). He noticed that when clients were in touch with their moment-by-moment *inner experiencing* within therapy, a non-linear change process or shift occurred (Rogers, 1951, 1957, 1961). This experience was seen by him as progressing from the client talking *about* things that are relatively remote, or external to themselves, to *honing in* on deeper concerns and bringing experiences that were out of awareness into awareness (Mathieu-Coughlin & Klein, 1984). When a repressed feeling was fully felt and accepted into awareness a new state of insight was achieved (Rogers, 1951, 1957, 1961). In an interview with Michele Baldwin (1987) Rogers described therapy as “a process of self-exploration, of getting acquainted with one’s own feelings and coming to accept them”. He said it “is most effective when the therapist’s goals are limited to the process of therapy and not the outcome” (p. 45). Rogers recognised that helping people become familiar with their own capacities and to become self-empowered were important factors in effective therapy. He believed that the inner core of a person was positive and constructive.

The techniques Rogers utilised included therapist *reflections* that would facilitate the client’s growth and development. Later he began to emphasise the *relationship conditions* or *core conditions* of empathy, unconditional positive regard and congruence which he saw as curative in themselves (Rogers, 1957). The therapist aimed to develop a genuine relationship with the client in order to facilitate the change process (Rogers, 1951, 1957, 1961). The therapeutic relationship was seen as providing a corrective experience for the client’s introjected beliefs of lack of self worth (Greenberg, 2011) when the client was “seen” and genuinely accepted in an unconditional manner. Rogers’ client-centred approach provided the fundamental principles or bedrock upon which PE-EFT was based (Greenberg, 2011).

### **Influence of Eugene Gendlin and experiential focusing.**

Greenberg (2011) wrote of Gendlin's concept that "the felt sense of the whole situation of sadness of loss contains more than sadness... and differs from emotions... [E]motions are more specific... and less uniquely intricate... than is felt sense" (p.17). Whereas Gendlin and Rogers regarded experiencing as the basic element of processing experience, PE-EFT takes emotion as the fundamental element and experiencing as a higher order, complex mix of affect and meaning that is the result of different levels of processing (Greenberg, 2011; Greenberg & Pascual-Leone, 1995; Greenberg & Pascual-Leone, 2001). Attending to felt-sense, symbolising it to create meaning combined with the recognition, arousal and regulation of basic emotions are necessary to provide access to implicit appraisal, action tendencies and needs that inform us about what is good for us and to move us to an adaptive action (Greenberg, 2011).

PE-EFT adopted Rogers and Gendlin's process view of therapist functioning and proposed that therapy be directive of *process* and not *content* driven (Watson et al., 1998). Paying attention to the client's experience is paramount, in conjunction with the relational and collaborative aspects of the therapeutic work. The therapist "is an expert on how to help the client *to experience*" (p. 19, Greenberg, 2011). Focusing informs the theory of PE-EFT and is included as an intervention or task within the PE-EFT model.

### **Influence of existential thought.**

According to existential thought the fundamental problem is *life* itself (Mendelowitz & Schnider, 2008), and Frankl (1959) posits that a fundamental human drive is to create meaning. Clients of existential therapy are encouraged to be open to change and to formulate alternative constructions and perceptions of themselves and their worlds by developing more satisfying strategies for living. One of the primary objectives of existential therapy is to have clients confront the *givens* of existence by *searching* within themselves while remaining fully present to themselves within the session. These givens include the inevitability of death, the conflict between freedom and human limits, existential isolation and the meaninglessness of existence (May, 1977; May & Yalom, 2005; Yalom, 1980). Each person has to choose how they want to

relate to the world and is responsible for that choice. In other words people determine themselves. The phenomenological exploration of the *self* is facilitated through the encounter with the therapist.

According to Greenberg (2011), existential therapy has influenced PE-EFT's "broader view of human nature and life's ultimate concerns" (p. 22). PE-EFT also adopts the view that meaning creation is central in human functioning and shares the focus on dealing with the ultimate concerns and choice (Greenberg, 2011). The subtle yet pervasive presence of existential philosophy becomes very evident in PE-EFT when a client's *cherished belief* about life is challenged (Watson et al., 1998).

### **Influence of Gestalt philosophy and enactments.**

According to Greenberg (2011), Gestalt therapy forms an intrinsic part of PE-EFT. The main goal of Gestalt therapy is increased awareness, and as a vehicle for achieving this, the *here-and-now* is emphasised. Using the phenomenological method, Gestalt therapists focus on tasks that facilitate the client's awareness, experiencing, and contact with the external world. Initially there was little emphasis on the therapeutic relationship, but this has changed in recent times and *I-Thou* dialogue has become a critical component within the therapy.

Like Rogers, Perls (1969) was of the view that many difficulties that people experience are as a result of a conflict between an image of themselves and their self-actualising tendency. People operate according to their *shoulds* rather than paying attention to their feelings and needs. Gestalt therapists offer *experiments* to clients that enhance awareness in order to encourage clients to be active agents in the creation of their experience (Perls, Hefferline, & Goodman, 1951). The aim of such interventions is to encourage clients to identify that *they* indeed are the ones thinking, feeling or doing. Experimental tasks such as two-chair work and empty-chair work are emphasised, but many other experiments are created by the therapist in the moment to assist clients to embody and intensify their experiences (Watson et al., 1998). Bringing the client's difficulties to the surface this way and analysing of tasks completed have been a central therapeutic foci. The Gestalt therapist makes process suggestions and observations and is considered process directive.



Perls (1951) proposed that a healthy organism “knows” what is good for it and will thus integrate the good and reject what is not. The *self* is seen to consist of different parts and to function by integrating polarities. Lack of integration results in dysfunction (Perls et al., 1951). A variety of interruptive mechanisms, such as introjections and projections, *block* awareness and prevent contact with the environment and need satisfaction. Other phenomena such as conflict between polarities, unfinished business, habits, avoidance and catastrophising also block awareness and the satisfaction of needs, and produce dysfunction (Perls et al., 1951). Motivation to have needs meet is a core tenet of Gestalt theory but according to Greenberg (2011) how those needs arose is not explained.

PE-EFT incorporates Gestalt principles of helping people experience their agency in constructing reality and identifying and reworking issues that impede contact with the present reality (Greenberg, 2011). The influence of Gestalt therapy on PE-EFT is observed in the use of the enactment tasks of two-chair and empty-chair but there is also a strong emphasis on collaboration within a safe person-centred therapeutic working environment. In addition, accessing and heightening emotional experience, searching the edges of experience, making experience vivid, together with deepening experience is emphasised by both approaches (Greenberg, 2011).

### **Influence of contemporary emotion theory.**

Contemporary emotion theory holds that emotion is fundamentally adaptive in nature (Frijda, 1986; Greenberg, 2002; Greenberg & Paivio, 1997; Greenberg & Safran, 1987). According to Greenberg (2002), emotion is a brain phenomenon that is vastly different from thought. “It has its own neurochemical and physiological basis and is a unique language in which the brain speaks” (p. 3). The emotional brain however, is not capable of analytic thought or reasoning and its rapid evaluations are imprecise, so, one needs to attend to, and reflect on, one’s emotions to use its information (Greenberg, 2002). Indeed, Oatley (1992) commented, that emotions are biological responses to problems in the management of human action that cannot be tackled by cognitive planning.

The limbic system is responsible for all emotional responses. LeDoux (1996) identified two different paths for producing emotion. The first pathway, via the

amygdala, is shorter and faster and sends automatic emergency signals to the brain and body and produces gut responses. The second pathway, via the neocortex, is longer and slower and produces emotion mediated by thought. In some situations it is necessary to respond quickly but at other times better functioning requires the integration of cognition into an emotional response (Greenberg, 2011). Significantly, emotion makes fundamental contributions to information processing (Greenberg, 2002). Contemporary Emotion theory, as explained by Greenberg et al. (2007) posits that

Emotion, at its core, is an innate and adaptive system that has evolved to help us survive and thrive. Emotions are connected to our most essential needs. They rapidly alert us to situations important to our well-being. They also prepare and guide us in these important situations to take action towards meeting our needs... (p.20)

Greenberg and Pascual-Leone (2001) presented a model of processing emotional experience that "...suggests that processes generating emotional experience occur independently of and, often prior to, conscious cognitive operations". They point out therefore that "working only at the cognitive level... to effect affective / emotional change is likely to prove ineffectual" (p.173). Greenberg has written extensively about the way that emotion is foundational to the construction of a *sense-of-self* and a key determinant of self-organisation (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2002, 2004; Greenberg et al., 2007; Greenberg & Paivio, 1997; Greenberg & Pascual-Leone, 2001; Greenberg et al., 1993; Greenberg & Watson, 2006).

In a recent workshop Greenberg (2010b) explained that emotions are a relational action tendency, a process of meaning construction and a primary signalling system. They have a neurological primacy, are often outside awareness, and precede language based knowing. With development, emotion is fused with cognition. It is important to focus on emotion because emotion provides the individual with information as a primary motivator of behaviour (Greenberg, 2010b). "What we make of our emotional experience makes us who we are" (Greenberg & Pascual-Leone, 2006, p. 617).

Very early in his career, Greenberg became convinced that emotion was central in therapeutic change (Greenberg, 2011). Indeed, Greenberg and colleagues (e.g., Greenberg & Paivio, 1997; Greenberg et al., 1993; Greenberg & Watson, 1998; Watson et al., 1998) have long argued that emotional arousal and depth of experience within a therapeutic session was essential in order to effect change in the client's affective functioning and view of themselves (also see Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2002, 2004; Greenberg et al., 2007; Greenberg & Watson, 2006).

Other research supports the idea that deeper emotional experiencing and emotional arousal are important in therapy (e.g., Beutler, Clarkin, & Bongers, 2000; Goldman, Greenberg, & Pos, 2005; Greenberg & Pascual-Leone, 2006; Pascual-Leone & Greenberg, 2007). For instance Goldman and colleagues (2005) investigated the hypothesis that *depth of emotional experiencing* was related to outcome. A sample of thirty-five depressed clients received 16 to 20 weeks of PE-EFT. Symptoms were measured using Beck Depression Inventory (BDI; Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961) and Symptom Checklist-90-Revised (SCL-90-R; Derogatis, Rickels, & Roch, 1976). Results showed that depth of emotional experiencing as measured by the Experiencing Scale (Klein, Mathieu-Coughlin, & Kiesler, 1986) predicted reduction in symptoms and an increase in self-esteem, as measured on the Rosenberg Self-Esteem inventory (Bachman & O'Malley, 1977). Increase in levels of experiencing across therapy was found to be the strongest predictor of change on these measures. Working Alliance was also measured using the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) and found to be predictive of symptom change. However, deep emotional experiencing predicted change on both the symptom and self-esteem measures over and above the change predicted by the alliance. An increase in depth of experiencing over the course of therapy was concluded by Goldman et al. (2005) to be "a unique predictor of symptom change and self-esteem in therapy in addition to the therapeutic alliance" (p. 256). However, these findings should be interpreted in the light of the relatively modest sample size so the authors did not suggest it was possible to generalise widely based on this sample. Despite these reservations Greenberg and Pascual-Leone (2006) suggest the implication is that good in-session events measured by high experiencing are important and relevant to good outcomes in therapy and well supported by the literature on the relationship between

client experiencing and outcome (see Greenberg & Pascual-Leone, 2006 for a review). This research does suggest however that intervening therapeutically at the emotional level by facilitating clients' access to their emotions and inner experiencing (as occurs in PE-EFT) has the potential to effect change (Goldman et al., 2005; Greenberg & Pascual-Leone, 2006; Greenberg & Pascual-Leone, 2001; Pascual-Leone & Greenberg, 2007).

Beutler et al. (2000) published guidelines for optimal treatments that evolved from the authors efforts to cross-validate dimensions revealed in their literature review. Principle 8, asserts "therapeutic change is greatest when a patient is stimulated to emotional arousal in a safe environment until problematic responses diminish or extinguish" (p. 205). However, what is critical is emotional expression in conjunction with reflective processing (Elliott, Greenberg et al., 2004; Greenberg & Pascual-Leone, 2006; Greenberg & Pascual-Leone, 1995). In simple terms, just changing thinking or just cathartic expression will not bring about long-term resolution of such states as depression. "Arousal is essential but not necessarily sufficient for therapeutic progress" (p. 615) and the "depth of the processing of the emotion... is curative in therapy" not the emotional intensity (Greenberg & Pascual-Leone, 2006, p. 616). However, as Principle 7 states "the likelihood of therapy change is greatest when the patient's level of emotional stress is moderate, neither excessively high nor excessively low" (Beutler et al., 2000, p. 205). Clients need to be helped in therapy to better identify, experience, explore, make sense of, transform and flexibly manage their emotions (Greenberg et al., 2007).

### **The influence of the dialectical constructivist perspective.**

The developers of Process Experiential-Emotion Focused Therapy have proposed a *dialectical-constructivist* view of human functioning to explain how people make sense of their emotions (Greenberg, 2004; Greenberg & Pascual-Leone, 1995; Greenberg & Pascual-Leone, 2001; Greenberg & Watson, 2006). From the perspective of *dialectical constructivism*, the *self* is a constantly changing but organised multiplicity (Elliott, Watson et al., 2004), seen as a dynamic self-organising system that is influenced by interaction with the environment moment by moment (Greenberg, 2011). The multilevel organisation of the self emerges from a dialectical interaction of many

component elements. Integration is achieved by an ongoing circular process of making sense of experience by symbolising bodily-felt sensations in awareness and articulating them in language, thereby constructing new experience (Greenberg, 2004).

Stability is experienced because people regularly re-create themselves out of the same basic component-elements as they interact with their situation (Elliott, Watson et al., 2004). Such stability arises from repeated constructions of the same state from multiple, constituent elements that are constructed, afresh, each time. These characteristic organisations impart character to the person, and are responsible for the more enduring aspects of personality. Adding or subtracting elements from the process of construction can alter these traits, making *character change* possible (Greenberg & Pascual-Leone, 1995; Greenberg & Pascual-Leone, 2001). Dialectical synthesis of emotion and reflection are the key to therapeutic change (Greenberg & Pascual-Leone, 1995; Greenberg & Pascual-Leone, 2001).

Dialectical constructivism has several implications for understanding how people change in therapy (Elliott, Watson et al., 2004). Much of the therapeutic work for the client involves various internal dialectical processes where separation and contact between different aspects are facilitated (Elliott & Greenberg, 1997). Evocation and explication of the various implicit self aspects and facilitation of psychological contact with those aspects results in a new integrative experience of self. Previously overlooked or silenced voices are encouraged to emerge so that the more dominant voices can hear those previously ignored voices and an internal self-challenge is created (Elliott, Watson et al., 2004). Assimilation and accommodation occur with both aspects undergoing change. Dialectical processes can be observed in the conceptualising versus experiencing domains of the client, and in the “splits” between the dominant voice that reiterates negative views of self versus a less dominant, more change-orientated voice of life and growth (Elliott, Watson et al., 2004).

### **The concept of emotion schemes in PE-EFT.**

According to the developers of PE-EFT (Elliott, Watson et al., 2004; Greenberg et al., 1993; Greenberg & Watson, 2006), the emotion system integrates information across a

variety of information-processing domains and is the most complex system of knowing that humans possess (also see Greenberg, 2002, 2004). They propose that emotion organises experiencing through *emotion schemes*, which are higher-order organisations. Emotion schemes can be viewed as involving tacit, non-conscious, cognitive-affective processes, internal models, or scripts (Oatley, 1992). An emotion scheme “involves a set of organising principles constructed from an individual’s innate response repertoire and past experience, that interact with the current situation and generate current experience” (Greenberg & Paivio, 1997, p. 3). They provide a constant readout of a person’s current state and are crucial in determining perception and in helping people mobilise their efforts for goal-directed action (Greenberg, 2002, 2004). They are “internal emotion memory structures” (Greenberg, 2011, p.38).

Because emotion schemes are not directly available to awareness, they need to be accessed through the experiences they produce. They can then be explored or expressed and reflected upon (Elliott, Watson et al., 2004; Greenberg & Watson, 2006). Emotion scheme processes can be understood in dialectical constructivist terms, as they are continually constructed and reconstructed, moment-to-moment. Each person has many schemes that may be activated separately or simultaneously, and the multiplicity of self-organisations or *voices* are an important source of growth and creative adaptation (Elliott, Watson et al., 2004).

The component elements of an emotion scheme as illustrated in the manual (Elliott, Watson et al., 2004) and expanded on the PET website (Elliott, 2004) are depicted in Figure 3.1. These elements are linked or clustered together in categories to form a neural network with activation of single elements spreading to other elements (Greenberg & Watson, 2006). Whilst there are linguistic elements, many of the components are preverbal or sensory and might include elements such as bodily sensations, visual images and even perceptions of smells (Elliott, Watson et al., 2004; Greenberg, 2011; Greenberg & Watson, 2006).

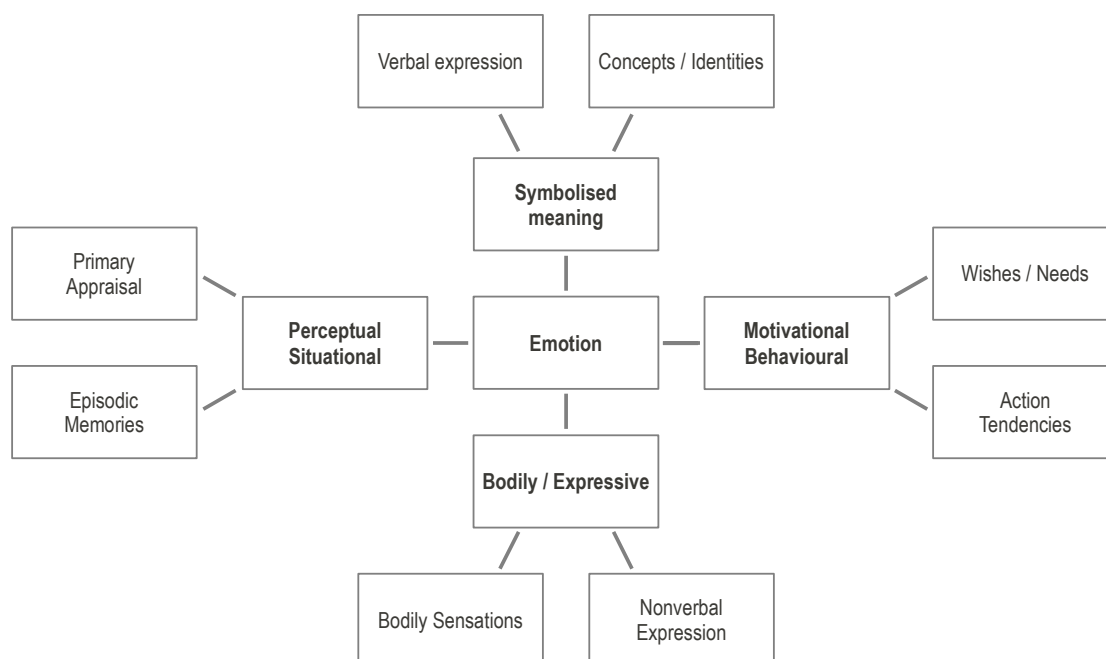


Figure 3.1. Elements of an emotion scheme.

Source: Elliott (2004); Elliott, Watson et al. (2004).

Table 3.1 includes descriptions of the elements of the emotion scheme. Optimal emotional processing involves all of the elements. It is difficult to process painful experiences if one or more schematic elements are missing (Elliott, Watson et al., 2004).

Table 3.1. Elements of the emotion scheme defined.

Element	Description
Perceptual-situational	Past or current environments that include immediate awareness of the current situation and episodic memories
Bodily-expressive	The emotion scheme processes expressed through the body, including both immediate sensations within the body and expression of the emotion

Symbolic-conceptual	Verbal or visual representations of the emotion scheme processes through reflexive awareness of perceptual-situational and bodily-expressive elements
Motivational-behavioural	Represent activated emotion scheme processes in the form of associated desires, needs, wishes, intentions or action tendencies
Emotion Scheme Nuclear process	Organises all the different components around a particular emotion and is often recognised after self-reflection on the other four elements

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Source: Elliott, Watson et al. (2004).

In order to change maladaptive experience, clients need to activate new adaptive experiences. In therapy, transformation occurs as new narratives are developed through assimilating those new experiences that occur in therapy into existing emotion schemes and/or generating new ones (Greenberg, 2004; Greenberg & Pascual-Leone, 1995; Greenberg & Pascual-Leone, 2001; Greenberg & Watson, 2006). For example, “a schematic emotional memory of fear and withdrawal from prior abuse can be synthesised with current empowering anger against violation, which motivates approach rather than withdrawal, to form a new sense of confidence or assertion” (Greenberg, 2011, p. 40).

Changing emotion schemes involves a number of general factors (Greenberg et al., 1993). The combination of safety and process facilitation provides the conditions necessary for schematic change. The therapeutic relationship provides interpersonal safety that leads to an increased processing capacity for the client, which in turn promotes an inward attending to self-experience. This extension of attentional focus, the facilitation of memory reorganisation and meaning construction, and the provision of new emotional and relational experiences all contribute to the potential for change (Greenberg et al., 1993). Interestingly, in a personal communication in February, 2010 Greenberg informed me that he doesn’t visualise the emotion scheme structure as it is shown in Figure 3.1. He believes that the development of schemes is best understood as the development of neural networks that represent the basic story of lived experience (see Greenberg, 2011; Greenberg & Watson, 2006) and sees the whole representation as an unfolding sequence leading from one node to the next.



## **The acronym for Process-Experiential/Emotion-Focused Therapy.**

The PE-EFT approach was originally termed Process Experiential (PE) therapy by Les Greenberg, Laura Rice and Robert Elliott (1993), reflecting its roots as a humanistic, experiential approach. The term Emotionally-Focused Therapy (EFT) had been used earlier as the name of Greenberg's couple therapy approach (Greenberg & Johnson, 1988). However, since the late 1990s, the term Emotion-Focused Therapy (EFT) has come to be applied to both individual and couple therapy (see Elliott, Watson et al., 2004; Greenberg, 2002, 2011; Greenberg et al., 2007; Greenberg & Goldman, 2008; Greenberg & Paivio, 1997; Greenberg & Watson, 2006). More recently, this emotion focus was added to the process-experiential emphasis in the name of the therapy. According to Greenberg, Elliott and Pos (2007)

[O]ver time, developments in the understanding of the role of emotion in human functioning and in therapy led us to see emotion as centrally important in the experience of self, in both adaptive and maladaptive functioning, and in therapeutic change, and the change in name reflected this development. (p. 19)

Robert Elliott, as Professor of Counselling at the University of Strathclyde, has set up counselling training there in what he refers to as Process-Experiential/Emotion-Focused Therapy (his acronym being PE-EFT). He also has a personal blog tracking some of the most recent developments in PE-EFT research and teaching (Elliott, 2010b). I too have chosen to refer to this approach as PE-EFT because of its original underlying principles that include the emphasis on the internal processing and symbolising of experience and emotional processing.

## **Greenberg's view of the development of PE-EFT**

In an interview with Denise Sloan (2004), Greenberg provided his personal account of the development of Process-Experiential/Emotion-Focused Therapy or his preferred

title of Emotion Focused Therapy. He spoke of a time in 1984, when he and Laura Rice wrote a book entitled, *Patterns of Change: An Intensive Analysis of Psychotherapeutic Process*. They were interested in identifying the most active change-processes, and looked at how to measure them (Rice & Greenberg, 1984). Greenberg's clinical training had been in person-centred and Gestalt therapies and later he began to integrate the person-centred relationship with Gestalt active interventions. He was also very interested in the interaction of cognition and affect and the role of awareness. These interests merged into studying the process of change. He examined how cognition influences meaning-making and emotion, and how these processes take place. In the interview, Greenberg identified the therapist as an *emotion coach* or a facilitative coach helping clients be more aware of their emotions, and to regulate, and transform them. Greenberg boldly stated that he saw CBT as a coping therapy that doesn't necessarily lead to change, (despite the research findings of equivalence). He claimed that PE-EFT gets to deeper underlying determinants that are affectively based and this facilitates change (Sloan, 2004).

Greenberg said, that for him PE-EFT started off being a more following, mirroring approach which assisted the client in accessing inner resources, finding the actualising tendency within. He noted that it has moved to a more interpersonal co-constructive view, in which as therapist he engages in more of a leading role, by guiding the process within a client's *proximal zone of development* (see Vygotsky, 1978, p. 84-91). Greenberg stated "[I]t's the two of us together creating something new... something happening between the two of us" (Sloan, 2004, p. 109). He claimed PE-EFT has the potential to restructure, reorganise or change the personality, although the emphasis is still on being process directive not content directive, therefore "guiding clients to pay attention to what's going on in their bodies or to speak to somebody in the empty chair" (Sloan, 2004, p. 110). Greenberg added that in recent years there is now more explicit focus on affect than originally. He said that working with emotions is "an a-rational process and so you can't just teach people rationally how to work with emotions without them actually experiencing the emotions themselves" (Sloan, 2004, p. 111).

## The Application of PE-EFT

The two basic principles of creating a genuine empathic valuing relationship seen as curative in its own right and deepening the client's experiencing in therapy (Elliott, Watson et al., 2004; Greenberg et al., 1993; Watson et al., 1998), underlie the Process-Experiential/Emotion-Focused Therapy (PE-EFT) model. Tacit experiencing is understood as an important guide to conscious experience because it is fundamentally adaptive and needs to be made available to awareness (Elliott, Greenberg et al., 2004). The sequence of activation, exploration, expression and reflection on emotion schemes is central to PE-EFT (Greenberg, 2002).

Since an important task of PE-EFT is to bring emotions and their associated action tendencies into awareness, PE-EFT practitioners differ from their more traditional client-centred counterparts in using more questions and conjectures to explore and stimulate the client's inner experience. In addition, attention is given to specific client statements or markers that indicate a client is struggling with a particular issue and is *ready* to work with it (Watson et al., 1998).

Briefly, the PE-EFT therapist tracks or follows the client's internal experience as it evolves moment by moment within the session, offering processing proposals to guide or facilitate meaning construction. The therapist seeks active client collaboration and works in the creative tension between "following" the client's experience and "leading" the therapeutic process. The distinctive patterns of therapist exploratory response styles are listed in Table 3.2.

Table 3.2. Therapist experiential response modes.

<b>A. Simple Empathy</b>	<b>Responses intended primarily to communicate understanding of immediate client experiencing.</b>
Empathic Reflection	Accurately represent most central, poignant or strongly-felt aspect of client's message.
Empathic Following	Brief responses which indicate that therapist understands what client is saying (acknowledgments and empathic repetitions).
Empathic Affirmation	Offer validation, support, or sympathy when client is in emotional distress or pain.
<b>B. Empathic Exploration</b>	<b>Responses intended to encourage client exploration while maintaining empathic attunement.</b>
Exploratory Reflection	Simultaneously communicate empathy and stimulate client self-exploration of explicit and implicit experience, through open-edge or growth-oriented responses.
Evocative Reflection	Communicate empathy while helping client to heighten or access experience, through vivid imagery, powerful language or dramatic manner.
Exploratory Question	Stimulate client open-ended self-exploration.
Fit Question	Encourage client to check representation of experience with actual experience.
Process Observation	Nonconfrontationally describe client in-session verbal or nonverbal behavior (usually with Exploratory Question).
Empathic Conjecture	Tentative guess at immediate, implicit client experience (usually with Fit Question).
Empathic Refocusing	Offer empathy to what the client is having difficulty facing, in order to invite continued exploration.
<b>C. Process Guiding Responses</b>	<b>Responses intended to directly facilitate useful client experiencing.</b>
Experiential Formulation	Describe the client's difficulties in PE terms, such as emotional avoidance or action on the self.
Experiential Teaching	Provide information about nature of experiencing or treatment process/tasks.

Structuring Task	Set up and offer specific help for continued work within a specific therapeutic task (including proposing, creating context, or offering encouragement for task engagement).
Process Suggestion	Encourage client to try things out in the session (“coaching”: feeding lines, proposing mental actions, directing attention).
Awareness Homework	Foster experiencing outside of session.
<b>D. Experiential Presence</b>	<b>Responses intended to reveal therapist’s emotional presence to client.</b>
	Generally communicated via speech, paralinguistic, nonverbal manner (e.g., warm/gentle vocal quality, responsive facial expression, self-deprecatory humour, exploratory manner, respectful silence).
Process Disclosure	Share own here-and-now reactions, intentions or limitations.
Personal Disclosure	Share relevant information about self.
<b>E. Content Directives (“nonexperiential”)</b>	<b>Responses intended to provide expert external perspectives on the client’s problems.</b>
	These include: <ul style="list-style-type: none"> <li>• Interpretation</li> <li>• Problem-solving advisement</li> <li>• Expert reassurance</li> <li>• Disagreement/criticism</li> <li>• Introducing nonexperiential content</li> <li>• Pure information questions</li> </ul> <p>These responses are not central to PE therapy and occur infrequently. When they occur, they are carried out briefly, tentatively and with an experiential intent.</p>

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Source: Elliott et al., (2003).

The work of the PE-EFT therapist is also characterised by the recognition of distinctive markers that inform the therapist of the need for a specific task or intervention. The PE-EFT interventions, according to Greenberg (2011), are regarded as particular ways of relating rather than technical treatments dealing with the client as an object. This marker-guided task strategy is combined with a genuinely prizing, empathic working relationship to foster a shared, engaging, safe environment that

enables the client to express and explore personal difficulties and emotional pain. A PE-EFT therapist, therefore, needs to follow the client through focused responsiveness, or attunement, in order to track their process, as well as assess whether to propose the use of more specific interventions or tasks (Elliott, Watson et al., 2004; Greenberg et al., 1993; Watson et al., 1998). However, the clients remain the experts and final arbitrators, and may reject the therapist's process directives to a task. The therapist is then encouraged to follow the client's direction. Table 3.3 summarises the general structure of a task PE-EFT.

Table 3.3. General structure of PE-EFT tasks.

	<b>Client</b>	<b>Therapist responses</b>
<b>Pre-marker</b>	Before a therapeutic task emerges the client gives some indication that something may be present, implicitly in the client's experiencing	Listen for and reflect salient issues by empathically exploring
<b>Marker identification and Task Initiation</b>	Indication that client is ready and willing to work on task, providing alliance is strong	Invite client to participate in the task  Set up the task
<b>Evocation of Difficulty</b>	Client begins to explore and express difficulty	Facilitation of initial exploration If vulnerability present affirm and provide empathic understanding
<b>Exploration and/or Deepening</b>	Client turns attention to internal experiencing, may re-experience previous events, search edges of awareness	Facilitate client re-experiencing Reflect unclear, emerging experience Encourage differentiation or elaborate experience
<b>Partial Resolution</b>	Emerging shift Client experiences some clarification of experience, accesses new aspects, May express needs or action tendencies associated with primary adaptive emotion	Listen and reflect Help client symbolise clarified experience May need to offer empathic conjecture Facilitate emergence of new meaning perspectives

	Client	Therapist responses
<b>Restructuring and Scheme Change</b>	Full <i>felt-shift</i> Deeper insights and understandings “aha” moments Client feels a marked, general sense of relief, empowerment or determination about experience Client expresses a sense of self as whole, acceptable and capable	Help client symbolise and stay with new understanding, appreciation and owning of experience Help client explore boarder meanings
<b>Full Resolution</b>	<i>Carrying Forward</i> into daily life Knowing what to do next	Symbolise shift in mood and sense of self Listen for and facilitate carrying forward and implications for change

Source: Adapted from Elliott, Watson et al. (2004).

The tasks of PE-EFT are intended to heighten the client’s inner experiencing so that this can be more easily symbolised into awareness and thus processed (Elliott, Watson et al., 2004; Greenberg et al., 1993; Greenberg & Watson, 2006; Watson et al., 1998). Different interventions pursue particular types of exploration suited to different types of issues and promote different types of resolutions. Some tasks are focused on the intra-psychic processes, others indirectly facilitate interpersonal functioning (see Method chapter 5 and Elliott, Watson et al., 2004; Greenberg et al., 1993). For example, an intra-psychic conflict within a person, or in Gestalt terms a *split*, is seen as two voices in one person, which can be resolved using the Two-Chair task. Evoking an emotional response can help the client to identify the impact of the events that gave rise to the emotion, to symbolise their relationship to the events, to discover their own needs and goals, and to recognise the reaction tendencies inherent in their emotional responses. This emotional activation and processing allows clients to become aware of the links between their inner experience, the external world and their behaviour (Elliott, Watson et al., 2004; Greenberg et al., 1993; Watson et al., 1998). Once these links are available to awareness and integrated through their emotional and rational systems, clients can reflect on them and make choices about alternative ways of acting that might enhance their adaption and growth, and facilitate their achievement of life

goals. Table 3.4 provides a summary of the different types of PE-EFT task markers, and the relevant tasks or interventions and end states.

Table 3.4. PE-EFT task markers, tasks or interventions and end states.

Task Marker	Task or Intervention	End State
<b>Empathy-based Tasks</b>		
Problem-relevant experience (e.g. interesting, troubling, intense, puzzling)	Empathic exploration	Clear marker or new meaning explicated
Vulnerability (painful emotion related to self)	Empathic affirmation	Self-affirmation (feels understood, hopeful, stronger)
<b>Relational Tasks</b>		
Beginning of therapy	Alliance formation	Productive working environment
Alliance difficulty (e.g. complaint, withdrawal, avoidance)	Alliance dialogue	Alliance repair (stronger therapeutic bond or investment in therapy, greater self-understanding)
<b>Experiencing Tasks</b>		
Attentional focus difficulty (e.g. confused, overwhelmed, blank)	Clearing a space	Therapeutic focus, ability to work productively with experiencing
Unclear feeling (vague, external or abstract)	Experiential focusing	Symbolisation of felt-sense, feeling shift, carrying forward
Difficulties expressing feelings or avoidance	Allowing and expressing emotion	Successful, appropriate expression of emotion to therapist and others
<b>Reprocessing Tasks</b>		
Narrative marker (internal pressure to tell difficult life stories, such as trauma)	Trauma retelling	Relief, restoration of narrative gaps
Meaning protest (life event violates cherished belief)	Meaning work	Revision of cherished belief
Problematic reaction (puzzling overreaction to specific situation)	Systematic evocative unfolding	New view of self-in-the-world functioning



Task Marker	Task or Intervention	End State
<b>Enactment tasks</b>		
Self-evaluative split (self-criticism, feelings of being torn)	Two-chair dialogue	Self-acceptance
Self-interruptive split (blocked feelings, resignation)	Two-chair enactment	Self-expression, empowerment
Unfinished business (lingering bad feeling about significant other)	Empty chair work	Letting go of resentments and unmet needs in relation to the other Self-affirmation, understanding or holding other accountable

Source: Elliott, Watson et al. (2004, p. 102).

Table 3.5 provides the steps of the experiencing task of *focusing*, which is an intervention that I utilise often in my therapeutic work with my clients. This intervention appears often in the case studies which follow, and so it seems useful to provide some detail about the steps.

Table 3.5. Steps in clearing the space and focusing.

STEPS IN CLEARING THE SPACE AND FOCUSING	
<b>Clearing a space</b>	<p>Aims to develop an adequate internal working space for experiential processing</p> <p>Induction of a state change by inviting client to turn inward</p> <p><i>Method:</i> Talk in a slow and steady voice, pausing regularly to enable client to assimilate the instructions.</p> <p>Check-in with the client to ensure they are following you and ask them to respond verbally or nonverbally</p> <ol style="list-style-type: none"> <li>1. Invite the client to become comfortable in their chair</li> <li>2. Invite the client to relax by taking a few deep breaths – grounding them in their body</li> <li>3. Invite client to close eyes (optional)</li> <li>4. Ask client to imagine an opening or a space in their mind / mind's eye</li> <li>5. Encourage them to allow this space to grow gradually over a number of steps</li> <li>6. If thoughts, objects or people enter let them move across 'as if on a movie screen'</li> <li>7. Encourage the space to be so large that reaches the edges of their awareness and beyond</li> </ol>
<b>Felt-sense</b>	<p>Facilitate development of an internal felt-sense</p> <ol style="list-style-type: none"> <li>1. Encourage the client to tune into their body sensations i.e. scan body for areas of tension or their unclear feeling</li> <li>2. Find a label: Ask the client to locate and describe the sensation or feeling – it can be a bodily sensation, a symbol, an image, a memory, a hope, a sound etc</li> <li>3. Offer exploratory questions to search for descriptors e.g. where is it, does it have shape, colour, texture etc?</li> <li>4. Reflect descriptors back to client – avoiding interpretation</li> <li>5. Resonating: Check the accuracy of the symbol / descriptors</li> <li>6. Ask open-ended questions</li> <li>7. Encourage the client to be open to spontaneous awareness</li> <li>8. Explore: Thoughts or memories may emerge that can be further explored and processed</li> <li>9. Monitor: Move back and forth from the bodily felt-sense or feeling to the thoughts associated with it</li> <li>10. Notice <i>felt shift</i>: Felt-shifts deepen understanding because of the consonance between the felt experience, emerging symbols and emerging meaning</li> <li>11. Stay with: Encourage client to stay with new or emerging experience</li> </ol>

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**STEPS IN CLEARING THE SPACE AND FOCUSING**


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<b>Carrying forward</b>	<p>Clients may get a sense of relief, describe an ‘aha’ moment, a deeper understanding</p> <p>Having a deeper understanding of the insights gained by the focusing, the client may begin to imagine what in their life or situation needs to be changed</p> <p>This may take the client further into exploration, offer insight to action strategies or provide a sense of achievement and completion</p>
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Source: Adapted by Harte (2006); Elliott, Watson et al. (2004); Gendlin, (1981); Greenberg et al., (1993).

In summary, change process research has given rise to Process-Experiential/Emotion-Focused Therapy, an empirically supported experiential approach that integrates person-centred philosophy and Gestalt practice with modern emotion theory within a dialectical-constructivist meta-theory framework. The founders claim that the curative qualities of the person-centred working alliance are combined with the PE-EFT tasks to provide not only an effective therapeutic approach but also an efficient one (Elliott, Watson et al., 2004; Greenberg et al., 1993). PE-EFT as the therapeutic modality used in this study provides a framework for observing and reporting the details of change processes.

## **The Emotion-Focused View of Change**

The emotion-focused aspect of Process-Experiential/Emotion-Focused Therapy provides further theory and a model for therapeutic processes leading to change that can be tested against the data from this study.

In 1987, Greenberg and Safran proposed an integrative theory of emotional processing as a framework for understanding emotional processes and change in therapy (see Greenberg & Safran, 1987, 1989). They cited Ekman (1972) and Izard (1977) as having demonstrated that certain primary emotions, identified by facial and gestural expressions, were innate and widely generalised within the human species. Such primary emotions were hypothesised to be biologically adaptive responses that reflected survival needs and promoted survival oriented problem solving (Izard, 1977). Distinctive facial features were identified as corresponding to six specific

primary emotions; fear, anger, sadness, surprise, disgust and joy (Ekman, 1972). In addition to these primary emotions, Greenberg and Safran (1987, 1989) proposed that emotional experience becomes elaborated into subtle blends of emotions, such as love, pride, envy etc.

The Greenberg and Safran (1987, 1989) model was based on the idea that human beings constantly appraise their environment. These appraisals are subjected to ongoing conceptual evaluations that become more sophisticated as the individual develops. People accumulate memories that consist of images, associated autonomic arousal and expressive motor responses. “Emotional experience thus becomes coded in memory structures or networks that incorporate components from expressive motor, schematic and conceptual levels of the information processing system” (Greenberg & Safran, 1989, p. 23). However, problems can arise within this system: there may be an inability to synthesise certain immediate expressive motor responses and primary appraisals, or discrepancies can arise between levels of processing, or schematic memories can be a storehouse of negative emotional associations and response sequences. Greenberg and Safran (1987, 1989) proposed distinctions between four broad categories of emotional experience (see Table 3.6).

Table 3.6. Categories of emotional experience and their action tendencies.

Emotional expression	Description
Biologically adaptive <i>primary</i> affective responses	<p>Provide adaptive action tendencies to help organise appropriate behaviour</p> <ul style="list-style-type: none"> <li>• Anger at violation mobilises fight and defence of one's boundaries</li> <li>• Sadness at loss mobilises reparative grief by either seeking comfort or withdrawal in order to conserve one's resources</li> <li>• Fear in response to danger mobilises flight, fight or possibly freezing</li> <li>• Disgust organises one to spit out or reject some noxious experience</li> <li>• Shame organises one to hide from the scrutiny of others</li> </ul>

Emotional expression	Description
Learned <i>maladaptive primary</i> responses to the environment	<p>Can be learned as a function of trauma or strongly negative environmental contingencies in childhood</p> <p>Accessed in therapy for modification and restructuring</p> <ul style="list-style-type: none"> <li>• Fear in reaction to harmless stimuli</li> <li>• Anger in response to caring</li> </ul>
<i>Secondary</i> reactive emotional responses	<p>Often problematic and part of presenting problem</p> <p>Secondary to some underlying, more primary generating process</p> <p>Reactions to the thwarting of primary responses</p> <p>Not often the direct response to the environment</p> <p>Defensive or reactive processes</p> <p>Usually bypassed in therapy or explored to access underlying processes</p> <p>Readily available to awareness</p> <ul style="list-style-type: none"> <li>• Crying in frustration when angry</li> <li>• Expressing anger when afraid</li> </ul>
<i>Instrumental</i> emotional responses	<p>Emotional behavioural patterns learnt to influence people</p> <p>Emotions that are expressed in order to achieve some intended effect</p> <p>Explored, confronted, or interpreted in therapy</p> <ul style="list-style-type: none"> <li>• Crying to evoke sympathy</li> <li>• Expressing anger in order to dominate</li> </ul>

Source: Greenberg & Safran (1989, p. 25); Paivio & Pascual-Leone (2010, p. 137).

Pascual-Leone and Greenberg (2007) conducted a study of the process of psychotherapy, asking “*how* does change happen?” They cited an earlier study by Hunt (1998) who investigated whether emotional processing was a useful strategy for coping with dysphoria following a depressing life event. She concluded that when recovering from dysphoria “the only way out is through” (p. 361) and “that moderate levels of emotional arousal and distress may be a necessary component of effective cognitive change and eventual recovery from depression” (Hunt, 1998, p. 381).

The Pascual-Leone and Greenberg (2007) investigation used a task-analytic approach to investigate whether emotional sequences exist during the in-session resolution of global distress. Thus the focus of the study was not about the role of the therapist in facilitating client emotional change but rather about how clients actually

change. Task analysis consists of two main phases: a discovery-oriented phase based on rational empirical model building and a validation phase based on hypothesis testing (Greenberg, 2007). Both discovery-oriented and validation phases of a task analysis were used to examine this change process (Pascual-Leone & Greenberg, 2007). In the first round of discovery-oriented analyses, the sample consisted of six single sessions, each from a different client. Clients were selected from clinical trials of the resolution of interpersonal emotional problems (Greenberg & Malcolm, 2002; S. C. Paivio & Greenberg, 1995). The treatment protocol was PE-EFT to help individuals resolve long-standing interpersonal grievances using mainly empty chair enactments. The discovery-oriented phase of task analysis which involves a systematic program for constructing a specific model of client change process (Pascual-Leone & Greenberg, 2007) was done in three steps, by developing (a) a rational model; (b) an empirical model; and, finally, (c) a synthesized model (for a detailed description of this method, see Greenberg, 2007).

In the validation phase, which is the second part of a task analysis (Pascual-Leone & Greenberg, 2007), the model developed in the discovery phase is re-examined using empirical criteria to test a larger sample of cases. In this particular instance this involved re-examining the model in sample of 34 clients aged 27 and 59 ( $M = 42$ ,  $SD = 10.4$ ) including 28 women and 6 men, recruited from four clinical trials completed at a large urban university psychotherapy research clinic between 1991 and 2002. In the sample, 20 clients (58.9%) suffered primarily from mood disorders and another 6 clients (17.6%) suffered primarily from anxiety disorders. There were 8 clients (23.5%) who did not receive any Axis I diagnosis and of the total sample 13 clients (38.2%) had Axis II disorders. The resultant model is featured in Figure 3.2. According to Pascual-Leone and Greenberg (2007), each component in Figure 3.2 was identified as a necessary step in the non-linear process toward emotional processing.

In this model, global distress, such as feelings of despair, hopelessness etc., is described as a state of high expressive arousal but low specificity in meaning. When the client elaborates and differentiates their experiences of this state, they move either towards rejecting anger, or towards fear and shame. Clients in fear and shame experienced themselves as inadequate, lonely etc., and often carry with them an implicit meaning of “I am bad” or “I am weak” with action tendencies of closing down

or withdrawing. Enduring autobiographical memories perpetuate these self-concepts. The next stage of processing involves differentiating aspects of the presenting fear/shame into an existential need and a core negative self-evaluation. Both the need and the negative evaluation are partly evoked and yet the two parts are contradictory. Despite feeling somewhat disorientated, the client can overcome the contradiction and a new more positive evaluation can emerge (Pascual-Leone & Greenberg, 2007). This dynamic synthesis emerges through the interactive process until *constructive abstraction* (Greenberg & Pascual-Leone, 1995) or an emergence of a higher order truth takes place.

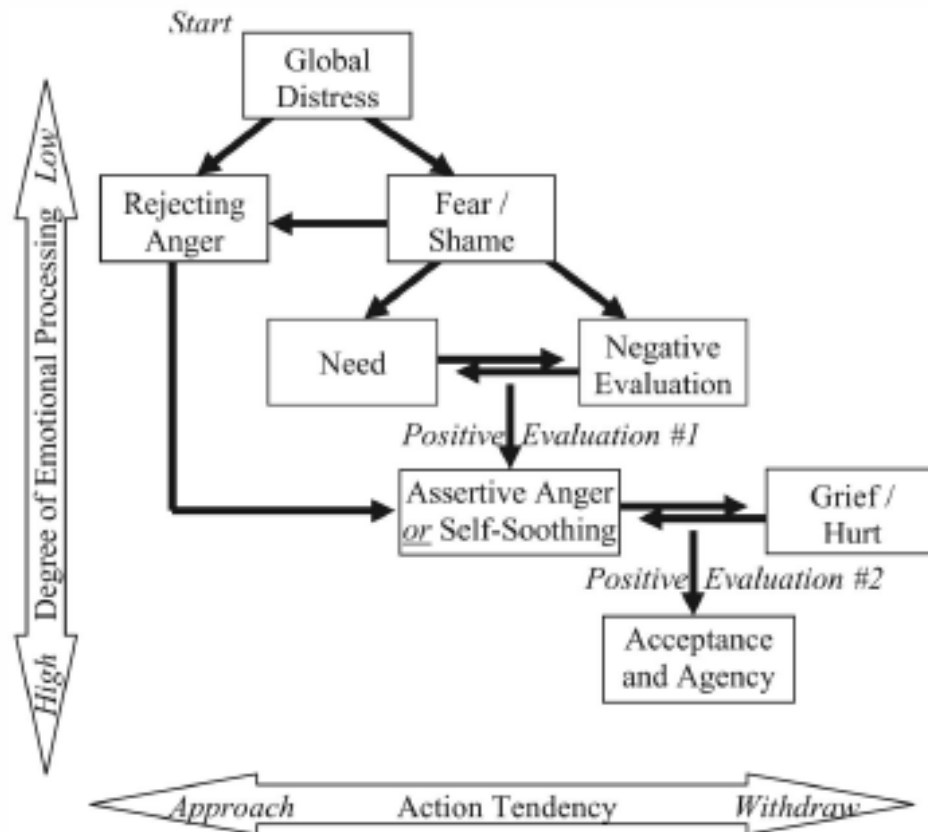


Figure 3.2. Rational/empirical model: A state-transition diagram for the emotional processing.

Source: Pascual-Leone & Greenberg (2007).

According to Pascual-Leone and Greenberg (2007), rejecting anger, a generic, undifferentiated type of emotion, is characterised by protest and hate, with high arousal and an action tendency of either distancing or destruction. Differentiation of rejecting anger can transform it into adaptive assertive anger that embodies a positive self-evaluation. That enables the setting of boundaries and fighting for one's rights and existential needs. Self-soothing is grouped with assertive anger in the model because according to Pascual-Leone & Greenberg (2007), they are functionally equivalent for processing emotional distress. Self-soothing or self-nurturing is the affective-meaning state characterised by fulfilling certain expressed needs oneself. Both assertive anger and self-soothing are considered healthy needs. However, the antitheses of this are the circumstances that led to the unfulfilled needs and consequent grief and hurt (Pascual-Leone & Greenberg, 2007).

The final stage toward resolution in the Pascual-Leone and Greenberg (2007) process model involves a second dialectical construction, a synthesis between the experiences of the assertive anger / self-soothing and the experiences of grief / hurt. "The dialectical synthesis of these two states creates a new experience of acceptance and agency... this is a second positive evaluation of the self as confident and future orientated" (Pascual-Leone & Greenberg, 2007, p. 879). Because emotional processing is dynamic, the emergence of agency and acceptance is not an end state but more a momentary experience in a journey of emotional processing. A client may experience "two steps forward, one step back" (Pascual-Leone, 2009, p. 123 ; Pascual-Leone & Greenberg, 2007, p. 880) throughout a session and across sessions.

Sequential progression through the Pascual-Leone and Greenberg (2007) model describes a differentiation of emotion states from the global to the more specific. In the series of the three-step emotional change process, successful clients move in their moment-by-moment experiences from "(a) a secondary emotion to (b) a primary maladaptive emotion and eventually to (c) a primary adaptive emotion that is activated through the articulation of an existential need" (Pascual-Leone & Greenberg, 2007, p. 885). The primary emotion experienced "is an immediate and direct response to the environment that is not reducible to or mediated by other cognitive-affective components" (S.C. Paivio & Pascual-Leone, 2010, p. 59). Stabilisation results from the repeated exposure to new information that initially created destabilisation of the



existing system but culminated in new strengthened ways of being (Greenberg & Pascual-Leone, 1995; Pascual-Leone, 2009). Healthy functioning as proposed by Pascual-Leone (2009) involves emotional flexibility, which is the ability to dynamically shift from one set of feelings and meanings to another, or from one self organising action framework to another (2009).

In their recent book *Emotion-focused Therapy for Complex Trauma: An Integrative Approach*, Paivio and Pascual-Leone (2010) emphasised the *experiencing* phenomenon originally conveyed by Rogers (1951) and elaborated by Gendlin (1996), as a “common change factor” (p. 78). As previously mentioned, experiencing refers to the process of exploring and verbally symbolising subjective internal feelings, thoughts, images, and/or bodily sensations and constructing new meaning. Using *both* the bodily felt-sense experiencing and cognitive information processing strategies, a dialectical synthesis emerges that includes the embodied felt-sense and the interpretative meaning. Paivio and Pascual-Leone (2010) state that “experiencing... is both a change process and a key intervention principle” (p.79).

A review of emotion research in psychotherapy by Greenberg and Pascual-Leone (2006) identified four major stages of working with emotions to facilitate change. Within a genuine, supportive and safe therapeutic relationship, the four stages of working productively with emotions are (a) emotional awareness and arousal, (b) emotional regulation, (c) reflection on emotion and (d) emotional transformation. However, prior to facilitating emotional processing, it is important to distinguish whether the client’s emotional functioning is adaptive or maladaptive, and to consider whether the presenting emotions are primary or secondary.

Primary emotions need to be accessed in awareness for their adaptive information and capacity to organise action. In contrast, maladaptive emotions need to be accessed in order to be transformed, in a process that exposes them to new experience and thereby creates new meaning. Secondary emotions need to be bypassed to get to more primary emotions. (Greenberg & Pascual-Leone, 2006, p. 612)

## **In Summary**

This study has been designed to contribute to process research by investigating change processes in Process-Experiential/Emotion-Focused Therapy (PE-EFT). Process research has been characterised by a variety of methodological approaches, such as task analysis, that can readily inform practice. Researchers are encouraged to combine scientific rigor and practical relevance (Timulak, 2008), and process research invites the view of the client and therapist, while employing a variety of measures and exploratory research strategies.

It seems particularly appropriate to explore change processes in therapy using PE-EFT. A unique aspect of PE-EFT is its development. Rather than a theory that has been researched to determine its effectiveness, PE-EFT theory has emerged from a rigorous investigation into what worked for clients in therapy, using the clients' own observations. According to Greenberg (2011) the strength of PE-EFT is in its theory of change, i.e. understanding *how* people change. Nevertheless, further process research and comprehensive qualitative research are still needed to contribute to the experience-near process research on PE-EFT (Greenberg, 2011), and it is this that this study aims to contribute.

## Chapter Four • Depression, Young People and PE-EFT

### Depression

A frequently treated state of distress or disordered mood, *depression* is considered the most prevalent mental health problem in the West (Greenberg & Watson, 2006; Segal, Williams, & Teasdale, 2002; Shaver & Brennan, 1991). The World Health Organisation (WHO) stated in The World Health Report on Mental Health (2001) that unipolar depressive disorders have placed an enormous burden on society and are ranked as the fourth leading cause of burden among all diseases (4.4% of the total burden of disease). These disorders were reported as the leading cause of the total Years of Life Lived with Disability (YDL), contributing 11.9% of the years lived with disability. In the age group of 15–44 years, depression caused the second highest burden of disease. The report predicted that if current trends continue, by the year 2020, the burden of depression will increase to 5.7% of the total burden of disease and worldwide it will be second only to ischaemic heart disease for both sexes. In developed regions it will be the highest ranking cause of burden of disease (World Health Organization, 2001).

Although depression is a medically defined, technical term used within psychiatry and psychology, it has also become a word used in everyday language to describe normal feelings, such as sadness or “feeling down.” Depression has been targeted by diverse therapeutic approaches and studied extensively in psychotherapy research. Depressive disorders are an official diagnostic category in the American Psychiatric Association’s *Diagnostic and Statistical Manual* (4th. edition; DSM-IV-TR; 2001), where a depressive mood is defined as a state of feeling sad or “down in the dumps” for most of the day, for more days than not, that continues for days, months or even years. (See Appendix A for DAS-IV-TR criteria). Treatment may include psychiatric, pharmacological or psychological interventions.

## **Prevalence and Impact of Depression in Australian Young People**

According to the WHO report, depression can affect individuals at any stage of the life span, although the incidence is highest in middle-age. There is, however, an increasing recognition of depression during adolescence and young adulthood (World Health Organization, 2001). The 2007 National Survey of Mental Health and Wellbeing (SMHWB), conducted by the Australian Bureau of Statistics (2008), was designed to provide lifetime prevalence estimates for mental disorders by asking respondents to report on experiences throughout their lifetime.

The SMHWB collected information from August to December 2007 from a representative sample of approximately 8,800 Australians aged 16–85 years (Australian Bureau of Statistics, 2008). The published report provided information on the extrapolated prevalence of selected mental disorders in the 12 months prior to the survey interview. Three major groups of disorders were investigated: anxiety disorders (e.g. social phobia), affective disorders (e.g. depression) and substance use disorders (e.g. alcohol harmful use). The report also provided information on the level of impairment, physical conditions, the health services used for mental health problems, social networks and caregiving, as well as demographic and socio-economic characteristics. Of the 16 million Australians aged between 16-85, the report suggested, almost half (45% or 7.3 million) had had a mental disorder at some time in their life. One in five (20% or 3.2 million) Australians of all ages had a mental disorder in the 12 months prior to the survey interview. In this 20%, anxiety disorders were the most common (14.1%), followed by affective disorders, including depression.

Affective disorders as described in the report involve mood disturbance, or change in affect, and include a depressive episode, dysthymia and Bipolar Affective Disorder. Most of these disorders tended to be recurrent, with the onset of individual episodes often related to stressful events or situations. Of people aged 16-85 years, 6.2% (995,900) had experienced an affective disorder in the twelve months prior to the survey. Depressive episode was the most prevalent affective disorder (4.1%). Women experienced a higher rate of Depressive Episode than men (5.1% compared with 3.1%).

Younger people were estimated to be more likely to have a mental disorder than older people. Just over a quarter (26%) of people aged 16 to 24 were estimated to have had a mental disorder compared to an estimate of 6% of people aged 75–85. Significantly, an estimated 161,400 young people aged 16 to 24 (that is 6.3%) had suffered an affective disorder (including depression) within the twelve months prior to the survey interview being conducted.

According to the SMHWB, people with comorbid conditions, that is the co-occurrence of more than one disorder, are likely to experience more severe and chronic medical, social and emotional problems than if they had a single disorder. Such people are more vulnerable to alcohol and drug relapses and mental health relapses, have a higher risk of suicidal behaviour, and make greater use of health services. Substance use disorders were more common for younger people (13%) than other age groups (Australian Bureau of Statistics, 2008).

As cited in a report published by the Commonwealth of Australia (1999), depression has links with such health risk behaviours as tobacco use, illicit drug use, alcohol misuse and dependence, eating disorder and obesity. There is accumulating evidence that depression predicts progression to both alcohol misuse and dependence in younger drinkers (Commonwealth of Australia, 1999).

The WHO Report also states that suicide remains one of the common and avoidable outcomes of depression and is the leading cause of death for young adults (World Health Organization, 2001). People suffering from depressive disorders have a risk of suicide 30 times that of the general population (Commonwealth of Australia, 1999). Suicide was also reported as most prevalent in the 15-34 year-old age group, where it ranks as the first or second cause of death for males and females (Australian Bureau of Statistics, 2008). A survey conducted by SANE Australia (2010) found that people with a mental illness are far more likely to self-harm and attempt suicide than are the general population. Their survey of 285 people identified that 93% of respondents had felt suicidal at some time and 34% had made a serious suicide attempt in the last twelve months. In addition, two thirds of respondents reported having a diagnosis of a mental illness prior to any attempt to end their life (SANE Australia, 2010).

According to the Discussion Paper published by the Commonwealth of Australia (2004) in regards to the needs of young people in Australia, the years of adolescence and young adulthood are a critical developmental period, particularly in terms of social and emotional wellbeing, as young people decrease their dependence on families and schools and move towards independence and autonomy. Rates of suicide are high, particularly with young men, and young people's rates of self-harm are substantially higher than those of adults. Young people with emerging mental health problems or disorders often have fluctuating symptoms and multiple difficulties. This report stressed the value of early intervention (Commonwealth of Australia, 2004).

### **Process-Experiential/Emotion-Focused Therapy and Depression.**

Emotion Focused Therapy (EFT, the more widely used acronym for PE-EFT) is listed on the APA list of Empirically Supported Treatments (ESTs) as a psychological treatment for depression. However, according to Greenberg and Watson (2006), depression is not a distinct disorder, but rather an experience that varies greatly from individual to individual and, within the same individual, from moment to moment and year to year. Some people are classically depressed, with low mood and loss of energy, but many are anxious, many are angry, many abuse substances, and many present with chronic pain conditions or other physical disturbances. Depression is considered by Greenberg and Watson (2006) to be a complex biopsychosocial phenomenon with no single cause which presents with great variability.

There are biological, psychological and social causes of depression, as well as affective, cognitive and behavioural aspects of the depressive experience. In addition, the diagnosis could be considered an abstraction, subject to definition by the culture in which the individual is embedded. Greenberg (2011) suggested that, on the one hand, diagnosis based on the DSM-IV-TR is not always relevant to treatment because this expert-based, non-empathetic approach to working with clients, is inconsistent with the kind of therapeutic relationship desired in PE-EFT. However, on the other hand, Greenberg (2011) and Elliott, Watson et al., (2004) state that knowing something about the patterns of general differences among clients with depression has assisted therapists to work more consistently with their clients by reducing some of the variability. Within a dialectical constructivist view, depression is viewed as an

emotional disorder of the self and involves a loss of the self's sense of vitality and ability to organise and be resilient (Greenberg & Watson, 2006). Central to this position is the recognition of clients as active agents in the construction and deconstruction of their depressive experience.

Harter (1998) developed a model for the development of depression in adolescents in which low self-worth, negative affect and general hopelessness were found to be high composite indicators of risk for depression. In addition, she and others found a direct path from depressed affect to low self-worth indicating a bidirectional causal relationship between emotion and cognition (see also Clark & Beck, 1999). These feelings of inadequacy and lack of support have also been proposed by Harter (1998) as developmental precursors to adult depression. According to Greenberg and Watson (2006), depression in adults seems to build on the feelings of inadequacy and lack of support laid down in adolescence with emerging shame as a core component. "In addition to shame, depressed adults who experienced loss or neglect as children carry the insecurity of abandonment and experience a lot of fear" (Greenberg & Watson, 2006, p. 46). People with depression lose their ability to tolerate and process their core anger and sadness, and so powerlessness prevails.

On the basis of clinical observations, Greenberg and Watson (2006) noted that "depression occurs if a person's weak or bad self-organisation is triggered or when it becomes the dominant organisation... involves the evocation of powerlessness, predominantly shame- and fear-based experience and dysfunctional ways of coping with the emotion generated" (p. 49). *Dependant-type* depression results for a person whose life experience resulted in poor attachment and *weak* sense of self. Such clients feel vulnerable to abandonment, feel fundamentally insecure, and withdraw from relationships. In contrast, *perfectionist-type* depressions occur when people have been subjected to high demands and low interpersonal support or have been badly treated. These people are highly critical of themselves and see themselves as *bad* and worthless. In therapy, these types of depression are often intertwined but may emerge discretely as core shame and core anxiety. People with depression often fear their core emotions. The core emotions of anger, sadness, fear and shame, according to Greenberg and Watson (2006) play a central role in depression.

## **Process-Experiential / Emotion-Focused Therapy Research on Depression**

Most of the research on PE-EFT and depression takes the form of three outcome studies comparing the efficacy of PE-EFT with other therapies for depressed clients. The three outcome studies include the York I depression study (Greenberg & Watson, 1998), the York II depression study (Greenberg, Goldman, and Angus, 2001, as cited in Elliott, Greenberg, & Leitaer, 2004) and the RCT conducted by Watson et al (2003). A few other studies using data from these outcome studies will be discussed that have direct relevance to this inquiry into the process of therapy with depressed young people.

### **PE-EFT Outcome Research.**

Although the present study is not designed as an outcome study, I will briefly review some of the results of the outcome research into using PE-EFT with depressed clients, since this helps to justify the use of this intervention with the participants in this study. For the interested reader I have placed more details of the outcome research in Appendix B.

In the York I depression study, Greenberg and Watson (1998) studied the effectiveness of PE-EFT in comparison to person-centred psychotherapy for depression. There were no significant differences on termination between the groups on the BDI but there were significant differences in favour of the PE-EFT group in the areas of greater improvement in self-esteem, reduction in overall symptoms, and fewer interpersonal problems. In addition, by mid-treatment clients undergoing PEEFT showed quicker response to treatment on all outcome measures than those in the person-centred treatment (Greenberg & Watson, 1998).

The working alliance appeared to be an overarching factor in the success in both treatments. Greenberg and Watson (1998) hypothesised that the client-centred therapy “seemed to work by validating people’s inner experiencing and helping them to use their experiences as a guide to the creation of new meaning and action” (p.

221). In the PE-EFT group clients referred to “both the relationship and the dialogues in the chairs as helping them to change” (p. 221). It could be said that the



addition of the specific active tasks at appropriate moments within the sessions seemed to hasten and enhance recovery. This study provided preliminary evidence for the probable efficacy of experientially orientated approaches in treating depression.

Client data was taken from the York I depression study and analysed by

Weerasekera, Linder, Greenberg, and Watson (2001). The researchers examined the development of the working alliance in both PE-EFT and client-centred therapy.

Results revealed that the alliance predicted outcome as early as session three. In addition, the alliance-outcome relationship varied with the alliance dimension. This was shown in measures of goal, task, or bond on the WAI (Horvath & Greenberg,

1989), in outcome measures (symptom improvement versus self-esteem, relational problems) and when in-treatment alliance was measured. Further analyses revealed that early alliance scores predicted outcome independently of early mood changes.

Although no treatment group differences were found for bond and goal alliance, the

PE-EFT group showed higher task alliance scores in the mid-phase of therapy. The level of pre-treatment depression didn't affect alliance formation.

The York II depression study by Greenberg, Goldman, and Angus (2001, as cited in Elliott, Greenberg, & Leitaer, 2004) replicated the York I study by comparing the effects of client-centred therapy and PE-EFT. Analysis revealed an effect size of .71 in favour of PE-EFT. The investigators then combined the York I and II samples to increase the power to test for differences between the groups. Statistically significant differences were detected on all indices of change for the combined sample, which provided evidence that the addition of the PE-EFT interventions to the client-centred empathic relationship improved outcome.

Goldman, Greenberg, and Angus (2006) published further analyses of the findings of the York II study. At the end of treatment, 100% of participants in the PE-EFT group were no longer depressed compared with 95% of the relational client-centred group. Results on clinical significance were similar to or better than those from other studies (see Goldman et al., 2006). Several factors should be considered when interpreting these findings. Therapist and research bias could have affected the results if therapists were biased towards seeing the person centred approach as less effective than the PE-EFT. The researchers considered that therapist and researcher bias could

have confounded the results but subsequent analysis of the bias did not yield significant results (Goldman et al., 2006).

In the York II study (2001) 84% in the client-centred condition and 95% in the PE-EFT condition met the reliable change index RCI criteria (as cited in Goldman et al., 2006). When the samples from the York I and II studies were combined, 86% of clients in the client-centred condition and 89% of the PE-EFT condition met the RCI criteria (as cited in Goldman et al., 2006). By way of comparison, it is interesting to note that, in a review of the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program, Ogles, Lambert, and Sawyer (1995) found that for clients who completed at least 12 sessions and 15 weeks of treatment, 50% of clients in the Cognitive Behavioural therapy (CBT) condition and 64% of clients in the interpersonal therapy (IPT) condition met the reliable change index (RCI).

A study conducted by Goldman et al. (2006) aimed to determine whether the addition of specific PE-EFT interventions to the client-centred relationship common to both treatments enhances outcome in the treatment of depression. The addition of PE-EFT interventions to the relational conditions were found to increase the effectiveness of the treatment. The PE-EFT group showed superior effects for the alleviation of depressive and general symptom distress. In the combined York I and II sample analysis, PE-EFT showed superior results on all outcome indices, including relief of symptom distress, and improvement on interpersonal functioning and self esteem measures. In a very recent follow-up study conducted by the York II team the maintenance of reduction in depression over 18 months was investigated (Ellison, Greenberg, Goldman, & Angus, 2009). The Longitudinal Interval Follow-up

Evaluation for depression (Keller et al., 1987) was administered at the beginning of each six-, twelve- and eighteen-month interview to obtain evaluations of the previous six months. The BDI, SCL-90-R, RSE and IIP were also administered at the 6-month and eighteen month follow-up periods. Overall, there was support for the hypothesis that the addition of PE-EFT interventions to the relational conditions of client centred therapy would lead to increased maintenance of therapy gains (reduced depression) across follow-up assessments (Ellison et al., 2009). PE-EFT clients maintained

treatment gains of minimal or non-depressive symptoms for a significantly longer period of time across the follow-up periods. From clients' self reports

PE-EFT appeared to have led to more active and effective ways of dealing with emotional distress in the follow-up periods.

Watson, Gordon, Stermac, Kalogerakos, and Steckley (2003) conducted a randomised control trial study comparing PE-EFT and CBT in the treatment of major depression. Sixty-six unmedicated, depressed clients, mean age of 41.52 (SD = 10.82), underwent a series of 16 weekly psychotherapy sessions. There were eight CBT therapists and seven PE-EFT therapists involved. Allegiance effects were controlled for by having an expert in each modality train and supervise the therapists. At the end of their training the therapists were considered competent in their trained approach and adhered to that approach. However, there was no formal assessment of that competency in the trained approaches.

There was no difference between groups in terms of clients' depression, self esteem, dysfunctional attitudes and general level of distress, and this finding is consistent with the majority of outcome studies (Watson et al., 2003). However, there were differences between the two treatments in terms of clients' reports of their interpersonal problems as measured by the Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, & Baer, 1988). Clients in the PE-EFT group were significantly more self-assertive and less overly accommodating, less self-sacrificing, less domineering and controlling. Watson et al. (2003) suggested that the greater improvement in clients' interpersonal functioning may be as a result of the therapeutic relationship's modelling empathy, acceptance and positive regard. In addition, specific tasks of PE-EFT may have helped clients' to improve their interpersonal functioning, since in two-chair and empty-chair tasks, clients are encouraged to express their needs and to request changes in appropriate, non-blaming ways and to listen to the other's response. There were several limitations as cited by the researchers. For ethical reasons a wait-list was not employed and the small sample size meant that small effect sizes could not be detected. In addition, all the data collected was from self-report measures and there were no evaluations made by external observers. The method of recruitment of clients and a high rate of attrition may have implications for the generalisability of the findings. Further, no long-term

follow-up data collected, thus maintenance of treatment effects could not be determined.

In summary, the developers of PE-EFT have conducted numerous well-designed outcome studies that provide evidence that PE-EFT is an efficacious treatment for depression in adult populations. The addition of the PE-EFT interventions to the client-centred empathic relationship improved outcome and led to increased maintenance of therapy gains in PE-EFT clients. Whilst there was equivalence when compared to CBT there were differences between the two treatments in terms of improvement in interpersonal problems in favour of PE-EFT.

### **Process oriented PE-EFT research.**

A number of non-outcome, process oriented studies pertaining to use of PE-EFT for depression have also been carried out. Watson and Greenberg (1996b) conducted a study that included thirty-six unmedicated clients, 25 females and 11 males, who had been diagnosed with major depression on the DSM-III-R criteria (American Psychiatric Association, 1987). Clients were randomly assigned to two treatments: (1) client-centred therapy which focused on empathy, unconditional positive regard and congruence within the working alliance and (2) PE-EFT which implemented the three relational conditions and also the three active, marker guided interventions. Six process measures were used to assess clients' in-session performance and to determine differences across the two treatments (see Watson & Greenberg, 1996b for more details).

The Watson and Greenberg (1996b) study identified a pathway of change from in-session process and problem resolution to post-session change and final outcome. The therapist offered an intervention at a specific presentation of a marker that enabled the client to process their experience and come to an in-session resolution (Watson & Greenberg, 1996b). Individual interventions were matched to highly specific problem formulations but congruent with the client's processes. Three types of interventions were utilised for three different specific problems. Two-chair work was indicated for self-critical splits, empty-chair for unfinished business and systematic evocative unfolding for problematic reactions.

Watson and Greenberg (1996b) reported that “overall the marker guided active intervention sessions resulted in significantly deeper emotional and internal experiencing and greater problem resolution for splits and unfinished business than did the client-centred sessions” (p. 272). PE-EFT clients showed significantly deeper levels of experiencing and exhibited greater expressive qualities than the client-centred clients. The PE-EFT clients were more internally focused, able to express their emotions and immediate inner experience in novel ways and were more in touch with their needs. These clients were also able to reflect on their experience and resolve their problems in more meaningful and productive ways. These preliminary findings support the concept that specific interventions have a significant role in the change process (Greenberg & Safran, 1987, 1989; Watson, 1996). In addition, small in-session changes, as well as the ability to symbolize and reflect on experience may result in intermediate changes, which may accumulate over the course of treatment resulting in a reduction of symptoms at the end of treatment (Watson & Greenberg, 1996b). The authors warned that these findings should be regarded with some caution as they are preliminary and need to be verified with a larger sample. Further suggestions were made by Watson and Greenberg (1996b) that in future studies it could be advantageous to collect a larger sample of sessions in which clients resolve one of the investigated problems to more fully illuminate differences in client processes across the two treatments as well as to replicate the links with final outcome.

Shifting the focus further toward the process of therapy, a study by Pos, Greenberg, Goldman, and Korman (2003) explored the importance of early and late emotional processing during the development of treatment, in relieving depressive and general symptomatology, improving self-esteem and interpersonal problems. Data were taken from the York I depression study, which studied thirty-four clients who underwent 16 to 20 PE-EFT sessions for depression. Emotional processing was defined as depth of experiencing during emotional episodes or in-session segments in which clients expressed or talked about having experienced an emotion in relation to a real or imagined situation. Emotional processing abilities were found to have improved during treatment. Results indicated that early and late emotional processing predicted both decreases in symptoms and increases in reported self-esteem. Pos et al., (2003) demonstrated by hierarchical regression models that late emotional processing

mediated the relationship between clients' early emotional processing capacity and outcome. This was the sole emotion-processing variable that independently predicted improvement. The working alliance added an independent contribution to explaining improvement after researchers controlled for the emotional processing (Pos et al., 2003). Thus the depth of emotional processing at the end of therapy was coincident with psychotherapeutic improvement. However, because this investigation measured late emotional processing at the end of therapy, the researchers were not able to demonstrate the change process from one stage of emotional processing to the next. To achieve this, the authors suggested emotional processing would need to be explored in a more differentiated manner so that the importance of particular stages of emotional processing to deeper processing and to outcome could be established more clearly (Pos et al., 2003). Another issue the authors raised that remains to be empirically resolved is the causal relationship between emotional processing and outcome.

Recently, Pos, Greenberg, and Warwar (2009) tested a model of change in experiential therapies for depression. The investigators combined the York I and II clinical trial samples to give data from the seventy-four participants who had received either client-centred or PE-EFT treatments for depression. Emotional processing and alliance strength were measured quantitatively using the Experiencing Scale (EXP; Klein, Mathieu-Coughlin, & Kiesler, 1986) and the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), across three phases of therapy: beginning, working and termination. The aim of the study was to test theoretical assumptions concerning the interrelationships between therapy process and outcome. The assumption that both emotional processing and the alliance improve as a result of treatment was supported. Clients' emotional processing became significantly and consistently deeper during the working phase of therapy and continuous alliance building was demonstrated during the treatment (Pos et al., 2009). This study also provided stronger evidence that increasing clients' emotional processing is directly related to good outcomes in experiential therapy for depression. Pos et al. (2009) stated "as a whole... support... has been found for emotional processing as a core change process in experiential therapy. Changes between beginning and working phase emotional processes best predicted symptom outcomes..." (p.1063). In

addition, the alliance was shown to “potentiate emotional processing within the working and termination phases of therapy for all but the interpersonal problems” (Pos et al., 2009, p. 1064). A measure of alliance was taken after session one and it was shown that even though alliances became significantly stronger across therapy phases, better session one alliances meant better outcomes (Pos et al., 2009). The authors recognise that psychotherapy process research using statistical modelling analytic procedures is hampered by small samples. Despite the small sample a best-fit model emerged but the results will require cross validation (Pos et al., 2009). According to the authors future studies are needed to establish the theory that certain therapist behaviours lead clients in and through moment-by-moment emotional processes. This is the level of process that is now required to help improve training, treatment, and efficacy.

The study presented above indicates that the working alliance *and* the specific PE-EFT interventions have significant roles in the change process. Watson and Greenberg (1996b) identified that the marker guided active interventions of PE-EFT clearly result in significantly deeper emotional and internal experiencing and greater problem resolution for depressed clients. In addition, emotional processing has been shown by Pos et al (2003; 2009) to be a *core* change process. What these studies don’t do is identify whether there are *other* key elements necessary for the change process. These might, for example, include shifts in bodily felt-sense as a result of reprocessing an episodic memory by accessing primary needs.

### **PE-EFT and depression: Case study research.**

Watson, Goldman, and Greenberg (2007) published a collection of case studies to complement an earlier manual, *Emotion-Focused Therapy for Depression* (Greenberg & Watson, 2006), which expounded the theory and practice of EFT (the more widely used acronym for PE-EFT) for the treatment of depression. Greenberg and Watson (2006) presented the etiological factors that contribute to depression, the mechanisms of change and the particular interventions that facilitate change. The case study book by Watson, Goldman, and Greenberg (2007), *Case Studies in Emotion-focused Treatment of Depression: A Comparison of Good and Poor Outcome*, looks more closely at “how a brief therapy for depression using emotion-focused techniques

unfolds over the course of treatment” (p. ix). Clients were drawn from three different research studies, spanning a 15 year period, that investigated the effectiveness of brief PE-EFT compared to client-centred therapy and to CBT. Despite PE-EFT being effective for many clients, some did not improve over the 16 to 20 session treatment. The authors argued that “to improve the clinical practice, teaching and understanding of the change factors on psychotherapy, psychologists need to understand the differences between those clients who are able to benefit from short term treatment and those who are not” (Watson et al., 2007, p. 3). The objectives of presenting the case studies were (a) to provide a comprehensive overview of how the different combination of tasks and client objectives optimised successful outcomes (b) to look not only at good outcomes but also at cases that were not so successful in order to understand the factors that may contribute to poorer outcomes and (c) to identify client factors that might contribute to successful outcome.

The six in-depth case studies, three that culminated in good outcomes and three that did not, offered an opportunity to see inside the therapy room and understand how the process of therapy progressed. Each of the six clients, known by pseudonyms, varied in their backgrounds, personalities and their opinions of how their depression emerged. Case formulation as described by Greenberg and Watson (2006) was used to tailor specific interventions to each client’s presenting problem and these were process orientated and tentative (also see Elliott, Watson et al., 2004; Goldman & Greenberg, 1995; Watson et al., 2007).

Three phases of treatment; *bonding and awareness*, *evoking and exploring* and *transformation*, were used to provide structure to each case study presentation (see Greenberg & Watson, 2006). Meticulous session-by-session descriptions, including extensive transcripts of dialogue and post session evaluations, and a variety of objective process measures were used to describe the client’s cognitive-affective processing and moment-by-moment experiencing within the sessions. Measures included the Beck Depression Inventory (BDI; Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961), Symptom Checklist-90-Revised (SCL-90-R; Derogatis, Rickels, & Roch, 1976), the Rosenberg Self-Esteem Inventory (Bachman & O’Malley, 1977), the Inventory of Interpersonal Problems (IIP; Horowitz et al., 1988), the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), and the Experiencing Scale



(Klein et al., 1986). “By triangulating information from clients, therapists and third-party observers, we attempted to present an in-depth picture of what occurs in a single session and over the course of a 16 to 20 week treatment of depression using [PE-]EFT” (Watson et al., 2007, p. 21).

Briefly, in the good outcome cases the three clients improved dramatically on the BDI so that at the end of treatment their scores were zero (Watson et al., 2007). They no longer exhibited signs or symptoms of depression. Each client engaged readily in therapy and quickly formed a positive alliance with his or her therapist that was present from the beginning to the end of therapy. The three poor outcome studies were chosen to illustrate specific difficulties with the different phases of the PE-EFT depression treatment model and to identify different client profiles that may lead to poor outcome. According to Watson et al. (2007) “one client reported feeling more depressed at the end of treatment according to his score on the BDI; the second reported feeling better immediately following the last session but relapsed 10 days later... the third did not change significantly on the BDI...” (p. 22). Two clients experienced difficulties in the working alliance that prevented them from benefitting from the short-term PE-EFT treatment. The therapists of these two clients reported that the clients were unconvinced about the usefulness of examining their emotions in session and were reluctant to explore their emotions. All three clients expressed a deep sense of shame that made it difficult for them to share their experiences with their therapists (Watson et al., 2007). The authors were able to identify client and therapist variables that were common to the good outcome cases and those common to the poor outcome ones.

The Pragmatic Case Studies in Psychotherapy (PCSP) online journal published a comparison of two clients, taken from the successful condition of an RCT for Emotion-Focused Therapy (EFT) for depression (Fishman, 2011). A poor-outcome client “Tom” (Watson, Goldman, & Greenberg, 2011) was compared with a good-outcome client “Eloise” (Goldman, Watson, & Greenberg, 2011). The aim of such a comparison was to provide an opportunity to investigate holistically and in detail the individual and interactive roles of a variety of factors that affect outcome for each client (Fishman, 2011). The systematic case study investigation highlighted how the PE-EFT model of therapy was translated into an individualised case formulation, how

the treatment manual was adapted for each client, how the therapy unfolded, and how the client's personality characteristics, life history and current life circumstances influenced the outcome (Fishman, 2011). Data were collected from observer-rated measures of emotional processing during therapy, the client's perception of change as measured by post-session and post-therapy questionnaires, and the therapist's perceptions of change as measured by post-session reports and post-therapy interview data, to form an understanding of what contributed to change (Goldman et al., 2011; Watson et al., 2011). Whilst there was an inclusion of some process measures in these cases there was a strong emphasis on the data collected through self-report inventories and outcome measures.

For example, the Emotion Episode (EE) process measure (as cited in Pos et al., 2003) was used to identify key segments which were tracked across the entire case (Goldman et al., 2011). These episodes were identified where the client experienced emotion in response to a situation, real or imagined, and where the narrative theme changed or a new emotional response was expressed. Emotional responses were coded according to a list of 15 possible emotions. In the case of Eloise over the course of her therapy episodes of joy increased as pain/hurt and fear/anxiety decreased. In a post assessment interview she described the emotional changes she had made as being more able to let things go by not being stuck in negative feelings and her anger had gone.

Another inventory was the General Session Evaluation Questionnaire (Orlinsky & Howard, 1975) which was administered to the client with the aim of identifying whether each session had been helpful/not helpful and whether something was perceived to have changed in the session and how this might translate to alternative action. The PE-EFT chair tasks were identified by Eloise in her post-therapy assessment interview as important as they allowed her to identify and cope with her anger at her parents, particularly her father. Significantly, Eloise's assessed working alliance WAI was high throughout therapy. The authors ascertained that the process of identifying the core emotional processes that were causing Eloise's difficulties and bringing forth new information about her experience were key change events. More detailed investigations of *how* these changes occurred were not included in the analysis. The good-outcome case study of Eloise provided support for the PE-EFT

model and some insight into the change processes. Evidence was provided that identified the way that PE-EFT treatment set processes of change in motion, and that suggested that these changes led to the remission of Eloise's depression (Fishman, 2011; Goldman et al., 2011).

On the other hand Tom, was considered sceptical about therapy and struggled to explore his emotional experience because, as explained by the authors, his sense of shame and his fear of the pain associated with such feelings made it difficult for him (Watson et al., 2011). His assessed working alliance (WAI: Horvath & Greenberg, 1994) was *good* and ranged from 64% to 90% at the end of therapy. A low to moderate in-session change was reported in the first ten sessions on the Client Task Specific Change Measure-Revised (Watson, Shien, & McMullen, 2009). In his post-session interview Tom said that after the later sessions he said he was able to challenge his automatic thoughts and self criticisms more, felt better about himself and was more accepting and compassionate towards himself. The authors concluded that the 16 session treatment was not long enough for him to deal successfully with the issues he brought to therapy. It took him 11 sessions before he became fully engaged in the therapeutic process. Further barriers to his success were that he was reclusive and had an almost nonexistent support network. In addition, he had experienced emotional neglect as a child, was self punitive and had not learned to care for or nurture himself.

It could be concluded from these case study investigations that not every client can benefit from short-term PE-EFT treatment. Clients who are self-focused and able to be reflective about their experiences and explore them in a purposeful way seem more likely to experience a shift in perception, mood and behaviour. The therapeutic relationship can provide an antidote to a client's feelings of shame and can engender hope as clients begin to feel valued and supported for both the good and poor outcome cases. According to Iwakabe (2011) who provided a commentary on the two cases by means of a comparison, although Tom's assessment of the working alliance was moderately high, Tom was reluctant to self-disclose and in the early sessions there were disagreements between Tom and the therapist regarding the goals and tasks of therapy. This contrasted significantly with Eloise, who, from the beginning of therapy, expressed difficult emotions more freely and began the process of identifying the core emotional processes that were causing her difficulty (Iwakabe, 2011). So while Tom's case was

*unsuccessful*, he did achieve limited *success*, as important changes were just beginning to emerge as the therapy came to an end.

The information gained from this comparison is highly valuable not only to clinicians practicing but also to those clinicians and trainees who want to learn what actually happens over the course of therapy. The case comparison method is a viable research approach in studying the process of integrative psychotherapy (Iwakabe, 2011). A determination of whether clients are ready or have the capacity to engage in short-term treatments and readiness to examine their emotions in session will be key factors in identifying whether PE-EFT will be appropriate for them.

## **Summary of Research and Aims of this Study**

There is a consensus among research professionals about the need for investigations that employ collaborative systematic qualitative methodology into what works in therapy (Cooper, 2008; Elliott, Greenberg, & Leitaer, 2004; Elliott & Zucconi, 2005). Researchers have argued that it is important to look at change-processes in therapy (Elliott, Slatick, & Urman, 2001) as a means to help close the research-practice gap (Elliott & Zucconi, 2006, 2010). We know that PE-EFT is effective through the sort of outcome research studies reviewed above and we know something about how it works at a process level. It is very consistent across all of the research listed above that the working alliance is a key to successful change in therapy. The PE-EFT tasks have also been shown to be significant factors in facilitating change, and the degree of emotional processing has been shown to be a core change process. The question still arises as to whether there are other factors that contribute to the process of change, or that provide sustainable improvement. Understanding what works from the client's point of view is also a vital consideration, so that further research is needed to illuminate the change processes involved in PE-EFT. There is no current process research investigating depression in young people, so it is particularly needed. So examining change processes with young people who have depression may provide a vehicle to further our understanding of the change processes in PE-EFT. My research project aims to address some of these issues by following the journeys of four young women with depression through therapy to post-therapy. As a consequence, the study

investigates client as well as therapist perceptions of therapeutic effectiveness together with client perceptions of what, in both the therapy and their broader lives, may have contributed to any changes they experienced.

Change processes in therapy: Case studies in Process-Experiential / Emotion-Focused Therapy

## Chapter Five • Methodology

### Introduction

Since methodology refers to more than simply ways of gathering data or a set of methods and includes the philosophical assumptions that underlie a study, I have attempted to make these philosophical assumptions explicit. During this process, I have confronted and been challenged by my own values, beliefs and prejudices.

The style in this section is a deliberate expression of my presence as the researcher in the data generation and gathering. In the first section of this chapter I explain the origins of my methodological approach, and the steps by which I came to identify the overarching paradigm<sup>3</sup> and articulate the philosophy that has helped me attempt to conduct ethical, practice-based research. I explain the corresponding choice of research methods, discussing how quantitative and qualitative methods can co-exist within the same research endeavour. I have also suggested a set of criteria upon which the reader may assess the quality and thoroughness of my research. In the participants' section the reader is introduced to the four young women who took part in this research. In order to identify therapeutic changes I chose a number of inventories and measures and these are listed and described in the measures section.

### From Methods to Research Paradigm

While it is logical to move from the broader perspective of the research paradigm to the particular methodological approaches chosen, in reality I began at the level of methodology and only later defined the values and philosophical assumptions that underpinned my approach to this research. In the interests of providing a transparent record of the research process, I will therefore follow the sequence of my methodological choices as they in fact occurred.

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3 I use the term *paradigm* to describe the best known epistemological stances (e.g. positivism, constructivism) as distinct belief systems that influence research questions and how they are answered (Morgan, 2007).

As a psychologist working as a person-centred counsellor within the humanistic philosophy, the idea of an approach that mixed quantitative and qualitative methods appealed to me from the start. But was it possible to combine qualitative and quantitative methods without violating their underlying philosophical principles? According to Guba and Lincoln (2005) who addressed the issue of commensurability between paradigms, the answer is “a cautious yes” (p. 201) especially if the paradigms share similar values.

There have been several approaches put forth as means of legitimising the practice of *mixing* methods; such as pluralism (see McLeod, 2003b), multi-method (see Brannen, 1992), bricolage (see Lincoln & Denzin, 2000) and the pragmatic approach (Fishman, 1999; Morgan, 2007, see below). The editors of *The Journal of Mixed Methods Research* defined *mixed methods* as “research in which the investigator collects and analyses data, integrates the findings, and draws inferences using both qualitative and quantitative approaches or methods in a single study or a program of inquiry” (Tashakkori & Creswell, 2007, p. 4).

I liked the idea of approaching this research as a *bricoleur*. Lincoln (2000) explained that *bricolage* is the practice of bringing together (typically) methods, whatever appears to work best in a given context and with a given group of research participants. As a bricoleur I have the potential to employ multiple methods to uncover new insights and re-examine accepted explanations, while being sensitive to individual differences and recognising that the object of inquiry is inseparable from its context (Kincheloe, 2001, 2005).

### **The pragmatic approach within a participatory inquiry paradigm.**

As I began to explore possible methodologies, I strongly resonated with the pragmatic approach because it concentrated on methodology as an area that connects issues at both the abstract level of epistemology and the mechanical level of actual methods. Fishman (1999) and Morgan (2007) independently discussed the concept of the *pragmatic* approach, first developed by philosopher-psychologists William James and John Dewey at the turn of the last century. Morgan wrote that



A pragmatic approach would deny that there is any a priori basis for determining the limits on meaningful communication between researchers who pursue different approaches to their field. Instead, a pragmatic approach would place its emphasis on shared meanings and joint action. (p. 67)

The pragmatic approach emphasises inter-subjectivity and focuses on processes of communication and shared meaning. The goal of research within the pragmatic approach is not for knowledge alone but to improve the lives of particular individuals, groups or communities within specific contexts (Fishman, 1999). The pragmatic study begins with an explicit guiding conception of the problem and allows for a combination of quantitative and qualitative methodology by combining the focus and structure of the positivist model with an emphasis on the hermeneutic thick description of case context (Fishman, 1999). In addition, a pragmatic researcher acknowledges her role as a reflective-practitioner and participant-observer by recognising that the very nature of the case-study draws the researcher into intensive contact with the client, making it impossible to maintain a neutral, detached stance (Fishman, 1999). This suited my philosophy about how my research should be considered and conducted.

In line with the pragmatic approach, my study examined the journeys of four young women struggling with depression who were counselled with Process Experiential-Emotion-Focussed Therapy (PE-EFT) in a culture where Cognitive Behavioural Therapy (CBT) was the prevailing treatment for depression.

Although I have taken a pragmatic approach to this research and focused on methods, I have found the participatory inquiry paradigm (Heron & Reason, 1997; Guba & Lincoln, 2005) useful for its axiology and extended epistemology. These have encouraged me to articulate the values embedded in this work, and to find a place for the experiential and practical knowing that PE-EFT itself employs. The participatory inquiry paradigm also encourages researcher and researched to work collaboratively (Heron & Reason, 1997). The characteristics defining this inquiry paradigm are listed in Table 5.1 below.

Table 5.1. Basic beliefs of the participatory inquiry paradigm.

Issue	Definition	Participatory
Ontology	What is the form and nature of reality	Participative reality – subjective-objective reality, co-created with mind and cosmos
Epistemology	What can be known?	<p>Critical subjectivity in participatory transaction with cosmos; co-created findings</p> <p>Extended epistemology:</p> <ul style="list-style-type: none"> <li>• Experiential – direct encounter, knowing through empathic resonance with another</li> <li>• Presentational – symbolisation of experiential knowing</li> <li>• Propositional – knowing in conceptual terms expressed as statements or theories</li> <li>• Practical knowing – how to do something; skill or competence</li> </ul>
Methodology	How do we find out what can be known?	Political participation in collaborative action inquiry; primacy of the practical; use of language grounded in shared experiential context.
Axiology	What knowledge is valuable?	Practical knowledge about how to flourish with balanced autonomy, cooperation and hierarchy in a culture is an end in itself and intrinsically valuable

Source: Heron and Reason (1997).

Briefly, reality here is seen as subjective-objective and articulated by one person within an inter-subjective field and a context of both linguistic-cultural and experientially shared meanings. Collaborative research is done by people with each other and not by researchers on other people. The axiological question about what is intrinsically worthwhile is addressed explicitly in this paradigm. According to Heron and Reason (1997) the primary purpose of human inquiry is in the service of human flourishing, with knowing of the world consummated as action and understood as essentially transformative.

Since the pragmatic approach endeavours to gain knowledge in pursuit of desired goals, is inter-subjective, uncommitted to a single theory, integrates methodology, and seeks findings that are co-created or value-mediated and aimed at improving social

programs, I found it compatible with the participatory inquiry paradigm in practice. The *pragmatic case-study paradigm*, as described by Fishman (1999), provided me with the study design to investigate PE-EFT effectiveness and individuals' experiences of the therapy by combining quantitative and qualitative methodology. The case-study method elaborated further in the next section offered me an opportunity to understand the real-life experience of being counselled utilising PE-EFT from the perspective of my client/participants. I selected assessment methods from both quantitative and qualitative domains (see Measures section, p. 109).

## Case Study Methodology

The choice of design, data collection and data analysis methods for this study have been primarily guided by a general framework proposed by Elliott and associates (see Elliott, Slatick, & Urman, 2001; Elliott & Zucconi, 2005, 2006, 2010), and supported by McLeod (2010). I have chosen this framework for two reasons. Firstly, it provided me with a systematic research protocol to follow. Secondly, the International Project on the Effectiveness of Psychotherapy and Psychotherapy Training (IPEPPT), initiated in 2004, encourages a coordinated collaborative effort towards practice-based research and training research.

I utilised an integrative strategy and drew on the set of principles suggested by Elliott and Zucconi (2005, 2006, 2010) as necessary and sufficient for successful practice-based therapy research. Their research framework offers three design levels: minimum, maximal and systematic case study. Minimum designs are appropriate for use in private practice settings where only a limited number of effects can be investigated, and maximal designs are appropriate for well-resourced research centres (see Elliott & Zucconi, 2006; 2010 for a more detailed explanation). The third design level, which I have chosen to use, was the systematic case design.

When thinking about case-study research in counselling and psychotherapy McLeod (2010) argued it is important that this type of inquiry be understood in relation to a set of multiple purposes.

1. To make a contribution to shared professional and scientific knowledge by presenting carefully documented and rigorously analysed case-based evidence
2. To enable users of therapy (clients, purchasers) and practitioners to gain an understanding of what actually happens in different forms of therapy for different client problems
3. To provide a structure for personal and professional development in therapists, in the form of opportunities to reflect on practice. (p. xv)

My reasons for choosing a case study methodology are fourfold. Firstly, I was interested in investigating whether being counselled with Process-Experiential/Emotion-Focused (PE-EFT) *works* for young people with depression, and in determining from their perspective *what* in the PE-EFT counselling worked for them, and the case study allows for rich enough data to understand this.

Secondly, I wanted to research in naturalistic settings in order to provide understandings relevant to counselling practice. Yin (2009) defines the case-study as “... an empirical inquiry that investigates a contemporary phenomenon in depth and within its real life context” (p. 18). The case-study method has been recognised as having the potential to contribute knowledge and understanding that is highly relevant to counselling practice (McLeod, 2003b; McLeod & Elliott, 2011). Clinicians want to know what is helpful in the therapy and value findings arising from research conducted in naturalistic settings. Detailed analysis of individual cases can yield information that is potentially, immediately applicable to the counselling relationship and the complexity and subtlety of psychotherapy (Stiles, 2005). Such experience-near research aims to reveal and honour the client’s lived experience (Schneider, 1999) and to be more acceptable to practitioners.

Thirdly, a further reason for the selection of the systematic case study method is that it has been used specifically to analyse the effects of PE-EFT. Watson, Goldman, and Greenberg (2007) chose the case-study method for a book highlighting the comparison of good and poor outcomes of six clients counselled with PE-EFT within a short-term framework. The researchers chose this method because the case-study method offered a more thorough overview of how the PE-EFT tasks and client objectives could be linked in order to maximise the potential of a positive outcome.

They also considered that the case-study provided an opportunity to examine what went well in therapy and what was not so successful, thus highlighting the factors that may inhibit or enhance successful resolution. More recently, *Pragmatic Case Studies in Psychotherapy* published a case comparison involving a good-outcome and a poor-outcome case drawn from the York RCTs (Goldman, Watson, & Greenberg, 2011; Watson, Goldman, & Greenberg, 2011). The object of the case comparison method was to analyse the two cases so that the process and structure of PE-EFT could be revealed. This method seemed compatible to my current study where I evaluate four case studies.

Fourthly, the case-study method seems well suited to describing and making sense of the processes of change (McLeod, 2003b). According to Elliott and Zucconi (2005, 2006), systematic case studies, as a method of change-process research, specifically examine the four aims that I have also adopted as my research questions.

1. Demonstrate whether change has occurred,
2. Examine the evidence for concluding that therapy was responsible for the change
3. Examine alternative explanations for the change
4. Examine which processes in the therapy might have been responsible for change. (Elliott & Zucconi, 2005, p. 9)

My research attempts to address all four change process issues described above.

I also built into my study the design features presented by Elliott (2002b) as useful for increasing the internal validity of single-case research designs. He suggested focusing on collecting systematic quantitative data and not relying on purely anecdotal evidence. These data can include:

1. Multiple assessments of change over time
  2. Multiple cases (a form of multiple baseline design)
  3. Change in previously chronic or stable problems
  4. Immediate or marked effects after the intervention (clinical significance).
- (Elliott, 2002, in an amended list taken from Kazdin, 1981).

In setting up the design of this research I have endeavoured to address all these areas, and to use items 1, 3 and 4 as points of triangulation within each of the four individual case studies. In order to satisfy item 2 above to I have presented four cases. The specifics of how I have addressed these four areas are presented below.

### **1. Multiple assessments of change over time.**

Inclusion of demographic data, as well as data on therapy process and outcome using multiple sources and measures (as listed in Table 5.2), offers a comprehensive set of protocols for single case investigation. I have methodically ensured that each of these research protocols has been incorporated within my research (also see Measures section).

I have used an embedded design that allows each individual case to include the collection and analysis of quantitative data (Yin, 2009), in order to add opportunities for extensive analysis, enhancing the insights into the cases. The embedded design enables both the systematic examination of the case as a whole, and of individual sessions as subunits within themselves and in terms of how they relate to the total case or cases. According to Fishman (1999) there are two potential advantages of the embedded-design studies. Firstly, they allow the researcher to recognise variability among the subunits and secondly, they offer an opportunity to understand the case as a whole in more depth.

Table 5.2. Systematic case study research protocols.

<b>Protocol</b>	<b>Description</b>	<b>Measure</b>
1. General client/therapist background information	Essential for providing interpretive context for the case, as well as a basis for generalizing the conclusions of the case study.	Initial Screening Interview (Appendix L) Therapist stance is made explicit (see below)

Protocol	Description	Measure
2. General quantitative outcome measures	Measures of client symptom distress or specific diagnostic inventories Administered at the beginning and end of therapy, and preferably at regular intervals during therapy	Depression was measured using: Beck Depression Inventory (BDI-II; Appendix D) Depression, Anxiety and Stress Scales (DASS; Appendix E) Conducted after session 6 and 12 and at 6 and 12 month follow up
3. Qualitative Interview about client change and important therapy processes.	Useful to employ a semi-structured interview to complement the quantitative measures.	e.g., Change Interview; (Elliott et al., 2001) (Appendix I) Conducted by original principal supervisor after sessions 4, 8 and 12 and at 6 and 12 month follow up
4. General therapy process	Qualitative post-session assessment of helpful aspects of therapy.	e.g., Helpful Aspects of Therapy (HAT: Appendix E) Form; (Llewlyn, 1988). Administered after every session
5. Records of therapy sessions.	Detailed therapist process notes and audio or video recordings of therapy sessions are very useful for pinpointing, corroborating, or clarifying issues or contradictions elsewhere in the data.	All sessions were videotaped and process notes taken for each session. These were reviewed as part of the analysis.
6. Measure of therapeutic alliance	Several different alliance measures have been developed over the past 25 years	The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). (Appendix H) Conducted after sessions 4, 8 and 12

Source: Taken from Elliott and Zucconi (2005, p. 10).

## 2. Multiple cases (a form of multiple baseline design).

Since the evidence from multiple cases can potentially be more compelling and considered more robust (Yin, 2009), I have researched four cases here. The multiple-case design provides an opportunity for cross-case comparison and greater latitude for applicability (Fishman, 2005; Schneider, 1999). Utilising multiple cases in this project was a form of replication in that one therapist worked with four clients (McLeod,

2003b; Yin, 2009), and provided the means for a simple comparison between the cases (Iwakabe, 2011).

### **3. Change in previously chronic or stable problems.**

Elliott and associates (2004) suggested researchers look for change in chronic or stable problems, and this study focuses on depression. Research on PE-EFT with adults with depression has generated useful information about its effectiveness, and insight into specific change processes in adult populations (Elliott, Greenberg et al., 2004; Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg & Watson, 1998; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003). I therefore designed the present study to examine change processes in depressed young women, a less researched population.

### **4. Immediate or marked effects after the intervention (clinical significance).**

The assessment of clinical significance was utilised to evaluate the PE-EFT intervention effect (see section on *Clinical significance* on p. 125).

## **Role of Researcher-Practitioner**

I have readily recognised my role in this research as a *reflective-practitioner* and *participant-observer* (Fishman, 1999; Morrow, 2005). *Reflexivity*, as the process of reflecting critically, is a conscious experiencing of the self as both inquirer and respondent, as the one coming to know the self within the process of research itself (Guba & Lincoln, 2005). Indeed, the very nature of the case-study draws the researcher into intensive contact with the client making it impossible to maintain a neutral, detached stance. This was particularly pertinent as my role as PE-EFT practitioner also encouraged me to develop a strong working alliance with my client/participant, an alliance that according to a positivist paradigm perspective could potentially compound my role as the researcher.

Although challenging positivist practice in this way, I, like Fishman (1999) and Elliott (2001, 2006, 2010), still value the use of standardised, quantitative measures which in this study document the base rates of the depression and provide repeated measures of it over the course of counselling. Fortunately, the practice-based research



I value lends itself to the use of a variety of research methods, both quantitative and qualitative and particularly suits the case-study design. The need I see to align the research question with the method of investigation has been raised by Eells (2007) and others (e.g., Elliott, 1995b) as a vital consideration. This is of critical concern to my research. Eells (2007) warns that a mismatch between problem and method can potentially lead to conceptual confusion.

The Rogerian philosophical underpinnings of PE-EFT had a major impact on the way that this research was designed and conducted. I was aware that Greenberg, Rice and Elliott (1993) had described *out-of-mode* responses in therapy as violating the basic humanistic principles of growth and choice as well as departing from the guiding principle of empathic attunement. I chose to take this concept further by conducting this study *in-mode*, not only keeping in mind these humanistic values but engaging in them at every possible level.

To provide the professional context for myself as a *practitioner*, I should note that I received six months' intensive training in PE-EFT, taught by Dr George Wills, as part of the first year of my doctoral program. When I conducted the counselling with the four young women during the second year of the doctoral program, I was registered as a provisional psychologist and had about 50 face-to-face clinical client hours.

## Participants

It is customary to identify the individuals who take part in research as *participants*. However, the individuals who agreed to be involved in this research were volunteering to become clients of counselling as well as research participants, so *client/participant* could also seem an appropriate term to identify the young people who gave their time to take part. Since I value the Rogerian person-centred core conditions of respect, genuineness and congruence (Rogers, 1957), the descriptors I use to refer to the young women who took part in the research will also reflect this and remind the reader these are young people who committed their time, energy, effort and were prepared to open themselves to the process of therapy in the name of research.

Young people were recruited from La Trobe University Australia. Posters (see Appendix C) on student noticeboards within the university, invited young people (aged between 18 and 25) who suspected they were depressed to be involved in the research. These posters offered interested individuals twelve free Process-Experiential Emotion-Focused (PE-EFT) counselling sessions in exchange for their involvement in the research. Potential client/participants needed to exhibit moderate to severe levels of depression, as assessed by the Beck Depression Inventory (Beck & Steer, 1987; Beck, Steer, & Brown, 1996) and the Depression, Anxiety, Stress Scales (Lovibond & Lovibond, 1995). Due to its low-grade and often transitory nature, mild depression would not provide a true representation of the clinical depression that presents in therapy settings. In addition, individuals with only mild depression are unlikely to seek out therapy.

Over a period of six months only four young women volunteered to take part in the research. All four young women were undergraduate students; two were studying at La Trobe and the other two were enrolled at other tertiary institutions. Their ages ranged from 20 to 26 ( $M = 22.25$  and  $SD = 2.87$ ). Three of the young women lived at home and one lived in shared accommodation not far from her university. Interestingly, two of the young women were the younger of fraternal twins. Three of the four applicants were on prescribed medication. None of the young women suffered exclusively from depression, and I have included a list of comorbid conditions for each young woman in Table 5.3. Note that these are not their real names as I asked each young woman to choose their own pseudonym.

All four young women were students on low incomes and were appreciative of the free counselling service. In addition, one young woman stated her desire “to help someone else as a result of what I have been through.” I encouraged a collaborative attitude within the research and each of the four young women was invited to read the final draft of their case and offer comment (see section on *Ethical Considerations* on p. 128).

Table 5.3. Comorbid conditions of four young women.

Name	Age	Comorbid conditions
Katie	20	<ul style="list-style-type: none"> <li>• Eating disorder – suspected anorexia</li> <li>• Chronic fatigue</li> <li>• Panic attacks – managed by Aropax medication</li> </ul>
Ava	23	<ul style="list-style-type: none"> <li>• Panic attacks – managed by Zoloft antidepressant medication</li> </ul>
Sarah	21	<ul style="list-style-type: none"> <li>• Bulimia type symptoms</li> <li>• Vestibultis – painful intercourse – managed by Allegron antidepressant medication</li> </ul>
Chloe	26	<ul style="list-style-type: none"> <li>• Anorexia – managed</li> <li>• Vestibultis – painful intercourse</li> <li>• High levels of Anxiety</li> <li>• Other <ul style="list-style-type: none"> <li>○ Irritable Bowel Syndrome,</li> <li>○ Endometriosis,</li> <li>○ Polycystic Ovaries</li> </ul> </li> </ul>

## Measures

As mentioned earlier my choice of measures was primarily guided by Elliott and Zucconi, (2005, 2006, e.g. HAT, CI, WAI-S). However, in my endeavour to provide multiple sources of evidence, I chose other inventories as well because no single measure can capture all elements of the sought-for change during therapy (Kazdin, 1999, 2003). The Beck Depression Inventory (BDI-II, Beck & Steer, 1987; Beck, Steer, & Brown, 1996) and the Depression, Anxiety, Stress Scales (DASS, Lovibond & Lovibond, 1995) were utilised initially as screening instruments and as diagnostic tools to determine the presence and level of depression. Anxiety often exists comorbidly with depression and the DASS also provided a measure of anxiety and stress. The BDI-II and DASS inventories were then readministered as repeated measures during and after therapy to track treatment effects and to assess outcome. The Profile of Mood Sates (POMS) was included as an additional source of evidence because of its ability to assess mood changes produced by psychotherapy techniques

(McNair, Lorr, & Droppleman, 1992). The BDI-II, the DASS and the POMS provided a means of cross checking self-reported depressive symptoms.

The Helpful Aspects of Therapy (HAT) form (Llewelyn, 1988) was used to pinpoint significant therapeutic processes that may be associated with change on a sessional basis. The Change Interview (Elliott et al., 2001) was used to obtain clients' understanding of what had changed in therapy and how those changes were perceived to have come about, including factors that had interfered with change. Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) was included in the series of measures as simple means of identifying the strength of the working alliance throughout the therapeutic journey.

Despite particular measures not meeting the criteria of positivist reliability they can still have important meaning and value (Fishman, 1999). For example, the Concern Rating form (see Table 5.4) taken from the Simplified Personal Questionnaire, a scaled measure developed by Elliott and associates (1999), has been incorporated into this research design to allow clients to define the issues they wish to work with in counselling and to indicate the duration of those concerns (see Table 5.5). Within the Change Interviews those highlighted concerns are monitored and rescaled at regular intervals to determine whether changes had occurred over time (see Table 5.6). Establishing a list of concerns and goals for therapy provided an opportunity for me to shift the emphasis away from symptom reduction to a more holistic approach of assessing what was important for the client/participant and how a change in that concern might make a difference in their wellbeing. I have listed the measures of data below not in order of importance to the overall study but in the order they appear in the procedure.

### **Beck Depression Inventory - second edition (BDI-II).**

The BDI-II (see Appendix D) is a 21-item self-report that assesses the severity of depressive symptomatology in adolescents (13+) and adults (Beck & Steer, 1987; Beck et al., 1996), not only in psychiatrically-diagnosed patients but also in normal populations (Beck, Steer, & Garbin, 1988; Steer, Beck, & Garrison, 1986). The BDI has been described as the most widely used self-report instrument for measuring depressive symptom severity in both research and clinical settings (Nezu, Ronan,

Meadows, & McClure, 2000). Its role in this research was to act as a screening tool and a means of assessing the levels of depression at regular intervals throughout the counselling, thus providing an indicator of client change. The BDI-II has been found to demonstrate high internal consistency among college students ( $\alpha = .93$ ) and among clinical outpatients ( $\alpha = .92$ ; Beck et al., 1996). Validity coefficients were reported by Beck, Steer, and Garbin (1988) as ranging from .66 to .86. Participants are asked to choose one statement from among the group of four statements in each question that best describes how they have been feeling during the past two weeks, including that day. Scores of 10 and above are regarded as symptomatic of depression as diagnosed using the DSM-IV-TR.

### **Depression, Anxiety and Stress Scale (DASS).**

The DASS (see Appendix E), a 42-item self-report measure developed in Australia, is a set of three self-report scales designed to measure the negative emotional states of depression (D), anxiety (A) and stress (S), in older adolescents (17+) and adults, using a dimensional approach (Lovibond & Lovibond, 1995). The scales of the DASS have been shown to have high internal consistency and to yield meaningful discriminations in a variety of settings. The internal consistency of the DASS Scales in a sample of clinical and nonclinical volunteers was calculated, and the Cronbach's alphas for the DASS Depression, Anxiety, and Stress subscales were .97, .92, and .95, respectively (Antony, Bieling, Cox, Enns, & Swinson, 1998). The DASS has a high reliability and exhibits high convergent validity with other measures of anxiety and depression in both clinical and community samples (Brown, Chorpita, Korotitsch, & Barlow, 1997; Crawford & Henry, 2003). Participants were asked to use a 4-point scale to rate the extent they had experienced each state within the past week. Raw scores on the DASS can serve as guidelines for understanding symptom severity: normal (0-9), mild depression (10-13), moderate depression (14-20), severe depression (21-27) and extremely severe (27+). I have used multiple measures for assessment of depression because according to Kazdin (2003) no single measure can capture all the components and each measure can contribute to the interpretation. The DASS was used as a means of triangulation with the BDI-II. The DSM-IV diagnosis for the four young women

was Mixed Anxiety-Depressive Disorder and so it is advantageous to assess anxiety levels as well as depression.

### **Profile of Mood States-Short Form (POMS-SF).**

The POMS, (see Appendix F), is a 65-item, rapid, economical method of assessing transient, fluctuating active mood states for individuals eighteen years of age and older. The variables measured, derived from factor-analysis, include mood disturbance across six domains; *fatigue-inertia*, *vigor-activity*, *tension-anxiety*, *depression-dejection*, *anger-hostility*, and *confusion-bewilderment*. The POMS was used in this study in an attempt to assess distinct depressive mood states and to examine alterations in those depression states across sessions and at the end of therapy. Because depression was my main focus I administered the full inventory but only commented on data from that domain, which included 15 items from the depression-dejection scale. Alpha coefficient and other analyses have found the POMS to exhibit a highly satisfactory level of internal consistency, with Cronbach's alpha ranging between .63 and .96 for the POMS subscales, and between .75 and .92 for the total score (McNair et al., 1992). Construct validity has demonstrated that the POMS Depression scale correlated significantly with the BDI ( $r = .69$ ) and discriminant validity was shown in that the POMS scales were consistently more highly related to corresponding measures of mood ( $r = .666$ ) than non-corresponding mood scales ( $r = .495$ ; Nyenhuis, Yamamoto, Luchetta, Terrien, & Parmentier, 1999). Participants were asked to rate each item on a 5-point Likert scale based on how they were feeling *during the past week, including today*.

### **Concern ratings.**

I adapted a procedure outlined by Elliott et al. (1999) to simplify the process of identifying client concerns. Initially, the client and I undertook a mini brainstorming session generating as many potential items as possible. I then assisted her to clarify the items, rephrase and revise the problems to be more succinct. The refined items were then further discussed with the client to make sure that the list reflected her chief concerns. Ideally the terms should be present problems or difficulties, and should be worded "I feel," "I am," "I can't," "my thinking," and so on. The list should also reflect

specific difficulties the client wants to change through therapy and be in the client's own words. I wrote down the items, and then asked the client if anything had been left out, adding further items as needed, until the client felt that the list was complete. After the prioritizing, I then asked the client to rate how much each problem had bothered her during the past week. These ratings become the client's initial baseline score for the Concern Ratings, which were then revisited at each Change Interview where ratings were revised.

Table 5.4 provides a proforma for the Concern Ratings that each client highlighted in the screening interview (see *Procedure* section on p. 118), taken from the Simplified Personal Questionnaire (PQ) developed by Elliott, Mack and Shapiro (1999). This list is an individualised change measure, usually consisting of about ten problems that the client would like to work on during therapy. The items generated were those most important in the client's view. According to Elliott, Mack and Shapiro (1999), the reliability and validity of this measure are acceptable (mean inter-item reliability: .82; one-week test-retest reliability: .77; convergent validity with other measures of client distress typically ranges from .4 to .6). A study by Wagner (2003) identified that individualised measures such as the PQ measure different facets of change from nomothetic instruments, and that one outcome measure is not sufficient to measure the full spectrum of change that occurs across treatment.

Table 5.4. Concern ratings\* at screening interview.

Concerns	Not At All	Very Little	Little	Moder- ately	Consid- erably	Very Consid- erably	Maxi- mally

Note: \* scale from 1 being not all to 7 for maximum possible.

### **Duration of concerns.**

In addition to developing the list of concerns it was useful at to find out how long each problem had bothered the client using the Duration of Concerns form (see Table 5.5). This can help establish a retrospective baseline. At the time of the screening interview

I asked the client to rate how long each of the listed problems had bothered them. This duration of concern ratings form was developed by Elliott, Mack and Shapiro (1999) and again was part of the Simplified Personal Questionnaire (see above).

Table 5.5. Duration of concerns\* at screening interview.

Concerns	less than 1 month	1 – 5 months	6 – 11 months	1 – 2 years	3 – 5 years	6 – 10 years	more than 10 years

Note: \* scale from 1 being less than 1 month to 7 for greater than 10 years.

### **Helpful Aspects of Therapy (HAT) Form.**

The HAT Form (Llewlyn, Elliott, Shapiro, Hardy, & Firth-Cozens, 1988, see Appendix G) is a commonly used (see McLeod, 2010) brief, open-ended questionnaire completed by clients immediately, or as soon as possible after each session, preferably within 24 hours (Elliott et al., 2001). Such a questionnaire can be used to pin-point significant therapeutic processes that may be associated with change on the weekly outcome measure or to corroborate change processes referred to in later qualitative interviews. Clients are asked to describe in their own words the most helpful event in the session, and to rate how helpful it was. This seven-item questionnaire addresses the following areas of interest to the researcher; (1) the nature of the most *significant event*, (2) the reason it was perceived as helpful, (3) how helpful the event was, (4) where in the session the event occurred, (5) the approximate length of the event, (6) the nature of any other significant event (including a rating of helpfulness), and (7) the nature of any hindering event, if present (including a rating of hindrance).

A number of versions of the HAT exist but the version cited in Appendix G was chosen as not only was it recommended by Elliott et al. (2001) but it identified the most helpful *significant event* rather than the overall helpfulness of the session. The HAT is a relatively simple and efficient means of soliciting information from clients.



### **Working Alliance Inventory (WAI) – Short Form (WAI-S) Client Version.**

The concept of the working alliance is considered by Bordin (1979) to have three components; agreement on *goals*, consensus about the *tasks*, and the existence of a positive affective *bond*. The working alliance, common to nearly all therapeutic relationships, is conceptualised in this measure as the combination of (a) client and therapist agreement on goals (Goal), (b) client and therapist agreement on how to achieve the goals (Task agreement), and (c) the development of a personal bond between the participants (Bond). The WAI (Horvath & Greenberg, 1989) is one of the most commonly used inventories that assesses working alliance (see McLeod, 2010), and can be administered after the third or fourth session and at completion of therapy. It is a 36-item self-report instrument designed to assess these three related dimensions of the working alliance.

I chose the shorter version for this research because of potential savings in time and the ease of completion. The short form of the WAI (known as the WAI-S, see Appendix H) has 12 items and exists in two parallel forms, one each for counsellor and client. Only the client version was used. Busseri and Tyler (2003) were able to establish that the WAI-S is interchangeable with the full scale version by displaying comparable psychometric properties. Internal consistency estimates for client and therapist WAI-S subscales and total scores have been shown by Busseri and Tyler (2003) to be high with alphas ranging from .83 to .98. In summarizing the findings of various studies that tested the convergent and discriminant validity of the WAI, Horvath and Greenberg (1994) concluded that the relationship between the WAI and other non-alliance measures is lower than relationships between the WAI and other alliance measures. Each of the 12 items is rated in a 7-point scale, on which the lowest polarity is labelled (1) *never* and the highest polarity is labelled (7) *always* (Tryon & Kane, 1993). Total scores range from 12 to 84 with higher scores indicating a stronger working alliance

### **Change Interview (CI).**

The Change interview (CI; see Appendix I) is a 30-60 minute qualitative interview that can be administered at the end of therapy, or at predetermined intervals throughout or adapted for use as a follow-up measure. The CI was developed by

Elliott in 1996, revised in 1999, and published in 2001. It seeks three main kinds of information; (a) what the client sees as having changed over the course of therapy, (b) to what the client attributes those changes, (c) and helpful and non-helpful aspects of therapy (Elliott et al., 2001). Its purpose is to obtain clients' understanding, in their own words, of what has changed and how those changes have come about, including factors that have interfered with change. The CI highlights changes that may be missed by traditional questionnaires (Elliott et al., 2001).

The CI has been developed as an alternative to both randomized clinical trial designs and behavioural single case designs (Elliott et al., 2001). Such an interview can be used to help provide insight into the quantitative data, and can easily generate both general outcome and process information. Instead of using experimental manipulation and random assignment to rule out alternative causal factors and to pinpoint the sources of change, the CI elicits client narratives and causal attributions regarding therapy (Elliott et al., 2001). For some clients the CI may be distressing but the process of guiding clients in an open and exploratory way can also potentially allow them to assimilate their therapeutic work as well as providing a useful opportunity for researchers to understand change from a client's point of view.

Elliott et al. (2001) embedded a general framework in the interview that allows researchers to access clients' explanatory models of the change process in therapy and outside. During the Change Interviews within this study the client was also invited to complete a Concern Rating form as seen in Table 5.6, a form that adds categories to the version used in the screening interview (Table 5.4). The client was asked to reflect on whether a change had occurred since the last rating, whether the change was expected or not and whether the change would have occurred with therapy or not. In addition the importance of the change was also rated. A slightly modified version was used when assessing whether changes that had occurred in therapy were still evident at 6 and 12-month follow-up interviews.

Table 5.6. Concern ratings for client at session 4, 8 and 12  
and at 6 month follow-up\* including change expectations and importance\*\*.

Concerns	Before	At S-4	At S-8	At S-12	At 6-mth	Change was: 1 expected 3 neither 5 surprised by	Without therapy: 1 unlikely 3 neither 5 likely	Importance: 1 not at all 2 slightly 3 moderately 4 very 5 extremely
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Note: \* scale from 1 being not concerned all to 7 for maximum possible; \*\* scale from 1 to 5.

## Procedures

### **Counselling approach.**

The intervention used in this research was a course of Process-Experiential/Emotion-Focused Therapy (PE-EFT), described in the manual written by Elliott, Watson, Goldman, and Greenberg, (2004) entitled *Learning emotion focused therapy: The process experiential approach to change*. The development of PE-EFT, together with the underlying theoretical principles, has been explained in detail in Chapter 3.

### ***Adherence to the PE-EFT model.***

#### *Experiential Therapy Session (ETS) form.*

As a means of assessing competency in the PE-EFT method, Elliott (2002a) developed a set of checklists he entitled the Experiential Therapy Session (ETS) Form (see Appendix J). The form is a 20 page post-session self-report measure for assessing therapists' views of their use of the PE-EFT approach. Completing the form enables a practitioner to critically evaluate their performance in a PE-EFT counselling session or series of sessions (Elliott, 2002a). The form is divided into seven sections.

In the early stages of my training I used this form frequently as we attempted to show competency in the facilitation of PE-EFT tasks. I consistently reached a high level of task resolution and skilful facilitation of the task/s indicated. I have chosen not

to use this form to a great extent in my assessment of my sessions in this research because it is quite time consuming and would generate a great deal of extraneous data. However, I have used the items for *Client Modes of Engagement* to comment on my clients' processing. This ETS section ranks the extent to which the client was engaging in each of the modes of engagement during the session. These modes of engagement include the client's degree of attending, whether processing is at a purely conceptual or somatic level, assessment of avoidance of painful feelings or experiences, ability to internally attend to and examine unclear internal experiences, ability to express emotions actively, interpersonal contact, self-reflection and emergent action (see Elliott, 2002a). I also drew from it when I developed the observer checklist that was used to assess adherence to the PE-EFT model (see below).

*Observer checklist for validation of adherence to PE-EFT.*

I used the manual for PE-EFT (Elliott, Watson, Goldman, & Greenberg, 2003) and the Experiential Therapy Session (ETS) Form (see above) to develop a checklist (Appendix K) to use as a guide for assessing my adherence to the PE-EFT model. I asked Dr George Wills, my original principal supervisor and an expert PE-EFT practitioner, to view the video-taped recordings of my counselling work with the four young women and report on my adherence to the model. Dr. George Wills selected to watch the first 10 minutes, a mid 10 minutes and the final 10 minutes of the 50 videotaped sessions. He then provided me with an overall assessment of how adequately each task or intervention was adhered to for each client. Dr Wills' assessment of this is present in the Discussion (see Chapter 10, p.363).

**Procedures of data gathering**

I conducted a Screening Interview (see Appendix L) to determine the suitability of each applicant. A brief autobiographical history was taken and presenting symptomatology was identified as characteristic of depression by utilising the DSM-IV-TR (American Psychiatric Association, 2001) criteria. During the screening interview personal descriptors were elicited and areas of concern listed (see Appendix L). Levels of depression were ascertained by asking the young woman to complete a Beck Depression Inventory – second edition (BDI-II; see Appendix C) and

a Depression, Anxiety Stress Scale (DASS; see Appendix D). The selection criteria required each young person to exhibit moderate to severe levels of depression and to be aged approximately between 18 and 25. If a young person had presented with a more severe form of mental illness (e.g. schizophrenia) they would not have been included in the study but referred to the student counselling service at La Trobe. Only four young women offered to be part of the research, and contributed by completing questionnaires, allowing videotaping of their sessions and taking part in interviews. The suitability of each applicant is documented at the beginning of each case study in order to make it easier to observe the changes (if any) measured by both the quantitative measures and qualitative assessments across the period of treatment.

At the screening interview each client/participant received a copy of the Participation Information Sheet to read (see Appendix M). This letter provided the young woman with relevant information needed to provide informed consent for participation. Ethical considerations were also discussed with her to ensure a full understanding. The young woman was encouraged to ask questions about procedures and her commitment to the research. Once she was fully informed she was asked to sign the Consent Form (see Appendix N), and I kept these signed forms.

I also collected descriptive background information at the screening interview, including age, ethnicity, educational background and occupation, and asked the client to consider what issues she wanted to work with in counselling. These were listed on the Concern Ratings form (see Table 5.4). The duration of these concerns was also noted (see Table 5.5).

Each young woman then underwent a minimum of twelve PE-EFT counselling sessions in which I was the therapist. Counselling sessions took place within the university in rooms normally designated to student-practitioners of a Communication Disorder Clinic. The therapy sessions were video-taped with consent from the participants, and I viewed these at a later date as an aid to remembering significant events within the therapy and to assist in the write up of each of the case studies. Dr George Wills also reviewed these tapes in order to ascertain whether I had adhered to the PE-EFT Model.

At the conclusion of each session the client was asked to complete a Helpful Aspects of Therapy (HAT) Form (see Appendix G). The Profile of Mood States

(POMS; Appendix F) was administered every second session. At the completion of session 4 (and each subsequent 4th session), in addition to the HAT, clients were asked to complete the Short Form of the Working Alliance Inventory (WAI-S; see Appendix H) and take part in a 30-60 minute Change Interview (CI; see Appendix I). Change interviews typically are best carried out by a third party and in this case were conducted by my principal supervisor at the time Dr George Wills. These interviews were videorecorded and digitally voice recorded for later transcription. Permission for his involvement was contained in the Informed Consent Form (see Appendix N). The Concern Rating form was also completed at this time (see Table 5.6). The inventory administration schedule is summarised in Table 5.7.

Each client received a minimum of twelve one-hour sessions either weekly or fortnightly. If the client required more sessions this was made possible (see *Ethical Considerations*, pp. 128-128). Two clients requested and were offered extra sessions. Katie received a further six sessions and Ava two extra. If a client/participant had wished to cease participation prior to the 12 sessions, all efforts would have been made to find alternate therapeutic assistance. This never occurred. The BDI and the DASS were administered at session 6 and at the completion of therapy. There was a follow-up interview at six months in three cases and at twelve months for Ava who was unavailable earlier. The depression inventories, the POMS and the Concern Ratings form were re-administered and an adapted Change Interview was conducted at the follow-up sessions. See Table 5.7 for the inventory administration schedule.

Table 5.7. Inventory administration schedule.

Screening	I hour				
P Info Sheet Consent Form BDI-II DASS POMS	Concern ratings Duration of concerns				
Session 1	Session 2	Session 3	Session 4	Session 5	Session 6
HAT	HAT POMS	HAT	HAT POMS WAIS-S Concern ratings	HAT	HAT POMS BDI-II DASS
10 mins	20 mins	10 mins	25 mins	10 mins	40 mins
CI – 1hour					
Session 7	Session 8	Session 9	Session 10	Session 11	Session 12
HAT	HAT POMS WAIS-S Concern ratings	HAT	HAT POMS	HAT	HAT POMS WAIS-S BDI-II DASS Concern ratings
10 mins	25 mins	10 mins	20 mins	10 mins	45 mins
CI – 1 hour					CI – 1 hour
6 months Follow-up	12 months Follow-up				
BDI-II DASS POMS Concern ratings	BDI-II DASS POMS				
Adapted CI – 1 hour					

## **Methods of Statistical and Qualitative Analysis**

### **Use of quantitative inventories.**

Descriptive statistics were calculated on the age demographic data. Given that quantitative data was only taken from four individual cases, concerns about high type II error rates suggested that inferential statistical analyses, examining changes over time and so on, were not appropriate. As noted previously, the BDI-II and the DASS were used to assess the levels of depression. The pre-therapy scores were recorded for comparison with scores obtained during therapy, at therapy completion and at six-month and twelve-month follow-ups in order to ascertain the impact of therapy on symptoms. Descriptive data on Anxiety and Stress from the DASS were also calculated. The data collected from these inventories were reported in tables within each case study. The descriptive POMS data were calculated and graphically represented. Concern Rating data taken at the screening interview, during therapy, at therapy completion and at follow-up interviews were also analysed. Changes, either in a positive or negative direction, were ranked for each young woman and these rankings were tabulated. Each change was identified as being expected, or not, and it was noted whether in the client's view that change was likely or unlikely as a result of therapy. Each concern was ranked at the level of importance. This data and the change attribution data were tabulated. The assessed Working Alliance reported by each young woman was tabulated and documented within the case write-up.

### **Systematic case studies.**

To examine the therapeutic journeys of the four young women I undertook systematic case studies. I analysed the data from each videotaped session together with notes written at the end of each session. During the write up phase of the analysis (stage 1) I viewed each session and accurately transcribed large portions of the interview and took extended notes. Truthful representation of the sessions was an important consideration. This process of viewing and transcribing could take up to five hours for each session. I observed and recorded nonverbal body communications and made process observations. The full session was then documented in an abridged form that



included actual quotes (stage 2). This process could take up to three hours per session. However, despite carefully selecting what to include, I found the write-up of each session became quite lengthy and detailed. Therefore, summaries of each session were made (stage 3). The aim of the summary was to provide the reader with an accurate account of the core aspects of the session but to remove repetitive or less significant interactions.

This process of working through these stages of the analysis, whilst time consuming, enabled my immersion into the experience of each young woman within each session. Through this, and my experiential knowing via direct encounter and empathic resonance in the therapy, I endeavoured to articulate the reality of each young woman. In 1987 Rogers in an interview “On the use of self in therapy,” acknowledged “I do use myself [in therapy]” (M. Baldwin, 1987a; p. 35), and I was aware that I was using myself as an instrument of the therapy and of the research. I found watching the sessions challenging because I was so attuned to their experience that I was able “feel” their pain and anguish as I viewed each tape-recording. My analysis of the sessions was checked against the views of the young women who at the end of each session had been asked to comment on what they found helpful or hindering in the session. The qualitative data obtained from these HAT comments were added to the end of each session summary.

Dr George Wills conducted 30 to 60 minute Change Interviews with each young woman after sessions 4, 8 and 12 and the follow-up interviews. These interviews asked questions about changes that each young woman may have noticed as a result of therapy, and about what outside influences they thought might have contributed to those changes. Answers to those questions and questions about what the young women found challenging, difficult or painful within the therapy were also included in the write-up of each case via a thematic analysis of change (see Themes of change below). I viewed these interviews quite soon after they were conducted but had them transcribed by a professional transcription service. No identifying information was included in the final transcripts. In essence they did not influence the way I worked with the young women. However, if there had been reports of dissatisfaction I would have discussed this with my supervisor and made appropriate alterations to my style as necessary.

The personal descriptors the young women had been asked to provide at the time of the screening interview, and to review at each Change and follow-up interview, were also examined. The comments made by each young woman were directly quoted or summarised and located at appropriate intervals within the write-up of each case.

As part of my analysis I used emotion schemes, the hypothesised constructs of ways of organising experience that include the clients' perception of their situation, their motivational processes, their symbolic representation and their bodily expression. I utilised a template (see Figure 3.1, p. 57) taken from Elliott et al. (2004) to represent the emotion scheme of each young woman pictorially. These charts are included in the case study write-up with an explanation of their derivation.

### **Themes of change.**

Themes of change were elicited from the qualitative data taken from the semi-structured Change Interviews and from the adapted follow-up Change Interview conducted at six-months post-therapy in three cases and at twelve-months in the other, when each young woman was interviewed a total of four times for about 30 to 60 minutes. In order to elicit propositions about the changes that occurred as a result of therapy from the four young women's perspectives, I utilised a method of thematic analysis based on the "Listening Guide" of Gilligan, Spencer, Weinberg and Bertsch (2006).

The listening guide is a method of psychological analysis that attends to *voice* as a way to discover the inner world of another. It was developed in part as a response to a growing dissatisfaction with the coding themes used to analyse qualitative data (Gilligan et al., 2006). Through a series of sequential *listenings* the researcher attempts to tune into the *multilayered voice* of the speaker. The first step of the listening guide is listening for the *plot* via number of listenings. In the second step, the researcher listens to the "I" who is speaking, and the third step of the listening guide attempts to locate the contrapuntal voice. The transcript can be read through or audio recordings can be listened to. I utilised a variation on the first and third levels of this analysis.

The CI already had a structure built-in and so the process involved listening to the answers of three questions asked within the interviews. These three questions were chosen because they were they mapped onto the original research questions and were

questions already asked within the CI. The questions were asked in a number of different ways within the CI but I chose the following format of the three questions to assist me locate the themes of change while I listened.

1. What changes do you attribute to therapy?
2. What was missing, hindering, or painful in the therapy?
3. What outside events could explain the changes?

I listened to the digital audio files and at the same time read the transcripts of these interviews.

When I listened to the second and third question I was careful to notice what was difficult in therapy and the positive outside influences that may have facilitated change. I was careful not to dismiss or overlook these comments because of my bias towards finding a good outcome from therapy. This stage was like listening to the *contrapuntal* voice of the Listening Guide.

As I listened and read I highlighted the text and copied it to another document. I was left with a rather disjointed documentation of the themes for each interview. The final analysis pulled together what had been heard and read and consisted of brief summations and direct quotes highlighting each young woman's experience of change including what they found difficult. These summations were located at the appropriate intervals within the case report.

### **Clinical significance.**

Clinical significance refers not only to the assessed quantitative change as a result of an intervention but to whether that intervention makes a real difference in the everyday life of the recipient (Kazdin, 1999, 2003). It evaluates aspects of treatment that are not captured by more commonly used methods of evaluation. Table 5.8 highlights several methods that have been suggested by Kazdin (2003) to measure clinical significance. I used multiple measures of a depression for example because according to Kazdin (2003) no single measure can capture all the components and each measure can contribute to the interpretation. I followed the suggestion of Kazdin (2003) and included the comparison method, absolute change and subjective

evaluation that have been used to establish clinical significance because I had the appropriate data to comment on these constructs. A systematic enquiry into social impact wasn't factored into the original research design but if comments about social impact were reported by the young women, I have included them in the analysis.

According to Kazdin (2003), the comparison method is widely used within intervention studies. It examines whether post-treatment clients are no longer distinguishable from (or are within the range of) a normative well-functioning sample (Kazdin, 2003). In other words, clinical significance might be inferred from changes reported in the repeated assessments at pre- and post-treatment. I have utilised the BDI-II and DASS as a repeated measure assessment of depressive symptomatology. However, the normative data from standardised samples are rarely based on the scores of individuals tested on two separate occasions. Therefore, scores at post-treatment are not necessarily comparable to the data obtained in community samples (Kazdin, 2003). Ideally, a control study could handle this ambiguity. Fortunately, however, it is still possible, according to Kazdin (2003), to interpret clinical significance without a control group. Such interpretation depends on the extent that other criteria impact on the client's functioning in everyday life or the achievement of a change that makes a practical difference. These criteria include assessing absolute change and /or utilising subjective evaluation.

Table 5.8. Primary means of evaluating clinical significance of change in intervention studies.

Type / Method	Defined	Criteria / Measures
1. Comparison method	Client performance is evaluated in relation to the performance of others (e.g. normative sample, patient sample)	<ul style="list-style-type: none"> <li>• Similarity to normative samples at the end of treatment</li> <li>• Dissimilarity to a dysfunctional sample.</li> </ul>
2. Absolute change	Amount of change the individual makes without comparison to other people or groups	<ul style="list-style-type: none"> <li>• Amount of change from pre- to post treatment</li> <li>• No longer meeting the criteria for a psychiatric diagnosis</li> <li>• Complete elimination of the problem or symptoms</li> </ul>

Type / Method	Defined	Criteria / Measures
3. Subjective evaluation	Impressions, judgments, opinions of the client or those who interact with client that a change is clearly important and makes a difference in everyday life	Ratings of <ul style="list-style-type: none"> <li>• Current functioning</li> <li>• Whether the original problem continues to be evident or to affect functioning</li> <li>• Whether the change or changes produced make a difference</li> </ul>
4. Social impact	Change on a measure that is recognised or considered to be critically important in everyday life	Change reflected on behavioural measures e.g. days missed from work etc.

Source: Kazdin (2003).

The extent of change according to Kazdin (2003) is the “most striking characteristic of the meaning of clinical significance” (p. 695), yet clinical significance can occur whether the measured change in symptoms has been large, medium or not at all. By this somewhat confusing statement, Kazdin (1999, 2003) means that any amount of change that is acknowledged by the client and has some practical value thus might be clinically significant for that client. For example, for severely depressed and suicidal clients, who have been hospitalised, one significant indicator of improvement might be for them to return to everyday functioning despite their symptoms still being discernible. For a client who is less severely depressed a small change in symptoms may be meaningful for them. In some cases change in symptoms may not be possible but assisting clients in terms of coping with their symptoms or improving their quality of life may have an important impact. In my research Concern ratings were listed by each young woman and the degree of change was charted after Sessions 4, 8 12, and at follow-up interviews.

The determination of clinical significance was also established by subjective evaluation. In psychotherapy research, emphasis on symptom change may reflect the perspective of the investigator and may not actually reflect what is important to the client. The perspective of the client has not been well attended to in the evaluation of clinical significance (Kazdin, 1999, 2003). Actual or perceived change may be useful constructs to consider. Clients may retain their symptoms but may feel “better.” The

Change Interviews conducted after Sessions 4, 8, 12 and at follow-up interviews asked specific questions about whether change/s had occurred, the degree of noticeable change/s and whether change/s could be attributed to the therapy they had undergone.

## **Ethical Considerations**

After two minor amendments requested by the La Trobe Faculty of Human Services Human Ethics committee I received approval for this research in February 2007. The usual provisions for confidentiality of data and respecting client autonomy were adhered to in this study and the client-provided informed consent (see Appendix M and N).

Usually, counselling or psychotherapy is a private exchange. However, in the write-up of a case study a great deal about the process and the client's life and relationships is exposed, so "case studies involve a higher degree of moral risk than other research methodologies... for a client in a case study his or her *life* is being examined..." (McLeod, 2010). p. 54).

McLeod (2010) offers a set of guidelines for good ethical practice in research. These include adherence to the practice and research Code of Ethics of the professional groups to which the authors are affiliated. The researcher needs to make the procedures transparent to participants and state them clearly within the information. There should be informed consent initially, regular ongoing process consent, external scrutiny, the opportunity for the client to read the report and stipulate deletions or disguising for confidential purposes, and the provision of ongoing support for both client and therapist.

Fishman (2004), the editor of the online journal *Pragmatic Case Studies in Psychotherapy*, advises on ways for potential authors to protect the privacy of those clients presented in case studies. Reasonable steps must be made to disguise the identity of the client by changing the client's name, age, profession, ethnicity, educational status, and religion. It is suggested that the degree of such changes needs to separate those factors that are crucial to the clinical reality of the case from factors that are more peripheral.

My profession of psychology in Australia is bound by a Code of Ethics built on three general ethical principles: A. Respect for the rights and dignity of people and peoples, B. Propriety and C. Integrity (Australian Psychological Society, 2007). Confidentiality falls under Principle A.5. In this study, in order to ensure confidentiality was maintained, the names of the young women who volunteered and of their friends and family were changed and the young women chose their own pseudonyms. Other obviously identifying pieces of information have also been changed or omitted, such as residential locations, family history, and certain identifying events and medical conditions. I have also taken care to remove some criticism of family members and any other disclosed information that might be disrespectful or could be potentially misunderstood.

By encouraging a participatory and collaborative approach to the collection of data and the documentation of the young women's experiences I believe I have minimised the likelihood of identifying information remaining in the case reports. I gave each young woman an opportunity to read a draft of their case and have offered to remove any material they thought might cause them difficulty. This assessment of testimonial validity checks for both factual accuracy and interpretative sensitivity.

An ethical consideration I would like to acknowledge was the tension between my role as a person-centred therapist who is committed to a real relationship with my client, and my somewhat more instrumental relationship as the researcher who required them to fill out instruments, give feedback etc. I had to be mindful of the responsibilities that arise from being in therapeutic relationships with my clients. I was fortunate that none of the young women refused to complete any of the questionnaires but I was aware that if it came to a conflict between the welfare of the young women and my research agenda I would have chosen to be supportive of my client.

The issue of extending the counselling time frame was an example of the tension between my researcher and therapist roles. By the end of the study, one of my client/participants had made significant progress in relation to reducing her levels of depression and anxiety but still struggled with other ongoing issues. In June 2007 I decided to ask the ethics committee to allow an extension of the counselling so that I could continue to see clients who wanted this. I intended to follow a similar regime of

video-taping and inventory completion and would allow the client to continue therapy in 4 session blocks until they no longer felt they wanted to continue. This was agreed to by the committee. One young woman received a further six sessions and another two extra, but I no longer counselled any of the client/participants within the research setting by the end of 2007. At the end of 2008 however, one of my client/participants sought me out and asked to enter therapy as one of my private clients. I agreed. I became a fully registered psychologist at the end of 2008 and she continued to see me intermittently over six months. When I agreed to see this young woman privately I had not realised that she would still be with me as a client at the point where I was asking her to check her case study and veto anything she wanted removed. However, when I approached her she was very happy to read it and offered to edit it as well. She assured me she would feel free to challenge or disagree with me, or assert her needs.

The idea of exploiting clients for the therapist's professional gain was something that other researcher/therapists have struggled with (McLeod, 2010). Writing up case studies for publication can also have a significant impact on the therapist (McLeod, 2010). For practitioners to reveal themselves in what they write in such a public and formal medium can also be confronting and even agonizing. I was reassured that McLeod flagged these areas of potential impact because I too have found revealing myself as a researcher/practitioner has been particularly difficult and challenging as was the role of using my clients as research participants with the aim of obtaining my doctorate..

## **Criteria for Evaluating this Study**

Validity and reliability are the measures utilised to evaluate most quantitative research. The standard definition of the validity of a measure is the extent it assesses what it is intended to measure (Shaughnessy, Zechmeister, & Zechmeister, 2000). Reliability refers to the extent to which a piece of research could be replicated and produce the same results (Loewenthal, 2007; Yin, 2009). The concept of reliability also refers to the robustness of an inventory or test and its capacity to provide similar results in different situations or when administered by different people or at different



times (McLeod, 2003). However, the concepts of validity and reliability developed for use in quantitative research cannot be applied in the same way in qualitative studies (McLeod, 2003b).

A number of different criteria for judging the adequacy or plausibility of qualitative research have been offered. Elliott, Fischer and Rennie (1999) published recommendations for qualitative research studies in psychology, and Morrow (2005) examined the concepts of quality and trustworthiness in qualitative research in counselling psychology. In addition, Caulley (1994) sets out a list of the basic characteristics of a valid postpositivist interpretative enquiry. I have chosen to use an abridged version of Caulley's list combined with the recommendations stated in Elliott, Fischer and Rennie (1999) and Morrow (2005) to provide criteria by which the quality of my research can be judged by the reader. "Ultimately, the value of any scientific method must be evaluated in the light of its ability to provide meaningful and useful answers to the questions that motivated the research in the first place" (Elliott, Fisher et al., 1999 p. 216).

The evaluation criteria suggested for my research, and source, are listed below.

### **Researcher reflexivity.**

Through the process of reflexivity the author has an opportunity to disclose her personal values, interests and assumptions together with her theoretical orientation. Despite our best attempts, it is not possible to examine people's perceptions and experiences in a totally unbiased way. Thus, it is important for the researcher to explain how her experiences in and understandings of the world affected the research (Elliott, Fisher et al., 1999). This disclosure of values and assumptions helps the reader to interpret the data presented by the researcher in a way that assists the reader to more fully understand the data in its context and potentially allow for possible alternative explanations (Elliott, Fisher et al., 1999). Whilst making her assumptions implicit and her biases overt by approaching the research reflexively the researcher *always* believes something about the phenomenon in question and needs to question "whose reality is represented in the research" (Morrow, 2005, p. 254).

### **Description and selection of participant sample.**

Providing a selection of information-rich cases for in-depth study chosen by criterion-based sampling; i.e. use of a specific criteria to ascertain inclusion in the study, is a means of identifying that each case has been selected in a purposeful and considered way (Caulley, 1994; Elliott, Fisher et al., 1999; Morrow, 2005). Such purposeful sampling is a strategy used when the aim of a study is to understand something about certain cases without necessarily needing to generalise to all cases (Caulley, 1994).. Participants need to be described in relation to their life circumstances as it aids the reader in judging who or under what circumstances the findings might be relevant (Elliott, Fisher et al., 1999).

### **Adequate amount and quality of evidence.**

Thick descriptions involve giving details of the context and circumstances of a person's experience (Caulley, 1994). Such descriptions provide insight into the complexity of human phenomenon rather than attempting to oversimplify it. They may include narratives, quotes from interviews and/or descriptive statistics and will use any means that best represents that person's perceptions and understandings. The reader needs to be provided with a vicarious experience of the investigated phenomenon which may include patterns, regularities, or discovered themes and generated hypotheses. The reader's resonance enables a sense of the accuracy of the account through deeper understanding and appreciation (Caulley, 1994; Elliott, Fisher et al., 1999; Morrow, 2005)

### **Adequate sources of data.**

The type of data is important and ideally needs to include data from different sources or methods. Adequate evidence is not achieved simply by amount of data and has more to do with how rich the information is and how observant the researcher is (Morrow, 2005). The richness, breadth and depth of evidence/data gathered relies predominantly on the variety of data sources employed (Morrow, 2005). Multiple sources of data can include participant observations through self-report measures and/or interviews, therapist case notes and participant checks. Utilising diverse sources, methods or investigators the qualitative researcher can look for convergence

between data as a check of validity or accuracy. This important way to strengthen a study design through the combination of methodologies within the study is a process known as method *triangulation* (Brannen, 1992; Elliott, Fisher et al., 1999; Fishman, 1999; McLeod, 2003b, 2010; Patton, 1990; Yin, 2009). In addition, the multi-method strategy can be employed to enhance clarity (Brannen, 1992) and if conclusions generated by a number of sources are in agreement the researcher can gain added confidence in what has been found, and the interpretative status of the evidence is enhanced (McLeod, 2003b, 2010; Morrow, 2005). However, triangulation doesn't necessarily ensure validity but can contribute to it (Simons, 2009). Yin (2009) has warned

When you have really triangulated the data, the event or facts of the case study have been supported by more than a single source of evidence; when you have used multiple sources but not actually triangulated the data, you typically have analysed each source of evidence separately and have compared the conclusions from the different analyses – but not triangulated the data. (p. 116).

The criterion of adequate data also involves a deliberate articulated search for disconfirmation while within the research setting, which assists the investigator to question her natural tendency to seek confirmation of her findings (Morrow, 2005). By asking participants whether there were things outside therapy that might provide alternative explanations for the change is one method of identifying disconfirming evidence.

### **Trustworthiness.**

#### ***a. Credibility (internal validity or internal consistency).***

The investigator needs to ensure credibility or vigour has been taken into account in the research process and then effectively communicated to others (Morrow, 2005). Techniques such as prolonged engagement, persistent observation, triangulation, peer debriefing, researcher reflexivity, negative case analysis and member and participant checking increase the credibility of the research (Caulley, 1994; Morrow, 2005).

Credibility is also enhanced by a thorough description of source data and a fit between the data and the emerging analysis as well as by thick descriptions (Morrow, 2005). Prolonged engagement, which refers to a high degree of contact with the participants, provides opportunities to undertake in-depth pursuit of elements found to be especially salient through the engagement, or enables a search for negative instances. Checking both factual accuracy and interpretative sensitivity allows participants to provide input where possible and in doing this checking the researcher needs to honour those contributions (Caulley, 1994; Morrow, 2005).

***b. Transferability (external validity or generalisability).***

Thick descriptive data enables a narrative to be developed about context so that a judgment can be made to determine whether findings in one context could be *transferred* to another. Transferability becomes the aim rather than generalisability in qualitative enquiry. Generalisability considers whether the results of a study can be applied more generally or more widely or are only relevant to the specific context of the study (Morrow, 2005). Whether or not generalisation will be possible is a product of the type of study, the research setting and specific characteristics of the study. An investigator cannot make statements about transferability of her findings based solely on the data collected because the judgment must be made by the person seeking to make the transfer (Caulley, 1994). Thus the investigator needs to provide enough information through the case and its thick description for the reader to make a judgment as to whether transferability is possible for all or part of the findings (Caulley, 1994; Morrow, 2005).

***c. Dependability (reliability).***

Dependability results from the process through which the findings were derived and reported. It is improved by tracking the emergent design, documenting the data collection and maintaining an audit trail. The way in which the study was conducted needs to be as consistent as it can be across time, researchers and the analysis of techniques, in order to render the research as replicable as possible (Caulley, 1994; Morrow, 2005).

***d. Confirmability (objectivity).***

Despite the subjective nature of qualitative enquiries, the researcher's ability to present the data with a certain level of transparency provides the reader with an opportunity to judge the adequacy of the findings (Caulley, 1994; Morrow, 2005). Because research can never be objective the researcher must adequately tie together the data, the analysis and findings in order to preserve integrity of the findings (Morrow, 2005). Many of the procedures used to accomplish dependability are applicable to this study, particularly documenting the data collection and the management of subjectivity are essential (Morrow, 2005).

**The quality of the narrative.**

In qualitative research, the writing is a process of inquiry and interpretation, and the participatory inquiry paradigm raises the question as to whether the resultant constructions are authentic and fair (Guba & Lincoln, 2005). The inquirer needs to ensure that all voices, and differing views or constructions are presented, clarified and honoured in a balanced, even-handed way. In an endeavour to ensure the journey of the client is respected, the researcher needs to provide a rich case description of clients' experiences within therapy. This description can then potentially allow the reader to become attuned to the experience of the client. Ideally the description should provide a sense of the journey through the therapy process. According to Jackson (1998, as cited in Lincoln & Denzin, 2000) the truth of these new texts is determined by "the critical, moral discourse they produce; by the empathy they generate, the exchange of experience they enable and the social bonds they mediate" (p. 180).

I have endeavoured to conduct this research and present this thesis in a way that is congruent with my values and respectful of the young women who courageously shared their journeys with me. Therefore, I would hope this thesis would be critiqued particularly on the authentic representation of our joint experiences and the making of a worthwhile contribution to practice-based research.

## Summary

I am a *bricoleur*. In this study I have used mixed methods to attempt to uncover new insights and re-examine accepted explanations. This theory-informed study incorporates multiple observations collected using both qualitative and quantitative methods from the four young women throughout their journey through the counselling process. The research questions I aim to answer focus on questions about change. Did the young women experience change and is there evidence that therapy was responsible for that change? What processes in therapy might have been responsible for the change?

The choice of measures was primarily informed by Elliott and Zucconi (2005, 2006, 2010) and McLeod (2010). The data were analysed at the level of the individual and conveyed in the form of systematic case studies within the framework of Fishman's (1999) pragmatic case-study design and Yin's (2009) multiple-case embedded design. Themes of change were derived from the interviews conducted with each young woman at regular intervals throughout the period of counselling, and were included within each case. Clinical significance was also determined by the (1) comparison method, (2) assessment of absolute change and (3) subjective evaluation.

## Chapter Six • Case Study 1: Sarah

### Introduction

In this chapter I introduce the reader to the first of the four young women, who has chosen to call herself Sarah for this study. To avoid repetition and to fit the space available, I have elected to present this first case differently from the other three. For Sarah, I have chosen to present detailed narrative descriptions of *four* particularly significant sessions in her therapeutic journey, along with abridged versions of the remaining sessions, as well as the quantitative and qualitative analyses. I have chosen these four sessions because they highlight the moment-by-moment processing of Sarah's experience and how certain elements of my facilitation created opportunities for her to understand that experience more fully. Sessions 1, 2 and 3 were chosen because they show the development of the working alliance and the introduction of the PE-EFT tasks that provided occasions for Sarah to make connections to the possible causes of her underlying depression. I have also included a full session description of session 9 which highlights the use of two-chair work on some of the underlying issues of Sarah's vestibulitis which also, in my opinion, contributed to her depression. The full descriptions of all of Sarah's sessions have been included in Appendix O. The session accounts of the other three cases, Katie, Ava and Chloe, will be presented as very abridged versions in the separate chapters that follow, with the richer descriptions of their sessions placed in a series of appendices (see Appendices P to R).

In selecting a case to present that will yield most in terms of transferability and theoretical impact, McLeod (2010) suggested one option was to choose a typical good outcome or representative case, and this is what I have done. I have chosen Sarah's as the primary case to present because, firstly, her therapy offers an example of a successful outcome for her depression within 12 sessions. Secondly, she presented with a number of diverse co-morbid conditions and achieved positive outcomes across many of her presented concerns. Thirdly, I was able to apply Process-

Experiential/Emotion-Focused Therapy (PE-EFT) in a relatively standardised fashion and this may enhance the transferability of the case.

I have used a chronological format to present Sarah's therapy to you. We begin with the screening interview, where I provide a history of her reported concerns and an assessment of her suitability for the research. I have divided the sessions into groups of four and in each of those sections I describe in detail the issues raised by Sarah, how I journeyed with her empathically and how I was prompted by the PE-EFT markers to implement appropriate tasks. After every four sessions I give the client's and the therapist's reflections on the process of therapy thus far. After sessions 6 and 12 and at the follow-up assessments at 6 and 12 months I include the qualitative assessment of change. Finally, I discuss the clinical significance, the assessment of the working alliance, Sarah's core emotion scheme and other qualitative evaluations.

### **Screening Interview: 27<sup>th</sup> July**

Sarah, 21, was undertaking 4<sup>th</sup> year physiotherapy and had commenced her first placement. Tears filled her eyes as she described how stressed she was. She also worked four or five part-time shifts per week in hospitality and another couple of shifts as a retail assistant. Sarah lived at home with her mother and fraternal twin sister, Gina, and said she and Gina "get on really well... but trying to go out separately recently," because they had always done everything together and were working towards having separate social lives. Their mother was recovering from an operation to remove a cancerous growth. Their parents had separated when the girls were six. Their father lives nearby but they only see him every few months.

Sarah said she had been depressed for the last two to three years. "[It] goes in waves... always feel sad... don't feel there is a reason to feel sad." She had seen a therapist at the end of last year for a few months when she was struggling with issues around her career. "[I] don't think it addressed underlying issues... really liked her... would go back... I was happy for a while but when I stopped going it came back..." Sarah's level of anxiety was apparently dependent on her study workload. She also suffered bulimic symptoms, sometimes gorging on sweet food, eating a packet of "Tim Tams" in a single sitting. Last year she had put on 10kgs but managed to take off the



weight over the summer with the help of the therapist and careful eating. “I feel bad when I’m overweight... bingeing is comfort when I feel bad... [but then I] feel gross.” Sarah does not take recreational drugs and drinks only occasionally.

Sarah said she watched TV for relaxation, as exercise made her feel worse. She didn’t “feel good about my body...” but generally had a good appetite and ate well. Despite being somewhat anxious at night, she slept well. Sarah reported no difficulty concentrating but often struggled when making decisions. “Last year in clothes shops... couldn’t decide... felt so stupid.” Her moods tended to be low midweek, somewhat better by weekends, but she worried about things, often anticipating the worst. She was often irritable especially with her mother. Since Christmas Sarah had noticed she was “going red more than I usually did... everyone’s watching me... just go red... not embarrassed.”

Sarah became sexually active three years ago. Six months later she contracted a urinary tract infection and developed vestibulitis (painful intercourse). Although not in a current relationship, she was being treated by a pelvic physiotherapist and was taking what she believed was an anti-pain medication. During the screening interview I enquired whether she had ever been suicidal and tears welled in her eyes. Last year an event occurred that Sarah didn’t want to disclose that had a massive impact on her. We sat quietly for some time and then she explained that she had been sad before this time but this event complicated things for her. Sarah doesn’t have many friends, as Gina has always been her best friend. Last year she was in a relationship for about ten months and she was “sort of seeing someone” at the time of the screening interview. “I do want one... [but] I don’t want to be in a relationship right now... just can’t... don’t want to date random people.” I asked Sarah to think about herself: “I always think the worst... I haven’t achieved what I want to achieve... if I become successful then someone will value me... if I was successful other things wouldn’t matter.”

Sarah described herself as opinionated, quiet, a no nonsense person, down-to-earth and spiritual. I asked Sarah her main concerns for therapy. These were; feeling ugly, the vestibulitis, not having a partner, feeling depressed, the future, and the flushing. She wanted to worry about things less, wanted to feel like an interesting person, have a more positive outlook, and believe in herself. I briefly explained to Sarah the practical aspects and theoretical underpinnings of Process-

Experiential/Emotion-Focused Therapy (PE-EFT), and gave her details about her research involvement.

Table 6.1 lists Sarah's Concern Ratings for the issues she brought to therapy. Table 6.2 provides the ratings for the duration of the concerns.

Table 6.1. Concern ratings\* for Sarah at screening interview.

Concerns	Not At All	Very Little	Little	Moder- ately	Consid- erably	Very Consid- erably	Max Possible
1. Feeling ugly							7
2. Vestibulitis						6	
3. Not having a partner					5		
4. Feeling depressed						6	
5. Worrying about things							7
6. Future							7
7. Want to feel like an interesting person						6	
8. Want to have a more positive outlook					5		
9. Want to believe in myself						6	
10. Flushing							7

Note: \* scale of 1 being not all to 7 for maximum possible.

Table 6.2. The duration\* of Sarah's concerns at screening interview.

Concerns	< 1 mth	1-5 mths	6-11 mths	1-2 years	3-5 years	6-10 years	>10 years
1. Feeling ugly					5		
2. Vestibulitis					5		
3. Not having a partner				4			
4. Feeling depressed				4			
5. Worrying about things					5		
6. Future			3				
7. Want to feel like an interesting person					5		
8. Want to have a more positive outlook							7
9. Want to believe in myself					5		
10. Flushing	1						

Note: \* scale of 1 being less than 1 month to 7 for greater than 10 years.

### **Assessment of Sarah's suitability as a research participant.**

Sarah's current DSM-IV diagnosis could be described using the diagnostic category Mixed Anxiety-Depressive Disorder, a diagnosis supported by Dr. Wills (see Appendix A). The set of symptoms for the Mixed Disorder includes a persistent or recurrent dysphoric mood lasting at least 1 month. The dysphoric mood must be accompanied by at least four (or more) of the following symptoms; being easily moved to tears, worry, anticipating the worst, hypervigilance, sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep); irritability, fatigue or low energy, hopelessness (pervasive pessimism about the future), difficulty concentrating or mind going blank, low self-esteem or feelings of worthlessness. Sarah said that she cried often when sad, had felt sad for last two to three years, experienced low energy, irritability and hypervigilance (especially at night). She reported worrying, pessimistic thinking, low self-esteem and feelings of inadequacy and hopelessness.

Sarah had been suicidal a year ago. I assessed her levels of depression using the Beck Depression Inventory (2nd Edition; BDI-II) and the Depression Anxiety Stress Scales (DASS). She scored as *severely* depressed on the BDI-II and on the DASS. The DASS measures of anxiety and stress were found to be in the *extremely severe* range and *severe* range respectively (see Table 6.3 and Table 6.4 below). Sarah was considered a suitable candidate for this research because she exhibited a level of depression that was within the moderate to severe range and she was aged between 18 and 25 years of age.

Table 6.3. The BDI-II classification of depression at screening interview.

Sarah's BDI-II Depression Score	Minimal	Mild	Moderate	Severe
32	0-13	14-19	20-28	29-63

Source: Beck, Steer, & Brown (1996); Beck, Steer, & Garbin (1988); Beck, Ward, Mendelsohn, Mock, & Erbaugh, (1961).

Table 6.4. The DASS classification of depression, anxiety and stress at screening interview.

	Sarah's score	Normal	Mild	Moderate	Severe	Extremely Severe
<b>Depression</b>	25	0-9	10-13	14-20	21-27	28+
<b>Anxiety</b>	21	0-7	8-9	10-14	15-19	20+
<b>Stress</b>	28	0-14	15-18	19-25	26-33	34+

Source: Lovibond & Lovibond (1995).

## Sarah's Therapy: Sessions 1-4

The following account of the process of Sarah's therapy is based on summaries from video recordings of sessions, my rereading of case notes and my recall of process decisions I made within sessions. The Process-Experiential/Emotion-Focused Therapy (PE-EFT) approach encouraged me to be *present* to Sarah by being attentive, open and curious but also alert for an appropriate *marker*, an outward visible sign she was

grappling with a particular issue and potentially ready to *work with* that issue. At the end of each meeting Sarah was asked to record helpful aspects of the session and I have included these.

### **Session 1: 3<sup>rd</sup> August.**

Sarah wanted to talk about a problem she had with flushing. Despite being quite open about her issues and readily answering questions, she was somewhat tentative and would not elaborate freely on her experiences. Her responses were often hastily spoken and quite brief. So rather than ask more and more questions I decided to work with the issue of the flushing directly. The marker for *systematic evocative unfolding*, a *reprocessing task*, is when a client describes an unexpected, puzzling personal problematic reaction. I encouraged Sarah to describe an incident when the flushing occurred and notice her *felt-sense* in order to explore her internal reactions.

I asked whether the sensation associated with her flushing was present with her “...right now” and where she felt it in her body. With her eyes open, Sarah described feeling “it in my chest and cheeks...” a “heavy...” pressure “that I get with just general anxiety.” She described perceiving an orange rectangle with fuzzy edges in her chest. Thoughts arose: “[I] become really conscious of what I’m saying... how I’m acting... alright when others are talking... sometimes I think I’m boring so why would people want to listen.” Most of her friends are chatty and “go on and on and on...,” where she tends to be “the listening type person... people won’t judge me for anything I say.” Sarah was aware, however, that she missed out “[I] don’t say what I want to say sometimes... I sit back.” She reported being able to express her thoughts and needs at home and with small groups but would not engage in large groups.

I again encouraged Sarah to think of a recent situation when she found herself flushing. Sarah had been taking ballroom dancing classes and recalled last week’s individual session. At the beginning of the class she was fine. In her recollections she was aware of the mirrors and people looking at her. Her dance instructor made jokes and she could feel her face starting to get “a little red... but by the end of the session my face was like burning... my feet were icy cold.” I asked her to repeat the story but more slowly. The PE-EFT intervention of systematic evocative unfolding involves slowing the storytelling right down and incrementally retracing the events

sequentially. This is intended to increase body awareness of the events to be realised. In order to enhance the process and re-evoke the bodily felt-sense I encouraged Sarah to imagine entering the dance hall and explain in great detail what she did next. Whilst dancing with her teacher she noticed her face redden when he began to ask personal questions. As she recalled his questions her sense of uneasiness was apparent. He asked her “what do I like doing... [and] about the boy I was sort of seeing.” Sarah felt anxiety throughout her body. I wondered whether this dance instructor had moved too far into Sarah’s personal space. I reassured her that I would respect her need for space and was mindful of working only to a depth and pace that was comfortable to her.

As she returned to the recollection of her dancing, Sarah was aware that her cheeks were feeling “rosy” that her face was very red. “Oh my God my cheeks are getting red... I want to walk out but I can’t...” I invited her to notice her chest, and recall him asking her those personal questions. She grimaced. Sarah was concerned about being judged by her teacher and I was curious as to where that may have come from. “I judge people so much on what they look like, what they do and I think I’m quite judgemental and then I put those views back onto myself.” Her honesty was candid. “Do you feel you don’t live up to your own expectations?” I gently enquired.

I feel I don’t try... I choose to wear these clothes because it’s too hard to choose something nice... because it might look crap and someone might judge me for it... where if I just wear track suit pants I’m just wearing track suit pants and I’m comfortable and I don’t care if people judge me for wearing track suit pants... at night I dress up and I don’t mind people judging me because I look good...

Sarah’s attention returned to the lesson and she was aware of the other instructors watching her. Had she had that feeling of people watching her before? She immediately remembered being a young girl of five or six attending an independent school. There was a practice whereby “if you did something wrong you’d all sit in a circle and whoever did anything wrong would have to stand in the middle of the circle... the teacher would tell them off in front of everyone and so...” Sarah choked

back the tears and I was horrified. Sarah and Gina were often in the centre of the punishment circle “well that’s what I remember... I associate being the centre of attention as not a good thing for me.” I asked her to connect with her body, her bodily experience or *felt-sense*. Sarah felt an unease “just everywhere... like humiliation...” I asked her what the “little” Sarah needed. She wanted her mother. I encouraged the “adult” Sarah to enter the scene in her imagination and reassure her inner child as she felt the harsh scrutiny of the teacher and judgement from her peers. Unfortunately, “little” Sarah had no idea of what she had done *wrong* to deserve this treatment and no understanding of the punishment process.

At this point Sarah explained that her bodily felt tension was subsiding, a partial *felt-shift*, but she was aware that “little” Sarah was still crying. “She’s really confused and embarrassed.” I encouraged Sarah to comfort “little” Sarah until she felt reassured. I enquired as to whether her mother had comforted her and told her she was beautiful as a little girl. “I don’t remember... she didn’t play with us much... it’s interesting because I always have issues with mum and Gina had issues with dad.” I asked Sarah to revisit the punishment circle and notice her bodily felt-sense “[I] don’t feel like I’m all alone.” We returned to the dancing scene and I asked her to imagine her teacher telling funny jokes whilst they danced. Throughout the session Sarah’s face had been unresponsive but now she smiled warmly and her face lit up.

However Sarah’s painful recollections returned. “I just want to dance... just feel I can’t... I feel like I’m holding back... I want to dance like I want to...” She was worried she wouldn’t be able to do it and that she would be judged. Sarah had grown up feeling judged as not being good enough. When she went out with Gina they were constantly compared because they were twins: “I’ve always felt my sister is prettier than me... she’s more photogenic... when we go out all the boys love Gina...” Gina was driving home one night and a car pulled up beside them. “Oh you girls are really hot but the driver is hotter...” shouted one of the boys inside. I was appalled and Sarah sobbed deeply: “I just hate it.” She felt she must be attracting this to herself somehow, so I challenged that belief. “Even when I’m not with her... I still don’t feel pretty... like I try to stay positive.”

The session was coming to a close and I wanted to reassure Sarah that the work we would do over the next twelve sessions would enable her to get in touch with knowing

who she was and finding her self-worth. “There is nothing more beautiful than a person who feels confident and strong inside themselves and can walk with their head held high and it doesn’t matter what they wear.” I said. Sarah nodded and said she felt “definitely better.”

On her Helpful Aspects of Therapy form Sarah wrote; “talking to the little me when I was 6 -7 at school... I acknowledged the event and how I felt and was able to comfort the girl.” This was moderately helpful. She found “getting events off her chest about comparison with sister” was also moderately helpful.

### **Session 2: 10<sup>th</sup> August.**

Sarah said she had been “really scared” about going dancing last week. She talked herself through her distress and managed to get to the lesson. However, after forty minutes she did have a “hot flush... I had to go and get a drink, then my teacher came and we had a chat and he was really nice and then it was all fine.” Sarah was aware that her instructor “wasn’t as jokey and so I was a lot more relaxed... but I realised I go red when he gives me a compliment.” She was aware of something similar at her work with the predominantly male staff. “It’s like they’re analysing me or something... I get a bit intimidated or embarrassed.”

Sarah chastised herself for not being able to accept a compliment. She was able to accept compliments from Gina but didn’t believe males. “I think they’re just being nice...” She recognised that even if people told her she looked good she didn’t feel good and “I don’t want to be better than someone... but I do that comparison in my head...” I asked Sarah to notice where in her body she felt this sense of comparison. “My face” she replied. She became aware of the dilemma of wanting to avoid such situations and yet desiring to “face” them. The pressure “to get over this” was felt in her shoulders. I introduced the *experiencing task of focusing* with the aim of deepening Sarah’s understanding of her experience.

I asked Sarah to close her eyes and facilitated Sarah to *clear the space* (see Chapter 3 and Table 3.4) and then whilst facilitating a full body scan I asked Sarah to notice pressure and tension in her body. She noticed what she described as a brown, jelly-like area in her abdomen that felt like a nervousness that was unconnected to the pressure in her shoulders. She estimated that it had been there for four or five months and its



presence coincided with a difficult breakup with her boyfriend of ten months. “I know it will all work out... I like being single at the moment, so much better with uni and everything.” She missed “just knowing I could call him... I just feel really alone... more like a lost feeling.” Sarah had felt lost for the last two to three years: “I like questioned my life... kind of everything I was doing wasn’t good enough... I’m not living life as well as I could... I want to do more with my life... wasting...” I was surprised at this young 21-year-old feeling like she was wasting her life. “I don’t think I’m living how I want to live but I don’t really know what I want to do... I just want to have fun with what I do.”

I asked Sarah to revisit the sensations in her body. The pressure in her shoulders was now more prominent. Sarah’s high expectations of herself appeared to be the source of this pressure, as her mother was very accommodating, “she never says you have to do your homework I just do,” and her father didn’t appear to have much influence. However, “he didn’t come to graduation or my netball finals.” Rubbing her eyes Sarah recalled the events of her grade six graduation. “We were still seeing him around that time and he didn’t come... he didn’t show up... mum was sitting in the front seat and she was just crying... it was so embarrassing...” I wondered if Sarah wanted to be noticed by her father. “Yeah, I suppose but... dad isn’t one for giving much encouragement... I think he just knows we’re going to do well in our study or whatever...” Young Sarah felt sad and I encouraged her to have an internal conversation with her father about how disappointed she was that he was not there, and what she needed from him, and to ask him to tell her he was proud of her. She sat silently as she reflected on this internal dialogue.

I asked Sarah to return to the memory of the dancing instructor’s compliment and she experienced a “rush.” She was resistant to accepting the compliment, feeling it genuinely in her heart but not in her head “I let it in... but I kind of don’t believe it and no matter how many compliments I get I turn it into the negative.” I encouraged Sarah to trust the dance teacher’s good intention. Sarah further complicated the process “I don’t want to be seen like I’m up myself...” Laughingly, I acknowledged that “makes it hard...” and Sarah agreed.

Sarah recalled another school event. She had been doing something with a friend and “thought it was really good and the teacher said something... really put me

down... in front of the other kids... I just felt really crushed..." I asked Sarah to invite "adult" Sarah to explain to this teacher how she had done nothing wrong and the teacher should know better than to crush the spirits of beautiful little girls. Sarah felt a relief at the conclusion of that process, a *felt-shift*, and added that "'little' Sarah wants to go home and tell mum, she wants to leave the school... I don't think me and Gina ever said anything to mum." Fortunately, the girls were removed from the school after grade three.

A further body scan revealed that there was still the sensation of a pressure in Sarah's shoulders and chest but the brown jelly-like sensation in her abdomen was almost gone. The sensation in her chest was in relation to her father's absence at her grade six graduation. Sarah acknowledged she was upset at the time but "I think I kind of squashed it..." She needed her father to acknowledge her and say she was beautiful "I think I need him to actually say it." Sarah had believed she was close to her father before he left "but I don't feel like we were that close... he's quite a closed person." Sarah felt she had to manage on her own and received little reassurance from him after he left. There was unfinished business with him but the session time was up, though Sarah contemplated having a conversation with her father, "that's what I need to do." There was shift for Sarah from squashing her needs and wants to having a desire to assert herself. Sarah reported on her Helpful Aspects of Therapy form that doing the focusing exercise, identifying that she needed to talk to her father and working with letting in compliments was really helpful.

### **Session 3: 17<sup>th</sup> August.**

Sarah had had a good week. She still struggled with accepting compliments from her dance teacher but by the end of her last dancing lesson her face was only slightly red. Sarah raised her eating issue. "I always eat to avoid... at work I'm terrible... just eating to avoid talking to people... I've been doing that a lot in the past few weeks... I don't know whether that's because I don't really have a best friend." At her placements she found it really difficult to just chat and connect with people. I asked Sarah to explain the eating-thing. "I wake up in the morning and I know if I'm going to have a day where I eat a lot because at breakfast... I'll think about what I can buy or if there was cake in the fridge... I would eat it at breakfast." Things had improved somewhat

recently as she had disciplined herself to eat regular meals. Also “I have this thing about finishing stuff... when I have biscuits if I don’t eat them all I’ve so much anxiety... there were eight biscuits and two left... I was full but I couldn’t stop thinking about those two biscuits.” As the girls grew up their mother had been insistent that they eat everything on their plate. Sarah attributed her food concerns to “stress.”

As Sarah told me about a number of difficult situations she was encountering, she seemed quite remote from her feelings. I acknowledged that she was indeed under a lot of pressure from many different sources and so suggested the experiencing task of focusing to assist her to process these experiences. I encouraged her to close her eyes and *clear the space*, and facilitated a systematic body scan to look for areas of pressure and tension in her body. She felt a constriction in her throat that made breathing difficult, and envisioned a black narrow hard tube. I asked was it difficult to express herself verbally, and she said “in everyday life I often hold myself back from saying what I would want to say... I think I like screen myself, like how or what I think they’ll react to what I say.” At placements, Sarah felt uncertain about her position and was aware that she needed to assert herself but was hesitant. I encouraged her to seek out her supervisor to talk about her difficulties, and she felt confident to do so.

Sarah’s tension shifted to her chest. I invited her to think of another occasion when she felt this tension, and Sarah recalled getting the bad news that her mother had cancer. I enquired gently as to whether she was OK to talk about that and she agreed she was. Sarah had responded pessimistically to the news of her mother’s illness and wanted to know what would happen once the diagnosis had been made. She had feared the worst as the tumour was malignant and the doctors had been unable to find the primary source. I was concerned that Sarah felt she may lose her mother but she said, “I wasn’t worried about that... I was probably just more sort of selfish as well that I didn’t want to look after her or have that responsibility...” Before being ill, her mother worked a great deal and the girls had to manage on their own. I wondered whether the eating and this sense of aloneness were connected. “I think it’s also that wanting to avoid feeling a lot.”

Her eating was particularly problematic when she was relaxing. “I can’t sit down and like watch TV unless I’m eating... not so much at night but during the day.”

Sarah again felt that restriction in her chest. “The thought of being at home isn’t a nice feeling... it’s because mum’s at home... I don’t like eating or even being at home when mum’s there.” When Sarah eats, she said her mother makes comments; “don’t eat that or you won’t eat your dinner” and “do I need to take that off you?” Her mother also made rules about TV watching she thought unreasonable, and Sarah described her mother as “controlling... she has complete double standards.” Sarah had all sorts of advice she would like to give her mother in relation to her cancer

I haven’t had cancer myself but my idea of cancer is you really need to re-evaluate your life... and mum says she has but I think she hasn’t at all... she hasn’t changed anything... I think until she does she’s not going to get better... I could say 100 things she should do...

Sarah sounded like the parent. Holding back the tears Sarah said “but I don’t want mum to think she can’t rely on me.”

I felt Sarah couldn’t express her anger, though I acknowledged that I heard and understood her. I asked her to check in with her body again and to search for anything else that she might want to verbalize. After a long pause Sarah said there was something “but I can’t say it.” I explained that there wasn’t much I hadn’t encountered in my life and that I hoped in time that she could express herself freely with me. I reassured her that I would not be critical or judgmental. In the meantime she could journal or find some other means of expression. Unexpectedly, she began to tell me what concerned her most.<sup>4</sup>

The issue had distressed Sarah for the last 18 months. She cried openly. “It’s just really hard... I just feel so judged... hard to come to terms with it... ...I still totally freak out about telling someone... now that’s happened to me I look at everyone so differently.” She felt burdened by her situation and said “I just want a teenage life... I’m so responsible... ...I don’t want to be so serious.” Sarah reported that she “analyses every person I meet... will or won’t they [understand]... I don’t think I

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4 Some information offered by Sarah in this session has been omitted because she was confiding a secret and even though her identity is protected by a pseudonym, on ethical grounds it seemed important to respect her privacy.

should screen people like that.” I was concerned that Sarah might not see an ordinary life for herself, but she reassured me. “I’ll get married... but just really hard at the moment to kind of see what will happen.” Our session time had ended and I was aware we had only just begun to process this latest disclosure. Sarah’s last comment was that “everybody had responsibilities.” I agreed but acknowledged the amount of responsibility she carried was far more than most people of her age. I reiterated that she was courageous and capable and that she needed to be gentle with herself, not judge herself so harshly. I was concerned about her and suggested she contact me if she needed to. She assured me that she would be fine.

Sarah reported on the Helpful Aspects of Therapy (HAT) Form that she found it helpful to say what was on her mind and that she had someone to talk to about her situation. In addition, she found comparing and analysing the different responses she had also helpful.

#### **Session 4: 24<sup>th</sup> August.**

During the week Sarah had what she called a “sort of breakdown.” Upon empathic exploration, it seemed the issue contributing to the “breakdown” was the situation with her mother. Tears welled in her eyes as she explained that the tests had shown another malignant growth and the search for the primary tumour had been unsuccessful. “Mum’s like really sad...” Sarah realised her mother needed support “but I really don’t know how to... she’s trying to be independent but I feel guilty... like I should do more.” I suggested Sarah ask her mother what she needed and then assess what she was prepared to do.

Sarah was bewildered at her mother’s inability to confront her illness and this left her angry. I drew Sarah’s attention to the shift between anger and sadness and she said she noticed it as pressure in her shoulders. I suggested the experiencing task of focusing because I realised that the issues with her mother were too confronting to do an empty-chair at this time and saw that it might be possible to access her underlying dilemma more gently through her bodily felt-sense. Sarah described the pressure as two dark green rubbery strips, one on each side of her neck. “I think it’s the expectations I’m putting on myself or like I’m making everything more stressful than

it should be..." Sarah expected to be able to manage all these stressors and not be stressed.

A further body scan revealed an uneasy sensation in her stomach that had something to do with her appearance and putting on weight. Once again, I asked her to symbolise the sensation. She described a red rubbery dome-like structure, which she acknowledged held all her insecurities. Sarah gained a great deal of weight last summer and spent the winter on a strict diet. She had without realising become too thin and her family and friends criticised her. I asked her to refocus on the sensation and she said, "it's gone to my face..." Intrigued, I enquired if it had anything to do with the flushing. She agreed. "It was like fuzzy all over my face..." I asked what that meant to her, and with tears choking her voice she said, "I don't like being me." I asked her to search within and locate that part of herself that knew she was a worthwhile extraordinary person and was beautiful as she was. She located it "right in the middle of my body." Tears welled. "I feel like instead of living in there (*pointing to her heart*) I always live in my head." I answered, "that's where your true beauty is." She agreed. I said "your heart holds your truth, your essence... the knowledge that knows what's good for you... so get in touch with that and live everyday that way... be it... enjoy it..." Sarah explained that she felt good and the session came to an end.

On the Helpful Aspects of Therapy form Sarah reported that "asking mum what I can do for her" was helpful. In addition, "finding my inner voice and being able to sit with it and knowing I can relax when I do this" was also helpful. In the Table 6.5 I have highlighted the significant elements of each session.

Table 6.5. Sarah: Summary of bodily felt sense, symbolic representation, episodic memory, emotional arousal and felt-shifts – sessions 1 to 4.

Session and task	Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
1. Systematic evocative unfolding Punishment circle	pressure in her chest and cheeks an unease “just everywhere... like humiliation...”	orange rectangle with fuzzy edges in her chest	little girl in the punishment circle then comforted by adult self	tension subsided primary <i>shame</i> felt expressed her need to be reassured “I don’t feel like I’m all alone” felt relief → <i>shift</i>
2. Focusing <i>Accepting compliments</i>	pressure in her shoulders – high expectations of herself	brown, jelly-like area in her abdomen	difficult breakup with her boyfriend of ten months father’s absence at her grade six graduation – IC <sup>5</sup> put down at school by teacher – IC	partial shift primary <i>shame</i> felt  symbol gone full body relief → <i>shift</i>

- 5 I use the abbreviation IC to denote an imaginal confrontation or an internal conversation within a focusing task with a significant other/perpetrator. The client is encouraged to imagine a significant other/perpetrator in their “mind’s eye” or in their imagination rather than use an empty chair. Confrontation and assertions of the client’s needs is encouraged within the client’s imagination rather than out loud at an empty chair or therapist. Some clients find the empty chair enactment too confronting in the initial stages of therapy. Please note Paivio and Pascual-Leone (2010) use the term imaginal confrontation (IC) to denote empty chair work and Empathic Exploration (EE) to denote what I refer to as imaginal confrontation or an internal conversation.

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
3.	Focusing Eating issue	constriction in her throat that made breathing difficult tension shifted to her chest	a black narrow hard tube	difficult to express herself news that her mother had cancer issue that concerned her most	<i>anger and sadness</i>  distress divulging her concern <i>disgust</i> at herself – tears → <i>shift</i>
4.	Focusing Expectations of herself	pressure in shoulders  an uneasy sensation in her stomach  sensation in face	two dark green rubbery strips, one on each side of her neck a red rubbery dome-like structure fuzzy all over her face	stressed about assignments abandonment by mother at 16 put on lots of weight last summer “I don’t like being me”	anger sadness she can relax tension lifted → <i>shift</i>  primary shame/ <i>disgust</i> release of tears acceptance → <i>shift</i>



### **Client and therapist analyses of change.**

#### ***Client's analysis of change after session 4.***

After session 4, Dr Wills, my original principal supervisor, conducted a Change Interview with Sarah. She said about the counselling "it's been good... I like the fact that it's every week... and going through the body is really good... I think that I'm enjoying [life] better than I would be if I wasn't coming." She said she would like to change "my low self confidence, like my perception of myself..." but had noticed "my thoughts are slightly different but it's not changing my actions... if I go and eat a whole lot of food I don't put myself down about it, that's a big one." Sarah attributed these changes to the therapy. "I think that the therapy has been helping because it helps to identify... like the specific... like the feeling around the situation or... kind of find a strategy I can use to change it, to find out more about it."

Outside therapy her mother's cancer treatment, was making it harder for her, but her dancing classes had been a highlight. Interestingly, she claimed "therapy has helped with that [dancing] as well... more comfortable with that as well."

Sarah identified what worked for her. "I thought it was good...you know the techniques she uses are good ... to help bring up those emotions." In addition, "I think that it's just like generally having a chat at the start just helps, works well." Sarah spoke of her relationship with me: "she's very nice so you just can relax and you feel like she's interested in what you're saying and then sort of leads into it really easily." When asked about difficult or painful experiences Sarah said "yes, it wasn't like so difficult to a point that I couldn't talk about and I didn't feel like I had to talk about anything that I didn't want to..." and "in fact if I did find anything difficult and I didn't want to do that, she would try and change what she is going to do, so it would still kind of target the same thing, but it was not as confronting."

#### ***Therapist's analysis of process and change: Sessions 1-4.***

In session 1, I was aware that Sarah was quite willing discuss certain issues with me but was rather reserved when it came to exploring those experiences. I noticed the speed at which she spoke and that many of her answers were extremely brief, making empathic exploration difficult. Sarah's manner created quite a challenge, as I did not

want to interrogate her by asking too many personal or probing questions. I was careful to respect her privacy but also wanted to encourage deeper exploration of the underlying issues that may have manifested in her flushing experience. I chose to introduce the systematic evocative unfolding task not only because the marker was present but also as a way of facilitating her process of exploration without using questions that Sarah may have perceived as intrusive or challenging. This offered Sarah an opportunity to focus experientially on the lead-up to the flushing event, working systematically with some objective distance, rather than delve into it purely cognitively. I consider this approach to be more indirect and I believe Sarah perceived it as less threatening. I had been observant of Sarah's need for personal space and was able to reassure her that the work would be done at a pace and depth that she was comfortable with. Sarah was quick to pick up the concept of bodily felt-sense, and so by incorporating the bodily sensations in conjunction with the episodic memories we were able to efficiently uncover a core incident that had left her feeling ashamed and humiliated.

I could see this was an important first session because it set the scene for future sessions in that Sarah now had some insight as to how our work might progress. Over the course of the next few meetings Sarah spoke more freely and began to show me herself more willingly, apparently less fearful of judgement by me. In session 3 she shared what had been concerning her most. It was interesting for me to observe how Sarah progressed from some reserved unwillingness to share much of herself to openness and full disclosure. I believe the strength of the therapeutic relationship we had established enabled Sarah to explore areas of herself that had been hidden, and the PE-EFT tasks facilitated that process by gently challenging her without overwhelming her or shutting her down.

As her therapist I realised that Sarah's disclosure was a significant sign that trust was developing in our working alliance, but as a researcher I found it problematic. Ethically I struggled as to whether the details of the disclosure should be published. De-identifying clients in case studies can present problems on a number of levels (see McLeod, 2010). In this case, I wondered if the deletion of such details would compromise the accuracy of my representation of Sarah's experience on the one hand, or would compromise Sarah's privacy on the other. Sarah later read drafts of her case

that included the details of her disclosure without concern, but in the interest of respecting her autonomy and privacy and ensuring confidentiality, it was deemed best to remove the specific details of her disclosure.

My overriding commitment was to ensure that Sarah was given time and space to explore vulnerable aspects of herself. I was always mindful of setting the pace to suit her. In my facilitation process I sat patiently with open curiosity and waited for the emergence of the underlying issues. This can be challenging at times with a client such as Sarah who processes her experiences cognitively, but Sarah reported that the process of therapy helped her clarify her issues and, although we had not worked directly with her cognitions, Sarah noticed her thoughts had changed. At this point she reported that her actions hadn't changed but there was a willingness in her and courage to find out more about her herself and her presenting issues.

My experience of Process-Experiential/Emotion-Focused Therapy theory in practice tells me that the bodily-felt symbolising and the emotional expression of Sarah's experience, in conjunction with experiential exploration through the implementation of the tasks and the subsequent *felt-shifts*, were key factors in creating change for Sarah. In session 1, the systematic evocative unfolding enabled Sarah to remember and re-process the punishment circle experience that rendered being the centre-of-attention as humiliating for her. This experience appeared to be a core event in the development of Sarah's flushing. The *felt-shift* occurred when Sarah had been able to access her humiliation whilst standing in the punishment circle and express her need to be reassured and comforted by her adult self. In session 2, using focusing, we uncovered the difficulty Sarah had in accepting compliments, a difficulty that appeared to stem from her feeling devalued on a number of levels by her parents, and her father's absence at major events was a crucial contributor to this. As Sarah processed the issues around her father she experienced a *partial shift* but it wasn't until she reprocessed another childhood event where her teacher was particularly critical that the full felt-shift occurred.

A focusing was the most appropriate task in session 3 when Sarah discussed her comfort-eating issues. Sarah's constriction in her throat symbolised issues around not having a voice in everyday life. Interesting her binge eating caused her to stuff down her feelings with food and again this may have symbolically silenced her in social

situations, in relation to her mother's illness, at work and at her placement. Significantly, she had silenced herself about what she had been fearful of disclosing to me and others for 18 months. Interesting, the constriction in her throat lessened, the felt-shift, as she began to disclose what was troubling her most. In session 4, again through a focusing task, Sarah was able to identify that an uneasy sensation in her stomach that had something to do with her appearance and her weight. This was also connected with the flushing and through her tears she acknowledged she didn't like herself. Deep shame was associated with these disclosures. When Sarah accessed her emotions and openly acknowledged disgust in herself a felt-shift occurred. The idea of being busy and processing situations cognitively had been a way of coping and she yearned for a more heart-centred fuller life. Sarah's somewhat austere demeanour had softened in the last four weeks.

Sarah's modes of engagement (see Elliott, 2002a) in the therapy process in the last four sessions showed me that Sarah was able, though my facilitation, to turn her attention inward in order to access and assess her feelings, thoughts and bodily sensations. She was willing to examine her internal experiences with curiosity and acceptance, and was able to express her emotions freely by allowing the tears to fall and the anger to be expressed. My initial concern about her ability to process deeply because of her desire to withhold information diminished as she felt more familiar and comfortable with the processes. There was an easy flow and acceptance between us.

Sarah became more trusting of me, as evidenced by her disclosure and her willingness to explore difficult aspects of her life. My understanding of the building trust is that Sarah needed someone to talk to who would take her seriously and not dismiss her experiences. She needed validating and an opportunity to question, explore and make mistakes without being criticised or pressured with advice. Her ability to make meaning of her experience was developing but she seemed to need me to offer conjectures as a way of concretising her experience. Sarah's ability to take action as a result of her emergent understandings was still developing.

## Sarah's Therapy: Sessions 5-8

### Session 5: 31<sup>st</sup> August.

Sarah was coping with a great deal and her anger was palpable yet understandable. She recalled that when she and Gina got their drivers' licences their mother had stopped driving them around and said "you have to do everything for yourselves..." I was also aware of Sarah's sadness. She said, "I'm over it (*rubbing her eyes*) I can't be bothered... there's the part of me that doesn't care but the other part does..." The idea of the two-chair enactment task really concerned Sarah and so I suggested working with the conflict split internally through focusing. But "no I don't even want to... (*with tears*) too much to think about... I'm just getting angrier and angrier..." Sarah's vulnerability and obvious stress levels indicated to me that gentle empathic affirmation for her *vulnerability* was the appropriate response.

Last year the girls wanted to move out of home but were unable to afford to. "...So just kept living there but it's got harder and harder..." Sarah felt she would never be really close to her mother as according to Sarah, her mother had a fairly negative view on things and constantly offered advice. As I listened to Sarah I realised she also offered advice about what her mother "should" do. I suggested Sarah might consider discussing with her mother how they might change the way they communicate with each other by just listening to each other. I explained sometimes people just want to be heard as being given advice can be aggravating and disempowering. Sarah smiled. I laughed as I realised I too was giving advice. Sarah contemplated the idea: "I think how I respond to mum... that would make a difference."

I gently questioned Sarah as to whether she had compassion for her mother. "I do have compassion... because I work in health and you see so many people... there are so many worse things..." Significantly, Sarah said, "I want to learn how to be empathic..." She had observed one of her supervisors show support in group supervision for a student who had to go into surgery the next week. "There was so much empathy... you could tell she did really care." I acknowledged that Sarah showed empathy at times but also presented a protective "guardedness" which was lessening as we got to know each other. Despite Sarah's reluctance to take part in

enactment tasks, I felt the trust was building. Sarah reported on the HAT that “identifying how me and my mum interact... to realise why I feel angry and also how I talk with her so as I can change that” was helpful.

### **Session 6: 14<sup>th</sup> September.**

Sarah was generally doing well. The reports were finally submitted, she felt more comfortable with her mother, her “...eating’s so much better...” and she’d “been a lot happier...” She was however struggling with a group project and felt really apprehensive. I suggested a focusing task to work with her anxiety. I instructed Sarah to think of the group project as she scanned her body for areas of pressure and tension. Sarah noticed pressure in her upper chest. She visualised a solid green cylinder containing words that were “stuck.” She knew in her head she had the words but they were just not available. Sarah recalled how she struggled academically in grade 4 when she had moved from the independent school to regular school. She remembered a poster she had produced which she thought was fine when it wasn’t. “That’s why when I’m reading something I think it’s OK but...” The cylinder was now more transparent. Sarah acknowledged she needed “structure... but ...I want to do it my own way.” So the struggle for Sarah was to find a structure that still enabled her to be creative. I asked her to again focus on the cylinder and asked would it give her the words? “I just asked it and it said I could just have them.”

The felt sense shifted, and Sarah then became aware of a dark circular pressure in the front of her head. “It’s frustration... [about] life... why isn’t my life as good as other people’s... I don’t have as much fun... [I] can’t go out and relax for a minute...” I asked Sarah to consider sitting on the couch and relaxing. “When I think of it I go... (*crouching her whole body*).” The thought of sitting on the couch and not doing anything seemed impossible for Sarah. She felt it in her head. I explored further. “It’s like my face...” (*putting both hands to her face*). I asked her to track back and she remembered being about 15 and that when Gina started going out with her first serious boyfriend. “She wasn’t there anymore... I had to sit by myself.” Food gradually became Sarah’s friend. I directed Sarah to her body. She visualised a long, thin, solid, black image in her chest. Sarah felt sad but “I tried not to show it...” I asked Sarah to have an imaginary conversation with Gina explaining how she had felt. This helped to

shift the tension somewhat but more remained. “It’s just like [felt] I have no friends...” I asked Sarah to stay with and further explore this sense of loneliness. Sarah acknowledged she was angry with Gina and again I encouraged her to again have an inner conversation with her. After a long pause I checked in. “I’m just talking to her... I just didn’t know what to do with myself...”

I encouraged Sarah to find that part of herself that liked being on her own, was accepting of herself, and that knew she wasn’t a loser but was an interesting person. I asked her to imagine being able to relax without having to be busy. “I’m relaxing but there’s still... shouldn’t I be doing something...” Sarah’s mother and sister criticise her because she doesn’t consistently contribute to the household tasks. “I’ll do it when I’m ready...” This was Sarah’s structure and she wanted the freedom to do it in her time. I asked her to notice her body. It “feels good” she said. Acknowledging that it was OK to want to do it differently was important to Sarah. As a final check I asked her to think about sitting on the couch. “I’m bored!” We both laughed. The tension had shifted. Sarah reported that the insight that “structure is important to a degree... because I can generalise it to many areas of my life” was helpful. Interestingly, “feeling the happy energy in my stomach” was also helpful.

### **Analyses of change.**

#### ***Inventory assessments after session 6.***

At Session 6 I asked Sarah to complete the BDI-II and the DASS inventories again. The scores are tabulated in Table 6.6 and Table 6.7. Significantly, Sarah’s depression was now in the mild range on the BDI-II and in the normal range on the DASS. However, her stress levels were in the severe range, which was not surprising considering the pressure she was under in the last month of her course. Sarah’s anxiety levels were in the moderate range.

Table 6.6. The BDI-II classification of depression at Session 6.

<b>Sarah’s BDI-II Depression Score</b>	<b>Minimal</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
15	0-13	14-19	20-28	29-63

Table 6.7. The DASS classification of depression, anxiety and stress at Session 6.

	Sarah's score	Normal	Mild	Moderate	Severe	Extremely Severe
<b>Depression</b>	6	0-9	10-13	14-20	21-27	28+
<b>Anxiety</b>	11	0-7	8-9	10-14	15-19	20+
<b>Stress</b>	28	0-14	15-18	19-25	26-33	34+

### ***Session 7: 21st September.***

Sarah shared that she had had no further flushing incidents and now felt very comfortable with her dance teacher. However, at the end of her last class her “we had a quick practice... everyone was sitting around the edge watching and I didn’t even go red... [but] I stuffed up... I fell over (*laughing*)... [but] it was fine...” I was thrilled for her. Sarah still felt embarrassed at times but “I just take a breath... [say] it’s going to go away... it’s fine...”

Sarah’s mother had been in a lot of pain but refused to take painkillers, and she acknowledged that she was angry again. “I just have no sympathy... I feel terrible...” Sarah was angry that her mother was doing very little to help herself.” I asked Sarah whether she did things to make herself feel better when she felt bad. She paused “as I say that maybe I’m like that... I think I can probably be like that sometimes because I know with the vestibulitis... (*with tears in her eyes*) that’s been really worrying me in the past week.” Sarah had been attending a specialist physiotherapist who had suggested an exercise regime for her. The pain was still present despite her taking medication and using relaxation techniques. She cried at the thought of living with vestibulitis for the rest of her life. Sarah remembered the pain started about three years ago, “...it’s so interconnected with... my relationship... breaking down...”

I asked whether Sarah would like to work with this in a focusing exercise because I believed there was a possibility of unpacking some of the contributing psychological issues. I invited her to close her eyes, and take a few deep breaths as we *cleared the space*. I then asked her to formulate a question related to the vestibulitis and to repeat this question internally whilst I conducted the body scan. Sarah noticed pressure in her left shoulder. It appeared to be in the shape and colour of a “kidney-bean” with a



fabric texture. This reminded her of a cushion in her Nan's house but she didn't want to elaborate. Sarah had a good relationship with her grandmother. I wondered how the question Sarah asked at the beginning of the focusing related to her Nan. Sarah disclosed she had asked was "why is the pain there?" After some further exploration Sarah said, "maybe Nan went through this too."

I asked Sarah to revisit the pressure in her shoulder. "It's like a chest that's full of trinkety things..." I asked her to pull out something that had meaning for her. "In my head it's about money... you have to have money to be happy..." Sarah thought that if she couldn't "give sex... I'd have the money..." She realised that she would find someone to accept her, and decided to "put the chest in the ocean." The pressure in her shoulders had reduced to an experience like thin wooden strips. "It's about me liking me..." Her head started spinning but she was able to stay with the sensation, and her thoughts turned to "me relaxing... I sat on the couch all week and didn't eat." I asked Sarah to connect with the experience of relaxing her whole body because relaxing "frees you to experience good things... sex can be a good thing." Sarah replied "I think I associate it with negative things..." The word "slut" came to Sarah's mind. "I think it's a judgment that people make about girls and I worry would people make that about me..." Adult Sarah recognised that "it's all fine" to have numerous sexual partners but the younger Sarah needed reassurance. I suggested she have an internal conversation with those aspects of her that struggled to know that sex was OK. I asked Sarah to get in touch with the part of her that wants to make choices about being in a sexual relationship where she felt good about herself. "Yeah... that feels good."

Sarah reported in her Helpful Aspects of Therapy form that "going through all the different emotions/events from the vestibulitis" and realising "a lot about my values" were extremely helpful aspects of the session.

### ***Session 8: 5th October.***

Within the last fortnight Sarah had gone for a holiday up north to check out the idea of taking up summer jobs on the coast for about three months. Despite raising concerns about her working holiday and leaving her sister, Sarah wanted to work with the "the sex thing" because "last week was really good... it really helped..." In

addition, she raised an issue of presenting herself to young men as “...really cold... defensive... whereas with people who know me I’m so much more relaxed.”

We had used the focusing task last session as a means of processing the issues around the vestibulitis and so we repeated the process. Sarah easily identified an area in her chest that she described as a cloudy-grey, fuzzy, hollow cylinder. When she focused on the symbol “I get an image like sometimes my words get stuck... it’s like I have this big secret... I feel like I’m deceiving people...” The not telling was “kind of eating away at me.”

I asked her where she felt this “eating away?” Sarah pointed to her solar plexus and stated it was her “conscience” as she didn’t like to lie to anyone. Holding her throat, she spoke with a croaky voice “I need to know that I can talk about it... without crying... or freaking out...” I invited Sarah to locate a place within herself that felt the “freak out” and she gestured to her chest area. She was worried that if she told “someone they’ll tell people...” Sarah described the pressure as a flat stretched out maroon circle sitting in her chest. Negative statements came to Sarah’s awareness: “sex is bad... sex is not pleasurable... boys like use you...” Her body experienced sex as painful. I asked Sarah to observe herself having painless sex and to connect to the part of herself that felt good about her body and that felt spontaneous, alive and free. She enjoyed this. The bodily felt-sense had shifted slightly but the pressure still persisted. Upon further reflection Sarah recognised that she felt undeserving of a life of spontaneity and painless sex. I gently said that she was indeed worthy of such a life and more.

Sarah then turned her attention to notion that “people don’t like me.” I encouraged her to notice that part in her and focus on that for a moment. She acknowledged that her guardedness was about protection. In order to feel less protected Sarah felt she needed to be 100% happy with herself and be viewed “as an interesting person.” She assessed that she was 85% happy with herself at the moment. I asked Sarah to explore through her bodily felt-sense where she experienced this 85% within her and let it expand to 100%. She was able to do this and I likened it to feeling comfortable in her own skin. Sarah’s bodily felt-sense had shifted and despite there being some lingering negative sensations our session time was up and she was happy to leave it there.

Sarah's parting remarks were in relation to the flushing. "I was at dinner... and I felt myself going a bit red but it just didn't bother me and then it just went away... so happy..." I said that was a fantastic gauge as to how she was progressing. On the Helpful Aspects of Therapy Form Sarah wrote "filling up my self-confidence to 95%-100% made me realise I am almost at the point I want to be and that I do feel comfortable in myself." A second helpful event was the visualisation of observing herself having pain-free sex. In the Table 6.8 I have highlighted the significant elements of each session.

Table 6.8. Sarah: Summary of bodily felt sense, symbolic representation, episodic memory, emotional arousal and felt-shifts – sessions 5 to 8.

Session and task	Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
5. Vulnerability <i>Relationship with mother</i>	rubbing eyes tears		her mother's unavailability at 18 got licence mother stopped driving them had to look after herself	expression of <i>anger</i> and <i>sadness</i> – tears → <i>partial shift</i>
6. Focusing <i>Gaps in knowledge</i>	pressure in her upper chest  pressure in front of head  face  pressure in her chest	a solid green cylinder containing “stuck” words a dark circular pressure    long, thin, solid, black	move to regular school in grade 4  her life not as good as others   alone on couch at 15 b/c of Gina's first boyfriend → food only friend – IC Gina loneliness – IC Gina	ask cylinder for the words → transparent and vanished. expression of the frustration/ <i>anger</i> <i>shift</i> → joy  expression of <i>sadness</i> at being alone and <i>anger</i> towards Gina → <i>shift</i> relaxed → <i>shift</i> humour at being bored

Session and task	Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
7. Focusing <i>Vestibulitis</i>	pressure in her left shoulder	kidney-bean shape and colour and fabric texture full of trinkets	cushion in her nan's house – loves her so much it's about money if I can't give sex I'll have money	distress tears of <i>sadness</i> ↓ pressure in shoulders
	pressure reduced	→ thin wooden strips	felt bad about self taught a lesson “slut” mother judgements about sex	<i>anger</i> at vestibulitis spinning → relaxing  acceptance sex is ok → <i>shift</i>
8. Focusing <i>Vestibulitis</i>	pressure in her chest	a cloudy-grey, fuzzy, hollow cylinder	I have a secret lack of trust	
	solar plexus	eating away at me	friend dated a boy she liked	<i>fear</i> that no one will like her
	pressure in her chest	flat stretched out maroon circle	sex is bad undeserving of a spontaneous happy life & painless sex	recognition that not everyone will like her → comfortable in herself and body → <i>shift</i>

***Client's analysis of change after session 8.***

Sarah said in her Change Interview with Dr Wills after session 8 that it had been “really enjoyable... it’s been positive definitely... when I leave I always feel good, happy... happier... I’m doing really well... compared with that first session...” The vestibulitis was still a major issue Sarah wanted to change and she wanted to be more outgoing in “unfamiliar environments...” but felt like she was managing that better. “I find it really hard... I’m still not going to be a loud person in a group.” In addition, Sarah recognised “I think I think too much...” but rather than seeing this as a concern she would like to change she said “I think it’s more a matter of me finding things I really like doing and I’m really interested in socially with those types of people.”

In relation to changes, Sarah had noticed “I’m more confident in myself... I’m not as self conscious of what I do...” Before therapy she was “really judgmental of myself...” and “I don’t think I’ve got new ideas... I think it’s more about changing how I feel about ideas...” Another change she noticed was

I think one thing is I can relax... let my mind relax... think I’m also not so much in my head... I’m listening more to my body... if my head is telling me to go and eat something because I’m bored... when I go to eat it like my body like gets a sensation and I know that I’m not hungry and so I just put it down and don’t eat it... that’s what’s been happening... I can follow my body more... I can sit down and not eat... it’s like a calm feeling I have... I think I have that calm feeling more...

Sarah attributed these changes to therapy as “the main source... but also my dancing has helped a lot as well.” She explained

When you come in and talk about what’s present at the time and that’s probably what’s helped that’s good... and that leads into things yeah... it seems to have worked well... because I’m dealing with things that are bothering me at the time... With previous therapists where instead of

starting in the moment you go back to a past event like straight away and talk about that whereas I think this is more effective because it makes you realise how things relate and gives you more relevance for how you are feeling now... it really connects you more with your body... General chatting and conversation is useful and the specific techniques are like just maybe just create the space and find the feeling I think that's really useful and having a conversation with... between all the different parts or different people... me just like talking to myself as a younger person was useful.

***Therapist's analysis of process and change: Sessions 5-8.***

Significantly, in session 5, Sarah was able to get in touch with feelings of guilt, sadness and anger towards her mother. Her tears of sadness and expression of anger were appropriate primary emotions. I listened non-judgmentally, empathically explored and affirmed her conundrum. Sarah grieved about not being close to her mother. She seemed hesitant to work directly with the relationship with her mother and yet was visibly troubled by it. I was aware that on the one hand Sarah felt sad about her mother's illness and wanted to support her but on the other hand was impatient with her mother. I noticed how Sarah would become frustrated as she told me how she and her mother interacted and was particularly aroused when she told me how her mother offered advice or made uninvited suggestions. Despite the presence of a conflict split, the marker for two-chair dialogue, Sarah's vulnerability was most prominent and so I continued to offer empathic affirmations to show my support for her predicament. It was also evident to me that Sarah would find it too challenging to express her reactions to the possible outcomes of her mother's illness directly, as she had turned down the empty-chair enactment in a session previously. My sense was that Sarah was angry that her mother was facing a life threatening illness and that she felt ashamed that she was so angry. My hypothesis was that Sarah also felt angry at being somewhat neglected and abandoned by her mother and had become resentful that she now needed take on a caregiver role when she herself felt in need of care. I suspected she was also shocked that her mother's illness might be terminal and was not willing to face that possibility at this time. I sat and listened to Sarah's predicament, struggling

with the idea that this was what needed to be explored, yet aware that she was unwilling or fearful to explore this more fully at this time. In addition, whilst this was the most salient issue for Sarah in this session, it was not an issue Sarah had raised to work with initially. I considered her reluctance to face the issues with her mother more directly to be a defence mechanism that needed to be respected. She had to face the world, finish her course and manage coping with her mother's illness. Whilst the working alliance was strong I believe that if I pushed Sarah I would have lost her trust and willingness to explore her experience more deeply in future sessions. In terms of being person-centred I valued Sarah and would have only initiated the two-chair task if there was true collaboration. I was also aware that Sarah had been actively participating in a task in every session up until now and that perhaps a more integrative, conversational session was necessary.

Sarah, however, was open to learning how to change her communication style with her mother and was able to take some responsibility for her part in how they related. She was interested in hearing my suggestions of active listening and respectful interaction. In PE-EFT, making such interventions may be considered somewhat *out-of-mode*, but there is room for this as long as it is not the dominant mode of therapist responding. I saw such psycho-education or coaching as important in helping her develop a more meaningful relationship with her mother at a crucial time. Sarah also wanted to learn how to be empathic with her clients and was willing to develop a more respectful way of communicating with them. The emotional processing earlier in the session however was the significant event in this session.

The central work in session 6 was identifying that Sarah had a weakness in her writing, but rather than being adamant about doing it her way she had become interested in how some structure might enhance her performance. She recognised that she had developed a pessimistic view of things and had become overly responsible. I believe that as a consequence of the events of her childhood she had less opportunity to enjoy just being a child with few responsibilities and so as a young adult she became determined to find more joy in her life. However, Sarah generally found it difficult to relax, and so I used visualisations within the focusing task to assist her with relaxation strategies, and she responded well. Encouraging Sarah to practise these relaxation



strategies within the focusing enabled her to get a more embodied experience, and be more likely to practice them out of session.

When at 15 Gina entered her first serious relationship, Sarah was often left on her own feeling deeply isolated and had taken food to be her companion and to make her feel good. I chose to assist Sarah with confronting her sister by having an imagined conversation with Gina in a focusing, rather than using the empty chair enactment. As with the empty chair technique the verbal expression of the unspoken words, combined with experiencing the emotion helps a shift to occur for the client. Even an imagined conversation that taps into the emotion and the fundamental need that had been dismissed or ignored, can have a similar effect. This imagined conversation combined with simultaneous emotional expression created a felt-shift for Sarah. I encouraged Sarah to recognise that she was worthwhile and assisted her to build a stronger sense of herself separate from Gina.

Sarah recognised that she had limited ability to be compassionate and had been told she often presented to others as cold, controlled and defensive. Her grandmother accused the girls of not being considerate enough to their mother. I reminded Sarah that she had been able to exhibit a great deal of compassion for an eight-year-old she had been working with in her placement and that she showed deep and genuine concern for her sister. Recognising that her defensive persona was a protective feature, Sarah was able to explore the rigidity she had felt safe with, and became curious and willing to let go and be more flexible.

Since Sarah was determined to uncover the underlying issues related to her vestibulitis, through the focusing tasks in Session 7 and 8, she did indeed work through some of the suspected psychological contributors to the condition. I took up the challenge to facilitate Sarah's journey. She dealt courageously with her judgements of her parent's sexual partners and the idea of casual sexual relationships. The felt-shifts occurred as Sarah touched the distressing emotional moments and valiantly moved further into her painful experiences. To open her to new experiences, I took her through visualisations within the focusing task of painless sexual encounters, and worked on her developing a more positive body image and recognising that she did indeed deserve a healthy sex life. This apparently resulted in Sarah feeling more confident, willing to be spontaneous in social situations and to be less defended and

show herself more genuinely to others. Sarah's flushing had disappeared by session 7 and this also contributed to an increase in her confidence and happiness.

I consider that Sarah's ability to symbolise her internal experiencing, her bodily felt-sense, along with the emotional expression and experiential exploration I facilitated using the PE-EFT tasks resulted in the *felt-shifts* that were key to creating more lasting change. The combination of these elements worked together to help maximise the likelihood of change. Sarah was able to move from rigidly held views around important values to more flexible positions thus reducing internal stress and anxiety, and potentially resulting in a more relaxed way of being. Sarah reported feeling happier and more confident. She also recognised that she would never be a loud person but felt she could be more comfortable socially. In my view and in hers, Sarah's therapy had not changed her fundamentally as a person but had helped her to become more comfortable with who she was and less critical and more flexible in her thinking. I noted that at this point Sarah was also more able to trust and read her bodily felt-sense rather than relying purely on cognitive processing and potentially over-thinking as she had done in the past. She told me she felt more relaxed and I noticed she was more willing to be present to her in-session experiencing. I hypothesised that the revisiting of her internal experience through the focusing creates a familiarity and recognition that rendered Sarah to feel more stable and comfortable in her own skin.

## **Sarah's Therapy: Sessions 9-12**

### **Session 9: 12<sup>th</sup> November.**

Sarah was quite calm today despite having had an argument with her mother and not having heard from a "boy" she kissed last weekend. Sarah and her mother had argued over doing the shopping. I wondered if Sarah felt concerned at her level of anger directed towards her mother, as she said, "the only reason I feel bad is because she's sick... if she wasn't sick I would have refused to do it..." The radiation treatment had caused her mother's skin to blister and Sarah was aware of the pain her mother experienced. Her mother had lost more weight and Sarah remarked how small she appeared. However, Sarah remained quite scathing about her mother's attitude to her

illness and recovery. “She’s really doing so much... even though she’s resting she’s not really resting... she’s not helping herself... she did the gardening and was carrying all these bricks...” Her mother had booked in for meditation classes but had done too much during the day and was unable to attend the evening class. “She just doesn’t get it... to relax and actually rest.” I acknowledged that it must be hard for Sarah to watch her mother go through this and for a moment she connected to her sadness.

I wondered whether I should encourage Sarah to work with the issues about her mother but remembered she had been quite unwilling to do so in the past. I also remembered that we had committed to work with the vestibulitis and so suggested we turn our attention to that because in short-term treatments it is preferable to maintain a focus (Paivio & Pascual-Leone, 2010). Sarah said “I had a moment in the car the other day... it was just about sleeping with people and my issue with that...” She had listened to a CD that explained it doesn’t matter how many sexual partners you have had as long as the experience is positive and conducted with dignity. However, when Sarah thought about the possibility of a one-night-stand she felt the guy might potentially use her for sex. “I still don’t think I could sleep with anyone unless I was going out with him. I supported her need for boundaries. Sarah was also concerned that she lost herself when she became sexually involved. “I think it’s like my physical, and don’t know whether its spiritual... isn’t kind of in line about having sex.” Her sense of self was still developing.

Sarah was aware that her reserved behaviour was also “how I avoid being hurt... I don’t think like that’s my natural response... that’s like my intellectual response... cautious... like trying to contain it so something bad doesn’t happen...” I recognised a conflict split which is a marker for the two-chair task. We established that one was the “controlled” critical part and the other was the “free” spontaneous part. Fortunately, Sarah was willing to explore the split through the two-chair enactment task and moved to the “controlled” chair. Sarah described her felt-sense as she sat in that chair. “My body has a tight... (*pause*)... thing around it... contained... I know my limit... I’m predictable...” She spoke from the controlled aspect to the spontaneous one. “When you’re in control I can make mistakes that could ruin my life... do something embarrassing... that other people will judge me for... kissed the boy...” The freer aspect had emerged and she changed chairs. “When I sit here... when I’m free it’s only

when I'm really drunk... it's when I let myself be in this state... which makes it worse because I'm more out of control... because I'm so contained all the time..." However,

when I feel free it just feels like there's no restriction on my body... and that it's not that I say anything different or I act different it's just I think I am more relaxed and I give a different energy to people... I think [I'm] open and friendly... things will happen... I like being like this... it makes events more enjoyable and it means I have more fun...

Sarah changed chairs. "If I left you in charge all the time it wouldn't be right... I don't trust you... the only reason I don't trust you is because of what happened..." Sarah continued to chastise her free spirited side, which responded, "I know I made a mistake but I have learnt... I came to realise that there are just so many other worse things that could happen..." Sarah's free side acknowledged that boundaries were needed. Sarah's controlling side agreed that it was important for her to express her freedom to a certain extent and offered a solution. "It'd be good to start to go out and not have a drink... suddenly in the past year and a half I seem to like to drink every time I go out... I'd like for me to go back to not drinking..." The two aspects were in agreement that a couple of drinks would be fine and "I don't have to drink to be free..." Animatedly, Sarah returned to her original chair and we discussed the integrating process.

However, she added, "I have this slight anxiety... what happens if I go out and can't feel it... or being around drunk people is just..." I asked Sarah to locate the anxiety in her body and she pointed to her upper chest. She closed her eyes and described the sensation as soft, green and oval. "I would like to meet a boy who would like to go out with me... but I feel like I'm closing them off because I can't have sex... the sex may be unenjoyable... part of me knows it will hurt..." I acknowledged that it was evident to me that Sarah wanted sex. We both laughed. "I know that's the thing... and I'm so frustrated..." Again a conflict spilt was evident and so we returned to the two-chair task.

Interestingly, Sarah chose the controlling chair for the aspect that knew sex was going to hurt. "You shouldn't want to sleep with random people..." Sarah saw this

view as one of her strongly held beliefs. “You get judged...” Sarah was also concerned about the consequences: “I don’t want to get hurt... I’ve seen [what] my friends go through... they’ve been a mess... that scares me...” Sarah moved chairs

I just want sex... I just want to be a normal 21-year-old... instead of having you watching over me all the time... you’re always saying something to me... you restrict what I do... I get out of control when I drink because then I don’t have to listen to you... so it means my judgement gets swayed... I think it’s for the better most times but if you just relaxed... I’d be able to relax as well... I just want... sex...  
(*laughing*)

Sarah changed chairs. Seriously, “if I let you have sex what if it hurt... I don’t want you to go through any more pain...” She recognised the virtues of this protective stance but that it was also constraining. I enquired as to whether this side wanted sex. Sarah slowly said, “yes... I want a casual relationship too...” The two aspects were in agreement but Sarah wanted reassurance that sex wouldn’t be painful. The spirited aspect knew sex doesn’t hurt but was unable to reassure the other aspect. Sarah’s physiotherapist had suggested increasing the medication as a means of minimising the pain. Sarah returned to the controlling chair but felt that increasing the medication was “not quite the answer... I think I’m really scared that what if I do really like sex... (*smiling*)... I’m scared what the control side will do if I like sex... maybe I’d lose part of me...” I asked Sarah to sit with this realisation and check in with herself if she would really lose part of herself. “I’m not going to lose it... it will just relax a little bit... (*long pause*)... they know (*pointing to other chair*) that liking sex is good and want to like sex... but I’m just scared...”

Sarah felt “there’s something...” and I asked her to notice her body to locate it. After a long pause “I found it... right in here (*pointing to her lower abdomen*)... like my first boyfriend... I had a few bad experiences and then never really liked sex... and I think that not enjoying sex was better...” I encouraged Sarah to go to that moment when she made that “choice” that it was better not to enjoy sex. Sarah looked puzzled. I encouraged her to explain to the other aspect that she had made a choice not to

enjoy sex. Sarah closed her eyes and as a result of her internal dialogue experienced a felt-shift. I encouraged her to sit with the newness and she noticed her heart was beating really fast “I think that’s relief...,” and I offered that it could be excitement about having sex. Sarah returned to her original chair laughing that’s “really good... I’ve talked about this to many people and I’ve never come to that... so strongly... I can’t believe I think that or thought that...”

I reaffirmed the importance of Sarah listening to her intuition and being comfortable with herself and her beauty. “Everywhere I go in the past few weeks everyone’s been telling me how stunning and beautiful I am... the boy I kissed last Friday night said I was really hot...my mum’s friend said [I was] just glowing... a different person...” Tears welled in my eyes as I recalled Sarah’s words to me when she first started counselling. “I just want to be beautiful...” Sarah cried too. I acknowledged Sarah’s determination and commitment and that she was feeling her beauty “from the inside as well as people noticing on the outside.”

Sarah reported on her Helpful Aspects of Therapy Form that discussing her issues around sex and identifying “a belief I had which I never realised I had” was extremely helpful. Sarah also found “contrasting the controlled me and the free me” through the two-chair work was extremely helpful.

### **Session 10: 18<sup>th</sup> October.**

Sarah felt dejected. The boy she had kissed had ignored her, she had her “first real ugly day in ages...” and a major conflict arose with her mother about financial contributions to the household expenses. She had supported herself financially in every other way, and was furious. University assignments were almost finished, she had resigned from her part-time jobs and she was turning her attention to her working holiday trip up north. Rather than work through any of these concerns she again turned to the issue of her vestibulitis. “After last week... feel like my mind’s ready and I’m ready but physically it’s literally like (*making a fist with her right hand*) it’s not going to give an inch...” I said that “it’s almost as if you’ve got an argument between your brain and your body.” Sarah agreed and I suggested two-chair work.

Sarah easily designated a head-chair and a body-chair. Initially she sat in the head-chair. “I’m 90% ready but this (*both hands gesturing to the other chair*) is like the last

10%... why aren't you ready..." Moving to the body-chair "I'm still trying to protect myself from getting hurt... keep myself closed..." The vestibulitis developed during the end stages of a relationship three years ago. She had habitually hid her emotions from everyone but Gina, so friends never realised that the breakup hurt her. I asked Sarah to revisit the part of her body that feels pain with sex and suggest the idea of letting go. She didn't want to let go because she believed she would forget everything that she'd been through without learning anything. "I don't think I'm a more compassionate person because of it and I think that's really sad..." Sarah acknowledged through that attending so many professionals gave her insight about "how I'd like to treat my clients..."

I encouraged Sarah to ask her body "do you have any compassion?" and swap chairs. "Why should I have compassion for other people when I have to go through this myself?" She had not been shown much compassion as a child and often felt confused because the compassion from Gina had been peppered with criticism. Recently, when Gina had been crying, Sarah felt she was "so hard... I'm just so heartless..." I explained that I saw Sarah's behaviour more as a defence mechanism. I encouraged her to identify compassion as a place in her body and after a long pause Sarah said "if I let my body be compassionate for itself... I think it's connected with loving myself..."

Sarah noticed there was still something else. I asked her move to the head-chair. "I think I'm more accepting of you now but... I just need to be more comfortable with who you are." But Sarah's mind was pushing her body against its will. "Yeah, that's it exactly... my head's telling me I need to go to the physio, take my medication, do my exercises..." Sarah was committed to this program and logically was doing all she could but her body was not responding. I encouraged Sarah to ask her body what it needed and she swapped chairs. "I'm not responding because I'm not ready... it's yelling at me..." and she moved back to the head-chair. "Why not... that's so stupid... you've had this for three years... and then suddenly... I think it's about... it's about me feeling connected to you and being one with you..."

Sarah's "body" responded "I don't think you listen to what I'm saying... sometimes I don't want to have sex, I don't want to have sex and you shouldn't force those things just because you think you should..." Back in the head-chair Sarah said

“you should have sex every day...” Sarah had gleaned this belief as a result of complaints made by ex-partners that there was not enough sex in the relationship and this was the reason why her relationships failed. She also realised that when she no longer liked the guy she was unable to end the relationship and didn’t want to have sex with him. Sarah’s body had been putting out a clear message and her head realised it hadn’t been listening.

From the body-chair Sarah’s “body” asked for acceptance and “I need you to listen to me... and also before you eat...” Sarah’s “body” needed time out “to process my emotions and my feelings and things that happen... and I’m not just going to get over it... and you don’t need to get involved by overanalysing... I just need to be in that experience so then I can move on...” Sarah’s head agreed to “wait... and not suppress any of your emotions...” Agreement was reached that processing time would be set aside each day. Sarah returned to her original chair. “My head’s just spinning but my body’s like... relaxed... it’s like relieved.” On her Helpful Aspects of Therapy Form Sarah wrote “when I found agreement between my body and my head in regard to my vestibulitis, my body relaxed and my head listened” and this was greatly helpful.

### **Session 11: 26<sup>th</sup> October.**

Sarah’s academic life was ending and she was a bit uneasy about it. Sarah felt confident that “I’ll find my perfect job...” and had been applying for a number of jobs. She had been able to show her mother compassion during the week but found no time for Gina who was struggling with issues with her boyfriend. She had listened to her body and not done her physiotherapy exercises.

I suggested a focusing exercise as Sarah had a great deal going on but no specific issue was salient. She visualised a hard square red pressure sitting on top of her head: “I think it’s my personality... I think I find it hard for people to get to know me... for me to let them...” I asked Sarah to notice her bodily felt-sense as she talked. She visualised a whitish cream thin tube running along her sternum and felt nauseous. “I think it’s about being scared... that people won’t like me...” I encouraged her to stay with that sensation and identify when she had first felt this. Sarah remembered a girl in Grade 1 at the alternative school. The sick feeling developed into more “like a hollow feeling...” There had been a misunderstanding and Sarah found herself



punished. “I decided to screen what I was going to say...” In order to reprocess the incident I encouraged Sarah to find more appropriate words that she could say to that teacher and confront her in her imagination. “I wouldn’t change what I said I’d just explain it more...”

Sarah focused on the hollow feeling again and Gina came to mind. “People always compare us...” She remembered starting high school: “Gina wasn’t very friendly... then that’s what people thought of me... she just didn’t like to be friends and it didn’t bother her, it bothered me...” Sarah noticed an “evil dark grey cloud” in her chest. Gina “can be really annoying... [but] she’s really fragile... like I have to protect her...” It appeared that as Sarah had become more empowered and Gina more vulnerable. Sarah believed going up north would help break the symbiosis but was curious as to what might happen “if like she got sick... if she was dying or something...” At this point I reassured Sarah but was rather dismissive of her concern. I returned the focus to Sarah’s leaving. “I know I can do it but it’s like separating...” I responded that “with every change it’s like something dies... it’s not surprising you feel it’s a little bit like dying.” Sarah replied, “what if I miss her?” I asked Sarah to imagine Gina with her, sitting together but separate: “we’re still a little bit connected...” I acknowledged that as twins they would always have a unique connection. Sarah visualised that the dark cloud had condensed into a dark spot which she recognised as “fear... what will I be without Gina... I know we have been a lot more separate over the past few months...” The session was drawing to a close and I reminded Sarah how far she had come and her excitement at starting a whole phase of her life. She reported on her Helpful Aspects of Therapy Form that “separating from my sister... was helpful because it needed to happen and for me to realise that I will be OK” and the “personality scanning... letting my guard down” was also helpful.

### **Session 12: 16<sup>th</sup> November.**

It was two weeks since our last session and Sarah was smiling and vivacious. Job seeking was going well. Sarah shared a decision she had made when she first started therapy “I was, like, I want to have pain free sex before the last session...” She went on to explain a missed sexual opportunity but I supported her in her choice not to have

sex. Sarah's mother was doing better and said she would miss her when she was away but Sarah felt the separation would enable her to "actually *want* to speak to her..."

Sarah was overwhelmed with all that was going in her life and in particular with "boys" and so I suggested a focusing with the intention to facilitate some processing in the relationship domain. She felt pressure in her jaw. "It's about me being too sensible... my body feels like it wants to let go... but my head's like..." These statements were distinct markers for two-chair work and I invited Sarah to either have a conversation in her inner world or we could set up the chairs. Sarah decided to do the two-chair enactment task and allocated one chair as the sensible part of her and the other chair for the part that wanted to "do what I want to do... just having fun... my body..." She immediately sat in the chair that she also described as her body, the free and easy side. I wondered if this was a rebellious aspect. Laughingly, Sarah agreed. However, "I feel that I can't... like can't let it out..." This was the sensible side and I suggested she changed chairs. "I feel like I overanalyse the situation and I stop feeling..." Sarah swapped chairs. "I just want you to know how much more fun it is to be free... but I also get that my body is still scared..."

I encouraged Sarah to stay with that scared feeling and notice where she felt it in her body. The felt-sense in her chest related to concern about being judged by others and not being good at doing things. Sarah's default position to see the negative in a situation and praise for Gina made her feel unattractive. "It's the same as if I see one pretty person... I'm not that pretty... I'm just so selective on who I compare myself to..." I encouraged Sarah to attend to that blinkered judging part of herself and acknowledge she was pretty too.

Sarah returned to the issue with guys. "With guys that I like... I feel rejected..." I encouraged her to remember kissing the boy. "I just distanced [myself] like pulled away..." and she located a heavy sensation over her shoulders, chest and solar plexus, "like a [grey] ball filled up on one side... it's just like to protect myself..." I asked how long it had been there for and she said since she was "three or four." Her father had left when the twins were six and there was a great deal of tension in the house prior to his leaving. "I think I just withdrew and just relied a lot on Gina..." Sarah had felt she could not rely on people and "I still feel like I can't... the only person I trust is Gina." Sarah had needed to withdraw in order to protect herself. "I think I'm scared about

how sad I'd be... with rejection... I don't like being sad... I'm just worried I'd become too sad..." I asked where that really deep sadness originated. "I think it's just I'm pissed off with dad back from when I was little..." I encouraged the little Sarah to speak to her dad. "But I've had this conversation with him so many times..." I suggested that her relationship with her father was the model on which her relationships with young men were based and it was important for her to voice her anger and disappointment. She said, "It's about accepting that he did the best he could." I challenged this, because her anger as a primary emotion was valid and justifiable. I was curious to know if there was anything "under" the anger. "Just sad" she said without tears. I encouraged her to stay with that.

The sensation in Sarah's chest had intensified and was "really dark and heavy..." She was able to stay with the sadness and the sensation lightened. I asked her to notice her father and their connection: "it's OK but there's not much of a connection." The session had run well over time and I realised there was only so much we could achieve in this last session around the issues with her father and so I brought the session to an end by enquiring as to whether it was an OK place to finish. I realised we had been unable to finalise the two-chair work we had started and because of the time I was reticent to move Sarah to the other chair. Therefore only a partial resolution was achieved in this session. We discussed how Sarah had become "sensible" in order to protect herself from being hurt and that there may still be further issues to work with in respect to her father. Sarah reported on her Helpful Aspects of Therapy Form, that "realising how much dad has influenced my interaction with people was helpful because I was able to see where the emotions were coming from and then be able to modify my thinking about them." In addition Sarah stated that "establishing that me and Gina could both be beautiful" was also helpful. In Table 6.9 I have highlighted the significant elements of each session.

Table 6.9. Sarah: Summary of bodily felt sense, symbolic representation, episodic memory, emotional arousal and felt-shifts – sessions 9 to 12.

Session and task	Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
9. Two-chair <i>Conflict</i>	CONTROLLED chair – tight and contained SPONTANEOUS chair – sense of freedom, relaxed, open anxiety - upper chest  lower abdomen	soft, green and oval	sex hurt with first boyfriend – never said  being told she was beautiful	frustration at not having sex - both sides want sex recognition of choice of not enjoying sex → relief excitement → <i>shift</i> tears of joy
10. Two-chair <i>Conflict</i>	HEAD chair – ready for sex BODY chair – closed pressure in chest tingling in legs and arms		vestibular pain disappointment holding in emotions as 5 year old child shown little or no compassion	<i>sadness</i>  finding compassion acceptance for herself body relaxed → <i>shift</i>

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
11.	Focusing <i>Relationship with Gina</i>	top of her head	hard red square a whitish cream thin tube running along her sternum	Grade 1 – punishment circle misunderstood IC - teacher screen what she said	<i>fear</i> of not being liked  <i>disgust</i>
		felt nauseous hollow sensation in stomach chest  ↓ tension in head	evil dark grey cloud condensed into a dark spot	Gina's critical judgments ... what will I be without Gina the stress of life	<i>anger</i> at Gina <i>fear</i> of Gina dying but <i>sadness</i> she will be ok → <i>shift</i> no need to get too stressed – humour
12.	Two-chair <i>Conflict</i>	SENSIBLE/HEAD chair – overanalyses SPONTANEOUS/ BODY chair – rebellious, free and easy but fearful of being judged, rejected heavy shoulders, chest and solar plexus	like a [grey] ball filled up on one side	before father left she withdrew and relied on Gina IC – father	<i>shame</i>  <i>fear</i> <i>anger</i> and deep <i>sadness</i> → <i>shift</i> partial resolution

### **Client and therapist analyses of change.**

#### ***Client's analysis of change after session 12.***

Sarah reported in her Change Interview that her experience of therapy had been “very good” but she still wanted work on “relating better to men... I would like the friendship to be able to be closer... more fuller experience... more relaxed... [still] a bit controlled...” However, she had noticed that “I have a better understanding of what is going... I feel it’s just how I’ve learnt to interact with people [i.e. being controlled], it’s like partly that and partly my personality but there’s like a middle ground...” Sarah acknowledged too that “I think I’ve been a lot more positive since beginning therapy... that’s shown by interaction with other people... I did a job the other week, where I didn’t know anyone... I found it much easier to interact with new people...” Sarah offered another example of change.

Probably, just like relating the head and the body getting them to match... I wasn’t so aware so now I’m thinking about more of both, trying to integrate... I suppose it’s like tuning in and knowing if I should do something just how I’m feeling... going like that rather than just listening to my head...

The consequence of Sarah listening to her body was better management of her eating, which she attributed to therapy. “I think that definitely the majority [of change] was definitely due to therapy... but that also my dancing and my friends and stuff like that...” Specifically “I like the two-chairs, that was really helpful... we did a lot of head and body... [and] I think the focusing helped heaps... find a place of connection and explore that...”

Sarah explained the experience in more detail.

It was about four sessions ago, we were doing the chair work with the body... I suppose it’s like the realisation and acceptance... yes I think it wasn’t just that session it was an accumulation... or just everything... talking about something maybe completely different had a flow on

effect in some other area... when it happened that *click*... it was like a relief feeling I can't really explain it... it just happened because of what I think was the accumulative effect of the therapy techniques, the therapy techniques worked well for me, they just did... because you didn't have the therapist telling you what to do... you had to figure it out yourself...

Sarah also explained that "I think sometimes some things were a bit painful, that were discussed, but it was always my decision about what I discussed... you don't talk about things like that often so it's nice to get them off your chest..."

***Therapist's analysis of process and change: Sessions 9-12.***

In Session 9, I had observed that Sarah was still very angry with her mother for not taking better care of herself but I again became intuitively aware that she was still unwilling to work directly with how she felt about her mother. I held the view then and still hold it now that I can move towards painful issues in my clients and encourage them to explore them further but if my perseverance is met with resistance I may need to let go of that line of exploration. I may repeat this process a number of times. I call this *nudging*. I believe the client has an inner knowing of what they need to work with and I trust that knowing. Instead, we have been working with the issues with her mother more indirectly and this seemed to suit Sarah. My refocusing to the vestibulitis was in keeping with Sarah's initial goals of therapy, and in the most recent sessions Sarah had indicated to me she was determined to continue working with the vestibulitis. I believe however that despite Sarah's focus on this particular issue, the holistic processing provided by the PE-EFT tasks and emotional processing enabled other problematic aspects to be resolved as well.

During this session I noticed that Sarah was also more able to understand that her reserved demeanour protected her in certain situations, but that there was another aspect of her that wanted to be free and spontaneous. For the first time, Sarah was willing to explore this conflict split using the two-chair dialogue. As we set up the chairs we clearly identified a more "controlled" aspect of Sarah and a "freer," more spontaneous part. The two-chair dialogue was a big step for Sarah but fortunately she

had become more adventurous in her exploration of herself. When, in this enactment task I asked Sarah to notice her body as she sat in each chair, she was able to get in touch with how she felt about binge drinking, casual sexual encounters and her judgements about these behaviours. By uncovering more information through her bodily felt-sense Sarah was able to identify a choice she had made about not enjoying sex. She recalled earlier sexual experiences when sex had not been painful, but then remembered sex with an old boyfriend that had hurt. There had been tension in that relationship and Sarah didn't want sex with him anymore. Rather dealing with the situation overtly she had somehow made a "choice" that sex was not to be enjoyed. Through a visualisation, Sarah was able to reprocess those sexual events and imaginably confront her past boyfriend, resulting in a felt-shift. The subtleties around these so-called choices are often difficult to uncover when working purely cognitively and the felt-sense provided her with another useful level of processing. I think it was very significant that Sarah, who had in Session 1 viewed herself as ugly, in this session reported that not only was she feeling beautiful on the inside but others were noticing and commenting on her beauty.

In Session 10, I had remembered Sarah's resolve to continue working with the vestibulitis. I identified the marker for the two-chair dialogue as a conflict between "head" and "body." It seemed Sarah had learnt to control her feelings when interacting with people but had subsequently been judged by others as distant and cold, and I hypothesised that she had become fearful of being hurt and had struggled to show compassion. Interestingly, it became evident that Sarah didn't know what compassion was and she asked me to explain the concept to her. It appeared to me that Sarah had not been shown much compassion as a child and so it had been difficult for her to cultivate compassion for others or for herself. I think that the understandings that emerged from the two chair work were co-constructed between us, and we both saw that Sarah's internal critic, the voice of her "head," was driving her to go to the physio and do the exercises while her "body," the emerging experiencing aspect, wanted to relax and feel things. Her difficulty in expressing her wish to withdraw from an unsatisfactory relationship, seemed to be internalised as her body's response to sex. The bodily felt-shift occurred when Sarah was able to assert



herself and get in touch with her needs. We explored distorted beliefs that emerged during the process resulting in less of a fight between “head” and “body.”

By Session 11, I was very conscious that not only was Sarah’s academic life coming to an end but also her sessions with me. It crossed my mind that this was a significant transition period for her but she emphasised looking for a job and did not raise the “endings” as a concern at this point, so I stayed with what Sarah brought to the session. She said she had been able to show and express compassion for her mother. This indicated to me that although we had not worked directly with her relationship with her mother, our processing salient present day concerns had a domino-effect where linked issues such as improving interactions with others led to improved relations with her mother. The fact that in this session Sarah had no particular issue to work with, but seemed overwhelmed by many, was a marker for focusing. Sarah’s ability to cede some control about what was worked with in the session, and go with my suggestions, also seemed significant to me. She was perhaps beginning to trust the therapeutic process itself rather than attempting to control it.

I encouraged Sarah to explore in a focusing task her “distant” personality, and she recognised that she is often misunderstood because she doesn’t show her emotions. Sarah felt deep disgust as she remembered more events from primary school. She recalled a time where she felt misunderstood and punished by her teacher. This shifted as she confronted her teacher in her imagination. I encouraged her to express herself openly. As she talked about the idea of Gina dying and how she felt sad, I was aware that her emotional reaction to the idea of Gina dying may have been a projection about her mother as well but chose not to explore this more fully in the session. In hindsight, I was curious to see if exploring this issue more deeply via the bodily felt-sense might have been more beneficial. But I wonder if my sense of “not wanting to go there” was a combination of knowing it would be challenging for Sarah and that the session time was nearly up and there would not be adequate processing time. My focus became more on the symbol of death as an ending, as I hypothesised that the move up north and the separation from her sister was like a death in some way. When Sarah was confronted with *who* she was *without* her sister, and experienced fear at being alone and sadness at the loss, I supported her in sitting with these emotions until they shifted and some hope emerged. It seemed an appropriate

moment to ask Sarah to reflect on what had changed for her in the past three months and to become aware of this exciting new phase of her life.

In Sarah's last session, her focus was on relationships. What I believed was a conflict split emerged between the aspect of herself that was "too sensible" and an aspect that wanted to be "carefree." In the two-chair dialogue Sarah saw that by overanalysing things she shut down her feelings, and got in touch with a sense of shame when she recalled comparing herself to others and judging herself as lacking. I now recognise this split was actually a self-interruptive split where her sensible aspect silenced her carefree self. This is where I believe the session went awry. I followed Sarah's reaction to her parents' conflict rather than focusing on the self-interruption.

As Sarah spoke of the message her father had left her, that she wasn't somehow good enough, and expressed anger towards her father and underlying sadness, I conjectured to Sarah that her father's way of being with her had affected her ability to relate to young men. It was obvious to me we had only scratched the surface of this realisation and further exploration was necessary. My aim was to move from the two-chair enactment to empty chair work with her father and then back to the two-chair to conclude the session. Unfortunately, this did not happen I abandoned the idea because of time restraint and the complexity of the work. However, Sarah experienced a partial resolution and, when a full resolution doesn't occur in session, my experience tells me that the process continues outside the therapy hour. Sarah would be likely to reflect on her insights and meaning bridges, those links between what's happening in the here-and-now and the past, would still be possible.

I valued the fact that we had worked at a level that was comfortable for Sarah but was also aware that much of the exploration was left unfinished. Nevertheless, I noticed that these last sessions saw Sarah integrate and revise earlier understandings. I think essentially the twelve sessions had encouraged Sarah to trust her felt-sense as a useful means of providing information about her eating and interactions with others. There had been some integration between head and body, rendering Sarah more balanced in her views and accepting of herself. She had also become more confident and assertive. Her changes seemed aided by the combination of the working relationship, identifying and implementing the indicated tasks. Enhancing appropriate emotional arousal encouraged the possibility of felt-shifts and the

subsequent emergence of deeper understandings and creation of new meanings. In addition, the resolution of conflict splits, resolutions that involved an integration of both sides, assisted with Sarah's internal tension. Finally, Sarah's sense of self was strengthened by the validation and affirmation I offered her when she was vulnerable.

***Analysis of change according to clinical significance.***

As part of ascertaining whether the Process-Experiential/Emotion-Focused Therapy was effective in reducing Sarah's depression, various methods of assessment were used. Clinical significance refers not only to the assessed quantitative change as a result of an intervention but to whether that intervention makes a real difference in the everyday life of the recipient, and is determined by a number of methods (see Kazdin, 1999, 2003). These are (1) The comparison of client inventory scores in relation to normative samples, (2) the assessment of absolute change; that is the change the individual makes without comparison to other individuals or groups, (3) subjective evaluations made by the client in relation to changes in their everyday lives and (4) social impact.

***(1) Comparison method.***

At the end of session 12 Sarah scored "1" on her BDI-II which was within the minimal normative range of 0-13 (Beck & Steer, 1987; Beck et al., 1996; Beck et al., 1988). On the DASS Sarah's Depression score was "6" which was within the normal range of 0 to 9 (Lovibond & Lovibond, 1995) and her anxiety score was "3" which was also within the normal normative range of 0 to 7 (Lovibond & Lovibond, 1995). Therefore, it could be concluded that Sarah no longer suffered depressive symptoms as measured by the BDI-II or the DASS. Her measured anxiety was also in the normal range. The twelve sessions of therapy appeared to have a dramatic effect on eliminating Sarah's symptoms of depression and anxiety.

***(2) Absolute change.***

Figure 6.1 illustrates the overall decrease or absolute change in depression, anxiety and stress for Sarah over the twelve sessions when measured pre-treatment and after sessions 6 and 12. It is evident as shown by the graph below that there is a steady

decrease in Sarah’s measured depressive, anxiety and stress scores over the 5 months treatment. It is interesting to note that the BDI-II and DASS reflect a similar but not identical trend.

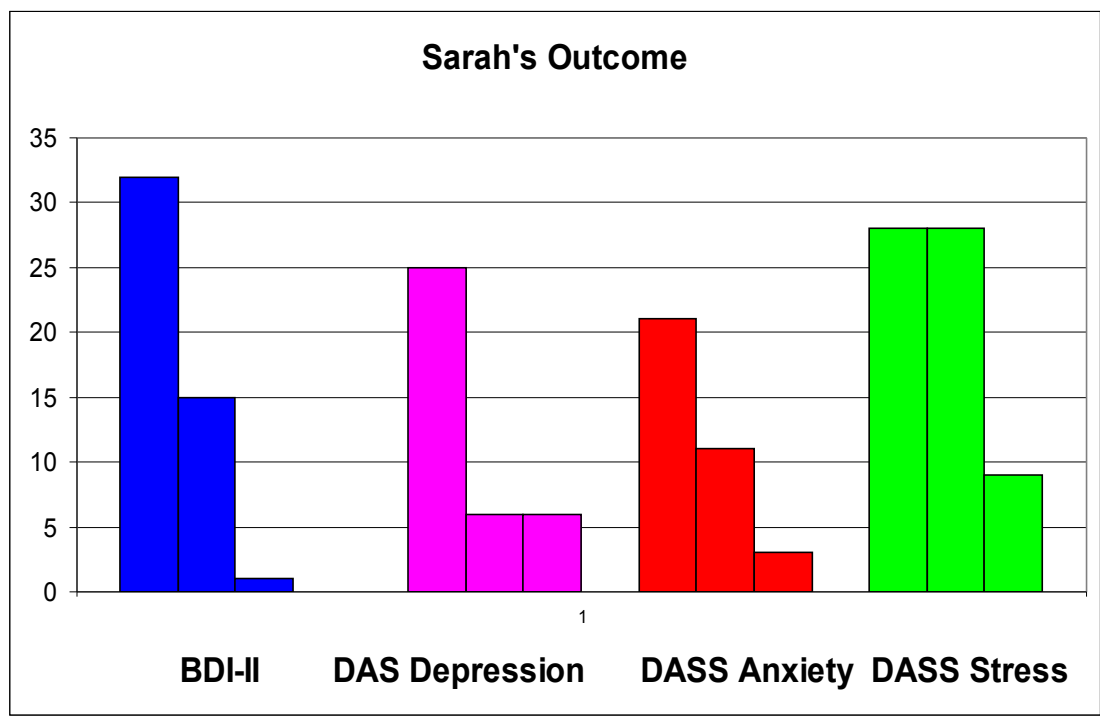


Figure 6.1. The BDI-II, DASS scores for Sarah at the screening interview and after Sessions 6 and 12.

(3) Subjective evaluation.

Sarah’s subjective evaluation was determined in two ways. Firstly, through the list of concerns (see later section on *Concern ratings*, p. 198) she made at the screening interview and secondly, documented in the themes of change identified within the Change Interviews (see client’s analysis of change sections above). Briefly, Sarah became more accepting of her appearance, her flushing ceased, her bulimic symptoms abated, she became less worried, and less depressed. She developed a more positive attitude to herself and her future and a sense of belief in herself. She attributed these changes to what she experienced and learnt in therapy; understanding herself more, recognising what is going on around her and the increased use of bodily sensing of emotion.

*(4) Social impact.*

At the end of the 12 weeks of therapy, Sarah reported that she was able to be more outgoing socially and felt more comfortable with herself in social situations because she did not feel so self-conscious. She began to enjoy the social outings independently of Gina and recognised she was interesting and seen as attractive. She felt she had learnt to interact with people more naturally, for example, becoming more comfortable with her dancing teacher and looking forward to her classes rather than being apprehensive and anxious. Sarah reported that at work she was able to be more assertive with her supervisors and more compassionate towards those in her care. She had also become more considerate and tolerant of her mother and more able and willing to take care of her. When her mother broke down Sarah had been able to stop what she was doing and go to her mother's side to comfort her.

The results of this clinical significance analysis indicate that not only had quantifiable changes occurred as a result of the PE-EFT sessions, but real differences in Sarah's everyday life were identified. The use of multiple measures of the given construct, in this case depression, provided corroborating evidence to confirm that a change in Sarah's depression had occurred, and she no longer had depressive symptoms.

## **Follow Up Reviews**

**One month later: Email communication 1<sup>st</sup> December.**

Sarah was now on her working holiday, and was very excited as she had secured an interview for a job interstate. She was also enlivened by positive contact with various "boys," making "really cool connection[s]" with them. She wrote in an email to me, "...so I am having this amazing time, feeling beautiful, and enjoying relaxing, and then the most aaahhhhh thing happened... [a] boy I met up with I went out with him and his friends, great time but to cut a long story short, had sex, no pain... I went to the bathroom after and I was just crying and I felt a bit crazy but now I can't stop smiling and I have this really fuzzy warm feeling."

**Six month follow-up.**

Sarah, now 22, was invited to attend a six-month follow-up Change Interview conducted by Dr Wills. At the beginning of the follow-up session I asked her to complete the BDI-II and the DASS. Table 6.10 and Table 6.11 show that Sarah's measured levels of depression, anxiety and stress had elevated slightly to the mild ranges. This is a slight elevation in her scores from normal to mild over the six months but her symptoms have not returned to the pre-therapy range of severe.

Table 6.10. The BDI-II classification of depression at 6 month follow-up.

<b>Sarah's BDI-II Depression Score</b>	<b>Minimal</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
19	0-13	14-19	20-28	29-63

Table 6.11. The DASS classification of depression, anxiety and stress at 6 month follow-up.

	<b>Sarah's score</b>	<b>Normal</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>	<b>Extremely Severe</b>
<b>Depression</b>	14	0-9	10-13	14-20	21-27	28+
<b>Anxiety</b>	8	0-7	8-9	10-14	15-19	20+
<b>Stress</b>	16	0-14	15-18	19-25	26-33	34+

Sarah told me she had returned from her working holiday of five months a few months ago and had been working as a subcontract physiotherapist two days per week. She was also supplementing her income with two to three waitressing shifts per week. She had been looking for more secure employment but at this point had not been successful as suitable jobs were quite difficult to find. Fortunately, Sarah had recently been for an interview interstate for a job that exactly fitted her requirements and she was optimistic about securing the position.

Whilst away, Sarah had had a two-month relationship. The sex had been good and any pain had been manageable. The young man was a pro-surfer. "He was really hot and I liked him" but they "didn't connect" and communication was a struggle. Sarah found herself losing confidence. He also had a very judgmental attitude, which

subsequently led to her breaking-up with him. It had taken Sarah a number of months to get over him and she was surprised at “how bad the relationship was.” Her eating had temporarily got out of control and she was astounded that she was still grieving. “I am sad but it can be easily turned around... roller coaster... really happy and really sad...” Sarah recognised she just needed to change her perception of things and knew deep down she was OK.

Sarah’s mother was much improved despite not working much, having little money and having broken up with her long-term partner. Sarah had enjoyed living away from home and was hoping once she secured employment to move out of home again. She now had a car and so no longer had to share cars. Whilst she was away she felt she and Gina had “become quite different,” but living together again Sarah was again surprised at their similarities. Her parting remark to me was that the work we did together “changed my life... so it was really good...”

#### **Client analysis of change after six months.**

I had modified the Change Interview slightly in order for it to serve as a follow-up measure. When Sarah reflected on her time in therapy whilst being interviewed by Dr Wills she again reiterated that she “found it really good... it was really helpful... it was a positive experience and it was never like upsetting in a bad way or anything like that... in the end I was able to talk about everything...” Sarah described the useful aspects of the therapy as “the method used... like visualisation... was helpful... how you can choose what you wanted to talk about or not want to... the fact it was weekly was really good... yes and that I felt relaxed and comfortable...” However, Sarah was struggling

I am a bit in between type of stuff at the moment... I suppose in some areas of my life I’m not where I want to be... I’m just trying to get there and it’s probably not happening... in my career and in myself, my self esteem and that sort of stuff... not where I was when I was in therapy... I think I would like a more secure job like a long term like a year contract... it’s more like I’m lost and back to not knowing what I want to do... indecisive... I just feel disheartened...

Sarah also had felt distant from her friends and not ready for a relationship at present.

I still haven't caught up with some people... I feel like I am probably a bit shy at the moment... just can't be bothered interacting with people, it's terrible... unless it's with people I really feel comfortable with I really prefer not to go... looking for a job... quite stressful... I think it's just about life... I just have nothing to offer to people...

Sarah said, "with therapy I noticed I was feeling better... and I think that I was thinking differently like more positive thinking..." She was uncertain as to how this change occurred "I'm unaware that an acute process has changed or anything... yes more like subconscious I feel, yes... it wasn't consciously kind of think about it but it still happened..." She reflected on her answers on the inventories I had asked her to complete before the interview and even though she had experienced a "mild to moderate" setback said

I feel I haven't gone back that far... it's more the just life and daily stuff that sort of it just happened really gradually but like a decline and then when I started to notice that this isn't going well I didn't know what to do... it's just feeling like my self-confidence is lacking...

When Dr Wills asked how she saw herself six months on Sarah said, "improved... I think it really helped... just now it would be good to get back on track because of all that's happening... yes it's just like life it's stressful..." Sarah would have liked sessions to have continued and then to be "spaced out to a gradual discharge..."

#### **Client's perspective after 12 months.**

Not long after the six-month follow-up interview Sarah secured that interstate job. She moved into a share-house and became actively engaged in the cosmopolitan social life there. "It's different having to make all new friends... has actually been surprisingly easy and I have been having lots of fun..." Sarah also enjoyed the more fulfilling work-life. "My job is great I couldn't have a got a better one, all the [clients]



I see just make me smile and it's definitely been the biggest reason to stay... sounds like it's all been smiles... of course it hasn't but so far the good is definitely outweighing the bad..."

### **Analysis of therapy and change after 12 months.**

#### ***Measures of client change.***

Sarah's assessed depression, anxiety and stress levels were now in the normal to mild ranges (see Table 6.12 and Table 6.13). Despite a great deal going on at the times these inventories were completed, Sarah scored only in the mild range of symptoms on the BDI-II and the DASS.

Table 6.12. The BDI-II classification of depression t 12 month follow-up.

<b>Sarah's BDI-II Depression Score</b>	<b>Minimal</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
12	0-13	14-19	20-28	29-63

Table 6.13. The DASS classification of depression, anxiety and stress at 12 month follow-up.

	<b>Sarah's score</b>	<b>Normal</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>	<b>Extremely Severe</b>
<b>Depression</b>	10	0-9	10-13	14-20	21-27	28+
<b>Anxiety</b>	8	0-7	8-9	10-14	15-19	20+
<b>Stress</b>	10	0-14	15-18	19-25	26-33	34+

Figure 6.2 graphically represents Sarah's outcome over the course of the 12 sessions of therapy and follow-ups. The trend shows that whilst in therapy Sarah's inventory scores reduced significantly. As mentioned above, at the six-month follow-up Sarah's scores increased to fall in the mild ranges for depression, anxiety and stress. This may have been situational. She was looking for a job and was working a number of casual jobs. At the twelve-month follow-up Sarah had secured a job and despite a move interstate was doing well. Her scores were not as low as when she attended sessions but she was managing difficult relationships, living interstate and coping with all the

challenges of a young professional woman. Sarah was able to adapt to her demanding new life style and, despite a relationship break up which caused her grief and took some time to recover from, she was coping extremely well.

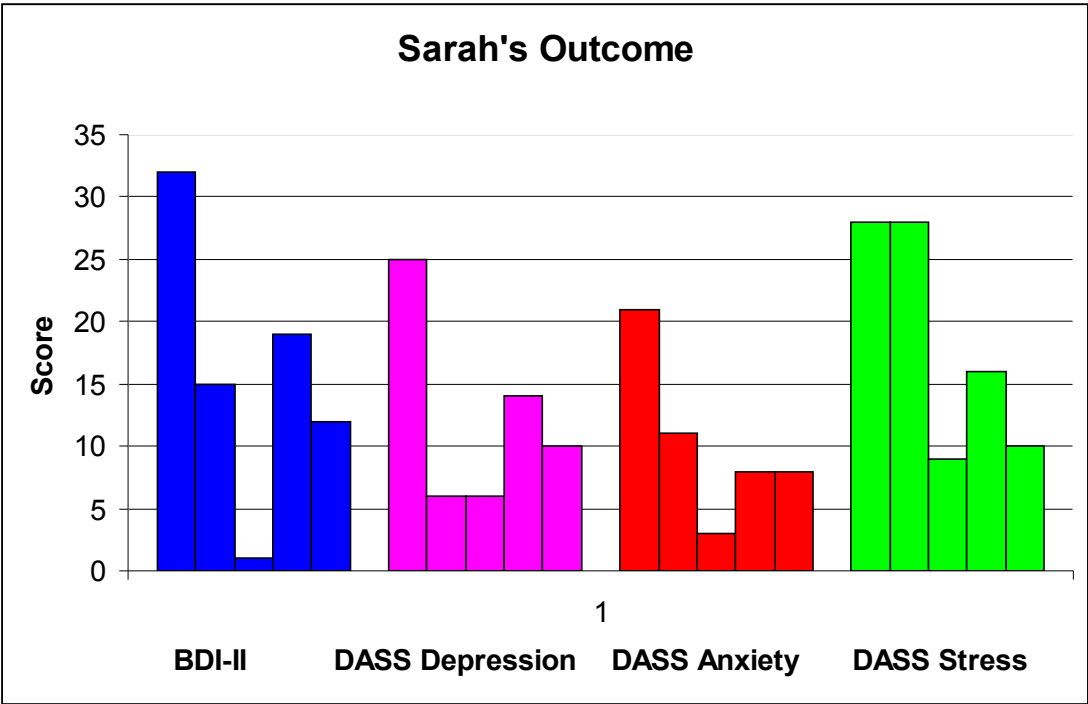


Figure 6.2. The BDI-II, DASS scores for Sarah at the screening interview, after Sessions 6 and 12 and at 6 and 12 months follow-up.

***Profile of Mood States (POMS).***

I have graphically represented the shifts in mood states on the POMS during the counselling period and at six and twelve months post-therapy (see Figure 6.3). Despite plotting all the POMS subscales I will comment mainly on the depression subscale as depression is the main emphasis of this research. At Sarah's screening interview and until her fourth session Sarah's levels of depression and anxiety, according to the Profile of Mood Sates, were "very high" and "high" respectively but they reduced steadily subsequently. Interestingly, at session 10 her depression score peaked slightly. During the previous week Sarah felt she had had a disastrous time when a boy she was

interested in ignored her, her eating got out of control, and her mother finished her last round of radiotherapy and wanted to give up work, offering the twins an ultimatum that unless they contributed \$80 per week to the household expenses the house would be sold.

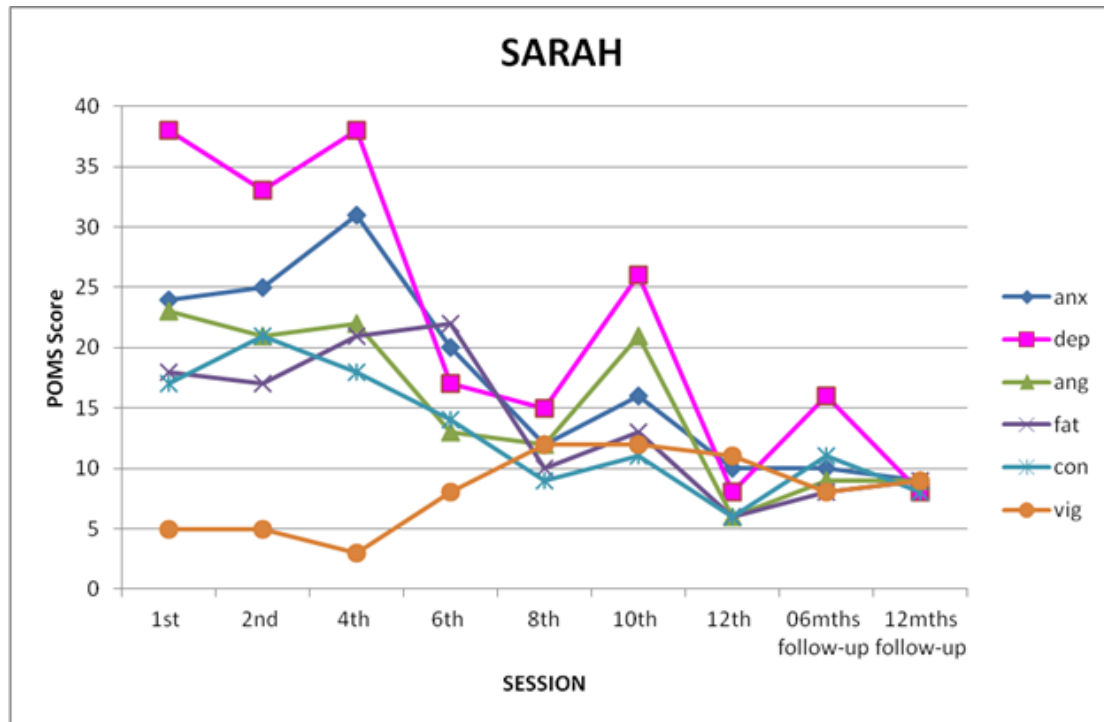


Figure 6.3. Profile of Mood States (POMS) scores for Sarah.

The ongoing therapy at the time appeared to have contributed to Sarah being able to work though the issues and the levels reduced with a small peak again at the six-month follow-up. At the time of the six-month follow-up Sarah was struggling to find suitable employment in the area of physiotherapy. It is also worth noting that Sarah's levels of vigour improved as her mood improved. Figure 6.3 graphically represents the shifts in mood states during the counselling period and at six and twelve months post-therapy.

***Concern ratings.***

In Sarah's screening interview, she had listed a set of concerns that she wanted to deal with in therapy. Table 6.14 tracks the changes in her concern ratings after sessions 4, 8, 12 and at the six-month follow-up. The most marked reduction in concern was Sarah's flushing. After session 8 Sarah reported it was no longer a concern for her. Overall, there was a reduction in most of her concerns by the end of therapy. After session 4 some of her concern rating increased a little, possibly as a result of an increased awareness of those concerns by working with them in the counselling sessions. After 6 months Sarah's level of depression, not having a partner and the flushing began to bother her a little more. Sarah expected therapy to assist her with her concerns about her depression and the concerns she had for the future but was surprised that therapy assisted with the vestibulitis, flushing and her self-image. All of the concerns Sarah listed were very important to her, and Sarah considered most of the changes she experienced would have been unlikely without therapy.

Table 6.14. Concern ratings\* for Sarah during counselling at 12 month follow-up.

Concerns	Before Therapy	At Session 4	At Session 8	At Session 12	At 6 month follow up	Change was: 1 expected 3 neither 5 surprised by	Without therapy: 1 unlikely 3 neither 5 likely	Importance: 1 not at all 2 slightly 3 moderately 4 very 5 extremely
1. Feeling ugly	7/7	7/7	5/7	3/7	3/7	4.5/5	2/5	5/5
2. Vestibulitis	6/7	6/7	6/7	3/7	3/7	4.5/5	2.5/5	5/5
3. Not having a partner	5/7	6/7	5/7	3/7	4/7	2.5/5	1.5/5	5/5
4. Feeling depressed	6/7	5/7	3/7	2/7	4/7	1/5	1/5	5/5
5. Worrying about things	7/7	6/7	3/7	2/7	2/7	2.5/5	2/5	4/5
6. Future	7/7	6/7	3/7	2/7	2/7	1.5/5	2.5/5	4/5
7. Want to feel like an interesting person	6/7	7/7	3/7	3/7	4/7	3/5	3/5	5/5
8. Want to have a more positive outlook	5/7	5/7	3/7	2/7	2/7	3/5	3/5	4.5/5

Concerns	Before Therapy	At Session 4	At Session 8	At Session 12	At 6 month follow up	Change was: 1 expected 3 neither 5 surprised by	Without therapy: 1 unlikely 3 neither 5 likely	Importance: 1 not at all 2 slightly 3 moderately 4 very 5 extremely
9. Want to believe in myself	6/7	7/7	3/7	2/7	2/7	3/5	2/5	5/5
10. Flushing	7/7	6/7	1/7	0/7	2/7	4/5	1.5/5	4.5/5

Note: \* scale of 1 being not at all concerned to 7 for maximum possible concern.

### ***Personal descriptions.***

During the screening interview Sarah described herself as opinionated, quiet, a no-nonsense person, down to earth and spiritual. She also mentioned having a strong work ethic and being motivated. She recognised that with others she was a bit standoffish and reserved. At the Change Interviews after session 4 and session 8 Sarah felt these descriptors were still the same. After session 8 she added fun, intelligent, multi-tasking and smiling. She thought others might just say that she was serious. “Last week someone described me as controlled... it was quite accurate at the time ... just that I’m controlled in the things that I do...” In addition, “I wouldn’t say I’m quiet... I think around my friends I’m not quiet [in other contexts] I can be...”

After session 12 Sarah still saw herself as fun, intelligent, spiritual. She felt that people would say she was driven, confident and motivated and that the original descriptors were still adequate but now she also saw herself as “happy.” When she explored the concept of being opinionated she saw it as sometimes good but not when it restricted her from doing things. However, she felt her views could be changed, but was happy to voice her opinions. “I’m not just going to sit back... I say I’m opinionated but I also think that I’m a very compromising person...”

At the six month follow-up Change Interview Sarah said “at the moment I would probably say that I’m... lost at the moment... and very thoughtful, still opinionated... and driven in what I want to do but just a bit more mellow...” and “I don’t think I’m quiet... just depends who I’m with...” When Dr Wills asked her again about being opinionated Sarah replied “yes I am just opinionated about my beliefs or like what is right or wrong... I don’t know what they are, more just like moral issues or, or anything that I think, that I will always speak my mind about something...” Sarah also recognised “I am judgemental it’s terrible... I am very judgemental especially on myself but also on other people... I think I have improved... I think it’s more external like materialistic image what society would think is right kind of judgement...”

### ***Measure of the working alliance.***

Initially, I experienced Sarah as somewhat reserved and apprehensive, and it took a number of sessions until she seemed able to speak freely. I respected her initial need

for privacy and greatly admired her level of disclosure as we continued to work together. Significantly, during the Change Interview after session 8 Sarah said

...I think the relationship you form or how much I trust my therapist generally is like really important and the relationship you have with your therapist is the whole therapy... kind of what I think anyway... I just suppose it's more... that empathy... if you feel relaxed and you feel comfortable and um yeah I suppose that empathy helps.

After session 12 Sarah reported, "she didn't force me to do it... like you're not telling them, and I think you get better results... "and her voice... she's relaxed and approachable and you can tell she feels compassion and empathises... I think she's good at her job... she doesn't treat me like I am a child."

Table 6.15 indicates the measured levels of the working alliance utilising the WAI-S over the course of the twelve sessions of therapy.

Table 6.15. Measure of the working alliance utilising the Working Alliance Inventory - Short (WAI-S) form.

	Session 4	Session 8	Session 12	Range
<b>Sarah's evaluation of working alliance Raw score</b>	77	77	83	12 - 84
<b>As a % of the total score possible</b>	92	92	99	

At the six-month Change Interview Sarah reflected on our work together.

I think that it was... she just made me feel really comfortable and never forcing a topic or sort of giving no choice in what I wanted to work on... her personal skills and personality... warm and friendly and non-judgemental if that's what you see and she's like empathetic and caring.



Sarah also said

I just think I'd like to be a therapist like Melissa... when I see my clients that's kind of what I aim to achieve but I do find it difficult... I am a bit more clinical, when I see clients I get stuck in... it's a little bit different... like when I'm doing an assessment.

## **Therapist's Analysis of Sarah's Therapy Process**

### **Sarah's core emotion scheme.**

An important goal in Process-Experiential/Emotion-Focused Therapy (PE-EFT) is to help clients access and process their emotions to change problematic emotion schemes in order to construct new meaning. I used the template below in Figure 6.4 to identify the core emotion scheme for Sarah. Whilst Greenberg (2011) and his colleagues suggest there a number of schemes operating moment-by-moment (Elliott, Watson, Goldman, & Greenberg, 2004), I hypothesise they constellate around a single core scheme. The emotion scheme illustrated below is based on the incident of the punishment circle that Sarah revealed in our first session. This experience somehow epitomised her experience of her life in general. Being the centre of attention created a great deal of anxiety and shame for Sarah. She wanted to be *seen*, accepted and understood and yet she often felt judged and alienated.

According to PE-EFT, enduring changes in Sarah's life could be achieved if this emotion scheme were reactivated in therapy under the therapeutic conditions of safety and permission. Then it could be reorganised to operate at a more adaptive level of functioning, or a new scheme created. Throughout the sessions Sarah exhibited feelings of anger, sadness, fear, and shame, but in my opinion it was her shame that was a prominent factor in her depression. The eating disorder, issues around body image and the vestibulitis may also originate in her deep-seated shame. In my view shame is like a "blanket" that sits over the other primary emotions of fear, anger, and sadness. Once we had been able to process Sarah's shame, her sadness emerged. This is consistent with the Pascual-Leone and Greenberg (2007) model (see Figure 3.2) that

shows that processing of fear and shame occur in the early stages of therapy, and grief and loss emerge in the later stages.

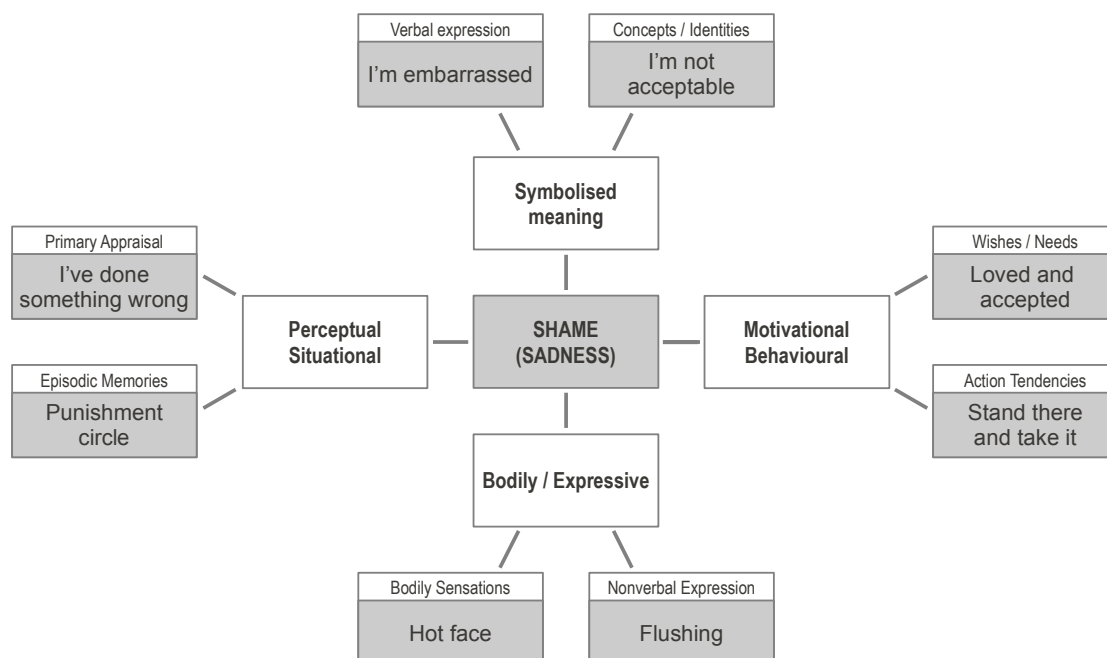


Figure 6.4. Sarah's emotion scheme.

Sarah was very guarded and often reticent to explore certain aspects of herself deeply, and she experienced depression and anxiety that, according to Greenberg (2011), are clearly affective disorders. Greenberg and Watson (2006), argue that shame manifests as depression where the self is felt to be flawed in some way and self-esteem is low, and individuals so afflicted often judge themselves harshly. Core feelings of shame are often deeply embedded and clients often attempt to avoid experiencing them as a way of minimising their distress. Resolution of the problem of shame, according to Greenberg and Watson (2006), is to be less critical and more accepting and consequently strengthen the sense of self. Compassion for self is regarded as an antidote for the shame, and Sarah struggled quite significantly with understanding and experiencing compassion towards others and herself.

In my opinion we had only begun to touch Sarah's deep sadness and perhaps another four to six sessions may have completed this process. Watson, Goldman, and

Greenberg (2007) offered 16 to 20 sessions to their depressed clients and so the twelve sessions I offered may have been insufficient. However, Sarah was very determined to use her twelve sessions efficiently and did manage an excellent outcome.

**Therapist reflections on the application of PE-EFT principles  
and the process of change.**

When I assessed my competency as a PE-EFT practitioner in this case, I referred to Elliott's (2002a) Experiential Therapy Session (ETS) form. When applying the PE-EFT principles I rated myself as able to apply them appropriately, consistently and creatively. Overall, I believe I was empathically attuned to Sarah's experience and offered understanding, presence and genuineness. As I was dealing with a young person with a developing sense of self and identity, I knew it was important for me to be reassuring and affirming of her to help in the development of her inner strength and enhance her self-esteem. I facilitated Sarah's progress by identifying the appropriate tasks and implementing them within a collaborative environment. For example, when Sarah was hesitant to work with the issues regarding her mother's illness I was able to remain mindful of her goals for therapy and stay within those boundaries for her comfort. I also offered alternative ways of working when Sarah was not comfortable with a proposed task. I was able to follow the framework of each task by encouraging internal attending, experiential search, by supporting emotional expression, and by offering containment and holding. The effect of this on Sarah was evidenced by her ability to process her concerns freely and openly.

Each task has a general structure (see Elliott et al., 2004, see also Table 3.3, p. 64). When a marker emerged for Sarah I was able to invite her gently to take up the task. But when she felt uncomfortable I created new ways to work with the tasks in order to adapt them for her without compromising the integrity of the task. Within the tasks Sarah explored and deepened her experience, usually experiencing a felt-shift. I was careful to track Sarah's internal experiencing, checking that she felt safe and comfortable to explore, and thus offered her opportunities to move through the painful aspects of her past experiences. This movement enabled Sarah to uncover new perspectives and new meanings that liberated her from old patterns and rigid forms of thinking. This allowed her to be clearer in her decision making, to feel more

empowered and thus to be confident to take action to carry those decisions forward. In PE-EFT terms, attending to all these components should maximise the potential for change, and clearly Sarah has changed.

My assessment is that what worked for Sarah was the combination of the working alliance and the therapeutic tasks. A key to the relationship was my empathic attunement, and a key to the task success was the facilitation of the activation and reprocessing of the emotion scheme that resulted in the felt-shifts that Sarah experienced. Attending to the felt sense and symbolising it helped create meaning. Appropriate arousal of emotions such as fear, anger and sadness provided access to implicit appraisals, action tendencies and needs that informed Sarah about what is good for her and moved her to adaptive action.

## **Chapter Seven • Case Study 2: Katie**

### **Introduction**

This chapter introduces the client/participant, who chose to call herself Katie, and presents the second of the four case studies in this thesis. It outlines the assessment phase, a brief overview of the therapy sessions, including key events, helpful aspects of the sessions as reported by Katie, analysis of change as viewed by Katie and myself, and outcome assessments. In the pursuit of succinctness here I have put the detailed descriptions of Katie's sessions in Appendix P for the interested reader.

### **Screening Interview: 9<sup>th</sup> March**

Katie, a thin 21-year-old, seemed younger than her chronological age. Her studies had been disrupted by “her condition” and she as yet had not managed to complete second year at university. She recalled three childhood problems: a fear of vomiting; an inability to sleep and a counting compulsion. As a young child she attended a psychiatrist for three months but remembers very little about the experience. Katie loved first year at high school and was voted onto the Students' Representative Council as well as obtaining an academic award. However, after a change of schools, she “lost all confidence and just went backwards and my anxieties started to run... I felt as though I had lost my place in life.” She was very aware of what she described as “compulsive thinking,” which she found very difficult to manage. In Year 11, Katie was

...still finding it hard to really fit in and be myself, I became extremely quiet, became scared of boys and was constantly worried about what people thought of me to the point where I would have anxiety attacks because I thought people were talking about me when they probably weren't even looking at me.

At this time Katie went on antidepressants and underwent counselling at a doctor's surgery, which included such techniques as band flicking, which she said "did nothing." In Year 12, Katie developed chronic fatigue and what she described as an "eating disorder." She referred to her condition as "bulimia but in different way," as because of her fear of vomiting she used laxatives and diet pills. She had sought help from an eating disorder specialist in her hometown and had found that helpful but discontinued because of travel problems.

Last year Katie weighed only 40kg. She had been compulsively exercising and when not exercising she could think of nothing else. Despite the chronic fatigue she would still exercise relentlessly. Her doctor prescribed the antidepressant Aropax, which lessened the anxiety that fuelled the desire to exercise but now she felt so exhausted that she was often unable to function. Katie was in a 16 month relationship with a young man she met while living on campus. She described herself as outgoing, the person who tells the jokes, the person who likes to be the centre of attention, the person who is emotional and moody in an "up and down" way.

I asked Katie to list the main concerns she brought to therapy. These were; a desire to maintain her weight, not to have weight as her main focus, to feel less tired all the time, to manage laxative use, to worry less about things, to feel less irritable, to feel more balanced, and not to feel so despairing.

Katie's goals for counselling were to become "well," by achieving and maintaining a healthy weight, to accept herself at that healthy weight, to become "better" for her boyfriend and family and to be able to think more clearly. I offered a hypothesis to Katie that there had been a shift from a fairly high level of anxiety as a child that moved to an eating disorder that now included a more depressed mood state. Katie's response was "it seems like the only way I get over something else is if something else takes its place." Table 7.1 lists Katie's Concern Ratings for the issues she brought to therapy. Table 7.2 indicates the duration of the concerns.

Table 7.1. Concern ratings\* for Katie at screening interview.

Concerns	Not At All	Very Little	Little	Moder- ately	Consid- erably	Very Consid- erably	Max Possible
1. Desire to achieve healthy weight							7
2. Desire to manage laxative use							7
3. Feel less tired			3				
4. Worry about things less					5		
5. Feel more balanced						6	
6. Feel less irritable				4			
7. Feel less despairing							7

Note: \* scale of 1 being not all to 7 for maximum possible.

Table 7.2. The duration\* of Katie's concerns at screening interview.

Concerns	< 1 mth	1–5 mths	6–11 mths	1–2 years	3–5 years	6–10 years	>10 years
1. Desire to achieve healthy weight					5		
2. Desire to manage laxative use				4			
3. Feel less tired							7
4. Worry about things less							7
5. Feel more balanced							7
6. Feel less irritable							7
7. Feel less despairing							7

Note: \* scale of 1 being less than 1 month to 7 for greater than 10 years.

**Assessment of Katie's suitability as a research participant.**

Katie's presenting problems included a complex mix of comorbid conditions. As the main focus of this research was on depression, I will mainly discuss her depressive symptomatology. However, I operate from a humanistic, person-centred perspective that considers Katie as a whole person, as so I, do not separate Katie's depression from her whole experience and her other presenting issues. Consequently, I will also include a partial interpretation of Katie's level of anxiety in this assessment, noting that anxiety and depression often present as comorbid conditions.

Katie's reported depressive symptoms were identified as characteristic of depression by utilising the DSM-IV-TR (American Psychiatric Association, 2001) criteria. The severity of Katie's depression was determined using two inventories; the Beck Depression Inventory (2<sup>nd</sup> Edition; BDI-II) and the Depression Anxiety Stress Scales (DASS). The DSM-IV-TR (American Psychiatric Association, 2001) distinguishes between Major Depressive Disorder and Dysthymic Disorder by the duration and severity of the depressive episode or episodes. In Katie's case her depression did not fit neatly into either of these categories. It appears the onset of Katie's depression was after the administration of the Aropax medication aimed at reducing her anxiety. However, Katie did describe periods of depression during her later school years. Prior to the regular use of the medication, Katie's symptom picture included high levels of anxiety, phobias, panic attacks and elements of obsessive compulsive behaviour. In addition, it was hard to distinguish between the symptoms of depression and the symptoms of her reported restricted food intake and chronic fatigue. Despite Katie's anxiety being managed by medication, Katie's current DSM-IV diagnosis could be more accurately described as Mixed Anxiety-Depressive Disorder, a diagnosis supported by Dr. Wills (see Appendix A).

Katie meets the DSM-IV-TR criteria for depression: periods of uncontrollable crying; inability to get out of bed; excessive fatigue; lost pleasure in most activities; constant worry; pessimistic thinking; restlessness, agitation and impatience; irritability; difficulty thinking and limited decision-making ability. Significantly, however, Katie claimed that she was not suicidal.

The inventory measures of Katie's depression indicated severe levels on the BDI-II and moderate levels on the DASS. The DASS measures of Anxiety and Stress were



found to be at the upper level of the mild range (see Table 7.3 and Table 7.4). Katie, despite her complex clinical presentation, was considered a suitable candidate for the research because she presented with severe depression and was in the correct age range.

Table 7.3. The BDI-II classification of depression at screening interview.

<b>Katie's BDI-II Depression Score</b>	<b>Minimal</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
31	0-13	14-19	20-28	29-63

Source: Beck, Steer, & Brown (1996); Beck, Steer, & Garbin (1988); Beck, Ward, Mendelsohn, Mock, & Erbaugh, (1961).

Table 7.4. The DASS classification of depression, anxiety and stress at screening interview.

	<b>Katies's score</b>	<b>Normal</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>	<b>Extremely Severe</b>
<b>Depression</b>	18	0-9	10-13	14-20	21-27	28+
<b>Anxiety</b>	9	0-7	8-9	10-14	15-19	20+
<b>Stress</b>	18	0-14	15-18	19-25	26-33	34+

Source: Lovibond & Lovibond (1995).

## **Katie's Therapy: Sessions 1-4**

The following very abridged versions of the sessions with Katie are taken from viewing of the video recorded sessions and evaluating case notes. At the end of each session Katie was asked to record events on the Helpful Aspects of Therapy Form and I have included these brief jottings. (See Appendix P for more detailed descriptions of the sessions).

**Session 1: 16<sup>th</sup> March.**

Katie proceeded to tell her story while I offered opportunities for exploration by gentle open-ended questioning, affirmation and empathic conjectures. Two main elements emerged in this session. Firstly, she remembered an event that she said triggered her into laxative abuse and restricted food consumption and I used *systematic evocative unfolding* to assist her in processing this experience more deeply. Katie recalled looking in the mirror and was struck by a realisation she had put on weight when at that very moment her mother made what seemed a perfectly innocent remark. “You need to do some exercise because you’re starting to put on weight.” Katie recalled that her body went stiff, her anxiety shot up and she became really upset and began to cry. Katie pondered on the impact her mother’s statements had on her.

Secondly, Katie believed that “thin” was attractive and wanted to look like Nicole Ritchie. She saw her as “too thin” on the one hand, but looking “really good” on the other. I invited Katie to take part in the enactment of *two-chairs*. Katie identified, while sitting in the first chair that people would notice she was small and she liked being noticed that way and allowed herself to be “mothered” by her friends at school and her two younger siblings. There was power in being small. However, in the other chair Katie knew she had learnt to be more independent by looking after herself since leaving home. Katie reported on her Helpful Aspects of Therapy (HAT) Form that the session had “brought up reasons for why I am the way I am and why I want to be thin” and “talking about my mother and what she said was a reason for beginning the eating disorder.”

**Session 2: 30<sup>th</sup> March.**

Two weeks later Katie talked about how her depression left her blank and feeling nothing. In the past her anxiety had consumed her thoughts and driven her actions. She looked around the room for the anxiety as if it was external to her. I asked her to search her body for it, and she located a pressure in her chest. Her life force or drive felt to her as if it had been stripped away by the effects of the medication. She described the sensation in her chest as consisting of light and bright colours with a lighter core. Using *focusing* we explored the bodily-felt symbol further. After processing her experience Katie said she felt “fresh,” more hopeful and not so low, a

*felt-shift*. At the end of the session Katie reported on her Helpful Aspects of Therapy form that talking about and “understanding my anxiety, classifying what it is, how it looks and how it feels” was useful for her.

### **Session 3: 20<sup>th</sup> April.**

I had not seen Katie for three weeks and the early stages of this session were spent re-establishing the therapeutic relationship. Katie recognised that on some level she was wasting her life. She wanted to talk, the marker for the *narrative* task, and I gave her space to express herself freely. Near the end of the session she said she had been nervous about coming to counselling but realised this was one place where she felt safe to be truly honest about her behaviour. I asked her to consider that she accept where she is right now and that she wanted to change but that at that moment it was too big a leap. Katie was visibly relieved by my acceptance of her “being OK right now.” There was a noticeable shift in her energy as she left the session. Katie wrote on her HAT form that “being able to accept where I am right NOW... and that even though I am not where I SHOULD be, I’m happy and content where I am now. Calming feeling” (*her capitals*).

### **Session 4: 27<sup>th</sup> April.**

Katie’s energy was somehow darker than last session and she appeared thinner than I had seen her before. I observed that her mind and her body were in conflict and suggested the enactment task of *two-chair* work. Katie described the two aspects as the “brain” and the “body.” She sat crouched and stooped and in a small and timid voice her “body” declared “I’m so hungry, I feel better if I eat.” Her “brain” retorted “...you are just not allowed to” eat. Katie declared her brain “is like an abusive parent.” The only compromise offered by her brain was “I want to look after you... I will pamper you with nice products and treatments... that’s all I can give at the moment.” Katie was struck as to how “hard it is to be this body... the brain is so evil... my brain loves me but won’t give me food... I don’t want to be in the prison anymore... you are abusing me... I deserve better.” Despite her body being allowed some voice and being able to identify some of its needs and wants, the brain had such an intimidating stance

it was unlikely that Katie could achieve full resolution of this conflict in this one session.

Katie reported on her HAT form that she had found it useful to separate her body and her brain. Katie wrote that “[m]y mind (at the moment) had total control over the body. The body feels like it’s in a prison.” (*This is a direct quote. It is interesting to notice third person language Katie used when she referred to her body.*) In the Table 7.5 I have highlighted the significant elements of each session.

Table 7.5. Katie: Summary of bodily felt sense, symbolic representation, episodic memory, emotional arousal and felt-shifts – sessions 1 to 4.

Session and task	Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
1. Systematic evocative unfolding Mirror Two-chair <i>Nicole Ritchie</i>	body stiff anxiety all over  CHILD-like chair – need to be looked after  More ADULT chair – independent	power of being small	looking in the mirror and heard her mother's remark about putting on weight  parents and siblings did things for her being small at school meant being noticed	shock, <i>fear</i> realisation of significance of event → <i>partial shift</i>  articulation and understanding of being small → <i>partial shift</i>
2. Focusing <i>Affect of Medication</i>	pressure in her chest sometimes it spread outwards	light and bright colours and had a lighter core it had no words a gauge thing	sense of lifelessness since going on medication	curiosity felt “fresh,” more hopeful, not so low → <i>shift</i> humour at the idea of controlling it
3. Narrative <i>Eating disorder</i>		wasting her life the thought of looking back in 10 years to this time really dismayed her	time her face was really drawn and she could feel the loose skin sitting on the bones	being accepted by me “being OK right now” a calming feeling a noticeable shift in her energy → <i>shift</i>

Session and task	Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
4. Two-chair Conflict	BODY chair – crouched and stooped and her voice small and timid  BRAIN chair – voice was louder and overpowered the body's voice	brain always won like a prison punished indefinitely like an abusive parent	so many rules around food  parents weren't like that as they were affectionate	my brain is like the abusive mother and I am the child (body) that can't escape  <i>anger</i> - body says I deserve better → <i>partial shift</i>

**Client and therapist analyses of change.**

***Client's analysis of change after session 4.***

After session 4 Katie underwent a Change Interview with Dr Wills. She explained she felt a little nervous at the start of the therapy: "it was going to be research and the thought of it... I was a bit sceptical about it because not a lot of treatments have worked for me." Katie had decided to be open-minded and give it a go and surprisingly "found that the sessions have been something really different, like it has challenged me to think about it in different aspects... I feel a lot better understanding..." Katie described the two-chair work

My mind has a lot more control, like... at the moment complete control over my body no matter how I am feeling... like she separated them... I was understanding that my brain was completely controlling my body and not allowing my body to get better... I just have never done that, like I have talked to people but I have never really understood my thought process...

And she went on

My mind speaks to my body as if it is a different person, it is not part of me, 'you can only do this' and 'you can only do that' and when Melissa separated me into two different chairs, one being my brain and one being my body I was able to talk to both sitting in either chair. It was amazing how I felt, like being able to say, allowing my body to say what it wanted to do without it being disempowered by my mind... I just never realized that I was doing it all that time... I want to try and make that 'you' and 'I' to be a whole, to be my mind and my body as 'I,' not my mind saying to my body 'you' as different.

She also found talking openly about things helpful

I don't know talking about it and hearing myself say it, allows me to understand it a whole lot better... I just better understand what I am actually thinking... it is good to know that somebody else holds my thoughts... I can just um, almost taking them outside and then putting it up on a pin-board and then we can work through them and discuss them... and I can get better from this, I, we can work through this, not that they have to be stuck inside me and racing round... I suppose it is out there, off me, not completely but it is, at least it is not just in me.

Katie acknowledged the therapeutic relationship and said I was

...not belittling or condescending or anything, it is just... she understands that... people do have problems no matter how weird they do sound... for her to be able to understand that and I suppose be accepting of me... I just get this calmness about me... don't know... I just feel so pleasant just nice, like I don't know to describe it, I just feel at ease.

And she added

I think Melissa makes me feel like it is alright to be where I am at and she lets me know that I am doing the best that I can now even though I am not there yet.

Katie found "splitting myself up in the chairs and that sort of thing, it is definitely hard... shame about the things you are saying when you know that they are wrong but that is how you do feel... it makes you feel better saying it." She found it challenging to hear some of her illogical thoughts said out loud but "we would talk through it, she would be like so what is it like... and she would put, like putting it in other words and



I would be like yes, yes that is it.” Katie would “go home and do it in my mind. I sort of, yeah, like why am I doing this?”

Outside of therapy Katie’s boyfriend has a major influence on her desire to change “I think he is the sole reason why I wanted to get better because I just, I want him to be part of my life... I would rather have him than the disorder.” Sometimes she would wonder if she was ever going to get over this, and in a non-pushy manner he would say “yeah, you will get there.” She felt his support was a form of security.

***Therapist’s analysis of process and change: Sessions 1-4.***

When I look back at the potential outcome for Katie I believe I was perhaps over confident that PE-EFT could help her. My supervisor, at the time, Dr Wills, a counselling psychologist with 25 years experience, encouraged me to continue to work with Katie, as she and I had developed a good working relationship. Katie’s attendance was sporadic and her ability to process her experience was compromised, probably due to a lack of nutrition. I felt we would make some progress in the sessions but were unable to reach full resolution in the tasks undertaken. This was somewhat disappointing for me but I was aware that people with eating disorders need to control their environment and this could extend to the therapy as well. As illustrated in the change interview Katie however, found the sessions interesting and different from previous therapy experiences and reported that she had developed new insights into her condition.

Katie was able to process some of her experience quite well but had definite limits on staying with her experience. There was little or no emotional processing. I felt deep compassion for Katie and a great deal of responsibility for her welfare. I was well supervised and certainly didn’t believe I was doing any harm by continuing with the sessions. I believed the PE-EFT work could make a difference in a positive sense. At the time I saw Katie there was no information or research about treating eating disorders with PE-EFT. I knew to follow the person-centred principles underpinning the model, to look for markers and to implement the tasks where appropriate at a slow and steady pace. Katie had already alerted me to her high levels of anxiety and attending to her concerns was important to me.

My aim was to provide a safe and collaborative working environment for Katie to explore her inner world and make sense of what had been happening to her in relation to her depression/anxiety and her eating disorder. In session 1, I felt we isolated a key moment in the development of Katie's condition, the "mirror scene" with her mother. The systematic evocative unfolding provided a means for Katie to access previously forgotten information. Her distress at her mother's comment was not fully explored as I realise now not only because it was our first session but also because of Katie's effective suppression of her emotions. As well, I felt that Katie's identification of an aspect of herself that "enjoyed" being noticed and "small" showed some insight into her condition and that she was quite courageous in this first session to show this vulnerable aspect of herself despite only a partial resolution being achieved.

In session 2, Katie minimised her concerns and this seemed a means of avoidance as she distanced herself from her emotional experience. I used informal focusing in order to determine her ability to focus her attention inwardly and potentially to assist her to learn a new way of processing her experience. It seemed that accessing her felt-sense and staying with the sensations was an important first step for Katie in learning how to manage and recognise her internal sensations as non-threatening and potentially providing useful information. Despite not processing any past recollections and so only again attaining a partial resolution Katie experienced a felt-shift that left her feeling somewhat hopeful.

Because I had not seen Katie for three weeks, session 3 was spent re-establishing the alliance. I called on the therapeutic processes of prizing and affirming Katie's experience. My aim was to follow the immediacy of Katie's experience, taking time along the way to investigate it by empathic exploration or deepen it by empathic affirmation. I was aware that most of the people in Katie's life judged her behaviour and it is an important person-centred principle to be accepting and non-judgemental. In a case such as Katie's, it was extremely challenging to take such a stance when it was obvious that she was involved in self-damaging behaviour. I was also acutely aware that she operated out of a strong set of rules. By gently challenging the "should" way of thinking I was attempting to assist her to accept herself as she was in the present moment. I wanted her to see that she was valued as a fellow human-being struggling with difficult life issues. This directive intervention by me could be considered *out-of-*

*mode* in the PE-EFT model but the developers make allowances for such interventions to be minimally present in the session (i.e. less than 1%) and ideally presented as an empathic conjecture (Elliott et al., 2004).

Upon further reflection I see that I was accepting Katie's decision not to change at this time, but wonder if I was being seduced into viewing her as 'not ready to change' (Dolhanty & Greenberg, 2009)? At our third session I was still gathering information and unwilling to challenge her at this time, but in session 4, Katie was struggling. On this basis I suggested two-chair work and this saw Katie's harsh, critical, "anorexic" voice of her "brain," oppose the small, seemingly defenceless "body." I was quite shocked to witness the powerful and unrelenting nature of Katie's critic whom she described as "like an abusive parent." It was astonishing how apart her "brain" and "body" were. I also noticed there was little feeling in the exchanges and Katie acknowledged that her brain controlled her emotions also. We achieved little or no integration between the two sides as the "brain" was only mildly compassionate for the plight of her starving "body." The function of the critic is protecting the client from painful feelings (Dolhanty & Greenberg, 2009). My sense was that we needed to revisit the two-chair work so Katie's "body" would in time find her voice and contact her grief and assertive anger.

## **Katie's Therapy: Sessions 5-8**

### **Session 5: 4<sup>th</sup> May.**

Katie raised two main issues in Session 5. Firstly, she alluded to how being "thin" and the way she wore her hair had become significant parts of her identity. Uncertain as to why these issues had become important to her I invited her into an internal exploration using *focusing*. She effortlessly pinpointed a bodily felt-sense in her chest and in her throat and visualised it as "dark" with a "hard darker core." Its critical voice told her "I don't like the way I am... it tells me what to do" and it fed off her negative thoughts. The process of attending to and working through helped the sensation in Katie's chest to lessen in size, a *felt-shift*, but she was exhausted and was unable to process the sensation further.

Secondly, Katie's thoughts went to her mother who she described as lacking in sympathy. She felt "bad about talking about mum like that." But according to Katie her mother was quite dismissive of Katie's sensitivities and would push her. "She thinks... she knows what's best for me..." Katie wrote on her HAT form that talking about her mother, "being simply able to get it all off my chest" and "finding out how my thoughts made the core of my anxiety worse," were useful aspects of the session.

### **Session 6: 11<sup>th</sup> May.**

In a period of about two years prior to the end of high school, three significant people in Katie's life had died tragically. Katie really wanted her mother's reassurance but she said her mother wasn't there for her and the people who came to the school from the city to offer assistance were unhelpful. "I was angry and I didn't want to talk about it... needed to do it on my own..." Katie was saddened because her attempts to talk to her mother openly in the past had got nowhere. Katie mused, "I don't want to have to deal with her disappointment and the negative things she's got to say... so I let things be." I introduced the *empty-chair* for unfinished business and asked Katie to envisage her mother and imagine that her mother would be a receptive listener. Katie easily found her voice and began expressing her frustrations and asserting her need for her mother to listen, understand, and accept her. However, she became resigned and we sat silently until she spontaneously kicked out her left foot in the direction of the chair. We both laughed. I encouraged her to kick the chair again and she kicked it over and it hit the floor. However, the release was short lived and her resignation returned. Katie reported on her HAT form that "saying what I wanted to my mother if she was in an understanding mood" was helpful.

### **Analyses of change.**

#### ***Inventory assessments after session 6.***

At Session 6 I asked Katie to complete the BDI-II and the DASS inventories. The scores are tabulated in Table 7.6 and Table 7.7. Katie's depression scores had come down considerably since her screening interview when her BDI-II score was 31 and DASS depression score was 18. This was a remarkable change. Katie's mood had definitely lifted significantly and despite her other symptoms being present her

depression had essentially abated. In addition, her anxiety and stress levels were in normal ranges.

Table 7.6. The BDI-II classification of depression at Session 6.

Katie's BDI-II Depression Score	Minimal	Mild	Moderate	Severe
1	0-13	14-19	20-28	29-63

Table 7.7. The DASS classification of depression, anxiety and stress at Session 6.

	Katie's score	Normal	Mild	Moderate	Severe	Extremely Severe
<b>Depression</b>	11	0-9	10-13	14-20	21-27	28+
<b>Anxiety</b>	6	0-7	8-9	10-14	15-19	20+
<b>Stress</b>	13	0-14	15-18	19-25	26-33	34+

### ***Session 7: 25<sup>th</sup> May.***

Katie was rule-bound and *stuck*. Despite rejecting my invitation twice, Katie agreed to *two-chair* work. Her body reported, "I'm really tired and feel sick... I'm just nothing." Her mind responded "I am really tired too... we have to follow the rules otherwise we will feel worse... I'm too tired to think... I AM ALWAYS GOING TO WIN!" There was a shocking reality to this statement. "The rules are there." She slumped forward in the chair and we sat in the silence of her despair for some time. I asked her to imagine herself in ten years time sitting in the chair in front of her, and enquired if there might be some information that the "Katie-in-ten-years" had for the "Katie-now." She moved chairs and contemplated silently for a few minutes and then said "feed your brain... don't be so stuck with the rules that are not real reality... they are not rules of life... they are rules you make me live by... I don't want live by them anymore." Katie's exhaustion had lifted and she stated that she was hopeful that she would not always feel like this. Katie reported on her HAT form that splitting herself into brain and body and then into "Katie-in-ten-years-time" was helpful as it gave her something

to work towards. She also wrote that “in the last few minutes just talking to reassure [me] that I can get through this” was useful.

***Session 8: 1<sup>st</sup> June.***

Katie looked radiant. She was animated, clear thinking and decisive. Routine blood tests had shown no bowel abnormalities and this reassurance was an incentive for a new start and so she wanted to stop taking laxatives. Katie had watched a DVD entitled “The Secret” and wanted to embrace the main elements of its philosophy by changing the way she thought through reframing and being grateful. Katie’s body wanted to focus on the positives but as far as her mind was concerned there were still “the rules.” Katie had recognised that her eating disorder had “made me the biggest liar... I have a disease... know what I am doing is wrong... feel really guilty... but I still do it anyway.” I hypothesised, “it sounds like you want to be more honest and more real about where you are and with the people who care about you?” She had become so used to lying that she was unsure about what was real “such a pattern of lying... you yourself didn’t even know...” Katie wondered if she became well “what will I spend all my energy on... what will I spend my time thinking about... I’ll have so much time on my hands.” On her HAT form Katie wrote that talking positively about life and the steps in wanting to make changes was helpful as was talking about stopping the laxative use. In the Table 7.8 I have highlighted the significant elements of each session.

Table 7.8. Katie: Summary of bodily felt sense, symbolic representation, episodic memory, emotional arousal and felt-shifts – sessions 5 to 8.

Session and task	Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
5. Focusing <i>Identity – hair and weight</i>  Narrative <i>Mother</i>	tightness in her chest and in her throat	dark with a hard darker core - solid and can't be broken... been there forever – “I don't like the way I am” formed from and feeds off negative thoughts	It controls me... it stops me from doing things... comes back if boyfriend gets too close... and when on own  Mother dismissive and insensitive sister vomiting mother dragged her along to look	sensation in chest lessened in size → <i>partial shift</i> exhausted and unable to continue  <i>anger</i> at mother “I'm like this” exhaustion lifted → <i>partial shift</i>
6. Emphatic exploration <i>Grief Mother</i>  Empty-chair <i>Mother</i>	leaning toward her right side  Katie kicked out her left foot in the direction of the chair kicked the chair again pushed it over	being weighed down by mother's disappointment in her  kicking out at her mother	three significant people in her life had died tragically funerals - mother emotionally unavailable  past interactions with her mother	<i>sadness</i> <i>anger</i>  <i>anger</i> , resignation laughter → <i>shift</i>

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
7.	Empathic exploration  Two-chair <i>Conflict</i>	chronic fatigue – whole body thing and depression “was just here” ( <i>pointing to her chest</i> ) BODY chair – numb MIND chair – rule bound	exhaustion “I can’t think about it”  “I’m just nothing...” “I AM ALWAYS GOING TO WIN!” stuck Katie-in-ten-years “you’ve got to eat” break the rules	remembering the rules	deep despair / <i>sadness</i>  hope / optimism exhaustion lifted → <i>partial shift</i>
8.	Narrative <i>“The Secret”</i>	radiant, eyes sparkling full of energy	“The Secret” DVD think more positively	her eating disorder “has made me the biggest liar”	hope  be more honest and more real with self and others



*Client's analysis of change after session 8.*

After session 8 Katie reported to Dr wills that again she found just talking really beneficial: "I don't have anyone else I can say completely everything to about everything, and it just feels really comforting to come here I can just blurt out or feel the way I want to feel." She found having "this time, my own time to say what I like and nobody to judge me" also comforting. Again Katie referred to the two-chair work "breaking myself up into... being able to separate parts of my body, or parts of my life time, like separating things and being able to talk with, different aspects and being able to separate sides..." Katie had never done things like that before in therapy but despite being challenged found it really helpful. "It opened up my awareness about my full understanding of everything that is happening."

Prior to therapy Katie said she

was just angry... angry with myself, I wasn't in a good place and everything was just so negative around me and now it's like I can enjoy being, I am happy with where I am at now... like I can enjoy it today when the sun's out and not consumed with all this negative thinking... and Melissa's just so positive and that sort of thing and just encouraging, yeah and I have never had that in therapy, it's kind of been like my link with God... it has just been really good and... it's like this security thing that I have got.

Katie said "I am probably more positive if anything, and probably a bit more happy actually and instead of feeling guilty about things..." Katie asked her boyfriend and family if they had noticed any changes in her. They agreed she was thinking more positively, was a lot happier and in a better place than she was before therapy.

Katie surprisingly felt ready for what she described as "the next step" in her recovery of her eating disorder. She wanted to stop taking laxatives and felt therapy had enabled her to get to this point,

I am not quite there but I am in a better place... like I still have my disorder, I didn't come into this thinking that I would be cured... at least I am doing something... and dealing with it and thinking about it which I didn't think would happen so I have probably improved...

An outside influence that impacted on Katie's reported changes was watching the DVD of "The Secret." She said

I just took a more positive approach with everything that I was doing and saying and it made me feel really good and I don't know I guess I really wanted to change... it has really taught me to be really happy with where I am at now and... just to be grateful and that sort of thing... and I feel like I can really understand this properly because of what Melissa has taught me, I don't think I could have watched that show and taken in all the positive things from it without the help of the sessions with Melissa... I probably wouldn't have seen it in that light.

Katie attributes these perceived changes to therapy.

Well therapy is the major one... like talking about all these things and... I don't think that there is anything outside that has really changed that wouldn't have happened, outside influences like 'The Secret' wouldn't have helped. Therapy has just been the main one.

***Therapist's analysis of process and change: Sessions 5-8.***

Identity issues in adolescence and young adulthood are key developmental hurdles. Young people need to develop a sense of self and personal identity and failure in that endeavour leads to role confusion and a weak sense of self (Erikson, 1963). I was pleased when Katie raised this as a concern to work on in session 8. The "mirror scene" with her mother, recalled in session 1, was a poignant moment in her search for her identity because when looking in the mirror we are looking to see *who* we are as well as critically evaluating *what* we look like. Her mother criticised how she looked

and I suspect Katie was left feeling deep shame about not being/looking good enough in her mother's eyes and may have felt a loss of her mother's approval. This was evident in her reaction at the time but we were unable to assess this emotional response in the session. I noticed other elements of Katie's striving to find her identity had emerged in previous sessions, such as wanting to look like Nicole Ritchie and enjoying being small and helpless. I think she had forged a relationship with her anxiety and felt lost when the medication had stripped that away.

Katie saw her hair and appearance as key components of her identity but was unclear about why these were so important, so I chose an exploration through focusing because I wanted Katie to understand herself from the inside out. When she saw the sensation in her throat as a sinister presence that told her what to do, I speculated this visualisation may have been a representation of her harsh critic, which hypothetically was her internalised mother. Feeling good in herself was an antidote to this uncomfortable presence but despite a *felt-shift* at this point, Katie was overcome by exhaustion and unable to process this experience further in the focusing. Upon reflection I would have liked to invite her to stay with the sense of exhaustion and explore what else may be present. Interestingly, when she opened her eyes she raised frustrations she had with her mother, although she felt she was betraying her mother by raising these issues with me.

I was curious about what had triggered Katie's eating disorder and this became clearer over the course of the next few sessions. I believe that the experience Katie shared in session 9 was a contributing factor. Three people close to her died tragically and suddenly in close succession. This left her angry and unable to find appropriate support. The counsellors sent from the city triggered her anger and her mother was unable to "be there" in a way that comforted her. I suspected that, despite a relatively stable family life with frequent demonstrations of affection Katie struggled to get her needs met by her mother, who would "go through the motions" by taking her to appointments etc., but was unable to provide the constant emotional reassurance Katie so desperately needed. She consequently didn't learn how to manage or regulate her affect. She used rejecting anger to keep people at bay and as an attempt to individuate. The milestones of separation and individuation had not yet been

achieved. In addition, I suspect now that she may have resorted to restrictive eating as a means of managing her deep grief at the tragic loss of her friends.

It seemed that Katie was trying to accept her mother but found it difficult to let go of her need for her. She demonstrated undifferentiated sadness but was unable to face what she may have missed in the relationship. She desired to separate but feared the loss; an ironic paradox. Putting her mother in the empty chair was particularly poignant as Katie expressed her thoughts and frustrations but again without much emotion. When I noticed her kick her foot towards the empty chair I saw she was angry and encouraged her to kick it as a display of anger.

In session 7, I gently challenged Katie to revisit the two-chair enactment of brain and body because the marker of the split was present. Both aspects were in a common experience of exhaustion but her brain was still unwilling to feed her body. I believe that the bold statement made by her brain that it was “always going to win” was a particularly significant achievement for her but there was little or no emotion visibly present. However, I did feel it. We sat in Katie’s despair for some time. I was waiting for a spontaneous move upward but it didn’t occur. In order to facilitate some hope at this point I asked Katie to imagine what it would be like if the problem were removed by asking her to consider what she wanted to do with her life. She had told me in her screening interview that she wanted to help people and she could see herself doing this in the future. This is where the idea of the Katie-in-ten-years time came from. This intervention was a deliberate attempt to distract her from her experience of despair as I was mindful of the risk of sending her out into the world despairing and not contained. It would have been more powerful if hope had emerged from Katie’s experiencing but nevertheless my intervention offered a some antidote to her despair.

Interestingly, in session 8 Katie was bright and happy and doing really well. I was uncertain whether the massive shift had occurred because of our work or something else, such as her watching “The Secret.” She acknowledged that our work together had enabled her to understand the philosophies presented in “The Secret” because I had talked about the importance of being in the *present* and being grateful. One of the relevant humanistic principles involves the growth tendency that moves clients toward hope. This tendency is not a defensive avoidance but an expression of needs and action tendencies. It could be hypothesised that having touched her despair in the

last session Katie now felt stronger, experienced a greater sense of agency, and was empowered and more able to cope. I was pleased for Katie but not naive enough to think this would be sustainable as relapses are so common amongst people with eating disorders. We had to wait and see.

Overall, I believe the relationship was a key factor in the work with Katie but the tasks had an important role also. The tasks offered Katie a challenge to explore things differently and took her beyond a purely cognitive appraisal of her situation. I wonder if I had had more experience whether I may have been more effective in the implementation of those tasks, or whether the progress we had made so far was significant in any case. The depression inventories certainly attested to our progress in relation to her depression and the mood improvement was supported by reports from her friends and family.

## **Katie's Therapy: Sessions 9-12**

### **Session 9: 22<sup>nd</sup> June.**

When Katie turned up three weeks later she reported she had failed to sit an exam and had been abusing laxatives. Her doctor suggested that Katie needed to recognise she had a “problem” and ought to have more specialist care in relation to her eating disorder. I offered to speak to her doctor. Katie was somewhat despondent and I suggested a *focusing* exercise. She described a sense of fear in her chest and remembered being four or five years old in the schoolyard when some Grade 6 boys bothered her. She felt frozen with fear. The elder brother of a friend walked her home. I asked her to notice the sensation in her chest and she reported it had shifted slightly, but was still there, a partial *felt-shift*. Katie was unable to recall anything further. I suspected Katie's fear prevented her from full exposure to this event and I didn't want to overwhelm and/or re-traumatise her by continuing. I conjectured that allowing herself to consider entering an eating disorders clinic may have triggered the recall of this experience and her fear in the face of what appeared to her as an uncertain situation. Katie reported on her HAT form that talking about the next steps to what she described as her recovery, was useful. Talking about her childhood experiences, including her anxiety, and feeling her emotions was also helpful.

**Session 10: 29<sup>th</sup> June.**

In this session Katie just needed to talk. The emphasis of our work together had shifted from understanding Katie's experience to diagnosing "the problem." I purposely decided not to diagnose Katie's eating disorder as anorexia despite acknowledging to myself it was indeed the condition to which she had succumbed. Katie talked about how she had had to lie to everyone to keep her story going. Now that she had decided to seek treatment at an eating disorders clinic she didn't have to "do anything" and everyone was off her back about what she "was doing." She described herself as manipulative and spoke freely of what she was capable of doing. I informed Katie that counselling would continue after the twelve sessions. Katie stated on her Helpful Aspects of Therapy form that being able to talk freely and openly was very helpful to her.

**Session 11: 6<sup>th</sup> July.**

Katie explained that she was fearful that her boyfriend would leave her. I was reminded of little Katie standing alone in the school yard feeling intimidated by those larger boys and directed her attention to her body. She remembered the boys were a "lot taller... just bigger people... still feel... I'm not an adult I'm a kid... people older than me have so much authority over me..." I asked Katie about the sensation in her chest and she described it as "solid in the middle, fuzzy and when it gets worse it goes all through my body... sort of feels gross." I encouraged Katie to go back to the event in the schoolyard. I asked her how the experience might have played out if she was able to ask for help and suggested that she consider the "adult Katie" going into the scene to look after the "younger Katie." "I'd pick her up..." and sooth her by saying "it'll be ok, you'll be fine." I asked how her chest felt now, and she responded "feels good... feel a sense of happiness... like a relief." This was our first successful reprocessing of a past event.

Another memory emerged. Katie had gone from a carefree, friendly youngster to a fearful, easily intimidated adolescent in high school. She had no insight as to why this had happened and her mother was unaware of Katie's pain. Her father took her to school on the way to work, and would regularly reassure her, but her mother refused to pander to Katie's fear. She remembered that she was having panic attacks at a really

young age and I asked her what she needed when she was younger. Katie responded that she needed her mother to reassure her that she would be OK. Katie reported on her HAT form that talking about her mother was helpful. She recognised that she needed reassurance from her mother and it was OK to be annoyed with her mother for not providing that reassurance.

### **Session 12: 20<sup>th</sup> July.**

Katie's voice was assertive and strong and with very little encouragement she said "[I] started to realise a few things... that **maybe I am angry with mum.**" I was unreserved in my surprise. She continued, "one night I was lying in bed and I was just thinking in my head what I'd say to her and I don't know but maybe **I'm doing this so she'll notice...**" Her words had a core chilling quality to them. Katie had not shown such reflective insight during or between sessions in the past. I believe this was a fundamental core issue for Katie and a major shift out of the fear reactions she had presented in previous sessions. I suggested an *empty chair* enactment but Katie completely ignored my suggestion and kept telling me what she would like to tell her mother. She continued animatedly but somewhat disjointedly

...I just want her to know that I'm not ok... I **am** not ok ... I **do** have an eating disorder... it's not as though I can cover it up (*holding her arms out to show herself*)... she's really in denial about it and I just feel frustrated with her... I put it in the back of my mind because I didn't want to get angry with her and she's my mum but I actually got frustrated... but then I feel really guilty... she'll say 'don't talk to me about it, talk to a therapist about it' (*loudly*) I need to talk you about it... you need to know what I am going through... all she has to do is listen... I don't want her to say anything back or help me through... I know she can't make me better I just want her to know and tell her... so many people have helped me and just cared... that's all I want... someone to care...

Katie reported on her Helpful of Aspects of Therapy form that “talking about mum... discussing that I am angry with her and how I want her to care about me... [and] talking about how I approach the situation” was extremely useful. In the Table 7.9 I have highlighted the significant elements of each session.



Table 7.9. Katie: Summary of bodily felt sense, symbolic representation, episodic memory, emotional arousal and felt-shifts – sessions 9 to 12.

Session and task	Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
9. Focusing <i>Her problem</i>	sense of fear in her chest there as long as she can remember	felt frozen	four or five years old standing in the school yard - Grade 6 boys unable to move	<i>fear</i> elder brother of a friend walked her home – sensation shifted slightly → <i>partial shift</i>
10. Narrative <i>Diagnosis</i>	diagnosis of anorexia and entering an eating disorders clinic		lying and manipulating	relief to speak openly
11. Focusing <i>Fear her boyfriend would leave</i>	sensation in solar plexus - spread through whole body  throat gagging sensation in chest	fear boyfriend will leave her – need to control  feel like a kid solid in the middle, fuzzy and when it gets worse it goes all through whole body feels gross	constant need for reassurance as a kid  boys in school yard <i>adult Katie going into the scene to look after the younger Katie</i>  fear of boys liking her changing schools mum didn't get it dad reassured her dad's breakdown	anxiety / <i>fear</i>  felt shift feels good... feel a sense of happiness... like a relief → <i>shift</i>  <i>sadness</i>

Session and task	Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
12. Narrative <i>Mother</i>	anger at mother	I'm doing this so she'll notice	interactions with her mother	assertive <i>anger</i> <i>disgust</i> at her mother's behaviour → <i>shift</i>

**Client and therapist analyses of change.**

***Client's analysis of change: Sessions 9-12.***

After session 12 Katie explained to Dr Wills that, “the therapy has been very, very good... I've just had so many turnarounds during the whole thing... haven't ever progressed this far to be able to reveal this much of myself with anyone else... it's continuing to improve.” Katie said she had made a breakthrough “I've been angry with my mum about having my disorder... for a long time. Not to blame her but that she doesn't understand... she can't deny about me actually having it.” Katie said she had

never been able to say anything rude or harsh about her [mother] or anything... just sort of protecting her because she's my mum but now it's just kinda like, yeah I am frustrated with her and I do need to talk to her and ...It's okay to have different emotions and even if it is about my mum and that sort of thing, it's okay.

And she added

sometimes I feel like I'm doing, I'm almost in this position to make her look at me. Like I'm just going 'mum, I'm sick' so like I'm letting myself still be sick, so that she will notice... it's such a lousy excuse to have a disorder, like so that someone would notice me, like I just feel like it's kind of pathetic.

Another event that Katie explained as significant in the development of her eating disorder was “when my mum said I that I'd put on weight and... that's sort of how it all began... things like that that I'd never admit.” Despite difficulty in achieving these realisations Katie recognised “it sort of makes me feel better knowing.” Katie acknowledged I “never forced” her to look at these painful experiences so she was able to come to terms with them in her own time and at her own pace.

Katie explained she was happier, “I can just be myself” and she was “able to do more things... I’m sort of a bit more like open to doing things... just living again, not like locking myself up... and I can concentrate more on other things... more better days now than bad days... bit more energy.” She attributed these changes to therapy because “I haven’t changed a lot the way I eat, the way I do other things, like my lifestyle hasn’t changed. I think it’s more about feeling a bit more positive and better about things.” In addition, “I don’t think I feel as much I need to hide my disorder. Like I’ve got my own way of dealing with it... and I’m happy to say that to my mum as well... not being in denial with her.”

Again Katie didn’t expect the therapy to impact on her eating disorder “so the progression that I have made has been a whole lot more than what I thought that I’d make... I’m having more positive thoughts about there being a cure.” Katie explained that having weekly sessions was important to her “I don’t feel like I’m out in the cold like I’m trying to get to something ... I feel a bit more secure when I know it’s going to be here.” (*Interestingly, Katie only attended sessions on an average fortnightly*). The two-chair work was again raised as an important therapeutic task for Katie because voicing her thoughts “out aloud... it really sort of hits home... like, ‘if you eat enough food you’ll feel better’ and ‘you’ll have so much more energy to think, to feel different...’ the other side can listen... it’s like reality... like a slap in the face.” Katie takes these dialogues home and “I’ll do it in my head at home, I’ll look at it from both sides.”

When asked if there was anything Katie felt was missing from her therapy she said “if I felt it I would have said it to Melissa that I wanted to do something...” She said that I enabled her to talk freely “and helps me understand everything and I like it.” Katie explained it was not hard for her to come to sessions, and that “because of the sessions... I think a little bit more [about] making myself that sick that I couldn’t attend.”

### ***Therapist’s analysis of process and change: Sessions 9-12.***

By session 9 Katie again had missed sessions and was struggling. She was under pressure of exams and abusing laxatives had made her physically sick. I was somewhat at a loss about the direction of our work but I was determined to continue to support

Katie. We had made progress and she was still attending albeit intermittently. I wondered whether a more explicit commitment from her was necessary but I also wanted her to make the choice about her attendance. It appears to me now that, as we had touched on some painful experiences, Katie's strong defence mechanisms of over-regulation and distraction may have been exacerbated. I now recognise that the function of the symptoms of her anorexia was to render her without feelings. Significantly, Katie's doctor suggested that she needed to recognise she had a "problem" and wanted to recommend more specialist care in relation to her eating disorder.

The focus of the counselling appeared to no longer be about Katie's depression but more about managing her eating disorder. Whilst much of the work related to her eating disorder, there was a substantial reduction in depression scores during the course of therapy. Thus working holistically, as my primary objective meant that the counselling sessions were directed by what was present for Katie in the session. Interestingly, in session 9, Katie was able to partially process, through a focusing, a childhood event where she had felt intimidated by some larger boys. While Katie had no insight as to how this remembered experience related to her present circumstances, I suspected that both situations held the prospect of an uncertain future for her. I was mindful of Katie's overall wellbeing, and with this in mind I agreed to consult with her doctor. I was however concerned that her doctor wanted to provide Katie with a diagnosis and that Katie's fledgling sense of agency had been potentially undermined by her doctor.

In session 10 Katie wanted a diagnosis. I am aware that diagnoses can be useful if the client benefits from knowing such information. However, in the case of Katie and other young people with eating disorders, it can potentially align the young person's emerging fragile identity with the identity of disorder. Katie had already said to me that the only thing she could succeed in was losing weight and that this gave her a sense of achievement. Her body thinness was an integral part of her identity. The focus for Katie was no longer on hiding her condition but she focused a great deal of energy on what should be done next. Interestingly, the work we had already achieved seemed now to be devalued, considered unrelated to her current situation and even compromised by this emphasis on diagnosis and medicalised treatment.

In session 11, I found I wanted to give Katie reassurance when she raised a fear that her boyfriend might abandon her and she remembered as a child needing constant reassurance. However, I gently persevered and asked her to return to the schoolyard scene, although Katie had previously found it difficult to stay with her bodily-felt internal experience because she preferred to work primarily from a cognitive framework. However, she was able to process this event successfully and experienced a *felt-shift* that culminated in a sense of happiness and relief. This was a small but important step in assisting her to find alternative ways of working through painful past experiences.

When Katie reported her difficult transition to high school and her mother being absent emotionally, I wondered how the “little inner girl” felt about her mother not understanding her. Interestingly, I recorded in my case notes “the little girl needed something she was not getting and so was working hard to be noticed.” I saw little Katie as profoundly lonely.

Just prior to session 12 Katie had been able to get in touch with how angry she was with her mother. I believe this was significant. The challenge was now to continue the processing in session and assist her to continue to differentiate the primary anger and sadness from overall distress, the rejecting anger and secondary sadness. I saw Katie as a highly sensitive child (see Aron, 1998) whose hypersensitivity had been pathologised. I think Katie desperately sought her mother’s approval. My experience of Katie fitted with the description offered by Dolhanty and Greenberg (2009) who wrote that “the intensity of longing for her mother is interrupted by the shame and distress of feeling fat, which highlights the effectiveness of body image distress as a means of escaping affect” (p.376).

### **Analysis of change according to clinical significance.**

#### ***(1) Comparison method.***

The demonstration that post-treatment clients were no longer distinguishable from (or were within the range of) a normative well-functioning sample defines the comparison method of clinical significance (Kazdin, 2003, 2009). At the end of session 12 Katie scored 1 on her BDI-II which was within the minimal normative range of 0-13 (Beck & Steer, 1987; Beck et al., 1996; Beck et al., 1988). On the DASS Katie’s

Depression score was 11 which was within the mild normative range of 10 to 13 (Lovibond & Lovibond, 1995) and her anxiety score was 6 which was within the normal normative range of 0 to 7 (Lovibond & Lovibond, 1995). According to these measures, which are a guide that indicate the presence of depression, Katie, post-treatment scores were in normal range and she would be unlikely to be considered to be clinically depressed.

**(2) *Absolute change.***

Absolute change refers to the amount of change an individual makes without comparison to other people or groups. At the completion of Session 12, I asked Katie to complete the BDI-II and the DASS inventories again, and Figure 7.1 illustrates the overall decrease or absolute change in depression, anxiety and stress over the sessions. Katie's depression scores had reduced dramatically between the screening interview and session 12.

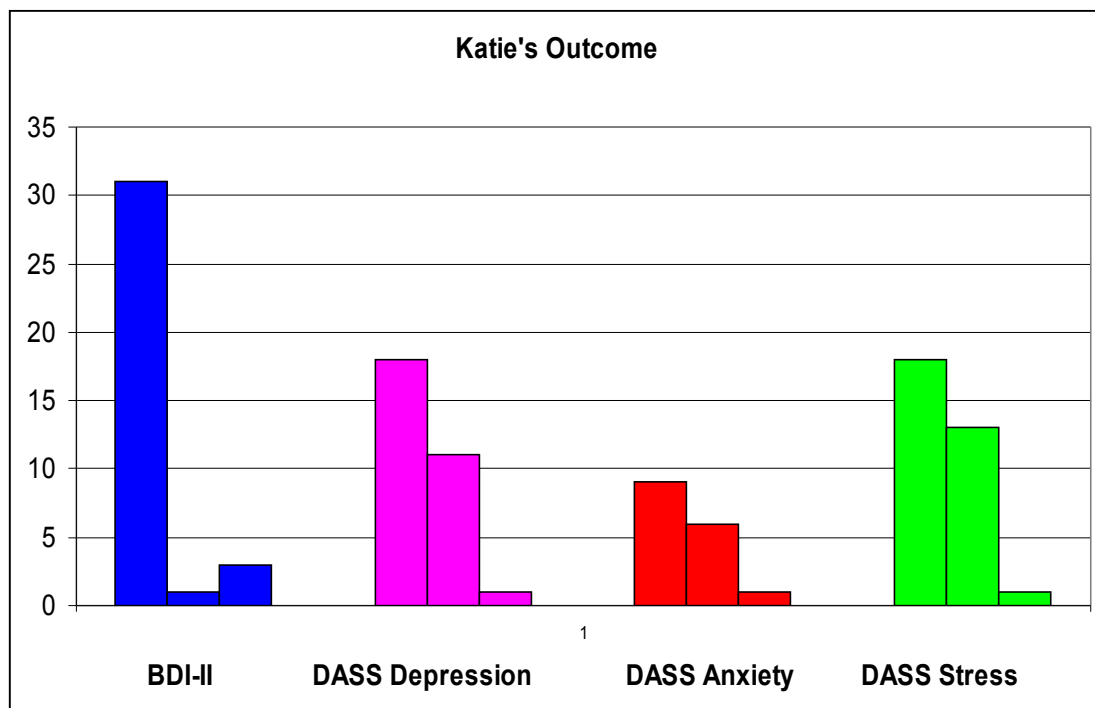


Figure 7.1. The BDI-II, DASS scores for Katie at the screening interview and after Sessions 6 and 12.

**(3) *Subjective evaluation.***

Katie's subjective evaluation was determined in two ways. Firstly, through the list of concerns she made at the screening interview (see later section on *Concern ratings*, p. 249) and secondly, documented in the themes of change identified within the Change Interviews (see client analysis of change in sections above). According to Katie, she became less worried, less irritable, more balanced, and her level of despair lessened over the course of therapy. She reported being happier and more accepting of herself and her eating disorder.

**(4) *Social impact.***

Both her boyfriend and her doctor noticed that Katie's mood had improved significantly over the course of therapy and that she was no longer depressed. They agreed she was thinking more positively, was a lot happier and in a better place than she was before therapy. Katie also felt she had been able to stand up to her parents and others more confidently and was more independent. Her relationship with her parents had also improved.

## **Extra sessions**

**Therapist analysis: Sessions 13-18.**

Katie no longer had depression according to the inventories, but ethically I felt it was in Katie's best interest to continue with the counselling. I recognised that continuing to see Katie would not affect the research regarding the twelve sessions but would interfere with any follow-up measures. See Appendix P for fuller descriptions of these sessions.

Briefly, despite Katie requesting weekly sessions she attended very sporadically. I saw her six times within three and half months. I had arranged for her to consult a student clinic about her nutrition where a transition program was developed for her so she could be monitored and supported in her recovery. Initially she was very excited about this but over time her resolve had waived and her weight reduced further. She told me she had lost purpose to her life. Katie's doctor and her father,



independently of each other, requested to attend our 18<sup>th</sup> session (*which became our last session*).

Katie's doctor arrived early to the session and was quick to express her concern about Katie's further drop in weight. I emphasised that since the diagnosis of anorexia the decline had been rapid and her doctor agreed but didn't see that her insistence on providing a diagnosis for Katie was a precipitating factor in Katie's decline. When Katie and her father arrived her doctor took charge. Katie was surprisingly open and up-front and acknowledged that whilst she was attending appointments she was "doing my own thing." Katie said her boyfriend thought it was "now time to go to hospital" and with resignation she agreed knowing it had to get to this. Katie's doctor declared that she was unable to continue to be responsible for maintaining Katie's physical health and that hospitalisation was the only course of action. I also thought at the time that it was potentially not possible to continue with this counselling whilst Katie's physical health was so compromised but on some level I felt I had let her down.

Katie had not really considered hospitalisation before, having being told by her doctor that she was not "unwell enough" to need inpatient treatment. I was also aware that our therapeutic relationship had been set up within a research setting and I was wondering how to transition this out of the research setting and continue to support her. At the time, I have to admit that I was relieved that the responsibility of Katie's care had been taken from me despite my frustration and regret that I had not a better alternative to offer her. Katie was in hospital for 6 weeks. Approximately six months after her last session I invited Katie to attend a six-month follow-up session and complete the inventories as specified in the inventory administration schedule.

## Follow Up Reviews

### **Analysis of therapy and change after six months.**

#### ***Six month follow-up change interview.***

At the six month follow-up conducted by Dr Wills Katie reported that she had had a difficult six months "things have been very up and down... I've been close to going back into hospital again... yes so I'm still unwell... mentally feeling not too bad... I

broke up with my boyfriend recently which made things a little bit difficult.” She was still harbouring anger and resentment towards him and finding the transition to single life hard. She has had to “stand on my own two feet... and not rely on other people.” Katie said she “hadn’t really moved from where she was before... I know I need to do something but...” She was seeking the assistance of an eating disorder specialist who “is very full-on” and who tells Katie how dire the consequences will be if she doesn’t change her behaviour. Since being hospitalised last November, Katie had not taken laxatives and was proud of this achievement. However, her bowel wasn’t functioning and she had endured a number of hospital procedures. In addition, Katie explained that she replaced the laxatives with eating less and exercising more to remain anorexic. She recognised she was still very self-absorbed and was still trying to control things.

Katie said going into hospital was the worst thing she had ever done in her whole life. “I went in a happy person with an eating disorder... I wasn’t suicidal or too depressed... but I came out a lot worse... I’ve had suicidal thoughts... which I have never ever had in my life.” She felt disempowered and often confused. Fortunately, her parents have been very supportive but have put continuing pressure on her to complete her studies, which she described “as dry as hell and boring.” Altruistically, Katie said “whatever results you get out of this [research] hopefully you will be able to use it for somebody else.”

#### ***Client analysis of change after six months.***

Katie explained that she had found the counselling helpful and had found the sessions really comforting and reassuring. “Since therapy I feel I can get over my anxiety a lot quicker... I can think more logically about things,” and “[I’m] definitely more independent... a lot more alive with people and can organise myself a lot better...” Her relationship with her parents had improved and “I’m not nearly as moody” with them.

I sat both my parents down and I go “I don’t like the way that you’re yelling at me... you yell at me it makes me nervous, it makes me anxious, I can’t eat, it makes me spiral... you’re putting too much

pressure on me all I want you to do is support me and just not yell at me anymore...” and they haven’t since.

Katie’s father acknowledged he yelled because he was frustrated so Katie made “a pact that he wouldn’t yell and I wouldn’t and I would try harder too... so me and dad are on really good terms and mum’s trying her hardest too... a lot better than what she was.”

Katie has also been able to stand up to others “I’ve had to sit people down and I go ‘I don’t like the way you’re treating me, it’s crap, I don’t deserve it...’” Even with her ex-boyfriend she said “I go ‘I can’t handle it anymore,’ I go ‘don’t be mean to me. Stop it, stop yelling at me and stop.’ I’m not keeping anything inside...”

When asked about what specifically was helpful in the counselling Katie said

splitting my body and my mind apart and actually listening to my brain and listening to my body and when my body is hungry eat something... oh closing my eyes, visualising where I feel things... visualising what feeling I get when I am anxious... [what it] looks like... the texture of it and that sort of thing... going back to my childhood, where I was, I didn’t realise that it completely stemmed from it... and that sort of thing... actually I still use techniques that she’s told me... just being able to talk to somebody not being judged.

Katie found the therapy “comforting which I don’t receive that from very many people.” She also explained

after my sessions I came out feeling like, I really am a good person I’m doing OK where I am at, I’m OK, I’m doing the best I can... whereas with some people it’s just not good enough... and I don’t know she’s just a lovely person so it’s just made it...

And she went on

I think being with Melissa made me see the good things in life and just gave me, allowed me to get my confidence back... Melissa was... just I don't know she's just so bubbly and happy and it's just fresh, nice fresh and it's just like there is more to life than this... very comforting and the reassurance of somebody saying you're worth it and you're fine and you're OK like you're a good person or something, that's all you want to hear... I'm happy with who I am and I'm fine with who I am so yeah. I do miss coming to sessions.

Katie found "being angry at my mum" difficult "I've never been angry at her at all... yeah it was difficult but it was good I felt just a weight lift..." Finally, of counselling "I think it's really good... I think it's her approach to people... especially that are sensitive that are finding things difficult. This kind of therapy is very helpful... it's what you need to hear especially if they're in a negative environment." Katie also said that even though she didn't actually progress in relation to her anorexia she "hadn't progressed with anyone else either..."

### **Analysis of therapy and change after 12 months.**

#### ***Twelve month follow-up.***

After approximately twelve months I did not ask Katie to come in for another meeting but I did ask her to complete a number of inventories and give me an indication of how she was managing. This was one of my last contacts with Katie. Included in the return envelope was a letter. She wrote "my bowel is playing up now since May this year (one month before the six-month follow-up). It just doesn't work. Five hospitalisations with a colonoscopy scheduled for January. On Sunday I had a "like stroke" incident where my speech was funny, slurring my words. I'm fine. I'm waiting on CT results and that's why I am anxious." However, Katie went onto write "thank you ... you have taught me to think differently and I have taken the tools you've provided me and will continue to use them throughout my life."

### ***Measures of client change.***

At the completion of Sessions 6 and 12 and at the 6 and 12 month follow-ups I asked Katie to complete the BDI-II and the DASS inventories. Figure 7.2 illustrates the overall decrease in depression, anxiety and stress over the sessions and the follow-up period. From session 6 onwards Katie's depression scores had continued to remain stable and within the normal ranges.

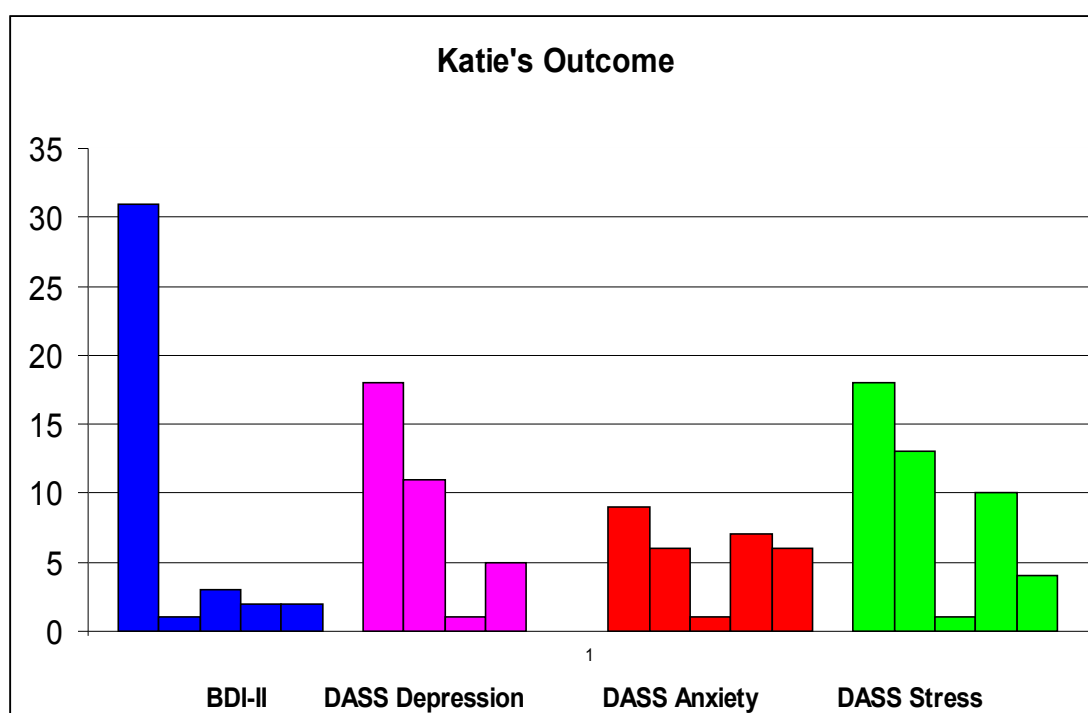


Figure 7.2. The BDI-II, DASS scores for Katie at the screening interview, after Sessions 6 and 12 and at 6 and 12 months follow-up.

### ***Profile of Mood States (POMS).***

At the conclusion of every second counselling session, Katie was asked to complete a POMS inventory. Figure 7.3 graphically represents her shifts in mood states during the counselling period and at six and twelve months post-therapy. As depression was the main focus of this research I will only comment on that mood subscale, but clearly the other mood states move in line with the depression subscale.

As might be expected, at Session 6 and Session 12 Katie's level of depression was measured to be at substantially lower levels than pre-treatment, which corresponded with the BDI-II and DASS measures taken at the same time. At session 10 however, Katie's POMS score on the depression subscale had returned to pre-counselling levels. During this time, Katie's doctor had encouraged her to come to terms with the fact that she indeed did have a "problem" and it was possible that Katie began to identify herself as suffering from anorexia.

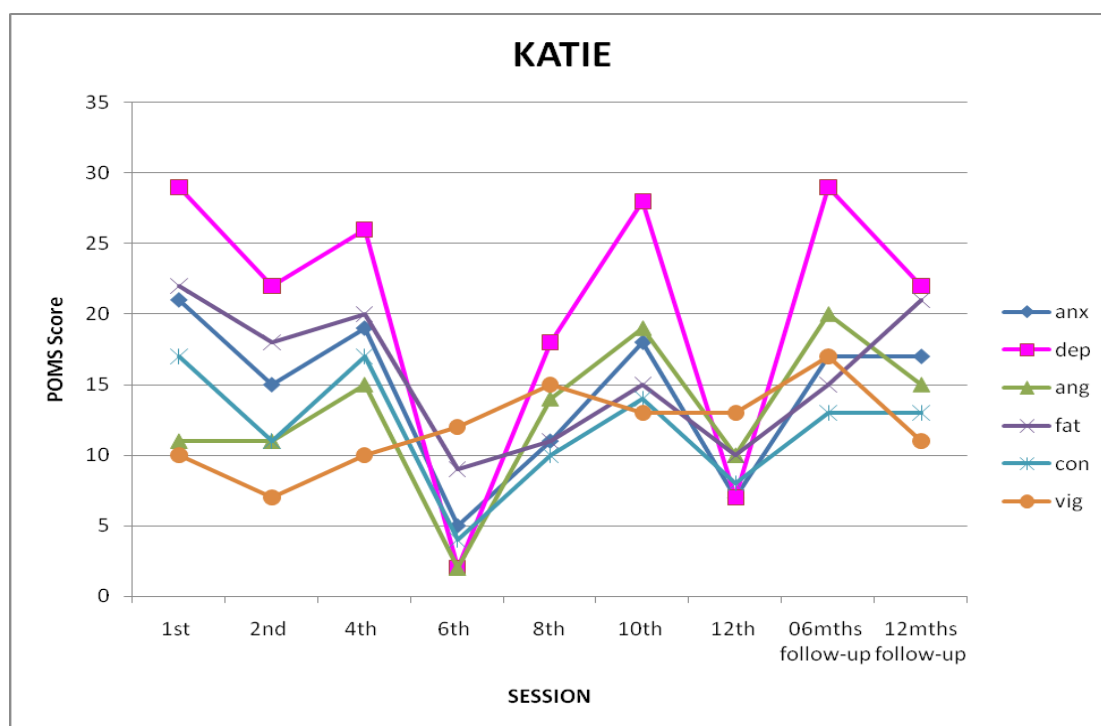


Figure 7.3. Profile of Mood States (POMS) scores for Katie.

Inventories assessed at the six and twelve-month follow-ups indicated that Katie's depression level scores, according to the BDI-II and the DASS, remained within normal range. However, on the POMS inventory at the six-month follow-up, in June, (see Figure 7.3) the depression scores were again at the pre-counselling level. At the twelve-month follow-up, in December, the depression scores on the POMS were lower than at the six-month follow-up but not as low as the scores at Sessions 6 and 12. Katie's experienced a very difficult six months following the counselling. Her six-

week hospital stay had been extremely traumatic and she was recovering from the break-up from her boyfriend. In addition, she had also undergone a number of hospital procedures over the previous twelve months. Therefore, in retrospect it was not surprising that Katie's scores on the POMS show elevated levels of depression at the six-month follow-up as a result of her relationship breakdown and her health concerns.

### ***Concern ratings.***

In Katie's screening interview, she had listed a set of concerns that she wanted to deal with in therapy. Table 7.10 tracks the changes in her concern ratings for sessions 4, 8, 12 and at the six-month follow-up. As can be observed in this table the issue relating to her weight did not significantly change over time. Her success at managing her laxative use was actually achieved as a result of the inpatient stay in hospital. However, and importantly, Katie's concerns with worry, irritability and despair did lessen throughout the course of the therapy.

The concerns raised by Katie were moderately to extremely important to her, and she was surprised by some of the changes that occurred during therapy, especially by feeling less tired and irritable and feeling more balanced. She expected that it would be unlikely that her weight would no longer be a main issue for her. Despite seeing a small change in her level of worry, Katie neither expected nor was surprised by this change. Katie reported that it was unlikely that the reported changes would have occurred without therapy.

Table 7.10. Concern ratings\* for Katie during counselling at 12 month follow-up.

Concerns	Before Therapy	At Session 4	At Session 8	At Session 12	At 6 month follow up	Change was: 1 expected 3 neither 5 surprised by	Without therapy: 1 unlikely 3 neither 5 likely	Importance: 1 not at all 2 slightly 3 moderately 4 very 5 extremely
1. Desire to achieve healthy weight	7/7	6/7	6/7	6/7	6/7	2/5	2/5	4/5
2. Desire to manage laxative use	7/7	7/7	7/7	7/7	1/7	2/5	1/5	5/5
3. Feel less tired	3/7	3/7	6/7	2/7	2/7	4/5	2/5	4/5
4. Worry about things less	5/7	3/7	5/7	3/7	3/7	3/5	2/5	3/5
5. Feel more balanced	6/7	2/7	2/7	2/7	2/7	4/5	2/5	3/5
6. Feel less irritable	4/7	2/7	2/7	1/7	1/7	4/5	2/5	3/5
7. Feel less despairing	7/7	4/7	2/7	3/7	2/7	3/5	2/5	3/5

Note: \* scale of 1 being not at all concerned to 7 for maximum possible concern.



***Personal descriptions.***

At the screening interview, Katie had described herself as “outgoing, the person who tells the jokes, the person who likes to be the centre of attention, the person who is emotional and moody in an “up and down” way.” At session 4, Katie said she was “still very similar to... I am definitely still all of them.” When asked to compare how she described herself at session 4 with the way she described herself at the screening interview Katie said she was more content and more at ease because she had been able to understand herself.

At session 8 when asked the same question Katie said

no, I am still the same, I am probably more positive if anything, and probably a bit more happy actually... yeah, instead of feeling guilty about things... I can do it at my own pace and be happy with where I am at, yeah, instead of changing as a consequence.

At Session 12, she said “I’m definitely happier... a lot happier. ...I’m sort of a bit more like open to doing things... just living again, not like locking myself up... I can concentrate more on other things.”

At the six-month follow-up Katie declared she was more assertive and “definitely more independent... a lot more alive with people and can organise myself a lot better.” She had not been as moody with her parents who rang her regularly. She had found the breakup with her boyfriend difficult and was still coming to terms with whether she had made the right decision. Her emotional state depended very much on how she was physically and she hypothesised her moodiness may be just her. “I am moody when I’m well like it’s just... but I try my best. I am still the same sort of person.”

**Measure of working alliance.**

The working alliance significantly predicts outcome, and despite a slight drop at Session 8, Katie scored the level of the working alliance as very high (overall within the 90<sup>th</sup> percentile, see Table 7.11). I valued Katie considerably and as I reviewed our

sessions together I was reminded of the genuine warmth between us, and my concern for her wellbeing. I feel somewhat saddened, however, that I was not able to make further inroads into the underlying issues around her eating disorder. The scope of the research and the ambiguous nature of the ongoing counselling, meant that it was unlikely I could enter the long term therapeutic relationship necessary to evoke the sort of change required. However, at the end of Session 12 when I offered to work with her doctor, to assist in finding her a dietician and to continue the counselling Katie spontaneously leapt out of her chair and hugged me. She was very appreciative of the work we did together.

Table 7.11. Measure of the working alliance utilising the Working Alliance Inventory - Short (WAI-S) form.

	Session 4	Session 8	Session 12	Range
<b>Katie's evaluation of working alliance Raw score</b>	80	77	84	12 - 84
<b>As a % of the total score possible</b>	95	92	100	

## Therapist's Analysis of Katie's Therapy Process

### **Katie's core emotion scheme.**

In terms of the PE-EFT goal to help clients access and process their emotions to change problematic emotion schemes and construct new meanings, it was important to understand Katie's core emotion scheme, and I used the template below in Figure 7.4 to clarify this. The dilemma for Katie was having the central primary emotion as fear because it might prevent her from being able to process the experiences that are triggered by that fear. The fear may take many forms. Hypothetically, her infantile fear of abandonment may have led to separation anxiety, and subsequently to a fear of not being in control. Being fearful by its very nature encourages avoidance behaviour. Katie acknowledged she would rather have the physical pain than the mental pain, and believed feeling sick and exhausted was better than being anxious. When Katie's

emotion scheme was activated she operated from an instinctual survival state and her body was flooded with chemicals as a result of the fear reaction. She was unable to fight or flee but could freeze. Subsequently, Katie's emotion scheme has become compounded by her ongoing life experiences and therefore her core emotion has become harder to reach. Her complex set of presenting symptoms presents layers of defence very remote from its source.

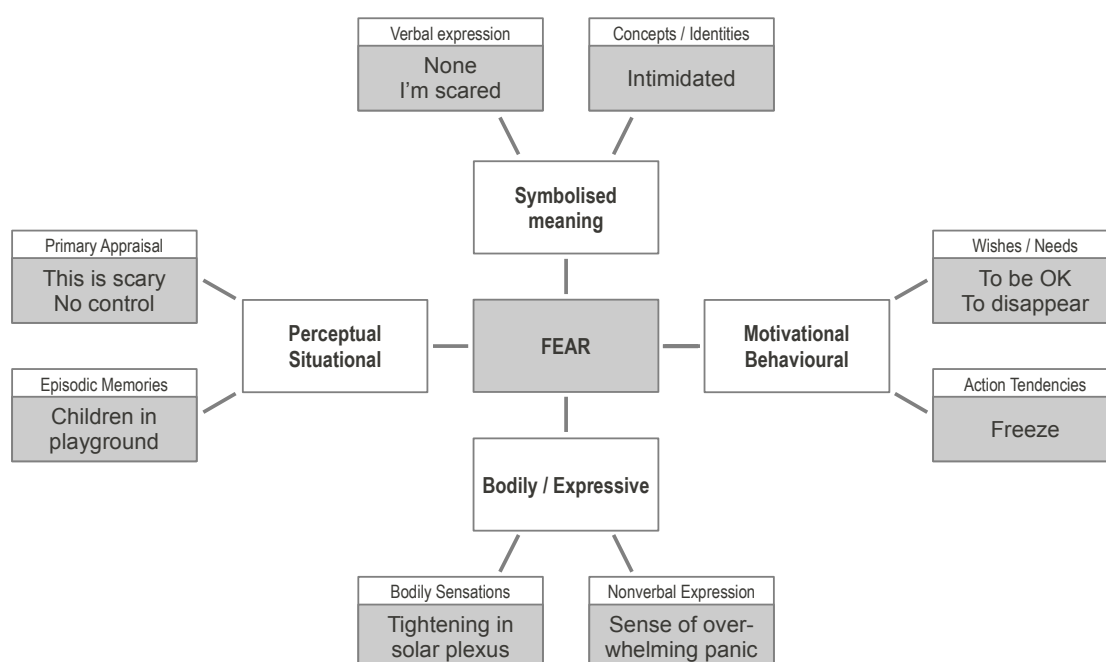


Figure 7.4. Katie's hypothesised core emotion maladaptive scheme.

I hypothesised that Katie has experienced herself as deeply insecure, vulnerable, powerless and unable to survive alone. When a depressogenic event occurred it triggered Katie's core maladaptive emotion scheme of fear. The deaths of three of her friends were likely triggers. Once this was activated Katie felt worthless, alone, abandoned, unloved and empty. She generated negative beliefs about herself, and feelings of abandonment, basic insecurity and shame. This sense of the self as vulnerable occurred in interpersonal situations where there was a loss of connection. Katie felt she needed to control everything around her to compensate for her lack of adequate reassurance. According to PE-EFT, for Katie to make enduring changes in

her life, she needed to have this emotion scheme reactivated in the permissive safety of therapy. Then it could be reorganised to operate at a more adaptive level of functioning, or a new scheme created. In relation to Katie's depression, I believe this was only partially achieved. Despite her reported scores on the BDI-II and the DASS being within normal levels by the end of therapy, the POMS still indicated depression as a mood state was present. In addition, the symptoms of her eating disorder were still evident and according to the holistic PE-EFT theory I would have expected these to have reduced or become more manageable if we had adequate time. In my opinion Katie's condition would be more suited to long-term experiential therapy.

### **Therapist reflections on the application of PE-EFT principles and process of change.**

Katie tended to external and conceptual modes of engagement, as identified on the Experiential Therapy Session (ETS) Form (Elliott, 2002a). Her emotional processing was very limited and she had developed somatic symptoms as evidenced by the Chronic Fatigue and the eating disorder. Katie was an expert at avoiding or holding painful experiences at bay and found turning her attention inward difficult. She was not trusting that her internal experience might provide her with a means of managing her affect effectively and so found it difficult to stay with vague, painful or ambiguous experiencing. Katie also controlled the expression of her emotions. For example, she talked about crying but never cried within the therapy hour. Her ability to self-reflect was filtered through her anxiety and eating disorder and so she found it difficult to stand back from her experience in order to develop a more meaningful perspective. She was initially unable to apply the results of her limited experiential work to any problem solving or productive action. My ratings for Katie on the scales of the ETS Form Client Modes of Engagement (Elliott, 2002a) were generally very low.

Katie and I did develop a trusting relationship but despite my support she was unable to trust the process of the therapeutic work enough to commit to it fully. I applied myself to the PE-EFT treatment principles by remaining empathically attuned to Katie's experience as much as she would allow me "in." I was genuinely prizing and collaborative. I facilitated her process as much as she would allow me and was very respectful of her defences. I was able to implement the tasks adequately but had to

abandon them on almost every occasion because Katie was unable or unwilling to continue. For me there was a real tension between facilitating Katie by pushing her (*leading* her too far out of her proximal zone of development) and staying within the parameters of her willingness (*following*).

### **Overview of therapy process and outcomes.**

I saw Katie as a determined young woman who struggled to take control of her life. She came to therapy expecting perhaps not to change but her openness and willingness to try new things enabled her to gain more self-acceptance, resulting in a stronger sense of herself. At session 12 the journey for Katie really had only just begun and she was optimistic, but after that things took a serious turn for the worst.

In hindsight, I would now advocate more strongly for Katie not to be given a diagnosis and perhaps would work harder to keep her out of hospital. I acknowledge that Katie saw an opportunity to manipulate the situation and us by “going through the motions” knowing her next true goal was hospital. I am also aware that in session 12 Katie got in touch with deep anger towards her mother. In session 13 she talked more about her anger with her mother and I wrote in my case notes it was like “the lid is off and the rage is emerging.” I was pleased for her that she was getting in touch with her feelings but I didn’t recognise at the time that the emergence of these intense feelings would trigger such a strong resurgence of her restrictions on eating. Katie had said in a very early session that she could cope with physical pain but not emotional pain. She had not developed any way to deal with the onslaught of this psychogenic pain other than through her eating disorder. In my opinion her anorexic behaviour was her means of avoiding all feeling. I am reminded of the statement about the “wish for recovery” from the article by Dolhanty and Greenberg (2007) which stated “I’d rather die than feel.” For Katie it was “I’d rather go to hospital than be angry with my mother.”

Katie’s depression did shift and this was a good outcome. However, the decline in her health and the hospitalisation was a poor outcome. For us to have to have achieved a better outcome for Katie I believe we needed long-term therapy of perhaps 18 to 24 months. Our aim would have been to transform Katie’s maladaptive shame and fear by accessing the sadness of her grief, by processing her losses and enabling

her to be in touch with her assertive anger. “Such transformation, along with the acquisition of a new capacity for managing and tolerating internal experience, would lead to the development of a sense of mastery, agency and efficacy in navigating her world, and facilitate a relinquishing of the eating disorder as a means of managing affective experience” (Dolhanty & Greenberg, 2009, p. 382). But it is worth noting that Katie wrote in her last correspondence with me that I had taught her to think differently and given her tools that she will continue to use throughout her life. This is a considerable gain resulting from her therapy.

## **Chapter Eight • Case Study 3: Ava**

### **Introduction**

I would like now to introduce you to my third client/participant who chose the pseudonym, Ava. This is the third of the four cases I will present in this thesis, and I have used a similar format to the case of Katie. I have included detailed descriptions of Ava's sessions in Appendix Q.

### **Screening interview: 27<sup>th</sup> April**

At our first meeting Ava, 21, was darkly dressed and somewhat withdrawn. She was undertaking her final semester of an undergraduate degree at one of the major universities in the state and was feeling very stressed about her studies. Her parents were south-eastern European and arrived in Australia before Ava and her sister, her elder by five and a half years, were born. Ava's sister's fiancé moved into the family home when Ava was thirteen but they left to move interstate when Ava was sixteen. Ava has worked casually in the retail sector since she was fourteen. She drank alcohol socially but did not take in illicit drugs as she was "too scared."

At fourteen Ava started to experience panic attacks. Two years ago she was so "scared of everything" that she stopped driving, attending university or going out. At the time a "bad relationship" of two years was ending and she felt depressed and suicidal. She would "go to bed early and stay in bed... can't get up... muscles ache don't want to move... don't want to be at home." Ava saw a psychiatrist who prescribed Zoloft but the sessions with the psychiatrist were about medication management not counselling. She explained "I have no panic now but I still get depressed... but it is something I'll always have... [have to] hide a lot about myself." She described constant negative thoughts, how she was "always thinking the worst" and how hard it was to change the negative thinking. Ava said she was extremely pessimistic. She had coped with her depression by going out with friends. Ava got very restless and agitated, and didn't sleep well. Her medication had assisted in reducing

her panic attacks but may have contributed to strange vivid dreams that wake her in the night. Occasionally, she lost interest in things and her concentration was at times impaired.

Ava described herself as anxious, nervous, always thinking, intelligent, loyal and a good friend. I asked Ava to list the main concerns she brought to therapy. These were; issues about how she viewed herself, and the desire to decrease her level of sadness, to improve her relationship with her mother, to meet someone (a suitable partner) and to become less anxious. I briefly explained to Ava the practice and key theory of PE-EFT. In addition, I gave her details about her research involvement. She smiled and said the counselling “sounds exciting.” Below in Table 8.1, are Ava’s Concern Ratings for the issues she brought to therapy. Table 8.2 provides the ratings for the duration of the concerns.

Table 8.1. Concern ratings\* for Ava at screening interview.

Concerns	Not At All	Very Little	Little	Moder- ately	Consid- erably	Very Consid- erably	Max Possible
1. How I view myself						6	
2. Feeling sadness				4			
3. Relationship with mum							7
4. Meeting someone					5		
5. Anxiety			3				

Note: \* scale of 1 being not all to 7 for maximum possible.



Table 8.2. The duration\* of Ava's concerns at screening interview.

Concerns	< 1 mth	1-5 mths	6-11 mths	1-2 years	3-5 years	6-10 years	>10 years
1. How I view myself						6	
2. Feeling sadness					5		
3. Relationship with mum				4			
4. Meeting someone				4			
5. Anxiety						6	

Note: \* scale of 1 being less than 1 month to 7 for greater than 10 years.

### **Assessment of Ava's suitability as a research participant.**

In psychopathological terms Ava's presenting problems included, depression, panic attacks and anxiety. Anxiety and depression are often comorbid disorders in adults. Despite considerable overlap, anxiety and depression are considered as two distinct discrete conditions but share a common underlying aetiology (Clark & Watson, 1991). This conceptualisation posits that there is a temporal relationship between the two, with anxiety predating depression as seen in Ava. Significantly, anxiety and depression can be distinguished by their dominant negative emotional state. The key emotion of anxiety is fear, which is predominantly future-orientated whereas the key emotion of depression is sadness, or grief, which is past-orientated.

Ava's reported depressive symptoms were identified as characteristic of depression according to the DSM-IV-TR (American Psychiatric Association, 2001) criteria. The severity of her depression was determined by administering; the Beck Depression Inventory (2<sup>nd</sup> Edition; BDI-II) and the Depression Anxiety Stress Scales (DASS). As in Katie's case Ava's depression did not fit neatly into either of the DSM-IV-TR (American Psychiatric Association, 2001) categories of Major Depressive Disorder or Dysthymic Disorder. Ava described periods of depression at the time her sister left for interstate with her brother-in-law and more recently at the time of the break-up with her boyfriend. Despite Ava's anxiety being managed by medication, her current DSM-IV diagnosis could be categorised as Mixed Anxiety-Depressive Disorder, a diagnosis agreed to by Dr. Wills (see Appendix A).

Ava described periods within the past twelve months of a desire to “stay in bed... don’t want to move.” She said her “depression stopped me from being happy or relaxed” and she had periods where she lost pleasure in most activities. She reported fatigue, lack of energy in conjunction with restlessness, agitation and inability to stay asleep. She often struggled with concentration and procrastination, and worried about her studies. In addition, Ava’s pessimistic thinking created intense anxiety for her. Significantly, however, Ava claimed that she was not suicidal but had felt that way when her relationship broke down.

The inventory measures of Ava’s depression indicated severe levels on the BDI-II and moderate levels on the DASS. The DASS measures of Anxiety and Stress were found to be also in the moderate range (see Table 8.3 and Table 8.4 below). Ava was a suitable candidate for the research.

Table 8.3. The BDI-II classification of depression at screening interview.

<b>Ava’s BDI-II Depression Score</b>	<b>Minimal</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
31	0-13	14-19	20-28	29-63

Source: Beck, Steer, & Brown (1996); Beck, Steer, & Garbin (1988); Beck, Ward, Mendelsohn, Mock, & Erbaugh, (1961).

Table 8.4. The DASS classification of depression, anxiety and stress at screening interview.

	<b>Ava’s score</b>	<b>Normal</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>	<b>Extremely Severe</b>
<b>Depression</b>	19	0-9	10-13	14-20	21-27	28+
<b>Anxiety</b>	10	0-7	8-9	10-14	15-19	20+
<b>Stress</b>	23	0-14	15-18	19-25	26-33	34+

Source: Lovibond & Lovibond (1995).

## Ava's Therapy: Sessions 1-4

### Session 1: 11<sup>th</sup> May.

Ava missed her sister. She spoke rapidly, gesticulated actively, fidgeted compulsively and pulled at her hair and clothes. When directed to her body Ava said "...I have so much to say that I lose my breath (*holding her hand to her upper chest*)... so much I want to say about her... wish she was back... a tight feeling." Ava yearned for her sister's support, as she felt suffocated by her mother. She described her mother's often extreme behaviour as screaming at her and berating her.

There is no talking to you... a person can't talk to you... there is no getting through to you... you are the way you are and that's it... whether I talk to you like a human or an animal you are just like that... you are that way and that's it!

Ava was caught between the extremes of loving, wanting to please and being very dependent on her mother and a desire to get away and be independent. "I'm just like... (*gesturing*) pull[ing] my hair out." She had a dream that within the next three years she would meet someone, fall in love, get married and move out as that would fix everything. Ava's sister was a "hard act to follow" because she had met all the expectations of her family. Ava was "a complete opposite from what they wanted" and considered the source of all her mother's problems. She felt her mother had overly sheltered and protected her on the one hand, and criticised her for not being independent on the other. I encouraged Ava to talk freely with me about her difficulties and said that I "heard" her. Ava let out a huge sigh as we sat in silence and tears welled in her eyes. Something had shifted.

Ava wrote on her Helpful Aspects of Therapy form, "when the therapist told me she was there for me (rather than my sister) and that I could tell her all the things that I can't tell my sister. This felt like a weight had been lifted from my shoulders... relief... like pressure in my chest was released. I cried when I told the therapist about

what ‘I wish’ to happen like a dream I have that would resolve all the issues I’m facing now.”

### **Session 2: 1<sup>st</sup> June.**

Ava missed the next three scheduled sessions. She had had a car accident in her parent’s car on the way to the last session and since then had been unable to get out of bed and was experiencing dissociative-type symptoms. She pulled her cardigan across herself, and wished she could walk around all day with her arms folded that way because it felt tight and secure. In bed she would have every corner of her doona tucked in tightly around herself and not move. Ava said she felt numb all over, not present “like I’m somewhere else... ..in a daze” and “I feel like I’ve been bashed...” I invited her to close her eyes, notice the tension in her body and breathe, with the aim was of slowing Ava down. I acknowledged she was really suffering and felt “battered and bruised.” She let out a deep sigh and yawned and said she felt a “release of the tension” in her body. I asked “what would your body be telling you?” and she replied “...sounds so cheesy... ‘start loving me... just love me there is nothing wrong with me.’” Mirroring each other we crossed our arms across our bodies and swayed slightly as if rocking a hurt child. I noticed her stroking her own thigh and patting her knee soothingly. I became aware of a calmness around her as she sat quietly. She agreed “I feel it... the whole body thing... I can feel it.”

Ava reported on the Helpful Aspects of Therapy form that closing her eyes and thinking about what her body was telling her was helpful because it made her realise that her body was constantly communicating with her. In addition, she found taking the time to really feel the aching, bruised feeling throughout her body was also useful.

### **Session 3: 8<sup>th</sup> June.**

Ava talked about her “fear of death”, and that she had been discouraged by others from talking about it. I asked her to talk openly and suggested a focusing. Ava closed her eyes, I helped her to “clear a space” and invited her to turn inward and notice where the tension resided in her body in relation to her fear. She felt it in her chest, a “black, hard prickly thing.” Its emergence was so overwhelming Ava suddenly opened her eyes. She was frightened.

Ava explained how in the past she would go to a place in her imagination. This place was a warm beach where the sun would be shining. I invited her to close her eyes again and to explain to me what she “saw” of these surroundings, which she then described in great detail. I suggested that she might like to use this visualisation to help her cope with the black, prickly mass in her chest. She immediately and spontaneously started to work on getting the sun to burn up the mass. The energy in the room significantly changed. She stretched and yawned. Ava was excited by the prospect of having some control over this “thing” that had controlled her as long as she could remember.

Ava wrote on her HAT form “definitely the most helpful event today was visualising my fear and how I could overcome it by creating and thinking about a place where I feel completely happy and in control.” In addition, “seeing my fear, picturing it, confronting it, looking straight at it and with a sense of talking to it” was greatly helpful.

#### **Session 4: 26<sup>th</sup> June.**

When Ava arrived she was agitated, picking at her clothes and jumper. She recalled a dream she had had where a friend had died and even though she was very upset and crying there were no tears. Her friend had become an ex-friend because she would exclude Ava and talk behind her back. The falling-out had never been properly resolved and I suggested that Ava imagine her ex-friend in an empty chair in front of her. I invited Ava to speak to her imagined friend and express how she really felt about her friend’s treatment of her. Ava found it difficult to make eye contact with the chair. She fidgeted with her long black hair, combing it with her hair-clip and feverishly pulled at numerous knots. However, despite being so anxious she was able to hesitantly say what she wanted to express. Fortunately, Ava reported a great relief at having gone through the process and experienced a shift in the perception of her friend, a shift she did not elaborate upon.

On the HAT form Ava wrote that “confronting her [friend] about her feelings towards her and what happened between us” was an important and helpful event. “This event was helpful in that I felt I got all the things I needed to tell her off my

chest. I felt a sense of relief and had closure.” In the Table 8.5 I have highlighted the significant elements of each session.

Table 8.5. Ava: Summary of bodily felt sense, symbolic representation, episodic memory, emotional arousal and felt-shifts – sessions 1 to 4.

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
1.	Narrative Relationship <i>with sister with mother</i>	lose breath (hand to upper chest) a tight feeling	so much to say freeze up	visits home	global distress
		suffocating	pull my hair out dream “one day I’ll get married and leave” problem child feel like a kid	overprotected yet criticised for not being more independent mother’s behaviour ranting and raving	tears – <i>sadness, anger</i> tightness shifted she let out a big sigh of relief → <i>shift</i>
2.	Vulnerability Accident <i>Mother</i>	no feeling	suicide ideation no drive to live – not existing under pressure		global distress
		headache  wrapping cardigan around herself  chest  feel bashed body hurts all over... so tense	hide     numb - zoning out	mother compared her to others every corner of her doona tucked in need to feel safe mother criticising her	      deep breathes – release of tension body rocking whole body calm → <i>shift</i>

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
3.	Focusing Fear of death	felt in her chest	black, hard prickly thing use visualisation of sun to burn up the mass	go to a place in her imagination	deep seated <i>fear</i>  sense of safety sense of control → <i>shift</i>
4.	Narrative Dream		dreamt a friend had died crying but no tears		frustration
	Empty-chair Ex-friend	avoided eye contact with chair frenetic hair pulling		past experiences with friend – being excluded or ignored	severe distress → sense of relief and closure → <i>shift</i>



### **Client and therapist analyses of change.**

#### ***Client's analysis of change: Sessions 1-4.***

After session 4 Ava explained in her Change Interview with Dr Wills that she enjoyed the therapy but found it “emotional... it’s like I build up my week and Friday’s the day I can just let everything out... there’s always something to say.” Ava had taken some of the techniques we had done together in session and applied them successfully at home: “if I have been stressed by mum, take ten, fifteen minutes out and then I sort of try and block off everything, like I think back, calm down, focus on my breathing and I focus on how I’m feeling.” She attributed the change to therapy: “the decrease in anxiety wouldn’t have changed without the therapy.” But she also said “the how I see myself I think has changed more with meeting new friends.” In addition, Ava was becoming aware that “now I have noticed myself... like not caring as much as I used to about what people were thinking or what they say” and “I have noticed myself slowly starting to be like, starting to not worry about the things that usually worry me.”

One of the main things Ava found helpful was acknowledging

how I feel... like my emotions... that’s helped me a lot because before that I would just not notice what I was feeling and just push it aside or get angry at myself for feeling that way you know, like, oh, why are you sad or why are you anxious or why are you angry you know... but this therapy has helped me to feel like, it’s ok to feel, it so that’s been a big help.

When asked what was missing for her in therapy Ava explained that most of the work was focussed on the here-and-now and she would have liked to “talk about more or figure out things more things from my past and bring up the root of the problem, like stemming back, not just from the last few years but since I was a kid.” Ava felt confronted at times when asked about her mother and past relationships, “I sort of like cried and it has been painful for me to sort of let it out and I do feel weak at that

point and vulnerable and very you know fragile and whatnot and then in the end of it I feel good.” She felt she was also being disloyal to her mother

I shouldn’t be talking about my mum like this but then it helps me to talk about her... I constantly feel like I’m in the wrong when things go wrong with mum but through therapy I see that I’m not in the wrong and she can be in the wrong too... it’s more about finding you know a compromise with her

Interestingly, Ava raised that one of her biggest concerns was that she eventually wanted to come off her medication and

...still being ok, like I still feel that, you know, like the therapy helps but I feel as though like if I just stop taking Zoloft then the panic attacks will come back, the anxiety will come back, you know, everything will just come back and everything that I have learnt in therapy will be sort of... won’t matter anymore.

She noted that her psychiatrist told her that her anxiety was a part of her biological make up and she would always have to manage it. She explained “the tablet has stopped the panic attacks but they haven’t stopped the thoughts, like I still have those irrational thoughts like I still fear things like death or something bad happening.” Ava wanted a medication-free-life without the irrational thinking and heightened anxiety.

***Therapist’s analysis of process and change: Sessions 1-4.***

During our first session it was important for Ava to tell her story, and I was aware of a marker for narrative. The process of opening up to tell a difficult story, and Ava’s story was a difficult story to hear, was an important step in developing trust and forging an alliance. This would be particularly challenging because as a woman and a mother I would not only represent a potential for change and healing for Ava but also a possible nemesis. I was shocked much of the time as I listened, and reacted quite strongly internally at hearing about Ava’s mother’s controlling behaviour and lack of

insight into the impact that that behaviour was having on Ava. My aim was to be present to Ava's pain and frustration, to be sensitive enough to her dilemma and not to show my outrage and dismay too overtly. In this first session I wanted to work within Ava's proximal zone of development in order to best support her and thus not be seen as overly judgmental of her mother. In addition, there were times of vulnerability and through my empathic affirmation I wanted Ava to feel understood. Ideally the end-state of using the reprocessing task of the narrative was the relief Ava described. In addition, sitting with her in her vulnerability may have served to strengthen her sense of self.

In session 2, I explored Ava's experience of feeling "battered and bruised" because it appeared to me her body was storing certain experiences. This may have been a body memory from the car accident or it may have been a physical manifestation of her emotional state. I used empathic exploration throughout the session as a means of uncovering and expanding Ava's experience. I assessed Ava's suicidality. Despite not being actively suicidal she saw death as a better alternative to living. I sat with Ava in her vulnerability, affirming and supporting her as tears welled in her eyes. In order to ground Ava into her body and achieve some body awareness I asked Ava to notice the pulling of her cardigan around her chest. This assisted her to feel compassion for her body, which culminated in a felt-shift into calmness. It was as if Ava was in that "teenager' phase," when anger and rebellion are essential to healthy development, but her attempts at individuation were met with criticism and shaming from her mother. I surmised that her angry reactive outbursts oscillated with efforts at reconciliation in order to manage her adaptive desire to separate and yet cope with her deep sense of fear of losing her mother.

In session 3 I invited Ava to explore her "fear of death" in the task of focusing in order to assist her to explore what death meant to her. Despite being readily able to symbolise this fear it appeared that she found it difficult to stay with the experience. I used Ava's safe place as a temporary antidote to her fears and it seemed that she experienced a felt-shift. Usually I would encourage the client to stay with the sensation, allow a memory to emerge and reprocess that memory to uncover new understanding and create new meaning but Ava was unable to stay with her discomfort. The task facilitated a symbolisation of Ava's fear and had the potential to

give her a fuller understanding of where that fear originated, but the intensity of Ava's fear interfered with the possibility of a full resolution.

In session 4 I introduced the enactment task of the empty chair with Ava's ex-girlfriend in an attempt to achieve some resolution for the unfinished business Ava had with her. Ava's anxiety was extreme and upon reflection I would have liked to have paid more attention to it by encouraging her to ground herself more into her body and breathe more purposefully. This I believe would have helped alleviate some of her distress on a moment-to-moment, day-to-day basis. Despite this however, I supported Ava at the time to say what she wanted to say to her ex-friend as part of the task. A full resolution in this task was attained because Ava felt she had achieved a sense of closure and could potentially see her friend in the street and be okay.

## **Ava's Therapy: Sessions 5-8**

### **Session 5: 29<sup>th</sup> June.**

Ava said her parents labelled her the "problem child" and her sister the "golden child." Ava began to rebel against her parents when she was fourteen and at fifteen began a hidden relationship with a boy two years older from a different nationality and religion to her family. When her parents found out, Ava "was belted like no tomorrow... I remember I had bruises and scratches on my face." The relationship lasted on-and-off for about six years. She recognised that he was not a suitable partner, not because of his nationality but because of his treatment of her. Her most recent ex was also violent. "I am a weak person... I stayed in a bad relationship because I was too scared to come out of it." Ava wants the man to look after her, "I need to be looked after... can't protect myself..." a belief her mother regularly reinforced. I empathically conjectured "you used the word weak before, is that how you feel on the inside?" She nodded and I asked her where she felt that in her body. She held her hand to her heart and with tears in her eyes that did not fall she sighed, "[I'm] weak... can't do anything." We sat in a long silence. Ava was hopeful for her new relationship with Greg, 28. He was Ava's first sexual encounter but she was acutely aware that he was using her. Ava reported on her HAT that talking about her past and present relationships and how they had affected her was greatly helpful.

### **Session 6: 27<sup>th</sup> July.**

Ava had passed her exams but had not done as well as she had hoped and her mother reminded her daily that she was “a constant disappointment.” Ava was often the topic of criticism at extended family get-togethers and was very sensitive to their scrutiny. But Ava was reminded of the daughter of her cousin who was one and a half years old, “she loves me... doesn’t judge me... stay and play with her forever... I wish people were like that.” I said, “it touches you [that little girl?]” Tears welled in Ava’s eyes and she cried.

As a way of coping Ava said, “sometimes I zone out... I can’t see myself in five years time or the near future... it’s like I don’t exist anymore... my life ends here... it makes me so sad.” She felt that if she didn’t exist, no one would notice “...like there was never an Ava.” After some silence I reiterated that “there is an Ava” to which she responded through her tears “she’s fucked in the head.” After a long pause she replied “I can see that... if I’m not there no one is going to watch me.”

Ava said of her new relationship “even there I am trying to change who I am.” She was afraid of being alone and hung around Greg in the hope that he will love her and save her. Ava sat silently contemplating and then said tearfully “...I’ve been in love... with the wrong person... but I have never been loved by anyone... I’m sad about that... I must be a really bad judge of character because the people I attract are just not right for me... all my life always feel I’m being punished.”

Ava reported on her HAT form that talking about spending time with her cousin’s daughter and how it made her feel loved and happy was helpful, “it made me cry, [and] I felt a sense of release.” In addition, she was able to acknowledge how much it affected her when she was judged.

### **Analyses of change.**

#### ***Inventory assessments after session 6.***

At Session 6 I asked Ava to complete the BDI-II and the DASS inventories. The scores are tabulated in Table 8.6 and Table 8.7. Ava’s depression and anxiety scores had actually increased since her screening interview. In some cases client’s scores may increase as they begin to explore the issues impacting their lives. In Ava’s case the difficulties with her mother were highlighted in therapy and the opportunity for these

to change in the near future, by moving out for instance, was minimal. Ava's life circumstances were in many ways more challenging since she had finished her studies and was looking for a job. She was also struggling with her relationships both at home and with her lover. However, her stress levels had decreased from moderate to mild.

Table 8.6. The BDI-II classification of depression at Session 6.

Ava's BDI-II Depression Score	Minimal	Mild	Moderate	Severe
39	0-13	14-19	20-28	29-63

Table 8.7. The DASS classification of depression, anxiety and stress at Session 6.

	Ava's score	Normal	Mild	Moderate	Severe	Extremely Severe
<b>Depression</b>	24	0-9	10-13	14-20	21-27	28+
<b>Anxiety</b>	23	0-7	8-9	10-14	15-19	20+
<b>Stress</b>	18	0-14	15-18	19-25	26-33	34+

### ***Session 7: 3<sup>rd</sup> August.***

Despite arguing with Greg and then reluctantly apologising, Ava wanted his company. "I'd rather feel lonely with someone than be lonely alone." She swung between really liking him and being put off by his personality as he "...made me feel so bad about myself... so ugly." I initially suggested the empty chair task but she was reluctant so I suggested working with two chairs; "Ava that wanted to be with him" and "Ava who didn't want to be with him."

Ava knew she deserved better because he was not very lovable but she was unable to let go. Her decision to be intimate with him meant that she *had* to love him. "Yes... sort of to make it right so I don't regret what I have done... I settle for this if this is all I can get." Ava felt pressured to find a partner and settle down and admitted this pressure was a "big part" of her deciding to have sex with him. An argument between her "head" and her "heart" ensued. Her heart acknowledged she didn't love him or want to stay with him but "...I'm a failure... who's going to want to love or want to be

with a failure?” Ava’s heart said she needed the logic, rationality, clear thinking and confidence of her head and expressed a desire to listen more to that rationality. Ava’s head said, “it’s about time... I look forward to working with you!” Ava returned to the chair she sat in at the beginning of the session and was visibly excited and energised: she said it “feels good... feels better... more at peace.”

Ava reported that talking to the two parts of her personality (emotional Ava and logical Ava) and coming to an agreement was greatly helpful. She also found it useful to work through why she was holding onto her relationship.

### ***Session 8: 10<sup>th</sup> August.***

Ava was unwell, “really emotional and hormonal.” After meeting Greg her mother said to Ava “...princess you deserve so much better... he’s not right for you... [he] doesn’t have the level of maturity or intellect you have.” Ava was thrilled “for the first time my mum said I was smart!” She had dropped off his laptop on the way from work before going out for dinner with friends. They hardly spoke but when she changed into her evening clothes he made a move to initiate sex. “The whole thing was different because I felt good about myself... for the first time I used him for something.” Later they ended up at the same nightclub and she managed to ignore him all evening despite his attempts to make her jealous.

Ava still dreamed of making this relationship work. “...Ava the dreamer lives in a fairytale.” Through a mini-focusing process, I asked Ava to close her eyes and imagine her *imaginary* world with the aim of creating some sort of bridge or connection between *her* world and the *real* world. In her world there was sunshine, brightness and a feeling of wellbeing but the real world was “sort of blacker.” She wanted the real world to move into her world but then said, “I am colouring it in.” Her bridge between them was “...like a field... grass, like a park.” She explored this new world “lots of things to see... bigger than imaginary world.” She appeared calm and was smiling.

Ava liked “building a bridge between my imaginary world and the real world.” It was slightly hindering for her “talking about her intimate relationship with [her lover] and whether it would continue.” In the Table 8.8 I have highlighted the significant elements of each session.

Table 8.8. Ava: Summary of bodily felt sense, symbolic representation, episodic memory, emotional arousal and felt-shifts – sessions 5 to 8.

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
5.	Narrative	stomach - nausea		mother often unwell	fear
	Past relationships		Ava - problem child Sister - golden child	mother's beating criticism of her first boyfriend	despair
	Vulnerability	hand to her heart	I am weak – can't look after myself	recent boyfriend – first sexual partner	tears in her eyes shame affirmation by me - felt better → <i>shift</i>
6.	Narrative	her heart hurts	wants to be loved / liked change herself to accommodate others	argument with mother scrutiny at family get- togethers little niece's unconditional love	global distress  tears of appreciation sense of release → <i>shift</i>
	Mother	zoning out	feels like I'm nowhere – never was an Ava	photo of them together	tears of despair
	Greg Vulnerability		head / heart split – “like a war”		



Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
7.	Two-chair Conflict	STAY with Greg chair – he was her first HEART – emotional	I'm a failure		fearful of loneliness co-operation between logical and emotional sides visibly excited and energised “feels good, feels better, more at peace” → <i>shift</i>
		LEAVE Greg chair – you deserve better HEAD – logical	I have control		
8.	Narrative Greg	felt different looked and felt good	<i>tarty</i> – “I used him for something”	conversation mother had with Greg	confident laughter
	Focusing Bridge	imaginary world	sunshine, brightness and a feeling of wellbeing		calm and was smiling → <i>shift</i>
		reality	sort of blacker -field of grass as connection		

***Client's analysis of change after session 8.***

In her Change Interview with Dr Wills after session 8, Ava said “I’m doing better than I was before I started this, I think differently, I understand things a little bit better now, I can sort of rationalise things.” She said she still thought about things all the time and worries, but “I can control it better now.” Ava explained she was “getting a bit more confident,” and was able to be more accepting of herself when she felt down. In addition, Ava was able to explain her developing sense of maturity

It’s easier to cry over something... that... hasn’t gone your way... is an immature way of dealing with it. Whereas now this other part of me, this rational, logical part can sort of reason with that part of Ava, say it’s okay, yeah you can cry, you will get through it and be mature about it.

Her relationships had improved “I understand them a bit better now too ...they’re completely different relationships to what I’m used to... I’ve learnt a lot about myself through them I guess and about how I am through them.”

When asked about what may have specifically assisted in bringing about change within therapy Ava mentioned the empty chair work in session 4 with her estranged girlfriend and the two-chair work in session 7.

I can sort of communicate with myself, there is that part that makes her decisions how she feels ...emotionally ...and then there’s the part of me that would think logically and rationally about something and I feel... like a disagreement with... the two parts sort of thing and Melissa really opened up, my eyes to sort of trying to bring them... together and being able to communicate with each other just like a, I don’t know, just more peaceful now...

Again the therapeutic relationship was important

What helped me most I guess is like how I said earlier... she responds... and I get the feeling by her response she understands as what I'm feeling and then she accepts what I am feeling and she doesn't judge that what I'm feeling is right or wrong... she's on my side even if I am wrong I guess... and then at times when I am wrong I can acknowledge it through... the dialogue we have.

When asked whether there had been anything hindering her therapeutic work Ava responded

...not really... it did take me a couple of sessions to be able to open up about certain things, about certain experiences. I think that was most about me trying to become comfortable... to develop that level of trust but I think that's pretty much overcome now... Like for example those role-plays. At the start I wasn't comfortable. I couldn't imagine sort of confronting my friend or a partner but it ended up positive. Like I absolutely enjoyed it

Ava had missed a great many sessions and I asked Dr Wills to enquire about this

I think subconsciously I was afraid to keep coming back at the start like I didn't want to... bring up things that I thought I'd dealt with or forgotten about from the past. I didn't want to uncover all those things again 'cos I didn't know if I could deal with them again. I thought that oh, it's bound to happen in therapy and I just can't imagine going back there. But now that I have I sort of... crossed that and I've been fine. And that's because of Melissa and because of how she's understood me and how she's been accepting of me and of my experiences. So yeah, I'm happy about it now.

***Therapist's analysis of process and change: Sessions 5-8.***

In session 5, I recognised that it was crucial for Ava to continue to tell her story without judgment or ridicule from me. I attended to Ava's immediate experiencing as she journeyed through the unfolding of her narrative, and I attempted to create a safe environment for her to tell me openly about her problematic and traumatic relationships.

The idea that Ava was considered the "problem child" and had been beaten by her mother because she had been in a relationship her parents considered unacceptable appalled me. It appeared to me that Ava needed protecting from this young man, but her parents' actions and attitudes actually forced her to turn to him for support and solace despite his abuse of her. It was my opinion that she needed her parents, particularly her mother to assist her to see that his treatment of her was not acceptable, regardless of his ethnicity. This early abusive relationship occurred at a critical time in Ava's identity development and perhaps cemented her belief, as suggested ongoingly by her mother, that she was unable to look after herself. Fortunately, Ava had the fortitude to break from these abusive relationships, recognising they were not good for her, but as a consequence her self-esteem had been significantly weakened.

I believe that the person-centred relational elements in PE-EFT were the essential ingredients in my work with Ava. In line with this, I thought she needed reassurance, acceptance and prizing in an attempt to reverse and repair her perceived sense of having a flawed personality. This, however, would take time. Ava's generalised fear, doubt in herself and lack of faith that she was indeed a good and capable person were hindering aspects in our work together. It was essential to strengthen her sense of self through the relationship with me. However, Ava's attendance was haphazard and the momentum of the work was interrupted by long breaks between sessions.

I was aware that Ava was struggling and despite processing her current experience, I felt Ava's symptoms were not alleviating, as evidenced by her depression scores not reducing after session 6. There was a real tension in me to move the work more quickly by using the tasks more regularly, and yet I was informed by an innate knowledge and a recommendation by the PE-EFT developers that we needed to move at a pace comfortable for the client. In addition, there was a real dilemma in me about

bringing Ava to an understanding that life at home was unbearable but offering her no clear option as how to leave it by moving out.

Even though I paid some attention to Ava's zoning out, I was again reminded as I wrote this part of the analysis that Ava was not often grounded in her body in-session or in her day-to-day life. In recent years I have become acutely aware that anxious and traumatised clients are regularly dissociating as a means of managing difficult and anxiety provoking situations. Through clinical observations with my clients and reading research by leading trauma practitioners, I have discovered that an antidote to the discomfort of anxiety and the subsequent dissociation can be offered by promoting *body awareness* to encourage grounding (Rothschild, 2000). This is simply achieved by inviting the client to take a number of deep breaths, to feel their back against the chair, feet on the floor, and toes inside their shoes. I believe if I had taught Ava this very simple grounding exercise at this time, I would have assisted her greatly in staying present and thus helped her process her past experiences more efficiently. I have also become aware that if a client is not grounded in her body she cannot process her experience adequately and may in fact experience re-traumatisation.

I now realise why I favoured the focusing task, because it has the grounding incorporated into it. However, I have also found that it is necessary to regularly check-in with the client that she is still grounded throughout the focusing process, as dissociation is likely to occur as painful or traumatising material is remembered. Ava had only been invited to do one focusing up to this point. Despite markers for empty chair and two-chair enactments being present throughout the session, Ava's vulnerability was obvious, and thus affirming and prizing Ava was the appropriate intervention. I needed to remind myself that sitting with her in her vulnerability does serve to strengthen her sense of self. The recollection of Ava's little niece loving and accepting her unconditionally was also a strengthening experience for Ava.

In my attempt to facilitate processing of Ava's issues with Greg, I offered two tasks in session 7. Empty chair again was too confronting for her and so I suggested working with two aspects of Ava. This proved useful, as she was able to get in touch with a more assertive aspect of herself that was small but emerging. Unfortunately, the emerging experiencing self was overwhelmed by her strong critical voice, most certainly her internalisation of her mother's voice, and so I needed to take time to

support her emerging experiencing self. Whilst the two-chair work had assisted Ava to identify aspects of Greg that were not conducive to loving him and to recognise that she deserved better, it seemed her emerging self collapsed under the critical voice. We were not able to strengthen the experiencing self and ultimately soften the critic. However, Ava reported finding the idea of “head” and “heart” useful and was able to recognise that a compromise between head and heart might achieve some harmony. I was encouraged by Ava’s realisations and felt optimistic that she might be able to stand up to Greg or even leave him. Ava experienced a definite felt-shift as she described feeling energised at the end of the session.

By session 8 we were continuing the process of assisting Ava to build a stronger sense of self that would enable her to trust that she was indeed deserving, and to recognise herself as lovable. Ava was seeking a secure attachment with Greg to ease her distress at being insecurely attached to her mother and her fear of abandonment because she felt she was somehow faulty and unlovable. Ava had learnt to be self-sacrificing in her relationships and this firmly entrenched trait was pulling her back to Greg. The purpose of our work up until now was uncovering Ava’s deep sense of vulnerability and inability to make decisions for herself or care for herself. My intervention to acknowledge Ava’s imaginary world as an important coping mechanism was in many ways in the service of this, allowing her to process her past experiences despite the mini-focusing being somewhat *out-of-mode*. Creating a bridge between her imaginary world and the real world was intended to encourage her to expand her awareness and experience the world as less black and white. I questioned the success of this intervention but my client-focus supports my following the client where she needs to go.

## **Ava’s Therapy: Sessions 9-12**

### **Session 9: 17<sup>th</sup> August.**

Ava’s mother had been checking up on her by compiling a list of calls made and received on her mobile phone and calculating her expenditure from her bank statements. She accused her of her “buying” her friends. Ava was furious at the invasion of her privacy. She felt the deep resignation, despair and sense of

hopelessness “in my back... feel like she’s jumping on my back.” Ava was hunched over rubbing her eyes “don’t know what to do... (*long pause*)... I’m stuck.” She leant forward scratching her head and pulling at her hair. “Take me away... put me in hospital.” Last night she “...started thinking stupid things... how would *she* feel... like if I just wasn’t here anymore... just died or something.” Ava did not cry. Raising her head she said loudly and angrily “I don’t want to be around you... not only do you invade my privacy by opening my mail but being next to you... you are invading my time with myself.” Ava wrapped her arms around herself. I had pulled a chair next to me and invited her to continue her dialogue to the empty chair but she said “I can’t talk to her... she’ll yell back... I know everything she’ll say... oh I just wish Prince Charming would come.” Ava kept pulling at her hair “it’s so thin!” and scratching her head. She had found some sleeping pills in the cupboard the other day and just wanted to take a couple so she could sleep “so I don’t have to feel that aloneness anymore.”

Tears welled in her eyes as she described a feeling of bugs growing inside her, under her skin. “Stupid mother, stupid mother, stupid bitch... why are you treating me like this.” I coached her gently to say the words more loudly and then she said “because she can... feels like pulling my hair out... itchy everywhere.” I conjectured that she was seething but I also noticed sadness. She explained she was “too angry to cry... I feel nauseous... like throwing up... then I feel like sleeping and doing nothing.” I encouraged her to stay with these emotions.

I encouraged her to stay with friends over the weekend and contact me if she needed. She was not actively suicidal. I reassured her that there was nothing “wrong” with her and said I considered her mother’s behaviour abominable. Ava reported on her HAT form that telling me about her mother’s behaviour had been helpful and she felt she had got “all her anger” off her chest.

### **Session 10: 24<sup>th</sup> August.**

Ava had survived the week having minimal contact with her mother. “I’m so over everything... I’m still sad... upset... I’m so drained... I feel like dry... all the water in me has been sucked out... I feel like a desert... drained... no life...” As Ava had described her symptoms in symbolic terms I invited her to do a focusing. She

immediately identified an area of pressure in her stomach which she described as like a green flat piece of glass that was hard to see through. She got a sense of five or six people who had pressured her during her transition to high school. She had been overweight, had few friends and had been teased relentlessly. Her first ex-boyfriend came to mind. She was still emotionally attached but was able to let him go through an imaginal confrontation process (IC)<sup>6</sup>. As she watched him move away she sighed deeply and experienced a felt-shift despite emptiness and sadness remaining.

A further search revealed a pressure in the back of her neck, which she described as a “grey shadow... a force.” Tears welled. She sensed this pressure had been there since she was about six years old. As she described its qualities she moved her chair back away from me and leaned over, resting her elbows on her knees with her face in her hands. She willingly continued. It was her mother’s expectations and she needed to “let it go.” I affirmed that Ava was a good, kind intelligent person who could be proud of herself. She sat up straight and took a deep breath. The pressure in her shoulders had lifted and she was aware that “I’m okay.” This sensation of feeling okay spread throughout her body and she described it as a beautiful blue energy. The session ended with my slowly and gently asking Ava to ground herself and open her eyes. Ava reported that she found the focusing very useful because she connected with knowing that everything was going to be okay. “I felt like I had finally closed the door on my past.”

### **Session 11: 14<sup>th</sup> September.**

Ava was very emotional as she shared that her doctor told her she had had a miscarriage. Greg was very dismissive when she told him. “What was I thinking... there was no ‘us’... I’m such an idiot... feel disgusting... like a whore.” Ava leaned over rubbing her eyes as she acknowledged he didn’t care about her. He hadn’t even called for her birthday last week. Ava began to cry “...sad... because I now really, really, really see him... (*long pause*)... I still had that hope... this is the eye opener for me... it had to be that extreme for me to get it... why do I let it come to that?” He now has a girlfriend.

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6 I use the abbreviation IC to denote an imaginal confrontation or an internal conversation within a focusing task with a significant other/perpetrator.



Ava began to realise there had been “a potential baby... the thought that it was there... can’t get my head around it.” She was grieving but unable to say goodbye. Ava described “a heaviness” in her shoulders and I suggested a focusing. When she closed her eyes and connected with her pain she identified a need to be perfect and the pressure this caused her. She began to get in touch with a sense of the loss of the baby and the loss of the relationship that never really was. I encouraged her to talk to Greg in her imagination. Ava sat bold upright and took a few deep breathes, “[I] feel like hitting him.” I urged her to tell him how she really felt and if possible find a way to let go. She was overwhelmed by nausea and rocked in her chair. Fortunately, Ava was able to stay with the discomfort and experienced a considerable felt-shift. She realised she would be okay, that things happened in life and she needed time on her own to heal. Ava reported on the HAT form that the focusing helped and talking about what had happened in general had been useful. She understood she needed “time to grieve and understand the hurt and loss.”

#### **Session 12: 21<sup>st</sup> September.**

Ava was finding it hard to let Greg go, and was looking for closure. At a chance meeting she saw him dancing with another girl. “I wanted to vomit, cry... vomit all over him and this girl... I was just so gutted.” Ava ignored my suggestion of the empty chair. She questioned why he didn’t want to be with her and what she needed to change in herself to be good enough. She had somehow lost the ability to know herself as being an okay person. I encouraged Ava to find herself by closing her eyes and “get a sense of who you are.” Tears welled in her eyes. She remembered a recent dream where her attempts to find her own way were thwarted by her mother. I asked Ava who was the Ava that came to counselling. Did she feel the need to be someone I expected her to be or was she “herself.” Ava was silent for a moment and then shrugged her shoulders and said animatedly “me... I think I am more me than I am in real life.” We both sighed and laughed at this realisation. I was aware that her relationship with me was authentic and genuine and I encouraged her to bring more of that “real” self into the outside world. Ava reported on her HAT form that, “when Melissa said to take home with me an understanding that she cared and was still there for me, and that she really understood me as a person helped me a lot.” Ava also

added that the realisation through her dream and how she was treated as a child helped to explain why she was as she was. In the Table 8.9 I have highlighted the significant elements of each session.

Table 8.9. Ava: Summary of bodily felt sense, symbolic representation, episodic memory, emotional arousal and felt-shifts – sessions 9 to 12.

Session and task	Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
9. Vulnerability <i>Mother's invasion of her privacy</i>	in my back hunched over rubbing her eyes hid face in hands pulling her hair scratching her head	stuck... like kid... paranoid feel like she's jumping on my back	mother's invasion of privacy - list of phone numbers / expenditure  can't sleep suicidal ideation	global distress deep resignation and despair
Empty-chair <i>Mother</i>	tightness in chest pulling hair out... itchy everywhere hunched over head in her hands nausea scratching her head	"take me away... put me in hospital." like a zombie  bugs growing under skin	aged 7 mother didn't believe her	I don't want to be around you tears – sadness too angry to cry seething disgust partial release of anger → <i>shift</i>

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
10.	Narrative <i>Depressed</i>	dryness in throat...	dry... all the water sucked out... like a desert... drained... no life...		
	Focusing <i>Ex-boyfriend</i>	pressure in stomach	a green flat piece of glass that was hard to see through 5 or 6 people there	transition to high school hanging onto ex- boyfriend – IC	let him go huge sigh → <i>shift</i> smashed green glass
		pressure in the back of her neck chest on her knees	grey shadow... a force	six years old mother's expectations	tears of sadness sat upright pressure lifted "I'm ok." beautiful blue energy → <i>shift</i>
11.	Narrative Vulnerability <i>Miscarriage</i>		kick myself like a whore		global distress disgust sadness grief at loss
	Focusing <i>Grief</i> <i>Greg</i>	heaviness in shoulders	need to be perfect	IC – Greg	anger disgust "I will be okay" considerable felt-shift → <i>shift</i>
		sat bold upright and took a few deep breathes nausea rocked in her chair	feel like hitting him		

Session and task	Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
12. Narrative <i>Greg</i> <i>Dream</i>	hard to let Greg go gutted at seeing him	Muslim temple praying mother tried to take her away	change herself to be loved/accepted	disgust at herself tears of despair  crying in her dream aware she was her real self in therapy → <i>shift</i>

### **Client and therapist analyses of change.**

#### ***Client's analysis of change after session 12.***

At the Change Interview after session 12, Dr Wills asked Ava how therapy had been and she again reiterated “it’s been good... at the start it was a bit scary, but I felt very comfortable with Melissa... it was good to sort of be with someone... who’s not judgmental.” Dr Wills enquired “what impact does it have on you when you are in the presence of someone who’s not judging you?” Ava replied, “I feel better about myself... I’m feeling confident. I feel... I just feel happier, because I don’t feel like I need to be something that I’m not, or trying to be like someone... someone else’s expectation of me.”

Ava talked about the changes she noticed in herself.

I still feel like Ava... like, um, I can’t say that I’ve changed completely or I have a new... new... direction in life completely, but there are parts of me... I’m still me... like, I’m surprised by the fact that, you know, just little pieces have made a difference, like... I’ve worked out that I really did care about what people thought of me, and now... now I don’t care as much. Like... which I feel is good for me... it was a slow progress. I feel so good that I don’t think like that anymore... that I feel I don’t need to do that anymore, that I can be Ava... just... just me, like not the me that I think everybody else wants me to be.

However, Ava still felt that in order for her parents to be proud of her she needed to have an appropriate husband-to-be, according to the old cultural and traditional ways. She also said “I still feel like I have this need to be with someone to be able to feel complete as a person.” In relation to Greg, Ava explained

I have a sense of closure, I think, in regards to... not just in regards to my situation with him, but a closure within myself, like between an Ava that I was before and an Ava that I’m starting to become or that I am more like now.

Ava found the focusing exercises useful. She struggled to find words to fully describe the process,

Like imagine this and how I feel and what I sense of my body and, you know, just the sensations of thoughts it's, you know... I dunno, with her help... like she'll make me imagine what it looks like, what it feels like, what colour it is, and all that stuff... I draw a picture of this feeling [in my mind] and then when I can see what it looks like then I can sort of start... almost colouring it in ... colouring over it... I don't know, it makes things brighter ... [and] once it's got a form, it's just easier to handle... first, we acknowledged it, we formed it, and we overcame it and got rid of it.

Ava elaborated on her experience of the working relationship by using metaphorical language

I'm sharing the burden with her so it makes it less, like I'm ... we shared a burden and then throw it away, and we get rid of it... her nature is just warm... she comes across like she really does care, she... there's concern and... I feel like I can talk to her. She's like a guardian in a sense... like a light... a bright light and warm and shiny and it just shines up everything. Like it just shined up what's dark and sad and good in me, and what I'm wary about and what I worry about and I'm anxious about... it gets eradicated by this light. I think she shines a nice light. She's outside... but I think she's more helping me shine my own light... and when I think colours I think things brighter. Like what I've said before about the light, how she shines the light and it helps me find the light in me to illuminate the dark.

***Therapist's analysis of process and change: Session 9-12.***

In session 9, my intention was to sit with Ava in her vulnerability, and to journey with her empathically as she tried to make sense of her mother's behaviour. I was shocked when Ava told me about her mother's invasion of her privacy. I was aware that Ava loved and respected her mother but that her mother's behaviour had really unsettled her. I was very mindful to ensure that Ava was not actively at risk of suicide despite the presence of suicidal ideation. She talked about not being "...here anymore... [by] just... [dying] or something" but this was a passive response. As a means of ensuring her safety I encouraged Ava to seek support from other family members or friends.

I was keen to facilitate the processing of Ava's anger towards her mother by assisting her to express herself to an empty chair. Not surprisingly Ava found it easier to tell me how she felt, as confronting her mother in a chair technique would have been too intimidating and challenging. There was a shift however by her venting some of her anger. Whilst recognising that the person-centred approach of affirming and prizing assists clients to feel less anxious in session, I see that grounding Ava into her body would again have been a practical technique I could have utilised to reduce her heightened anxiety.

In session 10, I was curious to explore what was happening with Greg. I was aware that I had potentially played the disapproving mother and that she may have distorted her answer to please or defer to me. Deference is "commonly defined as the submission to the acknowledged superior claims, skill, judgment and so forth of another person" (Rennie, 1994, p. 428). This would not be surprising as I suspect that one of the ways Ava had managed to keep her relationships in the past a secret would be to provide slightly distorted or ambiguous answers to such direct inquiries.

I was aware of a sense of doom and heaviness in Ava and she described feeling "dry" and "empty." In past sessions I had found it difficult not only to introduce any tasks or interventions but to maintain her involvement in them. Ava had been vulnerable, and/or needed to tell her story, which according to the PE-EFT model required affirmation and gentle empathic exploration respectively. In this session, I was keen to explore her depressive symptomatology more deeply. In my opinion the experiencing task of focusing was indicated as Ava had described her symptoms in symbolic terms and we were able to process issues around her ex-boyfriend. Further



exploration uncovered issues with her mother's expectations of her. She became quite tearful but persevered. I was pleased Ava had managed to persist with the tasks in this session as I feel she would have experienced some relief and deeper understandings. She reported experiencing a felt-shift in her shoulders that culminated in a recognition that she was okay. I was aware that some progress was now happening in the work and was hopeful that Ava would begin to feel some relief in her symptoms.

In response to Ava's disclosure to me in session 11, about her unplanned pregnancy and miscarriage I again thought it most appropriate to listen to her story and sit with her in her vulnerability. When I asked her whether she might like to say goodbye to this lost part of her she was unable to quite own or connect with it. I also acknowledged she was grieving and needed support.

My aim of inviting Ava into a focusing task was twofold. The marker was present and I felt this intervention might give her an opportunity to process some of her grief. I wanted to provide an opportunity to say goodbye to the lost foetus. I have found focusing provides a semi-meditative observer perspective that enables clients who have experienced trauma or painful losses to touch the emotions of those traumas and losses but not be overwhelmed by them. This enables a client to process those experiences safely and not be re-traumatised. She did indeed touch some of the pain of the loss of the baby and the loss of the relationship that never really was a relationship. Ava also touched her anger at Greg. I asked her to visualise Greg in her imagination, an imaginal confrontation procedure, to assist Ava in the expression of her anger. This process is a form of desensitisation that enabled Ava to express herself without fear in a safe non-judgmental environment. She readily took up the idea by sitting bold upright, taking a few deep breathes and told him how she felt. Despite feeling overwhelmed by nausea she was able to stay with the discomfort and experienced a considerable felt-shift. As grief is often a solitary experience I asked her to create a space to withdraw, where that healing could take place and where she could grieve without scrutiny.

In session 12, I felt it was important to follow Ava's lead by again supporting her to tell her story, as she needed reassurance and support after having been through a traumatic event. Not surprisingly the offer of the empty chair task was rejected but what Ava did seem to get more in touch with was her sense that she needed to change

herself in order to be accepted and loved. We further uncovered her struggle to acknowledge herself as good enough. My desire for Ava was that she would learn to “know” herself and to trust herself to be okay. Fortunately, Ava had come to know herself “...more me...” in our sessions and that was reassuring to me, as was the fact that she liked my suggestion that she take my acceptance of her into her life and be true to herself. As I had offered Ava extra sessions, this was not treated as our last session. Despite all that she had been through Ava was able to acknowledge that she felt more accepting of herself, happier and more confident. She also felt she had achieved some closure with Greg.

***Analysis of therapy and change at the end of session 12.***

*Measures of client change.*

Ava completed the BDI-II and the DASS inventories at the end of session 12 and her levels of depression, anxiety and stress were still in the severe ranges (see Table 8.10 and Table 8.11). From Ava’s account it seems that at the time of the inventory assessments at session 6 Ava was pregnant. Further, at session 8 when Ava described feeling “really emotional and hormonal” it was plausible to assume that this was around the time she had miscarried. By session 12 Ava was aware of the miscarriage and was grieving that loss as well as the loss of her relationship with Greg. This may be a possible explanation for the lack of improvement in her depression. I would hypothesise that having the counselling was fortuitous for Ava at that time and potentially prevented her from suffering more intensely. My providing emotional support for her at this time in a non-judging way, I believe was very significant in her managing this unfortunate situation. A further explanation for Ava’s severity of depression during this time was the lack of continuity across sessions. Interestingly, Ava’s twelve sessions took five months as she missed many sessions for various reasons such as a car accident, work commitments, holidays and feeling unwell. Unfortunately, having breaks between sessions can create problems in maintaining the therapeutic momentum and potentially halt deeper exploration. I suspect Ava’s vulnerability and sensitivity contributed to her inability to attend consecutive sessions, a suspicion which was supported by her comments in her Change Interview. I imagine that she was also fearful of facing the issues underlying the presenting problems. It

was as if she needed time in between sessions to regain her strength to face dealing with her next presenting issue. In addition, due to Ava's ongoing levels of distress and vulnerability it was often not appropriate for me to implement any PE-EFT interventions. Therefore I chose to use person-centred empathic reflections to promote gentle self-exploration whilst I held Ava within the therapeutic space. The developers of PE-EFT argue that this purely person-centred approach is effective but not necessarily as efficient as when PE-EFT tasks are implemented (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2011). In experiential approaches, therapists are constantly attempting to balance responsiveness with directiveness. There is a continual assessment of whether to follow the client or propose the use of more specific interventions. In Ava's case I felt the need to follow Ava's direction of the process in order to develop a trusting, safe, supportive, working environment rather than potentially disempower her by implementing a task when presented with a marker. I was aware, however, that we were often dealing with current crises rather than processing the underlying issues of Ava's depression.

Table 8.10. The BDI-II classification of depression at Session 12.

<b>Ava's BDI-II Depression Score</b>	<b>Minimal</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
36	0-13	14-19	20-28	29-63

Table 8.11. The DASS classification of depression, anxiety and stress at Session 12.

	<b>Ava's score</b>	<b>Normal</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>	<b>Extremely Severe</b>
<b>Depression</b>	27	0-9	10-13	14-20	21-27	28+
<b>Anxiety</b>	24	0-7	8-9	10-14	15-19	20+
<b>Stress</b>	28	0-14	15-18	19-25	26-33	34+

## **Extra sessions**

Ethically, it was important to continue counselling Ava even though the extra counselling would not add to the research regarding the twelve sessions and would interfere with any follow-up measures. We agreed to assess whether to continue after a further six sessions. Six weeks later Ava returned.

### **Session 13: 2<sup>nd</sup> November.**

Ava was very agitated. She has gone off her medication and had endured many difficult family issues. As she could hardly speak, I suggested a focusing. Ava described a black empty hole in her solar plexus. She felt it had been there for a long time probably since she was small child. Ava was overwhelmed as she recalled being a small child playing in the park. I asked her to assist “little” Ava by bringing “adult” Ava into the scene. Ava moved her chair back away from me and said she just wanted to run away. She said “adult” Ava was stupid, should know better and can’t help “little” Ava. Ava saw no point in retreating to her imaginary world because when she wakes up everything was still the same. I asked her what she would like to wake up to. Ava replied, “a glowing her!” I then encouraged Ava to find that glowing aspect in her and explore whether that can neutralise the black hole. She was hesitant and explained the glow was not strong enough yet. I encouraged her to use her imagination to magnify the energy, and to fill the black hole and her entire being with white light. She was able to do this. She was speechless and unable to articulate her experience. Ava found the experience greatly helpful and wrote on her HAT form “throughout the focusing exercise I saw/imagined myself as... my ideal sense of self... in a place where I am happy, pure and protected.”

### **Session 14: 28th November.**

Ava had found a full-time administration job in one of the large hospitals and could no longer attend counselling. She had tears in her eyes as she told me, and said she would miss me, and the sessions. She had also met a Greek man, ten years her senior, whom she liked very much and who was good to her. She was still off her medication

and had no major panic attacks. She recognised that she was still highly anxious but preferred not to be taking the medication. Her sleeping had not improved but Ava was hoping the new job would make a difference to her life. I was aware she was embarking on a new life and through a focusing I encouraged her to look at the past and allow the “new” to enter. Whilst Ava thought about Greg and the miscarriage every day, she was able to visualise her new life. I encouraged her to take a moment to look back and notice the sadness of the loss of her past life past but be open to the joy and excitement of her new life. Ava reported experiencing a significant felt-shift of the tension in her stomach. She was able to say goodbye to Greg and felt less distressed about the miscarriage. Ava was able to turn toward her new life full of opportunity and possibility. Ava wrote on her HAT form “it was a way to say goodbye to the past and welcome the new, a chance to let go of the past.” In the Table 8.12 I have highlighted the significant elements of each session.

Table 8.12. Ava: Summary of bodily felt sense, symbolic representation, episodic memory, emotional arousal and felt-shifts – sessions 13 to 14.

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
13.	Focusing <i>Not good enough</i>	solar plexus	a black empty hole	as a small child playing in the park	white light filled black hole “I saw my ideal self... in a place where I am happy, pure and protected” → <i>shift</i>
14.	Emphatic exploration <i>New job</i> Focusing <i>Last session</i>	tension in her stomach	look at the past and allow the “new” to enter	let go of Greg less distressed about the miscarriage	sadness at loss felt a significant felt-shift in stomach → <i>shift</i>

***Analysis of change according to clinical significance.***

***(1) Comparison method.***

At the end of session 14 Ava scored 30 on her BDI-II which was within the severe range of 29 to 63 (Beck & Steer, 1987; Beck, Steer, & Brown, 1996; Beck, Steer, & Garbin, 1988) but this had decreased from the level of 36 measured at session 12. On the DASS Ava's Depression score was 17 indicating a moderate level of depression when compared to the normative range of 14 to 20 (Lovibond & Lovibond, 1995) and her anxiety score was 11 which was also within the moderate normative range of 10 to 14 (Lovibond & Lovibond, 1995).

In the last two sessions Ava had been able to work more deeply during the focusing and had been, in my opinion, able to symbolise her depression describing it as a black empty hole in her solar plexus. She had also been able to make a shift in letting go of her relationship with Greg.

***(2) Absolute change.***

At the completion of Session 14, Ava completed the BDI-II and the DASS inventories. Figure 8.1 graphs the BDI-II and DASS scores over the duration of Ava's counselling. After session 14 there was finally a reduction of six points on the BDI-II and ten points on the DASS. Despite still being in the severe range for the BDI-II Ava was only two points off the moderate range on the BDI-II. Her depression and anxiety levels on the DASS scale were in the moderate range and her stress level was mild. This was very encouraging despite only being slightly lower than her pre-treatment scores. A contributing factor to this improvement may have also been securing the job which would have enabled Ava to have independence from her mother.

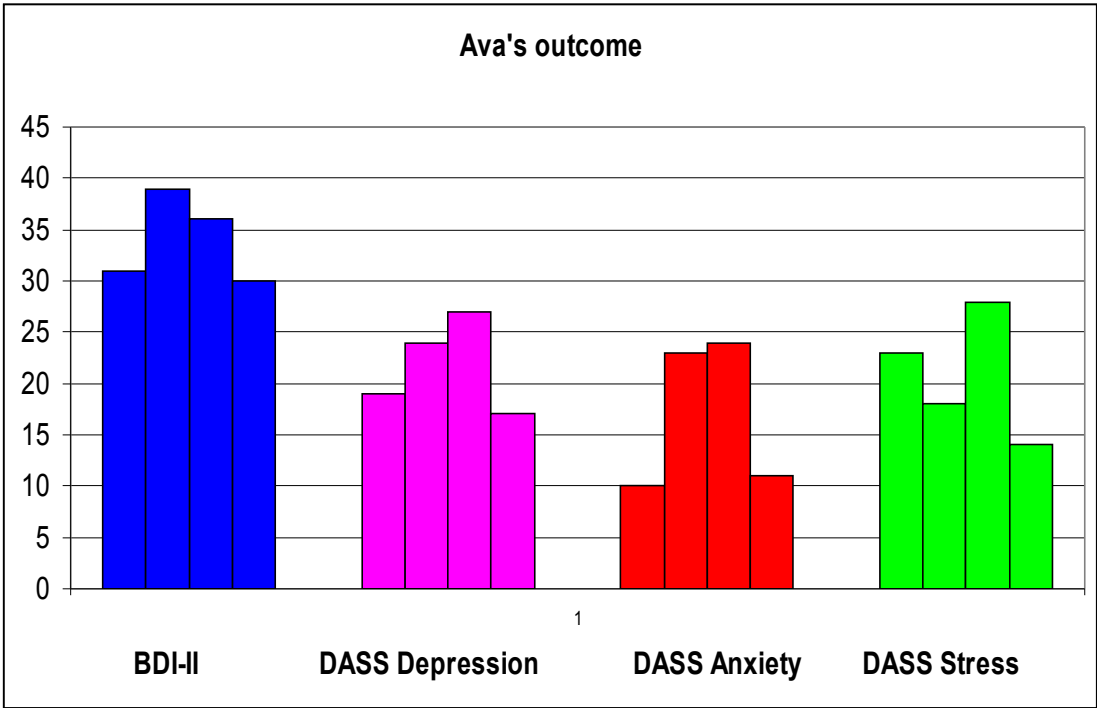


Figure 8.1. The BDI-II, DASS scores for Ava at the screening interview and after Sessions 6, 12, and 14.

*(3) Subjective evaluation.*

Ava's subjective evaluation was determined in two ways; firstly, through the list of concerns (see later section on *Concern ratings*, p. 303) she made at the screening interview and secondly, documented in the themes of change identified within the Change Interviews (see client assessment of change in sections above). Ava reported that she viewed herself more positively and cared less about others' opinions of her. She felt more in control and felt a little less sad. Ava experienced the non-judgmental therapeutic relationship as a key ingredient to feeling better about herself and said that she was more able to be herself, felt more confident and was happier as a result of therapy.

*(4) Social impact.*

Ava also did not share with many people that she was attending therapy but found her relationship with her mother had improved somewhat and this was important to her.



She described her new relationships as being quite different from before and she was enjoying the more fulfilling nature of them. She also managed to reach a point of closure with Greg that made an impact on her social interactions.

## **Follow Up Reviews**

### **Six month follow-up.**

Unfortunately, I was unable to contact Ava to attend her six-month follow-up interview. I was concerned for her. However, I persisted and after twelve months Ava came in for a follow-up interview.

### **Analysis of therapy and change after twelve months.**

#### ***Twelve month follow-up.***

My concern about Ava had been well founded. At the beginning of last year “it was bang... I hit rock bottom, and it happened at work. They gave me time off I had to see my psychiatrist, he implied that I had bipolar, and I got more anxious just from knowing that.” Only two months into the job, Ava realised she really disliked her work “it gave me no room to do anything I was just sitting at a desk, it was really, really restrictive.” Her psychiatrist wanted to put her on antipsychotic medication

So in my head I sort of thought first I’ve had anxiety and depression now it’s bipolar and in ten years from now I’m going to be a schizophrenic. But I don’t want it to be like that... I don’t want to try those medications I don’t want to be a psychotic because I’m not... I know it’s just... I hit a spot where I’m anxious because I didn’t like my job... I didn’t like what was doing.

However, Ava did go back on Zoloft and consulted a Cognitive Behaviour Therapist (CBT) recommended by her psychiatrist for 12 sessions. “She’d just sort of speak, while taking notes and talk... like, ‘snap out of it’... and then the other times she just really cut it down for me” by challenging her negative beliefs, “you’re not what you think you are you’re actually the opposite.” Ava had found this helpful to a point “it

[was] different... she had a different way of coming about things.” Ava said she felt I showed I cared about her and that I knew and understood her, “whereas this other lady was more straight forward to the point, like, ‘snap out of it’ sort of thing.” Ava felt the work we had done had enabled her to stand up to her psychiatrist and say no to the bipolar diagnosis and the use of antipsychotic medication. Prior to the counselling with me Ava felt she wouldn’t have been able to do this. Ava also recognised that “serious things were happening” last year and had felt supported by the counselling. The CBT work was more about being reminded she wasn’t stupid. In addition, our work together was “more about getting to know who you are... finding me... I definitely know myself better.” Ava regretted the counselling had finished when it did and said, “I would have loved to have kept going.”

On the more positive side Ava had flown overseas for three weeks last September, bought a car, found and commenced working in a new more interesting job and applied for an honours course for next year. With the help of her doctor, she had also been able to wean herself off the Zoloft and was medication-free while she travelled overseas. In addition,

I would never be the type of person to confront someone if they upset me, and you know this year I’ve done that like I’m sort of like I’ll tell them like, ‘back off, because I’m not going to take this shit’ I did that! I would never have done that! I would have gone to a corner and cried. And this year, you know, I was able to show strength, like you know, ‘I’m not going to let you walk all over me, and I expect an apology, you can’t treat people like that’...

Despite her setback Ava had also managed other anxious situations. As a result of her changing jobs, Ava explained that her anxiety levels have increased recently as she transitioned into the evening work of the new job. She recently found herself lost and panicking in her car on the side of the road late at night. Her mobile phone battery had died.

Then as I'm working myself up, I stop and go... you know what this is... you know it's going to pass, so just talk yourself out of it. You know, just tell yourself... nothing is going to happen, it's not going to get any worse than it is right now, just calm down there's nothing you can do, don't panic, don't panic, don't panic, and I did! I just felt I calmed myself down.

I recalled that one of Ava's goals was not being on medication for the rest of her life. She had successfully achieved that goal.

***Client analysis of change after twelve months.***

When Ava was asked if she was attributed some of the changes she experienced to the therapy she said

I can remember how I was... in comparison to how I am this year and what happened this year... it makes sense in my head, can't really explain... last year I was in therapy for support and I think there were more, a little bit more serious things happening then....

Ava felt the work we did together gave her the confidence to go overseas and do "things that Ava wouldn't normally do... Ava would have never refused something... if she needed meds she would take them... she just would have never questioned it." She felt she definitely knows herself better and the therapy was a journey of "finding me.'

Ava again reiterated that she found the Focusing helpful.

I think it would be hard to try on your own. But that was just a good sort of time to be with my own thoughts I guess, you know, in a positive way, you know, I'm always in my thoughts but... in the focusing stuff I could really ...it almost felt to me like I could slow down life in my head and put it together and watch it be. It was like a

mixed up part of what was in my head and I could put the pieces right... that's what it felt like. I really enjoyed that.

Ava recalled the sessions where I asked her to “confront some issues with people I had, it was hard.” In relation to Greg “I have knuckled down and ignore his calls... I can keep him out and just see him now and just say hi and not even approach him. I don't think twice, you know, I have it in the back of my head sometimes but...”

Ava's last remarks were

a friend actually said to me well, you are much stronger than you give yourself credit for, you say you're all these things, but you're not. You say you're weak and you can't handle life, you can't deal with the things that happen but you deal with it like anyone, there is a strength in you, you don't realize. I think this year has been very... like I think I really did get a lot of strength from the therapy.

### **Measures of client change.**

#### ***Profile of Mood States (POMS).***

At the conclusion of every second counselling session, Ava was asked to complete a POMS inventory. Figure 8.2 graphically represents the shifts in mood states during the counselling period and at twelve months post-therapy. As depression was the main focus of this research, I will only comment on that subscale. It is interesting, however, to note the movement of the other mood states in line with the depression subscale. There appears to be a consensus across the inventories that Ava's reported levels of depression were elevated at sessions 6 and 12. However, despite fluctuations in Ava's levels of depression according to the POMS measure, there was an overall trend of reduction in her depression by session 14.

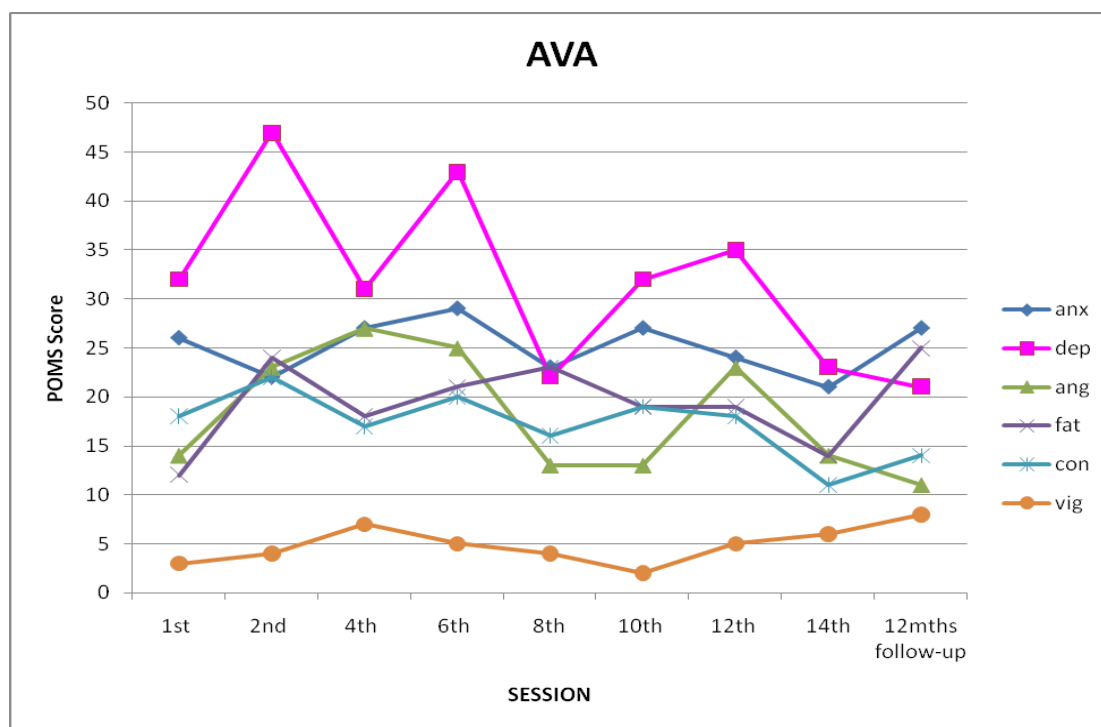


Figure 8.2. Profile of Mood States (POMS) scores for Ava.

### ***Concern ratings.***

In Ava's screening interview, she had listed a set of concerns that she wanted to deal with in therapy. Table 8.13 tracks the changes in her concern ratings after sessions 4, 8, 12 and at the twelve-month follow-up. It appears that therapy assisted Ava's view of herself to improve, her sadness to decrease and her relationship with her mother to improve slightly. Ava indicated that these changes would have been unlikely without therapy and they were extremely important to her. Meeting a suitable partner was moderately important to Ava and became less of a concern for her over the course of therapy despite her dream of meeting a man who would sweep her off her feet and lead her onto a better life. Managing her level of anxiety was very important to Ava but was not a major concern during therapy. Ava after session 4 added an additional concern. She wanted to be less worried about other people's opinions. This was of moderate concern and she indicated that she was less concerned about the opinions of others over the course of the therapy.

Table 8.13. Concern ratings\* for Ava during counselling at 12 month follow-up.

Concerns	Before Therapy	At Session 4	At Session 8	At Session 12	At 6 month follow up	Change was: 1 expected 3 neither 5 surprised by	Without therapy: 1 unlikely 3 neither 5 likely	Importance: 1 not at all 2 slightly 3 moderately 4 very 5 extremely
1. How I view myself	6/7	5/7	4.5/7	4/7	5.5/7	2/5	2/5	5/5
2. Feeling sadness	4/7	4/7	4/7	3/7	5/7	2/5	2/5	4.5/5
3. Relationship with mum	7/7	7/7	6/7	5/7	4/7	3/5	2.5/5	5/5
4. Meeting someone	5/7	5/7	4/7	2/7	6/7	3/5	2/5	3.5/5
5. Anxiety	3/7	2/7	3/7	3/7	5/7	3.5/5	4/5	4/5
6. Added later: Caring about others' opinions		6.5/7	4/7	3/7	3/7	4/5	2/5	3/5

Note: \* scale of 1 being not at all concerned to 7 for maximum possible concern.

***Personal descriptions.***

At the screening interview Ava described herself as anxious, nervous, always thinking, intelligent, loyal and a good friend. At session 4, Ava agreed these descriptors were still relevant. But said

I have noticed myself... like not caring as much as I used to about what people were thinking or what they say... doesn't matter what people think any more because they don't know me and it's not worth me stressing myself out over it and when really there could be nothing being said.

At session 8 Ava reported

I'm getting a bit more confident than I was before... I am probably, I'd still agree that I'm still obsessed... probably less now, definitely less now, I can control it better now, so it's more under control... I am a very loyal friend and I'd say I'd probably a bit more mature. I feel like I've grown up.

At session 12 Ava said "I think... [I'm a] great friend!", rather than just a good friend. She also acknowledged that she does feel more anxious and nervous than other people, but "I don't think that that's something that really describes me... I need to tell you 'oh yeah, I'm anxious and nervous', like, **there's more to me than just that.**"

At the twelve month follow-up Ava explained

Oh, I am the same person, sort of dealing with situations better... I think I was really dependent, I am a bit more confident. Things are going well... I think I feel more grown up. After having worked a full time job, now I have my own car, I'm starting to sort of, write my own rules.

### **Measure of the working alliance.**

On the working alliance, which brings together the relational and technical aspects of counselling and is a predictor of outcome, Ava's reported scores suggest a strong alliance overall. Her scores were very high (above the 90<sup>th</sup> percentile) and became stronger overtime (see Table 8.14). I valued Ava considerably and as I reviewed our sessions together I was reminded of her vulnerability, her strength and my genuine care for her. I had been concerned that we had not been able to shift her deep seated depression until the last few sessions but I recognised that she had experienced difficult life events that contributed to and compounded her depression.

Table 8.14. Measure of the working alliance utilising the Working Alliance Inventory - Short (WAI-S) form.

	<b>Session 4</b>	<b>Session 8</b>	<b>Session 12</b>	<b>Range</b>
<b>Ava's evaluation of working alliance Raw score</b>	77	80	80	84
<b>As a % of the total score possible</b>	92	95	95	100

## **Therapist's Analysis of Ava's Therapy Process**

### **Ava's core emotion scheme.**

I have chosen a different approach to the previous cases in determining Ava's emotion scheme. Greenberg and Watson (1998) have proposed a set of two emotion schemes related to depression. Perfectionist-type depression occurs if people have been subject to invalidation, high demands and low interpersonal support and have not formed a competent sense of self. These people are harshly self-critical, view themselves as "bad," inadequate and worthless and feel contempt for themselves. Dependent-type depression results if a person's life experience has left them with an unloved and "weak" sense of self as a result of poor attachment relationships and losses. They feel basically insecure. The two types are often highly intertwined.



According to Greenberg and Watson, the evocation of a person's core "weak/bad self" emotion scheme triggers depression. This is more than a negative view of self, others and the world in relation to loss and interpersonal difficulties. In Ava's case she quite clearly recognised herself as insecure, weak, unprotected and unable to cope on her own. Consequently, she remained vulnerable to interpersonal loss and abandonment and in my opinion suffered from the dependent-type of depression. There are elements of the perfectionist self-critical type, but the weak core self is predominant. In Figure 8.3 I attempt to map her depressogenic emotion scheme. However, the core emotion within this schematic representation of Ava's functioning is fear. Ava is fearful of abandonment, of rejection, of failure and freely expressing herself. Despite only having 14 sessions, Ava was able to shift some of her deep-centred sense of weakness and replace it with more confidence and self-assurance.

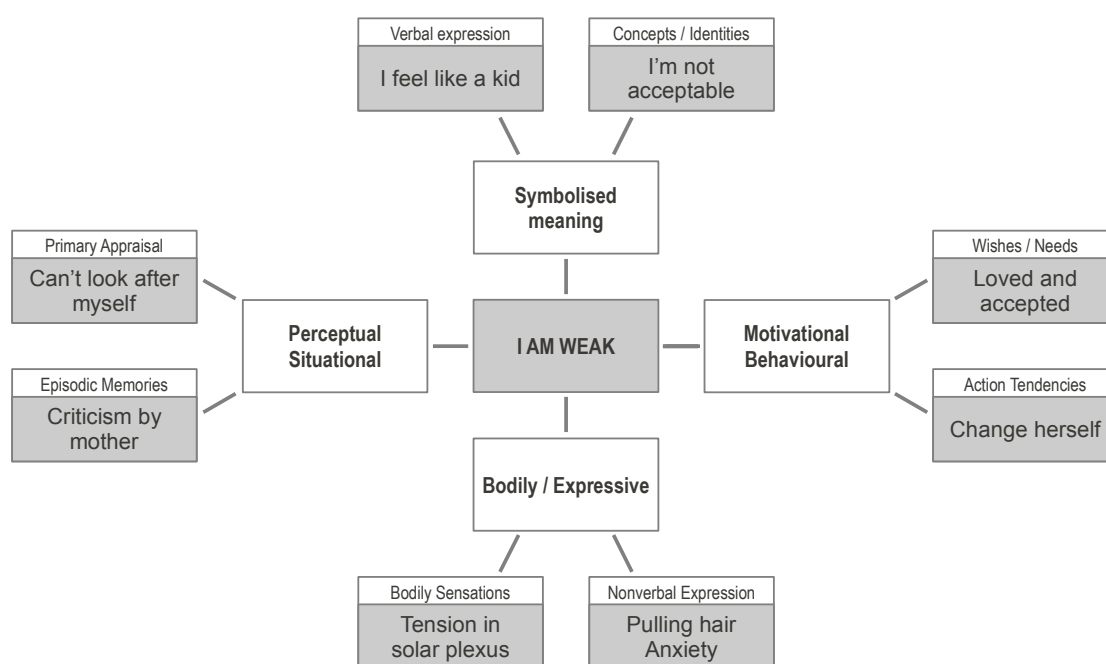


Figure 8.3. Ava's hypothesised weak depressogenic emotion scheme.

**Therapist reflections on the application of PE-EFT principles  
and process of change.**

Ava's modes of engagement as highlighted on the Experiential Therapy Session Form (Elliott, 2002a) tended to be distancing and avoiding. In the early stages of therapy she would generally hold painful and frightening feelings and experiences at bay. It wasn't until session 10 that Ava was able to sit with and work through a current painful experience. Ava missed many sessions and I believe the momentum of the therapeutic work was compromised by having to re-establish the working relationship each time. Overall she was able to turn her attention inward when encouraged and had a rich imaginary internal life. By the later stages of the work, Ava was more able and willing to examine unclear internal experiences with curiosity. She struggled however with staying with unclear, vague and ambiguous experiencing, often feeling overwhelmed and flooded by her emotions with little ability to self reflect on those experiences. I observed that Ava found it difficult to express herself assertively and that she took some time to be trusting of me and the process of therapy. She did however eventually open up by disclosing very intimate and personal information to me. She also became more willing to show her emotions to me by allowing tears to fall and expressing anger when felt in the sessions. It seemed Ava found it difficult to apply results of the experiential processing in sessions in action outside the sessions, as she was inclined to make assertions in sessions and not follow them through.

Despite Ava's reservations we were able to develop a good working relationship, although I believe she did not develop a complete trust in the PE-EFT therapeutic process overall and would often arrive at a session overwhelmed and needing to talk. I was empathically attuned to Ava and expressed my empathy and understanding of her sensitivity by showing care and affirming her when she showed vulnerability. I collaborated with Ava by creatively adapting the tasks as necessary. In my opinion, the trajectory of the work with Ava was certainly hindered by her reluctance to undertake the tasks but I was mindful that the relationship between us was more important than how many tasks we did or how well we did them. I was able to attend to Ava's micro-processes in the sessions by noticing her body language, and assessing her levels of anxiety and thus her willingness to undertake specific tasks. Because Ava presented at each session with quite intense and immediate issues, I was perhaps not as able to

facilitate her progress across sessions as adequately as I would have liked. I believe, however, I did facilitate adequate progress within sessions whilst still managing to maintain a good working relationship and attend to Ava's vulnerability. I facilitated Ava's self-development through reflecting, supporting and attempting to symbolise new experiencing. However, Ava's inner strength, agency and empowerment were still developing. A longer term of counselling would have perhaps potentiated these emerging attributes. Overall I believe carried out the PE-EFT principles consistently and implemented tasks where appropriate despite a reluctance in Ava that often resulted in only partial resolutions. As with Katie there was a real tension for me between *leading* or facilitating Ava's experience not too far out of her proximal zone of development and *following* or staying within the parameters of her willingness.

#### **Overview.**

Ava struggled with high levels of anxiety that impacted on her daily life and her ability to attend sessions regularly. The domineering and critical nature of her mother further undermined Ava's belief in herself as autonomous and self-sustaining. During the therapy period Ava experienced a relationship breakdown, an unplanned pregnancy and miscarriage. Despite these challenges, Ava's determination and tenacity saw her able to finish the series of counselling sessions, and to go off her medication, complete a degree, secure a job, go overseas and still remain hopeful that her life would improve. Ava's levels depression and anxiety did start to reduce after 14 sessions and I am fairly certain that had we been able to continue we would have seen a further consolidation of that change and ultimately a reduction in her symptoms.



## Chapter Nine • Case Study 4: Chloe

The last of the four case studies focuses on the client/participant who chose Chloe as her pseudonym. Detailed descriptions of her sessions are located in Appendix R.

### Screening Interview: 3<sup>rd</sup> August

Chloe, 26, a nutrition student, was in second year of the four-year course. Her boyfriend of four years, Steve, lived overseas and this caused her considerable distress. For the last 8 months she had been “crying every day... and couldn’t get out of bed... I stress about everything.” She also felt “guilty all the time,” worthless and inadequate. Steve was “a little bit controlling... he makes all the decisions.” Chloe said she was often restless and irritable. She had trouble concentrating and remembering information for exams, citing a suspicion of some form of dyslexia as a possible explanation.

When she was 16, Chloe’s then boyfriend, David, 19, was killed by a truck. She attended counselling but couldn’t recall anything about the therapy, and said it had “been ten years but I still think about [his death].” Chloe had struggled with an eating disorder since then and did everything she could to “disguise it.” Her weight could fluctuate considerably but currently was quite stable. Sometimes she would just “forget to eat.” At 19 she again had counselling for her eating disorder but the therapist “was rubbish...” and the nutritionist “was mean.” Chloe said; “If I don’t eat I have no memory... self sabotaging... I do that lot.”

Chloe said she didn’t open up to people close to her but found it easier to talk to strangers. She described her mother and twin as “very controlling”, but felt close to her sister despite her sister taking on the mothering role after her parents separated when she was three. Chloe suffered from many physical symptoms including Irritable Bowel Syndrome (IBS), endometriosis, polycystic ovaries and vestibulitis (painful intercourse). She was aware that her stress levels affected the IBS and she was on a restricted diet in order to manage the often debilitating symptoms. Keeping fit

through dancing and walking were a big part of her life but she said she was not fanatical about exercise.

I asked her about any thoughts of suicide. She sobbed, “yes... don’t want to act on it... people around me have... never do it... but sometimes it might be better for them if I wasn’t around.” She was driving the other day and a truck passed close on the other side. She thought “if I put my head out... get hit... why am I thinking that way... wasn’t even depressed... I just want to give up.” Chloe said she felt “like I’m weak... shouldn’t be thinking these things... I haven’t got a reason to be depressed, good family, great boyfriend, house to live in, I’m sick but...” I acknowledged her courage in coming into counselling at this time.

Chloe was not on medication at the time of the screening interview. She had dabbled in taking recreational drugs between the ages of 16 and 19 but had taken none since. She described herself as bubbly, confident on the outside but not on the inside, friendly, loving, caring and always putting others first. The main concerns she brought to therapy were issues about constantly worrying, depression, anxiety, lack of confidence, eating, lack of interest in university, memory difficulties, difficulty making decisions, trouble expressing feelings and not feeling in control. I briefly explained to Chloe the practical aspects and theoretical underpinnings of PE-EFT, and gave her details about her research involvement. Table 9.1 lists Chloe’s Concern Ratings for the issues she brought to therapy. Table 9.2 indicates ratings for the duration of the concerns.

Table 9.1. Concern ratings\* for Chloe at screening interview.

Concerns	Not At All	Very Little	Little	Moder- ately	Consid- erably	Very Consid- erably	Max Possible
1. Constant worry							7
2. Depression					5		
3. Anxiety							7
4. Lack of confidence		2					
5. Not Eating					5		

Concerns	Not At All	Very Little	Little	Moder- ately	Consid- erably	Very Consid- erably	Max Possible
6. Lack of interest in uni.							7
7. Memory							7
8. Making decisions							7
9. Over-expression of feelings						6	
10. Not feeling in control							7

Note: \* scale of 1 being not all to 7 for maximum possible.

Table 9.2. The duration\* of Chloe's concerns at screening interview.

Concerns	< 1 mth	1-5 mths	6-11 mths	1-2 years	3-5 years	6-10 years	>10 years
1. Constant worry							7
2. Depression							7
3. Anxiety					5		
4. Lack of confidence							7
5. Not Eating							7
6. Lack of interest in uni.			3				
7. Memory							7
8. Making decisions							7
9. Over-expression of feelings				4			
10. Not feeling in control							7

Note: \* scale of 1 being less than 1 month to 7 for greater than 10 years.

### Assessment of Chloe's suitability as a research participant.

Chloe completed the BDI and DASS, and was assessed against the criteria of DSM-IV-TR (American Psychiatric Association, 2001) with a diagnosis best fitting the diagnostic category Mixed Anxiety-Depressive Disorder, a diagnosis again supported by Dr. Wills (see Appendix A). Chloe meets the DSM-IV-TR criteria for depression within the mixed disorder: "crying every day..." for last 6 months; low mood and loss of interest in most activities; low energy; restlessness; poor concentration, hypervigilance; worrying; pessimistic thinking; low self-esteem and feelings of inadequacy and hopelessness. Chloe claimed that she had suicidal thoughts but would not act on them. Chloe scored as severely depressed on the BDI-II and extremely severe on the DASS. The DASS measures of anxiety and stress were found to be also in the extremely severe range (see Table 9.3 and Table 9.4 below). Chloe was considered a suitable candidate for this research.

Table 9.3. The BDI-II classification of depression at screening interview.

Chloe's BDI-II Depression Score	Minimal	Mild	Moderate	Severe
43	0-13	14-19	20-28	29-63

Source: Beck, Steer, & Brown (1996); Beck, Steer, & Garbin (1988); Beck, Ward, Mendelsohn, Mock, & Erbaugh, (1961).

Table 9.4. The DASS classification of depression, anxiety and stress at screening interview.

	Chloe's score	Normal	Mild	Moderate	Severe	Extremely Severe
<b>Depression</b>	34	0-9	10-13	14-20	21-27	28+
<b>Anxiety</b>	31	0-7	8-9	10-14	15-19	20+
<b>Stress</b>	41	0-14	15-18	19-25	26-33	34+

Source: Lovibond & Lovibond (1995).



## Chloe's Therapy: Sessions 1-4

### Session 1: 8<sup>th</sup> August.

Despite being “a bit resistant to get up and come,” Chloe readily engaged in sharing her array of concerns. I was acutely aware of her strong felt-sense and suggested focusing. Chloe described the pain in her head and shoulders, and symbolised it as a black rectangular shape with unclear edges and a hard dull plastic texture. “Sadness” she carried in her shoulders had been there a long time. People had let her down. When she was five, her eight- year-old cousin pushed himself up against her and “started to do things.” Her mother laughed. Tears fell. I asserted that what he did was wrong and asked her to tell her cousin imaginally that what he did was not okay. She sat silently and finally took a deep breath. I further encouraged her to visualize confronting her mother and suggested she may like to ask adult Chloe to support five-year-old Chloe in this confrontation. Chloe sighed with relief and reported that her inner child was “a lot happier.”

I asked Chloe to revisit that pressure in her shoulders. It was “definitely less but still there.” She was willing to continue, and recalled being 14 when her 18-year-old boyfriend forced her to have sex. Chloe was shocked to realise that he saw her as a slut. “I didn’t deserve it... I didn’t even know what sex was then.” I asked Chloe to contemplate that she was “not like that” and she sat more upright and breathed in deeply. She now realised that it was he who was in the wrong. “I was too young to know better.” She experienced a noticeable felt-shift, “such a release of stuff... feels good.”

Chloe reported on her Helpful Aspects of Therapy (HAT) Form that “closing my eyes was a good technique to really feel and see where the pain comes from.” She found the mediative experience of focusing extremely helpful: “going into myself and bringing up things that I was not aware that were still presently an issue for me” and “realising how much these past events continue to be a burden.” In addition, Chloe found my “understanding and restating what had happened was wrong helped my confusion of all the past events” and “feeling the lift of that heaviness... and telling/confronting those people” was also extremely helpful. Unfortunately noise

outside our room was hindering. At times, when I made suggestions in a slightly humorous fashion Chloe found this somewhat hindering and wrote “I would prefer soft tones to keep me in the meditative state.”

**Session 2: 17<sup>th</sup> August.**

Chloe was overwhelmed as her stepmother was hospitalised because of an overdose and she had been unable to contact Steve for support. In the focusing she described her felt-sense as a black moulded armour that would protect her from the onslaught of her family. She recalled being overshadowed by her twin sister Cassie, the blond-haired blue-eyed “golden child.” In a child-like voice Chloe tearily described an incident when at 9 her sister did not want to play with her and “some boys at school put me up on the monkey bar... I was scared of heights... and pulled my trousers down.” The only way to get off was to fall, and despite not being physically hurt she was alone, frightened and humiliated. I encouraged her to call on “adult Chloe” and have an internal conversation with those boys and her sister about their behaviour. After some time she took a deep breath and sat up straighter in her chair. The tension in her shoulders shifted, a felt-shift, and she smiled.

I then asked Chloe to think of her stepmother. Chloe felt stupid as when she had been unable to read or tie her shoelaces, her stepmother was critical and emotionally unavailable. She sat silently and when I enquired what was happening she replied, “they’re listening to me now... I’m having a conversation with them... I’m telling them what I need.” Chloe sat more upright and breathed deeply, obviously experiencing another felt-shift. She reported that the pressure in her head and heart was less. Chloe found talking about her stepmother and “bringing up the monkey-bars episode” was extremely helpful. So too was recognising that the fear of failure covered confidence and “knowing” she was not stupid. The focusing provided a means for her to locate that fear of failure, talk to it and subsequently imagine discussing it with her family. This was also extremely helpful.

**Session 3: 24<sup>th</sup> August.**

Chloe was struggling with her study. In the focusing task she easily identified a sense of great pressure in her chest: it was red with black edges, and resonated with the

feelings of being stupid. When asked where this had come from, she remembered being four, playing in the backyard with her brother, twin-sister and cousin<sup>7</sup>. They were teasing her. Chloe was aware of a tightness in her throat, which she identified as anger. “They took my Barbie.” Her stepmother didn’t intervene. I encouraged Chloe to assertively tell her cousin how she felt in an internal dialogue with him. Chloe sat for a long time, tears rolling down her face. She seemed really angry but experienced “blocking out,” being unable to be angry even internally. Chloe had observed her father’s indiscriminate angry outbursts and recalled her mother’s warning that anger “should be controlled” Chloe found no safe way for her to express her anger and was left confused.

I introduced the two-chair task to process Chloe’s self-interruptive split. Chloe sat immediately in the chair that represented the side that interrupted the anger. She said, “you should be a lady and not present yourself as your father does... people will judge you... and you’ll be like your father... losing control.” She replied from the other chair. “It’s okay to be angry... it’s okay to express your feelings and not bottle them up because it leads to worse problems... causing disease.” From the other chair, she said “it’s not okay to yell and scream in front of people.” She didn’t want to be like her father. I encouraged Chloe to allow the two aspects to work collaboratively through a series of chair swaps. We discussed appropriate anger expression and assertive action. Chloe lamented that she was often angry with herself. Chloe said at the end of the session she felt “good... less confused.” Chloe reported on the HAT Form that “the conversation between two chairs... debating between my two angers” was extremely helpful as it enabled her to understand how “to be angry appropriately therefore less confusion.”

#### **Session 4: 28<sup>th</sup> August.**

Chloe was despairing, as Steve had not contacted her. In an effort to process her unresolved grief I asked Chloe to notice her bodily felt-sense, close her eyes and take a few deep breaths. She described a large square black block with red edges across her chest, there since David died and now evident again since she was away from Steve. “They both left,” she said. Sadness and grief were in the black box with red edges of

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7 The cousin in the scene was the cousin who’d pressed himself up against her.

fear, but there was a “white light in the middle of it... like a diamond.” The blackness had a protective quality but also represented “stubbornness.” Anger and frustration were also qualities of the black box. Chloe became aware of a struggle, the *confusion*, between liberating the little white diamond, the desire to express herself freely, and remaining in the black box of perceived protection that constrained her feelings. She felt the little white diamond was “naive.” She wanted to follow her instincts but didn’t trust them.

I asked Chloe to return to her felt sense. The symbol had changed. “It’s like a glass cage that the white light... given a chance... break open by itself... the white light is [ready]... the black box isn’t...” Chloe said she was “...afraid of what will happen... my diamond’s quite vulnerable.” She acknowledged it was her stubbornness that prevented her from asking for her help. She had called on the protector Archangel Michael in the past for help and protection, and I encouraged Chloe to ask for his help now. Chloe sat upright and took a deep breath and said of the black box, “I broke it.” She then reported, “[I can] breathe more easily.” I encouraged her to take a few deep breaths and noticed a palpable sense of relief in her, a felt-shift.

Chloe reported that talking about how counselling brought things to the surface, and subsequently understanding what to expect, was extremely useful. In addition, “releasing the diamond... feelings of release... understanding I have support from higher beings — Archangel Michael” was also extremely helpful. In the Table 9.5 I have highlighted the significant elements of each session.

Table 9.5. Chloe: Summary of bodily felt sense, symbolic representation, episodic memory, emotional arousal and felt-shifts – sessions 1 to 4.

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
1.	Focusing Cousin <i>Mother</i>	pain in her head and shoulders	black rectangular shape with unclear edges and a hard dull plastic texture	disappointed people let her down at 5, 8yo cousin inappropriate sexual encounter mother laughed IC with mother and cousin	sadness      sighed with relief → <i>partial shift</i> in shoulder pressure <i>he</i> was wrong “such a release of stuff... feels good” → <i>shift</i>
		revisited pressure back of her neck and chest	blamed herself	at 14, 18yo boyfriend forced her to have sex	
2.	Focusing Monkey bar incident  Critical stepmother	pressure and tension at the back of her neck and the top of her shoulders	a black moulded armour that would protect her from the onslaught of her family	aged 9 boys left her hanging on monkey bar with pants pulled down IC boys and sister	tears global distress  a deep breath and sat up straighter in her chair - shoulders tension shifted → <i>shift</i> sat more upright and breathed deeply pressure in her head and heart was less  → <i>shift</i>
				at 8 couldn't read or do up shoelaces – IC stepmother	

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
3.	Focusing They took my Barbie	great pressure in chest	red with black edges and took up a great space	feelings of being stupid  at 4 teased by brother, twin-sister and cousin – “they took my Barbie” IC cousin angry outbursts by father difficult to express appropriate anger	global distress  anger, tears crying and laughing at same time block to full anger even internally.  black was fear
	Two-chair Self-interruptive	tightness in throat   self-interruption of anger	bright red more red and less black confusion		anger acknowledged less confusion → <i>shift</i>

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
4.	Focusing Stubbornness	chest	sadness, anger, grief and stubbornness were in the black box with red edges of fear, but there was a white light in the middle of it... like a diamond but naive a glass cage that the white light... given a chance... break open by itself Archangel Michael	David's death – she was 16  confusion	global distress  tears of sadness  her diamond was very tough and resilient sat upright and took a deep breath and said "I broke it" palpable sense of relief - breathe more easily → <i>shift</i>

### **Client and therapist analyses of change.**

#### ***Client's analysis of change after session 4.***

In her Change Interview with Dr Wills after session 4, Chloe noticed a “change for the better” despite feeling somewhat overwhelmed:

bringing everything up has been quite difficult... it's like I've scraped off the surface and I'm getting to the real stuff underneath... just getting in contact with myself really... I'm actually more aware of that, so that's helped me.

Chloe said she had noticed that “I can actually express myself more... I've actually taken that step to tell people... I'm actually feeling not that great... and actually getting and seeking support from other people... I could never have done that without counselling.” Chloe also realised, “it's okay to feel a certain way... it's okay to express yourself in appropriate ways... just basically understand my confusion...”

In addition, Chloe recognised, “I also see now that I've got underlying problems that I have not dealt with for years... I didn't realise it was there...” Chloe had come to counselling because she wasn't eating properly and was suffering “a bit of depression. I didn't realise that I had so many things that were going on my life I thought it was all trudging along.” Importantly, Chloe felt supported.

I feel pretty good at having Melissa to speak to... we're just very connected... finally have someone who is so perfect for me right now just great... I don't really talk to many people about my stuff. I'm usually the one that counsels them so it's been positive... I can tell her about spirituality... Melissa's the first one I can really talk to about it... it's very hard to be spiritually connected but not being able to be accepted by outsiders... we worked with Archangel Michael. I've used him before but I never tell anyone about it and it was good to have her know about him and to tell me to actually use him.



Chloe stated the focusing was

fantastic because I can actually express what I'm feeling without... someone looking at me... she just has a way to guide me through... every time without doubt she's been able to ask me the right question... so she's very in touch with what's going on... she's not leading at all...

In the first few sessions there was a lot of noise outside and Chloe found this hindering as she lost concentration whilst focusing. She found the last session painful as she began to recognise she was "just suppressing everything down." Chloe also stated that she was "really anxious to do the work... what I'm going to get out of this... looking at my diary, how many sessions have I got left and I'm going to be better by that time and I'm worried about that..." Finally, Chloe had been "suicidal last week" and wondered whether "maybe I need to up it and see her twice a week."

***Therapist's analysis of process and change: Sessions 1-4.***

In our first session I was aware that Chloe had a great deal happening in her life and was very easily overwhelmed. She had been hesitant to attend the sessions but once there was willing to engage. She was easily and naturally led to her bodily felt-sense. For some people this is a natural process and for others it has to be learnt (see Weiser Cornell, 1996). Asking Chloe to notice her felt-sense encouraged her to slow down the telling of her painful experiences and provided an opportunity for me to facilitate a processing them. Introducing a task in the first session may be considered unusual but Chloe's grief and distress were very evident. Chloe had also had some counselling before and I hypothesised she was ready to explore some of the underlying issues present within her.

I have found the focusing particularly useful for clients who are easily aroused and emotionally labile as it assists them to ground themselves in the physical sensations within their body. It also often provides a portal into unprocessed and unexpressed experiences that are "remembered" in the body (Rothschild, 2000). The semi-meditative state generated by "clearing the space" reduces the sense of an observer. The

client is less likely to be flooded by the memories and potentially re-traumatised because the pace of the exposure to the experience can also be regulated.

In getting in touch with her felt-sense, Chloe was able to recall memories associated with that bodily sensation and we were able to reprocess these events. When memories are remembered they become malleable and constantly undergo revision because of the process of retrieval and recollection (Jancin, 2011). Thus memories are open to reprocessing. My work with trauma clients has shown me that if a traumatic memory is accessed in conjunction with emotional arousal and body sensations it is possible to reprocess the event in such a way that the person is no longer plagued by the painful aspects of it. If the person is able to express the appropriate primary emotion and articulate their needs within the remembered experience, the associated painful emotional charge is lessened. The event is remembered as having occurred but the emotional intensity is greatly reduced. Dr Richard Lane (as cited in Jancin, 2011) wrote in his PhD thesis that automatic dysfunctional emotional processes arising from traumatic childhood experiences can be altered by activating the problematic memories, generating new adaptive emotional responses, and then storing the changed memories in stable fashion. I wrote in my case notes that Chloe “was able to focus on the bodily felt-sense really easily, got in touch with her emotions and was able to make meaning of these events releasing her from shame and guilt around these experiences.”

In session 2, Chloe was emotionally overwhelmed by her stepmother’s overdose and not being able to contact Steve. I introduced the focusing task. Chloe remembered her stepmother’s criticism of her and the “monkey-bar” incident, which also left Chloe feeling alone and humiliated, and so in this session it was important to reassure Chloe that processing these painful experiences was indeed important and potentially liberating. I am reminded of the article written by Pascual-Leone and Greenberg (2007) titled in part “the only way out is through.” The question of course is how to enter painful traumatic experiences in a way that does not re-traumatise the client but can bring about a positive outcome. Viewing her experiences within the slightly altered state focusing fosters, allowed Chloe to take an observer’s stance and broaden her overall view of the experience to include context. She was also able access her

emotional distress in a more measured way, stay with the emotions, and liberate the primary emotions needed for assertive action.

The theme of Chloe's ineptness was again present in session 3. When another childhood memory emerged of being bullied by her cousin, Chloe felt vulnerable and unprotected. Because she was angry but felt unable to express that anger even in her imagination, I identified a self-interruptive split and introduced the two-chair enactment indicated when emotional expression is blocked or suppressed. I was somewhat hesitant to suggest this task within the focusing but Chloe was finding it difficult to hold the idea it was okay to be angry. Fortunately, Chloe readily accepted the challenge. As I set up the task the energy in the room changed significantly from heavy and oppressive to being recharged and invigorated, a felt-shift. She was able to understand that the suppression of her anger led to indiscriminate outbursts and she made a commitment to herself to be more assertive as she began to feel angry rather than holding onto it for weeks. Resolution involved the expression of the previously blocked anger. However, I believe Chloe was only able to partially resolve this suppression.

In session 4, I suspected that Steve's temporary disappearance had triggered Chloe's grief over the loss of David and perhaps her father's departure when she was only three. I explained to her that the work we were doing brought buried issues to the surface and these strong reactions were quite probably connected to her unresolved grief and other suppressed emotions. I invited her to explore this despair. My aim was to approach and explore her bodily felt-sense gently by attending to the processing of her pain rather than promoting a cathartic release, which she did not think was useful. In the past, her crying sessions left her exhausted and depleted and I wanted to ensure we could find a more productive means of processing her grief.

Chloe's ability to symbolise her experience I believe is a key component in her ability to process her experience. The image of a diamond encased in a black box was a rich metaphor for her. I wondered if the struggle between the desire to express herself freely (the little white diamond) and the need to contain her feelings (the black box) symbolically represented the source of some of her ongoing confusion. She agreed. When I revisit this work with Chloe, in this analysis, I see her main difficulty as the ongoing suppression of her needs, resulting in depression and other physical

complaints. Chloe needed acceptance to feel safe enough to let go of the black box containment of her feelings. I was aware that I wanted Chloe to “let go” of the black box and so I metaphorically took a step back and reassured her that if she was not ready that was okay.

I found the symbolism of the diamond significant and proposed to Chloe that despite its small size, her diamond was very tough and resilient. Chloe searched for another protective mechanism and called on Archangel Michael as she had in the past. In a rather unusual intervention, but in keeping with Chloe’s beliefs, I encouraged her to ask for his help. Chloe courageously and symbolically “broke” the box and experienced a felt shift. This was a significant and powerful experience for Chloe.

## **Chloe’s Therapy: Sessions 5-8**

### **Session 5: 14<sup>th</sup> September.**

At this point, Chloe’s inability to eat concerned her most. In a focusing Chloe symbolised a protective grey cloud-like area from her throat right down into her abdomen. She recalled being a teenager obsessed with body image and wanting to look perfect so her peers wouldn’t pick on her. The grey area had something to do with a “sense of control.” Chloe remembered when as little girl her mother and sister “tried to control my life” and when she wanted to go off and be by herself, they’d say, “don’t be stupid.” I encouraged “little Chloe” to call on “adult Chloe” to advocate for her and “stand up to them.” Despite finding this challenging, Chloe was able to effectively say what she needed to, stating that it “feels good.”

The current trigger for not eating was Steve not “being here.” She believed she doesn’t deserve love, that he doesn’t love her or to want to be with her. I encouraged her to find the part that knows “you are lovable.” She located it but it was “very small... hidden... buried” and damaged by ex-boyfriends. This aspect of Chloe was very “weak” and in need of support, healing and nurture. Tears welled as Chloe integrated this aspect, recognising she needed time to heal. I enquired as to the grey cloud and Chloe explained it was “lighter.” Chloe reported on her HAT form that she found the “meditative state of the focusing” and “finding the part of me that knows she is loved” extremely helpful. In relation to her eating disorder, “realising that the

part of me was so battered is connected to the anorexia” and “talking about where the anorexia may have stemmed from” was also extremely helpful.

### **Session 6: 21<sup>st</sup> September.**

In the past few days Chloe had eaten well and was feeling better but she was still berating herself. Chloe recognised she was “going towards [success]... but pull myself back.” I introduced the enactment task of two-chair work. (*At the time I used the language of a self-interruptive split but actually set up the chairs for a conflict split*). Chair one represented the underdeveloped part of Chloe that wanted to be successful and the second chair represented her fears in relation to being successful. After a number of chair swaps the process halted as she felt “stuck.” When she didn’t know things she became confused and felt stupid. Sitting in the fearful chair Chloe felt a pressure in her chest and was feeling a “bit stuck... I think I’m dyslexic.” I encouraged her to sit with the stuckness. She felt heat in her chest and solar plexus and sensed bright orange red “like anger.” When she was five she recalled having trouble writing and “staying in the lines... hide it so no one will notice.” No one helped her. Chloe wore a persona of intelligence and no one would have realised she had gaps in her knowledge. I asked the “adult Chloe” to assist “little Chloe.” She sat with her dilemma and then “had a shift... positive affirmation helps negatives reduce.”

Chloe reported on her HAT form that the two-chair work and the focusing were extremely useful. “Focus centring work really enabled me to discover that I negatively prevent myself from moving forward and prevent any good change.” Chloe found the somewhat abrupt end of the session slightly hindering and wished “I could have kept going with moving past the negative aspect of preventing a change during the focusing work. Unfortunately it took me a long time to get there and would have liked to have kept going.” Chloe did add, “I really admired how Melissa dealt with wrapping up the session really well and subtly.”

### **Analyses of change.**

#### ***Inventory assessments after session 6.***

At Session 6 I asked Chloe to complete the BDI-II and the DASS inventories. The scores are tabulated in Tables 5 and 6. Chloe’s assessed depression and anxiety scores

are now within Moderate ranges. In addition, her stress levels had decreased from extremely severe to mild.

Table 9.6. The BDI-II classification of depression at Session 6.

Chloe's BDI-II Depression Score	Minimal	Mild	Moderate	Severe
24	0-13	14-19	20-28	29-63

Table 9.7. The DASS classification of depression, anxiety and stress at Session 6.

	Chloe's score	Normal	Mild	Moderate	Severe	Extremely Severe
<b>Depression</b>	16	0-9	10-13	14-20	21-27	28+
<b>Anxiety</b>	13	0-7	8-9	10-14	15-19	20+
<b>Stress</b>	18	0-14	15-18	19-25	26-33	34+

### *Session 7: 5<sup>th</sup> October.*

Chloe was exasperated at being stuck again. In the focusing she felt tightness in her shoulders, neck and back of her head. She visualised a heavy, dull, dark-green, layered metal brace or armour that had been present since she was a teenager, as a form of protection that supported her. There was also anger. Under the armour was “like a black spongy tar... keeping it all together...” Within the black tar she saw “light flashes of white light... star inside... my heart is contained by the tar” and the armour... the star is a lot bigger than last time and still in its glass cage... that can be opened.”

Chloe felt “anger with myself... towards my mother... a little for my dad... towards my cousin.” I asked Chloe to bring each person into her imagination and find a way to express her anger towards each one in turn. Her mother hadn’t protected her and not only had her father deserted her but she had taken on his anger. Symbolically, Chloe returned the anger to her father. The black tar shifted and Chloe sat upright, stretched her shoulders and took a couple of deep breaths. Chloe became aware that she could protect herself now but “sabotage still comes back... out of control... like a

little ball that's hard to catch." Chloe saw chastising herself as "what gets me going." I suggested she reframe this anger towards herself as "drive and motivation." She experienced ongoing shifts and was determined to rid herself of any remnants of the black tar of suppressed anger. The last remnants were "stubbornness." I asked her to reframe this trait as "determination." She sat quietly for a moment as she visualised the last of the armour dissolving away. She immediately opened her eyes, said 'that's great,' spontaneously jumped up out of her seat and joyfully hugged me. Chloe reported on her HAT form that working with the self-sabotage and anger was extremely useful. In addition, having internal conversations with the people that were connected to her anger, realising the underlying causes of the self-sabotage and finally removing the armour were also extremely helpful events.

***Session 8: 26<sup>th</sup> October.***

Chloe had spent two weeks with Steve in South Africa but had been unwell and was now grieving. I suggested a focusing. The tension in her back, shoulders, neck and head appeared like a tarnished black armour weighing her down with grey underneath and related to thoughts about how she should have done things differently. She had had unrealistic expectations, and now Chloe feared Steve might be her "second best..." and "the way I act pushes him away and I may lose him." I reminded Chloe that she deserved a good life and relationship. She located her sense of deservingness as buried deep in the "diamond" located in its glass cage within the greyness. "I know I deserve happiness but negative thoughts come in saying I don't." Chloe recalled her parents' relationships. "I've learnt from seeing... they had had such horrible relationships filled with anger that I get a sense that mine must be like that." Her parents had got married because her mother was pregnant at 16. "They didn't really know each other." Chloe was relieved when she realised that she and Steve really did know each other.

The "black tar is covering the positive side of things... so much negativity... just black covering everything." Chloe was able to visualise the blackness lifting. She sat straighter in her chair and felt "much lighter." She felt she needed love and support from those around her to turn the grey into fairy-floss "pink." She imagined sunshine beaming from outside within and from within outwards and the grey dissolved. In her

Helpful Aspects of Therapy Form, Chloe reported being reassured that how she felt was OK was helpful. “I was thinking that everything I was feeling and thinking was not normal. It was very helpful and reassuring to get an outside opinion to why I was thinking and feeling the way that I was.” In addition, the focusing allowed Chloe to be “grounded and concentrate on the session more and identify what was really going on.” She also liked being able to “offload” at the beginning of the session. In the Table 9.8 I have highlighted the significant elements of each session.



Table 9.8. Chloe: Summary of bodily felt sense, symbolic representation, episodic memory, emotional arousal and felt-shifts – sessions 5 to 8.

Session and task	Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
5. Focusing Anorexia	spanned from her throat right down into her abdomen	a protective grey cloud-like area “sense of control”	teenager – body image mother and sister “tried to control my life” – IC – adult Chloe advocate for little Chloe and counsel teenager on better ways to eat damaged by ex- boyfriends	“feels good” “you are lovable.” tears of sadness cloud was “lighter” → <i>shift</i>
6. Two-chair A self-interruptive process not a conflict Focusing <i>Stuckness</i>	chest  FEAR OF SUCCESS chair – pressure in her chest DESIRE FOR SUCCESS chair –	unlovable  stuck		
	heat in her chest and solar plexus	bright orange red “like anger”  persona of intelligence	5 yo having trouble writing – hid it so no one will notice	adult Chloe helped child Chloe  reminded of successes → <i>shift</i> “positive affirmation helps negatives reduce”

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
7.	Focusing Overwhelm	tightness in her shoulders, neck and back of her head	a heavy, dull, dark- green, metal brace black spongy tar protects white star inside glass box	anger at self sabotage towards cousin – IC mother didn't protect her – IC dad – IC – blocked adult support child feeds on the agitation – IC father – IC give anger back to him as taken it on  stubbornness	anger tears sadness → <i>shift</i> tears - “she's listening” → <i>shift</i>  listen to needs - “settled down” black tar shifted stretched shoulders deep breaths → <i>shift</i> vs. determination last of the armour dissolving away → <i>shift</i>
	Sabotage		orange case... keeps escaping		
8.	Focusing Overwhelm	back, shoulders, neck and head	weighty tarnished black armour with grey underneath greyness black tar is covering the positives sticky grey fairy- floss	holiday with Steve  not follow patterns of her parents – she knows Steve love and support from those around her	tears shame anger  blackness lifting sat straighter “much lighter” grey dissolved fairy-floss “pink” → <i>shift</i>

**Client and therapist analyses of change.**

***Client's analysis of change after session 8.***

Chloe explained to Dr Wills during her second Change Interview that despite the sessions not being long enough

Therapy has been fantastic... it's created a lot more of the awareness of what I was going through and how to look at things differently... how I feel after the therapy is really, really good, like a big weight has been lifted off... especially after the emotion focusing things feel lots has shifted.

Chloe was managing her suicidality. "I'm doing a lot better than I was not having so many suicidal thoughts... they do come occasionally but they're not as bad, nowhere near as they were before." In addition, she reiterated she "can talk to people a lot more and standing up for myself a little bit more... realise I don't have to be pushed around." Significantly,

I am aware more of my emotions and I can express them and I definitely have a little bit more control over my emotions... they're not as erratic as they would have been... the anxiety has definitely decreased especially at work... I'm talking myself through the anxiety rather than just trying to get over it.

And she continued

by giving me knowledge basically and telling me that it's okay to feel those things that yeah, just understanding that the things that I'm feeling are okay and rationalising what's going on it's not bad to feel that way... it's natural and things like that... those kinds of things I wasn't taught when I was younger... you were expected to know how to do those things...

Chloe enjoyed the focusing. “I’m sitting there inside myself...not looking at everyone, there’s no judgement, there’s nothing... it’s like I’m sitting there with it, just someone guiding me towards that area that I need to be with, and that just helps a lot.” Chloe found “the chair work has been really useful... acknowledging that there are two parts... the negative thoughts and positive thoughts... reality and fantasy.” She felt reassured that I acknowledged she was “spiritually aware” and that “I’m very sensitive... she knows that... we’re connected... I can feel that connection... while I’m under the focus work she just seems to ask me exactly the right questions at the right time.”

The first few sessions Chloe found painful when she was remembering

the molestation from my cousin about how it was... because I wasn’t really sure whether it happened or not... dealing with my father that I had no idea that I had issues with him... I’ve actually acknowledged and understood these things rather than putting it to the side... yes, and a lot of things to do with my stepmother and the way that she treated us and the way that I was kind of left to do my thing... left alone to kind of bring myself up so yeah, that was hard to actually acknowledge that and understand that’s where all these things were coming from.

***Therapist’s analysis of process and change: Sessions 5-8.***

Chloe’s processing style seemed suited to focusing and since she was readily able to get in touch with her bodily felt-sense I hoped this would provide her with an alternative means to understand her distress. Session 5 suggested this was occurring, as through the focusing she was able to identify how as a teenager she learnt by watching other people and understood that this was the beginning of her eating disorder. I saw it as significant that she recognised she needed control in her life because many aspects of her life were out of control. I encouraged Chloe to counsel, care for and advocate for her younger self and this facilitated a felt-shift and a change in perception. The idea that she could learn to take care of and love her abandoned

and lost inner child aspects brought Chloe to tears and created another felt-shift. I felt it was important for Chloe to validate herself and her needs.

In session 6, I identified a self-interruptive split when I reflected to Chloe that “part of you knows you are okay and another voice keeps putting you down...” But then I set up the task as if it was a *conflict* split by suggesting chair one represent the underdeveloped part of Chloe that wanted to be successful and the second chair represent her fears of being successful. There is an important difference here. Conflict splits are where one aspect of self is in opposition to another aspect which is how I set up the task but interruptive splits arise where one part of the self interrupts or blocks experience or emotional expression (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2011). The more appropriate task in this session would have been the self-interruptive two-chair enactment. The aim of the task would then have been to explicate the interrupting part so Chloe could see how she interrupted herself and encourage the interrupted part to become more empowered and challenge the interrupter. Interestingly, Chloe got stuck in the process. At the time I correctly took this to be a pattern in Chloe but chose to use the focusing to further explore her fear and stuckness. However, in hindsight I see that her stuckness was the very difficulty that would have been best processed in the two-self enactment for self-interruptions; indicating that the tasks I initiated were not necessarily the most appropriate ones.

When I abandoned the chair work and creatively went into an informal focusing, Chloe connected with her anger through her bodily-felt sense and had memories of struggling at school. She thought she had dyslexia. I believe that Chloe is a highly sensitive person (see Aron, 1998) who would withdraw and hide rather than tell someone she was struggling. She had no friends in primary school and I suspect was fearful most of the time. I explained to her that if exposed to extreme stress and/or trauma, children can often find it difficult to learn and subsequently end up with gaps in their knowledge. This happens because when the autonomic nervous system is activated preparing the body for fight or flight, cognitive functioning within the frontal lobes is suppressed (Levine & Kline, 2007). Survival is paramount. Part of Chloe’s survival mechanism was to show competency and she did this by putting on an intelligent persona. I believe that Chloe had not been given encouragement and I wanted to acknowledge her strengths by highlighting her resourcefulness and

persistence. However, she said she was “getting blocked by negative feelings.” This indicated we had not really addressed the most salient issue, suppression of her needs and wants, with the most appropriate task that session. Chloe, however, did find that my positive affirmation created a shift. The session had gone well overtime.

It was quite possible that Chloe might have had a form of dyslexia but in the scope of this counselling I felt normalising her experience in the context of her childhood experiences might be more useful to her. Despite my inadequate facilitation of the chair work Chloe was able to reach new meaning and experienced a felt shift in the session. Significantly, Chloe’s assessed depression and anxiety scores after session 6 were within moderate ranges and her stress levels had decreased from extremely severe to mild.

In session 7 Chloe was exasperated at being stuck again and we agreed on a focusing. The repeated presentation of Chloe’s stuckness ideally should have been a marker for me to deal with her self-interruptions. However, I chose to go with the focusing task because her feeling overwhelmed was a marker for focusing, Chloe had a natural affinity with the process and we had achieved success with it in the past. Chloe’s body awareness was quite sophisticated and the visualisations that emerged so easily from her felt-sense were quite remarkable. The symbolism was very powerful and easy for me to follow. For example, black spongy tar represented her anger and her heart was like a bright star contained in a glass cage that could be opened. She was also able to access and identify her emotions readily, especially her sadness. Despite finding anger difficult to express she was able to recognise its presence. She was also able to envisage the people in her life whom she had unfinished business with. I suggested she confront these people in the focusing so as not to interrupt the flow of Chloe’s process, intending it as a desensitisation process. Encouraging Chloe to be more assertive in her imagination was a preliminary step to empty chair work in session and to actual confrontations. I suspect Chloe liked the idea of letting her anger go in the focusing because confrontation was difficult for her and in the past had not always been met with the understanding and the positive outcome she had hoped for. Significantly, Chloe did experience a felt-shift as a result of processing her anger symbolically by giving that anger back to her father. To me this suggests that the combination of bodily felt sensation with emotional processing and access to episodic

memories or visualisations has the potential to promote change. The reduced depression scores support this hypothesis.

I was able to explain to Chloe that anger is an adaptive emotion when it is a primary response to feeling violated and that she may even use her anger to drive and motivate her. I admired Chloe's determination to rid herself of any remnants of the black tar of suppressed anger and was able to reframe "stubbornness" as "determination." This generated another visualisation of the last of the armour dissolving away and another felt-shift.

In session 8 Chloe had again been plunged into despair and was feeling she had not made the best of her time with Steve. The focusing again offered Chloe a means of processing her painful experiences and her emotions in such a way that she got in touch with a sense of her deservingness. Chloe wrote on her HAT form that she enjoyed off-loading at the start of the session and the focusing allowed her to be "grounded and concentrate on the session more and identify what was really going on."

## **Chloe's Therapy: Sessions 9-12**

### **Session 9: 16<sup>th</sup> November.**

Chloe felt sad and alone. "[I'm] waiting for [Steve] to come and rescue me..." She felt she had reality in her head and her dream in her heart. I set up the two-chairs: "gloomy reality" and "fantasyland." I explained that the role of reality was to provide a crucial "reality check" that often promoted safety considerations. Chloe was surprised by this because she "...thought it was all negative!" Chloe realised that she had often been fantasising and would get stuck there. I encouraged her to create a bridge between reality and fantasyland, which she did easily and spontaneously. She felt good. Chloe reported on her Helpful Aspects of Therapy Form that she wasn't suicidal anymore, and that "discovering it's okay to have both fantasy and reality joined" and using the two-chairs was extremely helpful.

**Session 10: 23<sup>rd</sup> November.**

Chloe had spent four years waiting for Steve and was uncertain how to reclaim her life. In a focusing, Chloe described a pressure in the back of her head and shoulders like a grey heavy weight. Tears fell as she said “I want to be needed... to be loved.” She visualised an old wooden gate covered in barbed-wire that kept people out. In the past she had opened it but got hurt as people let her down, except for Steve. Chloe described a rock-like crystal in her chest and a vision of her seeking out social contact but no one there. We explored Chloe’s expectations of others and her disappointment at their inability to meet her needs. I asked Chloe to focus on her inner crystal behind the gate and she saw people there but couldn’t touch them. I explained that we need to seek out multiple resources to fulfil our lives. The idea of a one-stop-shop was very appealing to Chloe, but she recognised it was not realistic, and she needed to reach out to others. She declared she felt a “lot better.” I challenged Chloe to decide whether she wanted “waiting” to dominate her life or to reclaim her life by taking responsibility and making choices about how to live it.

Chloe reported on her HAT form that the focusing was extremely helpful because it enabled her to become aware that “a lot of the problems were caused by me not letting others in or trusting them and that it is not others’ responsibilities to fulfil my needs.” Chloe also recognised she needed “to be kind to myself and take charge of my life with different activities rather than spending all my time waiting for others.”

**Session 11: 30<sup>th</sup> November.**

Chloe had failed her biochemistry exam and was chastising herself. She did see some shifts in her thinking and over the past few weeks she had been “eating better, haven’t been so stressed...” In the focusing she sensed a dark grey cloud that surrounded her head and neck area and a thick black-brown tar that encapsulated her heart. She also noticed a mesh covering her heart and brain and blockages between her head and heart. The thick toffee-like tar and the mesh represented the disappointment and expectations from her father and stepmother. I invited her to confront them internally, but Chloe wanted to process the experience her way by removing the mesh symbolically. She sat for a long time processing her inner experience. Finally, she said she understood that the disappointment will subside if she can drop unrealistic



expectations of herself and others. She experienced a felt-shift and the tension in her chest lifted somewhat and she saw a lovely pink heart. Chloe reported on her HAT form that “talking/venting what had been going on in the last week... realising I was slowly improving and utilising the information received from the sessions... focusing seeing the blockages between the heart and the brain” had been extremely useful.

### **Session 12: 7<sup>th</sup> December.**

Chloe felt she had failed her supplementary exam too and her distress was palpable. She recognised her ability on the one hand but questioned it on the other. I offered two-chair work as a way to process the conflict. One chair represented *despondent* the other *confident* aspects. In the despondent chair she noticed tension in her throat and heart and felt anger and disappointment with herself and a sense of failure. But she saw “a glimpse of happiness” on the other side. Her despondency was well entrenched and each side had difficulty hearing the other as there was a block in the process. (*Had I recognised this was actually a self-interruptive split I would have been able to facilitate this task more easily*). I decided to propose a renaming of these aspects. The despondent side held the more “female” attributes of sensitivity, compassion and acceptance whilst the confident side held the more “male” attributes of strength, power and confidence. I explained that we needed the positive attributes of both aspects and this made sense to Chloe. “There is just more understanding about why that’s there... (*pointing to the despondent chair*), very confusing being in that position...” I asked Chloe to visualise removing the dark grey blanket of depression that shrouded the other chair. When she then sat in that chair she declared it “doesn’t feel as black.” She continued, “I want to get in touch with your qualities because you drive us... but I’m important too because I hold compassion” From the confident chair, she said we “shouldn’t be so harsh on each other... I want what you’ve got... you don’t have to be fantasy, you can be real.” Utilising the two-chairs was certainly challenging but as a result of this somewhat elaborate enactment she had found resolution. “Oh, that feels a lot better...” I invited Chloe to attend another session if she wished but for various reasons this did not eventuate.

On her Helpful Aspects of Therapy Form, Chloe reported that “talking between two chairs of male and female parts of myself” was extremely useful. She described her

male aspect as “practical strong, [and] passionate” and her female aspect as “compassionate, but dwells on things too long” suffering depression and fear. “Understanding that both are important to have and to work together” was also extremely helpful. In the Table 9.5 I have highlighted the significant elements of each session.

Table 9.9. Chloe: Summary of bodily felt sense, symbolic representation, episodic memory, emotional arousal and felt-shifts – sessions 9 to 12.

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
9.	Focusing	left-hand side of her neck and shoulder	heavy grey cloud	waiting for Steve to come and rescue me	sad and alone
	Two-chair Conflict	DREAM chair – fantasyland procrastination			
	Focusing	RELATY chair – gloomy pressure in her head on the left side	black pressure in her head	alone as a child → fantasyland create a bridge between reality and fantasyland	anger at being alone bridge to move between the two internally → <i>shift</i> “Feels good”
10.	Focusing People let her down	back of her head and shoulders	a grey heavy weight	“I want to be needed... to be loved.”	tears
			old wooden gate covered in barbed- wire kept people out blocked	had opened in past but got hurt little Chloe “waiting to be loved and reassured”	reassurance
		in her chest	rock-like crystal	disappointment in others	be own best friend open the gate to let people in - felt a “lot better” → <i>shift</i>

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
11.	Focusing Overwhelm  Process it her way	pressure in her head, neck and chest     neck	dark grey cloud around head and neck thick black-brown tar around her heart mesh covering her heart and brain blockages between her head and heart	disappointment in her brain disappointment in herself – IC to self   fear of failure	if I let go and speak to people the disappointment will subside tension lifted → lovely pink heart “unblock” these pressures and allow energy to flow between these areas → <i>shift</i>
12.	Two-chair Conflict (? Self- interruption)	DESPONDENT chair – try so hard FEMALE tension in her throat and heart  CONFIDENT chair – can do it MALE	blanket of depression  having goal gave her confidence won't give up  dark grey blanket of depression	disappointment fear of failure	global distress anger expanded in her heart excitement happiness → <i>shift</i>  female – holder of compassion male – holder of confidence lifted → <i>shift</i>

**Client and therapist analyses of change.**

***Client's analysis of change after session 12.***

In her Change Interview with Dr Wills after session 12, Chloe reported that counselling had “been really good, it’s been really helpful, and helped me understand a lot about myself really.” She reflected that

At the beginning it was more so about family things... where things were stemming from and then it kind of just chipped off all of that and it got to the underneath, which is how I’m feeling now... how those past things have actually affected me and continued to my life now... things like not feeling smart enough, not having the confidence to do things that I wanted to do, self-sabotage, depression and staying in those kind of states... like I can look back and understand why it’s there... I have more compassion to those sides... I’m starting to understand where the triggers are coming from as well... so now during that process I would take a more positive outlook so listening to music or something that might bring me out of that trying to continue on with life rather than dwell on it...

Chloe acknowledged that she was generally more aware, able to “look after myself a lot more.” Her “anxiety isn’t there as much” and she was “reaching out to people a lot more.” She explained that “sometimes it’s a bit of a roller coaster” but “it’s a lot better since therapy... the depression is not as extreme... I am aware of it... I know what it is now... I understand a few things what to do... I’ve got a lot of compassion for myself now.” Therapy has been

helpful in my understanding of my life... the understanding of not being so hard on myself... it’s helped me to understand my stubbornness and the point of view of myself... understanding really of what’s been going on really, ‘cause I had no idea... I knew about the persona that I had at the beginning and I’m more aware of it now...

Chloe travelled a long distance to come to sessions and at times that was problematic. Painful aspects included “dealing with my dad and with the sexual abuse... and the family issues... talking about my boyfriend overseas, as well...” Finally, Chloe said it was the “best counselling I’ve ever done and it’s really, really helped a lot.”

***Therapist’s analysis of process and change: Session 9-12.***

In session 9 Chloe when was struggling with exam preparation and again felt overwhelmed, I identified Chloe as a “highly sensitive person” (see Aron, 1998) because she became so easily overstimulated. I explained to her that she needed to learn to respect her sensitive nature by taking “time-out” to nurture herself. Despite there being no marker present, other than her feeling overwhelmed, I decided to introduce a focusing task with the intent of directing Chloe to a more internal focus.

A key insight for me in this session was that Chloe had not learnt that reality had some positive attributes; she felt it was all negative and had managed to navigate her life by spending much of it in her fantasy. The apparent lack of parental support and guidance had astounded me in previous sessions but I was again reminded of how resourceful Chloe had become. In many ways it was not surprising that fantasy was more appealing because reality has seen her suffer her parents’ separation when she was small, bullying, various abusive sexual encounters and the death of her first love. I worked with the support she had found in her spiritual beliefs and Archangel Michael in particular. I was curious that she always called on only one angel. She said “like Steve... I can just have him and that’s it... I don’t need anyone else.” It felt it was important for Chloe to find multiple sources of support. It was also reassuring and significant that Chloe wrote on her HAT form that she was no longer suicidal.

By session 10, when Chloe recognised that her life was on hold and she was suspended in “waiting to be loved and reassured”, I thought that the key theme in this session was that people had hurt her in the past when she had let them in and it seemed she could only work on trusting one person at a time. By this stage I was hoping the therapeutic process may foster trust and that her trust in me might extend to others.

I found myself setting Chloe challenges in this session, asked Chloe to take up activities that expanded her and made her “heart sing” and to decide whether she

wanted “waiting” to dominate her life or to reclaim it by making choices how to live. I was surprised at my directive “coaching” positive psychology approach and wondered how Chloe had responded. She acknowledged that her rebellious side had emerged in opposition but said, taken as a whole, “it’s all good.” I also explained that this transition period was difficult.

When I next saw Chloe in session 11, she had discovered that she had failed an exam and had become despondent. I reminded her that life was not a series of happy days but often involved experiencing the full gamut of all emotions. Depression also has an adaptive function that bids us to stop, think, take stock and choose a strategy for action. It becomes problematic if the state lingers and/or attempted strategies are thwarted or fail, leaving the person feeling despondent. I suggested that the best way to manage fluctuations in mood was to become aware of them and pay attention to what you needed. Chloe saw the possibility but realised she didn’t do those things. She was concerned about how to study for the supplementary exam and we brainstormed a few ideas. This solution-focused strategy is considered out-of-mode in terms of the PE-EFT model, but my person-centered values prompted me to support Chloe in this way.

In an attempt to calm Chloe, I suggested a focusing task and again she was able to visualise and symbolise her felt-sense. She was disappointed in herself for failing her exam and since much of that disappointment seemed to come from her father and stepmother. I suggested she confront them in her imagination. However, she decided she wanted to process it her way. I liked that Chloe felt confident enough in the process to take such an initiative but also hoped that this was not an easy way out for her.

It appeared to me that Chloe had a heightened sensitivity to her surroundings and an intuitive ability that left her feeling different from other people. I was very happy to work with her in a way that didn’t pathologise her but assisted her to feel more accepting of herself in relation to others. Chloe’s spiritual experiences had contributed to her sense of isolation as it was a part of herself she often hid. Her sadness was related to how to manage what she knows and sees, and who to trust with such revelations. Dealing with the judgment of others had been difficult for her.

In session 12, when Chloe fought with her the struggle of not feeling intelligent enough to complete her course yet a strong determination to do so, I saw this as a conflict split with one chair representing the aspect that “can’t be bothered” and the other representing the aspiration of “being a good nutritionist.” I now see that this split was again more likely to be a self-interruptive split where the interrupter was the aspect that told her she was not good enough. Ideally the interrupted aspect would rally against this assertion. I was relieved to read that conflict and self-interruptive splits are not always easy to differentiate and that there can be an overlapping with elements of both being present (Greenberg, Rice, & Elliott, 1993).

A person who cuts off primary adaptive emotional experience and expression loses contact with their sense of self and their needs. This can result in feelings of hopelessness, helplessness, resignation or cynicism and be associated with a variety of psychosomatic symptoms (Greenberg et al., 1993). Chloe’s disappointment in herself, her sense of wanting to give up, and her disapproval of herself were the markers of her self-interruptive processes. When Chloe initially sat in the chair that represented the part of her that wanted to give up (that is the part that was being interrupted) and immediately chastised herself, I encouraged her to really get a sense of “you can’t do it.” This coaching would have ideally been something I may have suggested to her interrupter. It would have been more appropriate for me to invite her to first sit in chair that enacted the interruption, not in the interrupted chair.

Although Chloe did experience some empowerment in that chair and actually felt more confident when sitting there, because I had not set up the two-chair task adequately there was not enough clarity around which aspect was which and we reached an impasse. My way of explaining this at the time was that argument between these two aspects (more appropriately the overriding strength of the interrupter) was deeply entrenched. Despite my efforts to establish a dialogue and a natural softening between them, I struggled, and I thought this struggle paralleled Chloe’s experience. Something was interfering with each side being truly heard.

If I had directed the task successfully as a self-interruptive split, Chloe may have recognised that she was punishing or stopping herself and thus interfering with the full expression of her needs. I believe Chloe had learned to hold back expression of her needs because in the past her more adaptive assertions had been thwarted, ignored or



punished, which in turn led her to develop a set of interrupters or self control processes to ensure she would not allow herself to be so vulnerable again. When these interruptions become automatic people become helpless, confused and unable to get what they need. I see her eating disorder as another expression of this interruption. A successful resolution would result in her neediness being transformed into an ability to ask for what she needed and her inhibited anger transformed into assertion of her needs and rights. Fortunately, I was creative enough to facilitate a resolution for Chloe by renaming the conflicting aspects into male and female attributes. This renaming appealed to Chloe and she was able to continue with the task and achieve some collaboration between these two aspects; a partial resolution.

***Analysis of change according to clinical significance.***

***(1) Comparison method.***

At the end of session 12 Chloe scored 16 on her BDI-II which was within the mild range of 14-19 (Beck & Steer, 1987; Beck et al., 1996; Beck et al., 1988). On the DASS Chloe's Depression score was 15 indicating a moderate level of depression when compared to the normative range of 14 to 20 (Lovibond & Lovibond, 1995) and her anxiety score was 10 which was also within the moderate normative range of 10 to 14 (Lovibond & Lovibond, 1995).

***(2) Absolute change.***

Figure 1 illustrates the overall decrease or absolute change in depression, anxiety and stress over the twelve sessions. Chloe's level of depression and anxiety had gradually reduced over the course of therapy.

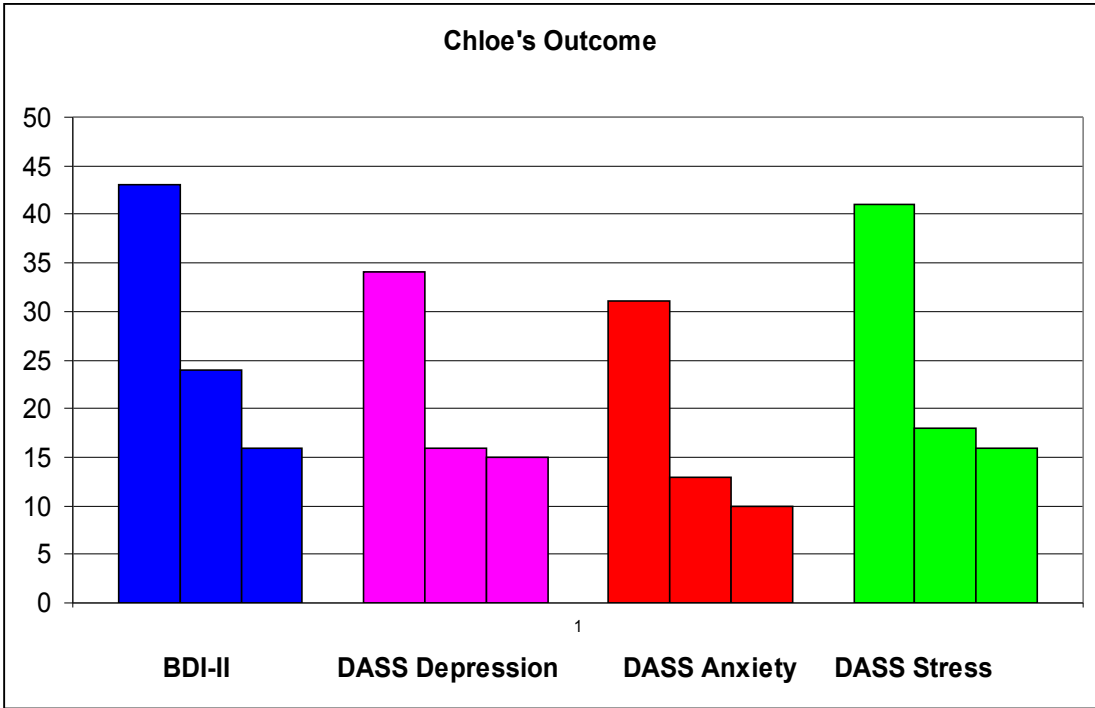


Figure 9.1. The BDI-II, DASS scores for Chloe at the screening interview and after Sessions 6 and 12.

(3) *Subjective evaluation.*

Chloe's subjective evaluation of the outcome of therapy was determined in two ways. Firstly, through progress on the list of concerns she made at the screening interview and secondly, through the she changes identified in the Change Interviews (see *Client and therapists analyses of change* sections above on p. 322, p. 333, and p. 343). According to Chloe she became less worried, less anxious, and developed more ability to make decisions and express her feelings more easily. Her memory improved, she became more engaged in her university studies and she felt more in control of her life over the course of therapy. These changes she attributed to being able to understand herself more and recognising that she needed to have more compassion for herself and to look after herself more.

*(4) Social impact.*

Chloe did not share with many people that she was attending therapy but found herself reaching out more to those around her for support. She was more open and less guarded with her friends about her struggles. Chloe said in her first change interview “I can actually express myself more... I’ve actually taken that step to tell people... I’m actually feeling not that great... and actually getting and seeking support from other people... I could never have done that without counselling.”

## Follow Up Reviews

### **Analysis of therapy and change after six months.**

#### ***Six month follow-up change interview.***

Chloe attended a six-month follow-up Change Interview with Dr Wills. She said, “I was doing really well and then my boyfriend came over.” Steve had arrived in Australia three months ago and Chloe was struggling. “I’ve just come completely backwards... it’s like I’m sabotaging it.” Chloe had lost confidence in her ability to stand up for herself

he’s a little bit controlling... if I say anything wrong... [worried] he’ll leave me or something... I’m finding it really hard to adjust and he’s there constantly all the time and I’m trying to be good, trying not to show that I’m depressed or anything like that... but it’s just really hard to keep that whole the whole mask thing going, the whole persona going for that whole time... he isn’t working at the moment... I’m studying a lot of the time... it’s a bit difficult with him just being there.

Chloe was struggling with her studies also. “Nutrition... it was just a large amount of information that we had to learn... I knew that I had to look at it but something in my mind was just saying you can’t do this, there’s no way that you can learn that...” In her exam preparation

I actually left it to the last minute... it's just because of my self confidence... I didn't have that thing to get it done... I sat in the exams going... [I] so could have known this but I just chose not to.

***Client analysis of change at six months follow-up.***

Chloe reiterated that she had found the counselling “really good... really helpful. Just made me realise how much I wasn't realising... how I wasn't aware of what was going on.” However, she felt she would “like maybe one a month kind of follow up... just to prevent myself from going backwards.” Since her boyfriend had arrived she felt “I'm going backwards a bit... I noticed a lack of confidence,” which she attributed to her current circumstances:

a lot has happened in six months. I'm still depressed and all sorts of things going on... I know how to deal with them more... but I still have those tendencies to sabotage myself... it was a lot worse back then... oh heaps better than I was... I can see the end of the tunnel it's just not reachable at the moment... whereas when I first came here nothing was reachable.

Chloe reported, “I've been social, more in control, more self respecting as well. I'm still trying to bury myself under study and things like that.” Dealing with issues from her past “understanding how I react to other people because of past events that have happened in my life” and working within her spiritual beliefs again were raised as important aspects to the counselling. “I was able to deal with a lot of my spirituality issues as well... that was a big thing... it was just amazing seeing that... and unblocking that.” In addition, Chloe found it important working with “issues with relationships, with my father separating and attachments issues with partners... also with understanding what had happened to me as a child abused by a cousin... that has sort of affected my sex life.” Despite finding some of the issues raised painful, Chloe explained that there was “nothing hindering at all...” and she would have like more sessions.

### **Analysis of therapy and change at 6 and 12 months post-therapy.**

#### ***Measures of client change.***

Throughout therapy, Chloe's depression levels steadily decreased. However, at the six-month follow-up interview her depression scores on the BDI-II had almost returned to pre-therapy levels, a relapse Chloe attributed to her boyfriend now living with her. After twelve months Chloe retook the inventories but was not reinterviewed. By that stage, her level of depression was minimal according to the BDI-II and within normal ranges on the DASS. See Figure 9.2.

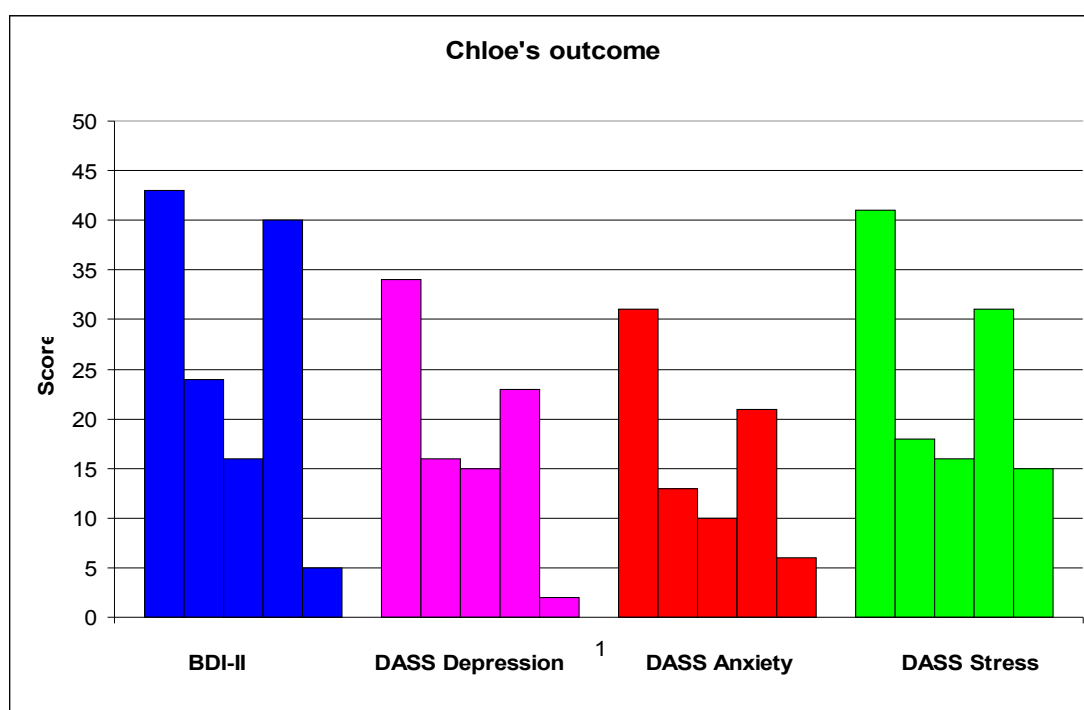


Figure 9.2. The BDI-II, DASS scores for Chloe at the screening interview, after Sessions 6 and 12, and at 6 and 12 month follow up.

#### ***Profile of Mood States (POMS).***

At the conclusion of every second counselling session, Chloe completed a POMS inventory. Figure 9.3 graphically represents the shifts in mood states during the counselling period and at six and twelve months post-therapy. As depression was the main focus of this research, I will only comment on that subscale. It is interesting,

however, to note the movement of the other mood states in line with the depression subscale. There appears to be a consensus across the other inventories that Chloe's reported levels of depression decreased at sessions 6 and 12. However, according to the POMS scores there were fluctuations in her levels of depression over the course of therapy. Despite a return to near pre-therapy levels 6 months post-therapy, attributed by Chloe to difficulties she was experiencing while living with her boyfriend, Chloe's depression levels were at normal levels at the 12 month follow-up.

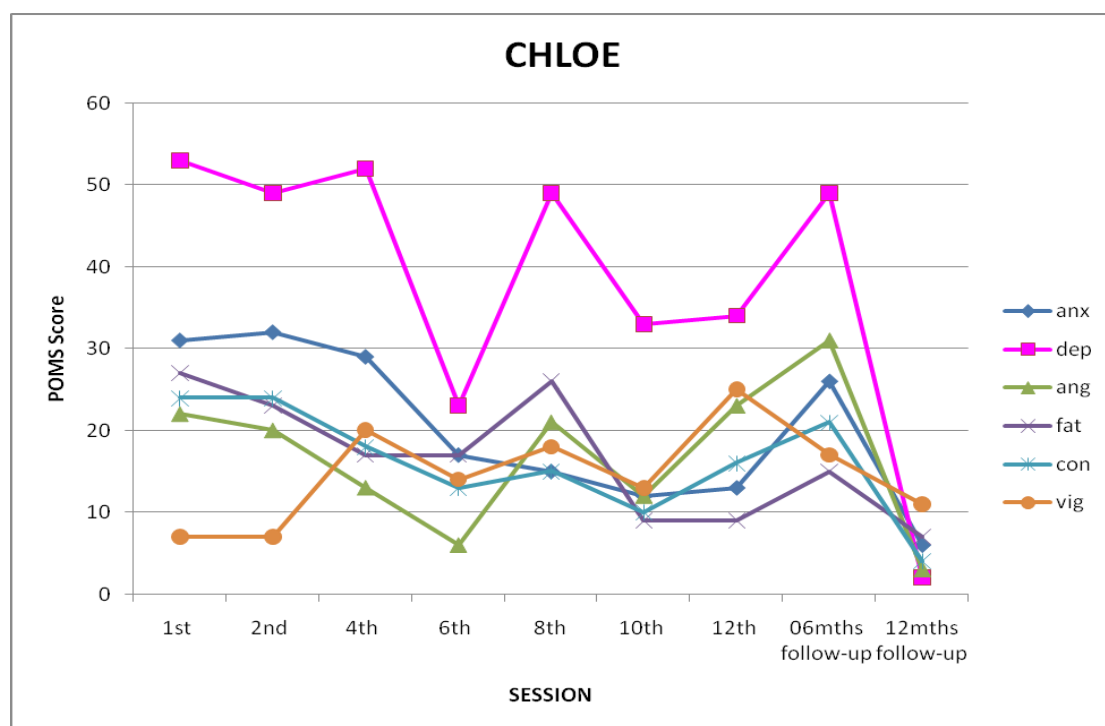


Figure 9.3. Profile of Mood States (POMS) scores for Chloe.

### ***Concern ratings.***

In Chloe's screening interview, she had listed a set of concerns that she wanted to deal with in therapy. Table 9.10 tracks the changes in her concern ratings for sessions 4, 8, 12 and at the six-month follow-up. Chloe's concern ratings for her depression remained fairly constant throughout therapy with some reduction by session twelve but a slight increase again at the six-month follow-up. This appears to be the general trend for most of her listed concerns. The most marked reduction in level of concern

was in relation to her eating. Her rated concerns about lack of confidence, expression of her feelings and feeling in control also reduced. All the concerns she listed were extremely important to Chloe. According to these reported ratings Chloe attributed changes to therapy. In addition, she was surprised in the changes to her confidence levels and the expression of her feelings but expected a change in feeling in control. Chloe found this form extremely confusing to complete, especially the statements about whether the change was expected and whether the changes were likely with or without therapy. It is quite possible these reported rankings on those two scales may not correspond to her true judgement of attribution.

Table 9.10. Concern ratings\* for Chloe during counselling at 6 month follow-up.

Concerns	Before Therapy	At Session 4	At Session 8	At Session 12	At 6 month follow up	Change was: 1 expected 3 neither 5 surprised by	Without therapy: 1 unlikely 3 neither 5 likely	Importance: 1 not at all 2 slightly 3 moderately 4 very 5 extremely
1. Constantly worry	7/7	7/7	5/7	5/7	6/7	3.5/5	2/5	4.5/5
2. Depression	5/7	7/7	6/7	5/7	6/7	3.5/5	2/5	5/5
3. Anxiety	7/7	5/7	4/7	3/7	4/7	3/5	2/5	4/5
4. Confidence	6/7	4/7	4/7	3/7	7/7	4/5	2/5	5/5
5. Eating	6/7	5/7	2/7	1/7	4/7	3.5/5	2/5	4/5
6. Interest in uni	7/7	5/7	5/7	5/7	5/7	3/5	2/5	4/5
7. Memory	7/7	5/7	4/7	4/7	5/7	3/5	2/5	4.5/5
8. Making decisions	7/7	6/7	4/7	4/7	7/7	3/5	2/5	4.5/5
9. Expression of feelings	6/7	6/7	4/7	3/7	5/7	4/5	2/5	4.5/5
10. Feeling in Control	7/7	5/7	5/7	3/7	7/7	2/5	2/5	3/5

Note: \* scale of 1 being not at all concerned to 7 for maximum possible concern.



***Personal descriptions.***

At the screening interview, Chloe described herself as bubbly, confident on the outside but not on the inside, friendly, loving, caring and always put others first. After session 4 when Dr Wills asked if she would still describe herself that way, Chloe explained,

I'm really a very bubbly person but on the inside... very confident on the outside but on the inside not confident at all... there's a lot of stuff going on in my own world that I don't let out... I quite like those things but I don't like [that they] are at odds with that persona... I don't like who I am... I like who I appear on the outside and yes it is protective but... I believe that if I try to deal with the things I am going through it... I can finally join the two links together and continue to actually express my happiness in the real person that I am rather than as a mask.

After session 8, Chloe described herself as “exactly the same” as she had originally in the screening interview. However, “I do feel like I'm starting to slowly look out for myself... in the exams I allowed myself a few breaks... rewarding myself... before I wouldn't have done that. I would have gone ‘no, we have to keep studying, keep going.’” At session 12, Chloe again felt the descriptors were accurate but “I'm reaching out to more people... I feel like I can be more confident to speak to people... I'm starting to look after myself a lot more now.”

At the six month follow up Chloe explained,

I'm an energetic, loving person but underneath it I suppose I have a mask... for everyone else I've got this mask that's not unhappy... [underneath] disappointment with guilt and feeling scared and really lacking in self confidence... I am a happy and bubbly person if I am alright but it's like at the moment I've got a few faces going on... I sent a message to my friend before saying I'm just sick of, just over thinking

and feeling... she's like 'you're fantastic, you have an infectious laugh and everyone loves you and blah blah...' and I was like oh... see everyone sees that but that's not who I really am... people see me as a happy, loving, positive person.

In relation to putting others first, "yes it's exactly the same I always look out for other people. If someone else is in trouble I will call them... so yes, I'm worried about everyone else."

***Measure of the working alliance.***

For the working alliance, which integrates the relational and technical aspects of counselling and is a significant predictor of outcome, Chloe reported maximum scores throughout the counselling period (see Table 9.11). Chloe felt supported, felt heard and believed that we were well matched. In session 4, when I said to Chloe "you aren't alone in your grief" she responded "it's quite nice that you feel what I'm feeling..." During her Change Interview with Dr Wills, Chloe said "I can tell her about spirituality... Melissa's the first one I can really talk to about it... we're just very connected... finally have someone who is so perfect for me right now... just great." In addition, at the end of session 7, Chloe spontaneously jumped up out of her seat and hugged me. Chloe acknowledged "she's sensitive... very attuned, very, very attuned... she's a lovely, lovely woman... she shows that she cares."

I also felt a reciprocal appreciation for her and found it easy to acknowledge her strengths when she struggled to locate them for herself. I am of the opinion that this strong bond between us enabled Chloe to access her internal processes deeply, and allowed her to navigate successfully through the aspects underlying her depression and achieve a positive outcome.

Table 9.11. Measure of the working alliance utilising the Working Alliance Inventory - Short (WAI-S) form.

	Session 4	Session 8	Session 12	Range
<b>Chloe's evaluation of working alliance Raw score</b>	84	84	84	12 - 84
<b>As a % of the total score possible</b>	100	100	100	

## Therapist's Analysis of Chloe's Therapy Process

### Chloe's core emotion scheme.

Each person's depression needs to be understood from the perspective of his or her individual experiences. Chloe suffered as a result of abandonment, isolation, unresolved loss, and lack of connectedness. An important goal in PE-EFT is to help clients access and process their emotions to change problematic emotion schemes and construct new meaning. There are potentially many such emotion schemes operating within an individual, but hypothetically only a single core emotion scheme. By deepening a client's experiencing within session, changes in the core emotion scheme can potentially lead to more effective emotional processing and ideally change occurs not only in the way in which clients construct their sense of self but also as a change in this underlying self-relevant cognitive-affective structure. I used the template below in Figure 9.4 to identify the core emotion scheme for Chloe.

According to Greenberg and Watson (2006), depression is often confused with sadness but "sadness is not depression" (p.61). Sadness can be an adaptive primary emotion triggered by loss, but can become maladaptive when the grief reaction does not resolve or becomes complicated by other life issues. In addition, the expression of anger can often open up into sadness. Some clients with depression may fear expressing their own anger as it may lead to abandonment. Chloe's predominant primary emotion is sadness. Her earliest recollection of feeling abandoned was as a small child when her doll was taken and she was teased. This sadness pervaded her life

but she also often experienced secondary reactive anger or rejecting anger (Pascual-Leone & Greenberg, 2007) as a means of pushing people away.

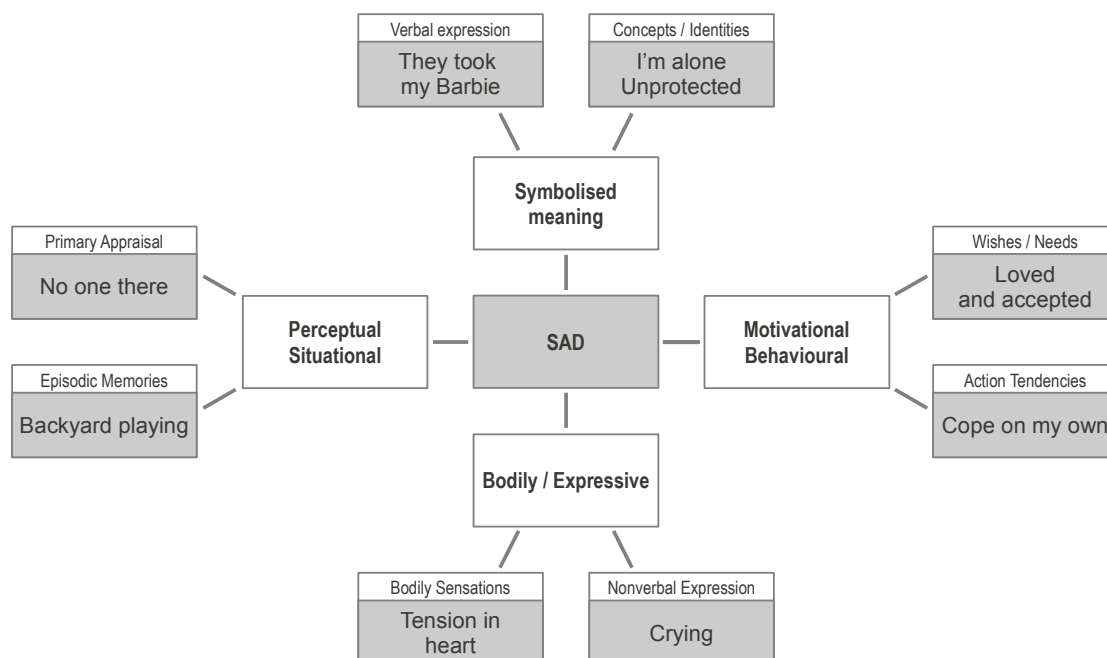


Figure 9.4. Chloe's emotion scheme.

### Therapist reflections on the application of PE-EFT principles and the process of change.

Chloe's self-interruptive processes pervaded our work together, but I did not correctly identify these. Timely PE-EFT supervision around the case formulation would have assisted me to correct this oversight. The subsequent analysis of Chloe's sessions highlighted for me the insidious nature of those self-interruptions. In her first session she told me that she had been hesitant to attend. I naturally thought that this was to be expected but now in hindsight see it might have been an expression of her self-interruptions. Another instance of Chloe's self-interruptions was her inability to access her primary anger even in her imagination. Despite accurately identifying a self-interruptive split in session 3, I overlooked its significance in our overall work together. I also missed suggesting two chair work for a self-interruptive split in sessions 6 and 12. Chloe's stuckness I accurately took to be a pattern in Chloe but I

didn't identify it as a self-interrupter. I now consider Chloe's procrastination and disappointment in herself to be self-interruptive mechanisms for Chloe.

In the focusing in session 4, Chloe symbolised the struggle between the desire to freely express herself (the little white diamond) and the need to contain her feelings (the black box). This symbolically represented the source of some of her ongoing confusion. I recognised that it was important for Chloe to feel accepted in order to feel safe enough to let go of the black box, which held her feelings. Ultimately this could lead to her feeling less confused, and in the meantime she needed control in her life to feel safe, because many aspects of her life were out of control.

Chloe's modes of engagement as highlighted on the Experiential Therapy Session (ETS) Form (Elliott, 2002a) tended to be internal and somatic. She suffered from a number of chronic conditions, such as vestibulitis, irritable bowel syndrome, endometriosis, and polycystic ovaries that have psychological and emotional components. Her illnesses may have given her a mechanism for getting her needs met. Her anorexic symptoms also were a means of holding unbearable feelings at bay (Dolhanty & Greenberg, 2007). Chloe was able to readily access and identify her emotions, especially her sadness, and despite finding anger difficult to express she was able to recognise its presence. Nevertheless, whilst Chloe presented as someone who was able to get in touch with her feelings quite readily, she did so in a way that accessed only the secondary maladaptive ones and she struggled to gain access to her more painful primary ones. Thus, despite her ability to experience quite high levels of emotionality she still managed to distance herself from her primary emotions and experiences.

Chloe was exceptionally adept at turning inward, attending to and examining her internal experiences. In the first few sessions I was able to mobilise this natural skill of hers to help her reprocess some of her traumatic experiences, and we used the focusing as a main means of processing her experience. She was articulate and openly curious but needed to control the situation. Her trust of me grew but in many respects she was leading the process. The focusing was comfortable for her and she discovered this was an effective means for her to work through many of her concerns. Chloe had a well-developed ability to self-reflect and would take the understandings she had in our sessions and consider them outside of session, although she struggled at times to

translate those understandings into action and would regularly arrive at sessions feeling overwhelmed. However, she did report being able to ask for more support from her friends and was socialising more.

I believe I was empathically attuned to Chloe's experiencing in each session and was able to enter her world by resonating with my own experience, sorting through what was presented and attending to what was most salient. However, I was perhaps too immersed in her experience and not able to distance myself appropriately in order to view the overall work more objectively, and thus missed the most salient overarching presentation of self-interruption. I collaborated well with Chloe and was very mindful of the importance of that collaboration. Her trust in people had been significantly affected by her caregivers, and I felt that developing an ongoing genuine, caring relationship was paramount to our work. I believe I attended to Chloe's micro-processes consistently, appropriately and creatively, and I facilitated her process through the tasks confidently on all occasions despite the process stalling on two occasions because I had overlooked the self-interruptive aspects of the work. Chloe always left a session with a sense that something had shifted and a sense of calm with which to face the world outside, and I consider that her self-development was made possible because of my ability to support, reflect and promote new meaning for her. She began to develop inner strength, agency and empowerment. Overall I believe I carried out the PE-EFT principles capably and proficiently.

As one of Chloe's main expressions was confusion I suspect that I too was involved in a parallel process of confusion. I was unable to take an overall perspective of my work with her and found that I was dealing with each session in an isolated fashion. However, I believe that when I work with what is most salient in the present moment for my client, in a process-orientated way, my client will present and work with whatever is most important to her, and there are various ways of accomplishing that process. The appeal of PE-EFT for me is that it provides a framework of *how to* work when a particular marker appears. The idea that the person-centred approach is effective but not efficient comes to mind. However, following the tasks prescriptively is not the only way to successfully navigate a person's experience.

Of all the tasks I have found the self-interruptive split the most difficult to identify and enact. So in 2010, I took a four day EFT workshop with Les Greenberg, in

Toronto, Canada, with the very deliberate intention of understanding and becoming more competent at undertaking the self-interruptive two-chair task. I believe I achieved that goal.

**Overview of therapy process and outcomes.**

Chloe was a particularly sensitive young woman (see Aron, 1998) who had internalised many negative messages from her difficult childhood experiences and had developed a number of chronic physical conditions. She was surprised that much of the therapy revolved around reprocessing unresolved issues from her childhood and early adulthood, and that she carried a great deal of sadness as a result of the premature death of her boyfriend that had considerable impact on her current relationship. At the completion of her therapy Chloe still experienced distress at times but was more able to manage her emotions and move through the difficult times with more awareness that they would pass. Chloe's depression scores significantly reduced and our work together did result in changes for her. I suspect Chloe would have benefited from another four to six sessions to consolidate and integrate the changes that had transpired over twelve sessions. Greenberg suggests 16 to 20 sessions as a recommended length of therapy (Greenberg, Goldman, & Angus, 2001; Watson, Goldman, & Greenberg, 2007; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003).





## Chapter Ten • Discussion

### Overview of Chapter

This study aimed to further our understanding of ways that Process-Experiential/Emotion-Focused (PE-EFT) psychotherapy can assist young women dealing with depression. The chapter that follows reframes the research questions and discusses them in the light of both client and therapist understandings of the therapy. I use a somewhat modified concept of the *emotion scheme* and its constituent elements, as a means of discussing my results. I then make comparisons between the findings in this study and previous research. I also map my findings against a research-based theory of emotional processing put forward by Pascual-Leone and Greenberg (2007), and consider the importance and applicability of my findings in relation to the research-practice gap. In addition, I present a sequence model for focusing to illustrate the mechanism/s of change that I observed. Finally, I comment on the strengths and the limitations of the project and discuss some of the ethical issues encountered.

### Was there Change Experienced and what Kind?

#### **Clients' perceptions of change as detailed in Change Interviews.**

Each of the four young women identified predominantly positive changes in their lives. For one young woman, Ava, a relationship breakdown, an unplanned pregnancy and a subsequent miscarriage interfered with her progress. But despite this she described her experience of counselling as very helpful and identified positive changes in her life. I comment here on the general themes and include specific examples where appropriate but the interested reader can find an elaboration of the themes in the appendices (Appendix S). The young women reported that there was a decrease in their presenting symptoms. They reported that their experiences of depression were not as extreme and their levels of anxiety had decreased considerably and for Ava had become more manageable. For Chloe her suicidal thoughts had diminished

significantly. All had a sense of feeling better and being more relaxed and Ava and Chloe said a “weight had lifted.”

Several themes emerged from the Change Interviews. In an attempt to remain true to the data the language used in the descriptors was as close to that used by the young women themselves. Firstly, the young women reported an increased inner awareness and acceptance of self. They described an increased self understanding, better inner communication, a decrease in confusion and more compassion and acceptance for self and other. There was a sense of feeling better about themselves and feeling less guilty. Ava came to see herself as “a good person.” Secondly, the young women all felt more confident and happier overall and were able to improve their approach to self-care. This manifested in better eating habits and in being less self critical. Chloe said, “I’ve been social, more in control, more self respecting as well.” Their view of their worlds shifted and they were able to look at themselves in relation to their lives and experiences differently. Chloe reported noticing such changes as “...it’s created a lot more of the awareness of what I was going through and how to look at things differently...” and “I’m starting to understand where the triggers are coming from as well.” Thirdly, there was more understanding of adaptive emotional functioning and they had developed strategies for emotional regulation. Ava commented that “...as I’m working myself up, I stop and go... it’s going to pass... just calm down... and I did! I just felt I calmed myself down.” Chloe noted “I am aware more of my emotions and I can express them and I definitely have a little bit more control over my emotions... they’re not as erratic...”

Fourthly, there were also cognitive changes. They described their thoughts as different and there was an increased ability to rationalise. Katie said, “I can think more logically about things... I have never really understood my thought process...” but now “I just better understand what I am actually thinking...” She described this as “... thinking differently like more positive thinking...” Fifthly, in terms of their own development, the young women said that they felt more mature, less childish and more independent. These reported changes translated into actions such as managing their lives more effectively and being more proactive, “...standing up for myself a little bit more...” For Sarah, listening to her body led her to eliminate binge eating and to better management of her eating.

Lastly, all four women acknowledged improvement in their interpersonal skills. Other than one offer to coach Sarah in reflective listening, I had introduced no interventions with the idea of addressing these issues, though the empty chair and imagined conversations could be understood as practising relevant skills. They stated that overall their relationships had improved with their friends and some family members. They were more social and interacted more easily. Sarah said; “It’s different having to make all new friends... actually been surprisingly easy and I have been having lots of fun...” Consistent with this, Ava also commented “...they’re completely different relationships to what I’m used to... I’ve learnt a lot about myself through them I guess and about how I am through them...” In addition, all of them were able to express themselves more and stand up for themselves more assertively. For Chloe, it had become easier to reach out and ask for help and support, and she was pleased to be “...actually getting and seeking support from other people...” This finding of an improvement in interpersonal skills is corroborated by the PE-EFT research showing that clients made significant improvement in such skills (see Pos, Greenberg, & Warwar, 2009; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003). See section on *Interpersonal skills enhancement and attachment* on p. 376.

#### **Clients’ perceptions of change as identified by personal descriptors.**

As part of the screening interview I asked the four young women to find words to describe themselves (see Appendix T). Despite this being quite a rudimentary method of assessing change it does indicate that many of the personality descriptors identified by the young women were stable over time. The developers of the Change Interview (Elliott, Slatick, & Urman, 2001) from which I adapted the screening interview didn’t suggest a ranking scale for these descriptors but I think it might have been useful if I had included such a scale to somehow quantify any potential changes. Overall the young women viewed the words they had used to describe themselves in the screening interview as still true of them at the end of therapy. However they added some. Generally the young women felt happier and more confident within themselves at the end of therapy. They also reported feeling more assertive and independent. These descriptors are consistent with the themes that emerged from the Change Interviews.

### **Changes identified by therapist.**

It was very evident to me that the changes that the young women described in their Change Interviews were also the ones I had observed. Each woman made differing commitments to the therapy within and outside the sessions. For three of the four young women attending sessions regularly was quite challenging. In addition, they all struggled with being ready or willing to expose their vulnerability but each one showed courage and remained engaged in the process. To me this was evident in their openness to expressing themselves fully emotionally and to engaging in the tasks. As the work progressed I noticed an increasing self-acceptance and willingness to get to know themselves that culminated in an ability to feel more comfortable in their own skins. All four young women initially reported body image and self image issues. All four women became more accepting of themselves and for Sarah and Chloe a more positive body image also developed. Sarah acknowledged at the beginning of therapy that she didn't like herself, felt deeply ashamed and viewed herself as ugly. By the end of therapy she was feeling beautiful on the inside and others were commenting on her external beauty.

The young women also developed a willingness to sit with their emotions both in and outside of therapy. They became able to experience grief and loneliness without always resorting to distraction or self-deprecation. Ava, despite feeling overwhelmed by nausea, the emotion of disgust, was able to stay with the discomfort and experienced a considerable felt-shift and a realisation that she would be okay, that things happened in life and she needed time to heal. Sarah recognised that being busy and processing situations cognitively had been a way of coping and as a result of therapy she now was able to find "my inner voice and being able to sit with it." She learnt how to trust her felt-sense as a useful means of providing information in relation to her eating and interactions with others. In all four there also emerged a willingness to explore rigidly held beliefs, become curious about them, and more able to let go of them and be more flexible. This reduced internal stress and anxiety, resulting in a more relaxed way of being, and in feeling happier and more confident.

Identity formation and individuation are important developmental goals in this age group (Erikson, 1963). As the young women became curious in the exploration of themselves they developed a stronger sense of self. There emerged a readiness to

acknowledge their own emotions and accept themselves, an acceptance that made them happier and more confident. Ava said “I feel better about myself... I’m feeling confident. I feel... I just feel happier, because I don’t feel like I need to be something that I’m not, or trying to be like someone... someone else’s expectation of me.” There was also some integration between head and body rendering the young women more balanced in their views and more accepting of self. This was evidenced in their ability to be more honest with themselves and others.

I noticed their relationships with themselves improve and that extended to improvement in their relationships with those around them. New friendships developed for three of the young women, and an increased ability to ask for support was a significant achievement for Chloe in particular. I became aware of their willingness to journey into their emotional pain and by doing so gain strength and assertiveness and the conviction that their emotions, thoughts and beliefs were valid and significant. Whilst I noticed many similarities in their changes, there were also differences in the degree and types of change because of their style of processing and also because of the life events that were present with them. I will highlight these similarities and differences within the remainder of this discussion.

### **Changes identified by quantitative measures.**

The women’s perceptions about improvements in symptoms were supported by a reported reduction in levels of depression as recorded on the BDI-II for three of the young women. Over the course of therapy, levels of depression as reported on the BDI-II, reduced from severe to minimal for Sarah and Katie, from severe to moderate for Chloe whilst Ava remained in the severe range. A similar picture of reduction emerged for the DASS scores except for Ava, whose score was initially in the moderate range, increased to severe and again returned to moderate. Movement for Sarah and Katie was from severe or moderate levels of depression, respectively, to normal levels and for Chloe the movement was from severe to moderate.

Ava experienced an unplanned pregnancy and a subsequent miscarriage during our work together. I believe these significant events contributed to the lack of reduction in the assessed levels of her depression on the BDI-II and the DASS at session 12. I had offered Ava more sessions, and at the completion of Session 14 there

was finally a reduction in the levels of depression on both scales. She ceased counselling at this point because she was offered full time work and was not able to continue to get to sessions. Despite still being in the severe range for depression on the BDI-II she was only two points off the moderate range. Her depression and anxiety levels on the DASS scale were in the moderate range but her stress level was mild. This was somewhat encouraging and further sessions may have consolidated her change. Overall, however, she reported positive changes in her symptoms on the qualitative measures. At her twelve month follow up interview, Ava had BDI-II and DASS depression scores on the low end of the mild range. In the discussion that follows I will comment separately on Ava's journey because her quantitative scores sit outside those of the other young women.

Katie was very keen to become part of the research and then proceeded to make extraordinary improvements on her BDI-II scores that did at first seem unexpected. I was concerned that she may have "faked bad" and then "faked good" because the statements are so explicitly the symptoms of depression. However, her improved mood was confirmed to me by her boyfriend and her doctor, thus dispelling this concern. However, her physical condition and psychological state did deteriorate further after she was hospitalised.

For all four young women the fluctuation of mood across sessions, as assessed by the POMS, was quite considerable. For example, depression-dejection domain scores over the course of therapy for all young women ranged from scores above 50 to as low as 5. By the end of therapy the depression levels reported on the POMS had reduced for all four and for Sarah and Katie quite significantly. This correlates with the young women's self reports. For Ava her depression scores on the POMS ranged between 47 and 22 and were lower at the end of Session 14 than at the time of her screening interview.

The assessment of depression by the POMS just following a session may reflect a felt-sense of relief or indicate if only a partial resolution had occurred within a session. In retrospect, I think that administering the POMS before and after every session (rather than only after every second session) might have given a quantitative report of more mood shifts and further insight into the process of change.

It is perhaps useful to be reminded that the BDI-II and the DASS are questionnaires that have been developed to assess the probability of the presence of psychological disorders such as depression and/or anxiety, where the POMS has been designed to assess psychological mood more generally and is thus not a diagnostic tool. However I attempted to increase the validity of my study by including this variety of inventories, and this then allowed several comparisons to be made. In other words the three quantitative measures provided a means of potentially validating, through triangulation, the qualitative changes reported.

### **Changes identified through concern ratings.**

Changes were reported by all the young women on most of the concerns recorded on the adapted Simplified Personal Questionnaire (Elliott, Mack, & Shapiro, 1999) in response to my question at the screening interview about the most important issues/problems they wanted to work on during therapy. In relation to the common theme of depression, three of the four women reported reduced scores on that concern, though Chloe did not report a reduction on this scale. Three of the four also reported a reduction in their anxiety, but Ava did not. Sarah reported changes on all the concerns she listed, Chloe and Ava reported changes on all but one item and Katie reported change on four of her seven concerns. The questionnaire included a question as to whether these changes were considered likely without therapy. Mostly the young women expected some changes to occur as a result of therapy and attributed those changes to the therapy. But some changes were not expected, and they were surprised that these changes emerged from their therapy experience.

A critique I would make about the concern rating process was that had I been more precise with the naming and labelling of the concerns the young women brought to therapy, the scaling might have been clearer and more easily understood. Chloe in particular found this questionnaire difficult to follow.

### **Development of skills.**

An interesting by-product of the sessions was the reported skills or tools that the young women were incorporating into their lives. They described the way they now managed difficult situations as utilising tools and reported changed thinking patterns.

This surprised me because I saw increased body and psychological awareness more as a process within therapy than as offering them a tool for managing their distress. Ava found the skill of grounding very useful and stated, “if I have been stressed...take ten, fifteen minutes out and then I sort of try and block off everything, like I think back, calm down, focus on my breathing and I focus on how I’m feeling.” Katie said very plainly “... you have taught me to think differently and I have taken the tools you’ve provided me and will continue to use them throughout my life.”

Sarah stated that “going through the body is really good... it helps to identify... like the specific... like the feeling around the situation or... kind of find a strategy I can use to change it, to find out more about it” and “I’m listening more to my body... when I go to eat it like my body like gets a sensation and I know that I’m not hungry and so I just put it down and don’t eat it... I can follow my body more.” This new skill led her to better eating management. Katie felt that since therapy “I can get over my anxiety a lot quicker... I can think more logically about things.” Ava reported that her new found confidence in herself enabled her to go overseas and to stand up to an authority who wanted her to take medication that she knew was not right for her. Chloe developed skills that enabled her to express herself more and reach out to others when she needed support, which she had not been able to do before therapy. She also developed skills to identify and manage her emotions more effectively. “I’m talking myself through the anxiety rather than just trying to get over it...”

The skills the young women described varied but overall could be described as improved emotional processing styles, and they believed they had developed these by applying what they had learnt indirectly in therapy to deal with distressing life events. This finding was in line with research conducted by Ellison, Greenberg, Goldman, and Angus (2009) that looked into the maintenance of gains following experiential therapies for depression.

### **Concluding that change did occur.**

In summary, the qualitative inquiry methods identified changes for all four of the young women. This was corroborated by the quantitative measures that identified that reduction of the depressive symptoms was identified for three of the four young women after twelve sessions. For Ava, I suspect her depressive symptoms were



compounded by her unplanned pregnancy and miscarriage but a small reduction was observed after fourteen sessions. As general screening tools in identifying the presence and intensity of depression the BDI-II and the DASS are very useful in terms of recognising what the changes are, but the significance of those changes within the lives of these young women was highlighted by the qualitative investigations. Changes occurred in their depressive symptoms, together with changes in other concerns important to them, such as a reduction in anxiety symptoms. Significant but unanticipated improvements in thinking and interpersonal relationships had also taken place. Now that I have identified that some change has occurred, let us turn our attention to how these changes may have occurred and whether therapy was responsible.

### **What was Reportedly Responsible for the Change?**

A number of elements were reported in the Change Interviews as responsible for the changes. These included the working alliance, therapist effects, and the PE-EFT tasks. On the Helpful Aspects of Therapy forms the themes reported were similar and included having someone to talk to, the relationship and the tasks. In the sections that follow I will elaborate on these themes.

#### **Working alliance and therapist effects on client change.**

A very strong theme that emerged when each of the young women was asked in the Change Interview what worked for them in therapy, was finding a relationship where they felt heard and valued. (See Appendix S for an elaboration of the themes).

All four emphasised that having someone to talk to was important to them, as they often did not have people to confide in when raising particularly difficult issues. This finding confirms the importance of forming a collaborative working environment with a strong alliance, a theme that has been well documented within the literature from as early as Rogers (1957) to Norcross (2010) and Greenberg (2011) more recently.

The working alliance in all cases was assessed as *strong* when measured on the three occasions (after session four, eight and twelve) using the Working Alliance

Inventory (WAI-S). Scores for the working alliance ranged from 77/84 (92%) at session four, to 84/84 (100%) by session twelve. Three of the women appear to have experienced a gradual development of the working alliance, whereas Chloe reported a strong rapport already at Session 4. Ava scored lower (77/84) on the WAI-S at Session 4 than did the other young women. This score still indicated a strong working alliance but there was a slight mismatch in which Ava believed this approach might be the best to work through her dilemmas. The trust waivered slightly also but by Session 14, belief in the process, agreement on goals and trust were scored at 100%. Greenberg, Elliott and associates have pointed out that a strong working relationship must be present in order to implement and facilitate the PE-EFT tasks (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2011; Greenberg, Rice, & Elliott, 1993).

Whilst my study did not ask for the young women's perception of my empathy, congruence and unconditional positive regard, these concepts nevertheless seemed to emerge when they described their working relationship with me. They acknowledged that I was interested in what they were saying and that I was not belittling or condescending. It appeared that the women felt I cared and that we had a strong connection. The young women valued that I was empathically non-judgemental, accepting, reassuring and understanding.

### **The PE-EFT tasks.**

The use of the PE-EFT tasks was also specifically raised by the young women in the Change Interview as a factor contributing to the changes they experienced. Once they had overcome their hesitations in participating in a task, the young women readily and even at times eagerly worked within the task or intervention as a means of furthering their understandings of their situations and leaving space for inner realisations. The tasks facilitated shifts in understanding and unlocked previously held maladaptive beliefs and patterns of behaviour. The *focusing* in particular was preferred by the young women as it grounded them, and enabled them to turn inwards and explore their inner world, and to feel less pressured to remain outwardly engaged with me. Ava described the focusing as a sense of slowing down life in her head and reconfiguring her experience so it felt right. Chloe said going into herself and being reminded of experiences from the past that she was not aware were still presently an

issue was extremely helpful. Generally, the focusing task offered them a mechanism to facilitate expression and further understanding that assisted in a shifted awareness.

Research (see Beutler, Machado, Engle, & Mohr, 1993) has shown that some clients who have a predominantly *externalising* coping style (i.e. those who deal with their problematic situations by acting impulsively or excessively) tend to do better with technique-orientated therapies than clients who have an *internalising* coping style (i.e. deal with problematic situations by turning inward and becoming self-critical and depressed). The PE-EFT interventions offer types of interventions suited to both coping styles, and the choice is guided by the recognition of distinctive markers that inform the therapist of the need for that task or intervention. Attention is given to specific client statements or markers that indicate a client is struggling with a particular issue and is ready to work with it. The issue is hot since there is a particular salience about the topic chosen to discuss.

All four young women exhibited primarily internalising coping styles but benefited from both the relational aspects of PE-EFT and the PE-EFT tasks, such as two-chair work. Whilst the chair work was somewhat difficult to introduce at first, all of the young women readily engaged in it once they became familiar with it. Some empty-chair work was also undertaken. I recognise that if I had been able to take the young women on journeys into the relationships with their mothers, over time the empty-chair intervention would have been used more often and could possibly have emerged within the two-chair dialogues or enactments. Acknowledging that there were two parts to their internal dialogues was to the young women quite a revelation. It resonated deeply for them. A recurrent theme of a *head and body* split emerged, which is not surprising considering that all four young women had body image issues and disordered eating patterns and were strongly influenced by what others thought and by images generated by the media. All four young women described the experience of splitting the head/heart and mind/ body as particularly novel and useful. Uncovering and becoming aware of the circumstances or triggers of their discomfort, and having a course of action for working through their reactions, was considered by all four as significant in improving the quality of their lives.

Ava was probably the most uncomfortable with the tasks and was often reluctant to engage in them. She was more comfortable with the focusing but found it difficult

to stay with her deeper underlying emotions as they emerged. She often presented in an extremely anxious state, which manifested in picking at her clothes and pulling her hair. I should have paid more attention to grounding her with the aim of reducing her anxiety and thus assisting her to be more able to process her experiences. I also believe she was very fearful that within the focusing task her feelings of inadequacy would somehow be confirmed. Her fearfulness meant that full resolutions within the focusing were not often experienced.

Ava found it particularly difficult to engage fully in the empty-chair enactment and avoided it at other times as well. Fortunately on one occasion she did achieve a shift, which culminated in her feeling less distressed about her friend and more comfortable when there was contact. "Like for example those role plays. At the start I wasn't comfortable. I couldn't imagine sort of confronting my friend or a partner but it ended up positive... like I absolutely enjoyed it." Once she grasped the concept of the two-chair enactment though, Ava actually felt quite energised and empowered. Another consideration in the work with Ava was that the ongoing negative events in Ava's life meant there was a great deal of crisis management which required immediate attention and took us away from working with the underlying issues. Her ongoing battles with her mother meant that she was still in an environment where her distress was being triggered very often. However, by the end of the fourteen sessions Ava had she was more willingly to remain engaged in the task and sit with her discomfort. Ava's primary means of processing was talking and from a person-centred perspective I often chose to hear her rather than insist on us embarking on a task.

For Sarah the therapeutic process had a cumulative effect. She was unable to determine the exact moment when she noticed change/s but could upon reflection recognise that changes had indeed occurred. Chloe reported that her suicidality had lessened and again we had not worked directly with this issue. The holistic approach of PE-EFT seems to enhance the overall wellbeing rather than targeting particular specific issues or behaviours (Elliott et al., 2004).

### **What worked as reported on the Helpful Aspects of Therapy (HAT) Form?**

The themes that emerged from the HAT forms support the themes that emerged from the Change Interviews. This commonly used brief, open-ended questionnaire on

Helpful Aspects of Therapy was completed by the young women immediately after each session with the aim of pin-pointing significant therapeutic processes that might be associated with change. As well as reporting these weekly, it was used to corroborate change processes referred to later in the Change Interviews. The young women were asked to describe in their own words the most helpful event in the session, and rate how helpful it was, rather than assess the session overall. The strongest themes to emerge were that the young women were helped by having someone to talk to, the relationship with me, and the therapeutic tasks. (See Appendix U for an elaboration of the themes as reported on the HAT form).

*Talking* was extremely helpful for all of the young women. Freely saying what was on their mind and having someone to talk to was important to them. For Ava the benefit of talking freely and openly was reported on the HAT form nine times over the twelve assessments. The *relationship* was described as another helpful aspect of therapy. Chloe wrote “It was very helpful and reassuring to get an outside opinion to why I was thinking and feeling the way that I was.” For Ava the relationship with the therapist was particularly significant. She wrote; “I could tell her all the things... like pressure in my chest was released... and that she really understood me as a person helped me a lot...” This finding is in line with the research conducted into factors contributing to positive outcomes (see Cooper, 2008; Duncan, Miller, Wampold, & Hubble, 2010).

The *tasks* were also reported by all four young women as being helpful aspects of therapy. The *focusing* was a particular favourite. Chloe realised through the task how much past events had burdened her and found the felt shifts and confronting people in her imagination helpful. The *two-chair* enactments were also described as helpful aspects of the therapy. For Sarah and Katie separating body and head/brain using the two-chair enactment task was found to be very helpful. For Chloe, “the conversation between two chairs... debating between my two angers” and “talking between two chairs of male and female parts of myself... understanding that both are important to have and to work together” was extremely helpful. These findings corroborate previous results from research conducted with PE-EFT (see Elliott, Greenberg, & Leitaer, 2004).

The *two-chair* enactments were also described as helpful aspects of the therapy. For Sarah and Katie separating body and head/brain using the two-chair enactment task was found to be very helpful. For Chloe, “the conversation between two chairs... debating between my two angers” and “talking between two chairs of male and female parts of myself... understanding that both are important to have and to work together” was extremely helpful.

### **Interpersonal skills enhancement and attachment.**

As reported above, all four women acknowledged in the Change Interview that there had been improvement in their interpersonal skills despite the fact that this was not a deliberate focus of the therapy. Improvement in interpersonal skills has been documented in the research on PE-EFT. Watson et al. (2003) suggested that the greater improvement in clients’ interpersonal functioning may result from the therapeutic relationship that is modelled, with its emphasis on empathy, acceptance and positive regard (also see Greenberg & Watson, 2006; Pos et al., 2009).

The contact with me provided an opportunity for these young women to develop a different relationship that ultimately may contribute to a more secure attachment style. All four young women had difficult relationships with their mothers, and had emotionally unavailable or absent fathers but avoided dealing with those difficulties directly. Where there had been less disruption to the attachment and more trust in the process, progress appeared steadier. Two young women in particular, Ava and Katie, had very insecure attachment with their mothers, and seemed to be the least trusting and had most difficulty opening up to the therapeutic process. Both were very open in their dialogue, but less open in their ability to *trust the process* of therapy in an experiencing sense and to trust their inner knowing. As the young women were encouraged to express themselves in two-chair and empty chair enactments they possibly learnt tools for successful conflict resolution and negotiation that they could transfer to their relationships outside of therapy.

Where there had been trauma, in the case of Chloe, , the trust in the therapist and the process of therapy was vital and yet was a development that could take time (Paivio & Pascual-Leone, 2010). Interestingly, for this young woman there was an immediate rapport as concluded by her WAI-S score and corroborated by her in her

Change Interview. There was some readiness in her to face the trauma but also avoidance because of its painful nature. She was comfortable in using symbols, but found it hard to assert herself to her perpetrators even in her imagination.

If we turn our attention back to the work of Harter (1998) we may see a conceptual framework for this attachment hypothesis. Harter (1998) developed a model for the development of depression in adolescents in which feelings of inadequacy and lack of support were proposed as developmental precursors to adult depression. As primary caregivers, our parents' role is to provide support and a sense of adequacy. According to Greenberg and Watson (2006), depression in adults seems to build on the feelings of inadequacy and lack of support laid down in adolescence with shame as a core component. Children who experienced loss or neglect often carry the insecurity of abandonment and experience a lot of fear and can become depressed. Greenberg and Watson (2006) state that people with depression lose their ability to tolerate and process their core anger and sadness, and so powerlessness prevails. This difficulty in being able to access and stay with core anger and sadness was evident to varying degrees in the work with these young women.

### **Alternative explanations for the change.**

In addition to the role of therapy, all the young women identified that there were other things in their lives that contributed to change. These other influences included significant relationships outside that of the therapy and some other activities. Sarah reported that her ballroom dancing classes were an important outside contributor to the positive changes she experienced. For Katie it was her boyfriend who had a major influence on her desire to change "I think he is the sole reason why I wanted to get better because I just, I want him be part of my life... I would rather have him than the disorder." Sometimes she would wonder if she was ever going to get over this and in a non-pushy manner he would say "yeah, you will get there." She felt his support was a form of security. Interestingly, after therapy she terminated the relationship stating he had been quite controlling. The DVD of the "The Secret" also had a significant but somewhat fleeting impact on her mood. The positive philosophical approach appealed to her and brought her some happiness. She found that our work together gave her the

basis upon which she could understand the philosophies within the approach. She clarified this by saying, “outside influences like ‘The Secret’ wouldn’t have helped... therapy has just been the main one.”

Ava stated that her friends and sister were important outside supports for her as she journeyed through her therapy. A friend told her that she was much stronger than she realised but she acknowledged “...I really did get a lot of strength from the therapy.” Chloe stated that her main outside support was her boyfriend, but the long distance relationship really stretched his ability to meet her needs. She found the situation excruciating and this in fact compounded the challenge of our work together. It is also interesting that she suffered a relapse when he came to live with her. She felt depressed but could “...see the end of the tunnel.” Fortunately, she found the work we had done enabled her to be more assertive. She said; “I’ve been social, more in control, more self respecting as well.” Despite all four young women having outside interests and other supports it appears that from their point of view the main contributor to the changes reported was the therapy.

### **The Process of Change as Explained by Working with the Emotion Scheme Elements**

It is clear that the young women attributed many of the positive changes they experienced to their therapy. They were further able to identify that the therapeutic relationship and the PE-EFT tasks were the major contributors to those changes. However, I was still curious as to *how* the PE-EFT therapy worked and whether I could comment on *what* the mechanism of change was from the data I collected.

I turned to the literature and the concept of the emotion scheme. Elliott, Watson et al. (2004) stated that PE-EFT primarily involves activating dysfunctional emotion schemes and facilitating more complete emotional and experiential processing so that the client can potentially restructure her dysfunctional emotion scheme and achieve more adaptive functioning. Despite Greenberg’s assertion that his conceptualisation of the emotion scheme is more like a neural network (see Greenberg, 2011), I think the schematic version as depicted in the manual (Elliott et al., 2004) and expanded on the PET website (Elliott, 2004), still provides a useful map for discussing mechanisms



of or for change. So I use the concept of the *emotion scheme* and its constituent elements as a means of discussing my results and to provide an explanation of the process of change as I observed it.

In the PE-EFT manual the *emotion scheme* elements are discussed as having an order of activation during emotional processing in therapy (Elliott et al., 2004). As already mentioned, optimal emotional processing involves all of the elements as it is difficult to process distressing experiences if one or more schematic elements are missing (Elliott et al., 2004). When all are activated in session there is potential for the client gaining a greater understanding of their experience, an understanding that leaves the emotion scheme open to restructuring. The suggested direction of activation moves from the *perceptual-situational* to the *bodily-expressive* to the *symbolic-conceptual* to the *motivational-behavioural* and finally to the primary emotion (Elliott et al., 2004). It is worthy to note that Elliott et al (2004) don't specify the order of work on emotions, which will vary with the task. I also believe that the elements of the emotion scheme act variously as entry points for different clients to allow fuller and deeper processing of the emotion. What I mean by this is that, for example, if a person's processing style is more cognitive, a memory or a self-concept may be explored as a means to enter the emotion scheme. Exploration of the other elements is then required to activate them and to achieve optimal processing of that experience, involving emotional expression, a felt shift and likely restructuring. It is logical in focusing-orientated work to start with the bodily aspect of the emotion scheme.

My observations of the processing of the young women, especially within the focusing task, suggested a slightly different order of processing than that proposed by Elliott, Watson et al. (2004). Figure 10.1 depicts an emotion scheme with a reordering of the sequence (numbered), renaming of some of the elements and the addition of two other elements. I have slightly changed the labels of some of the sub-elements so as to more closely represent the observations of the process I experienced and observed.

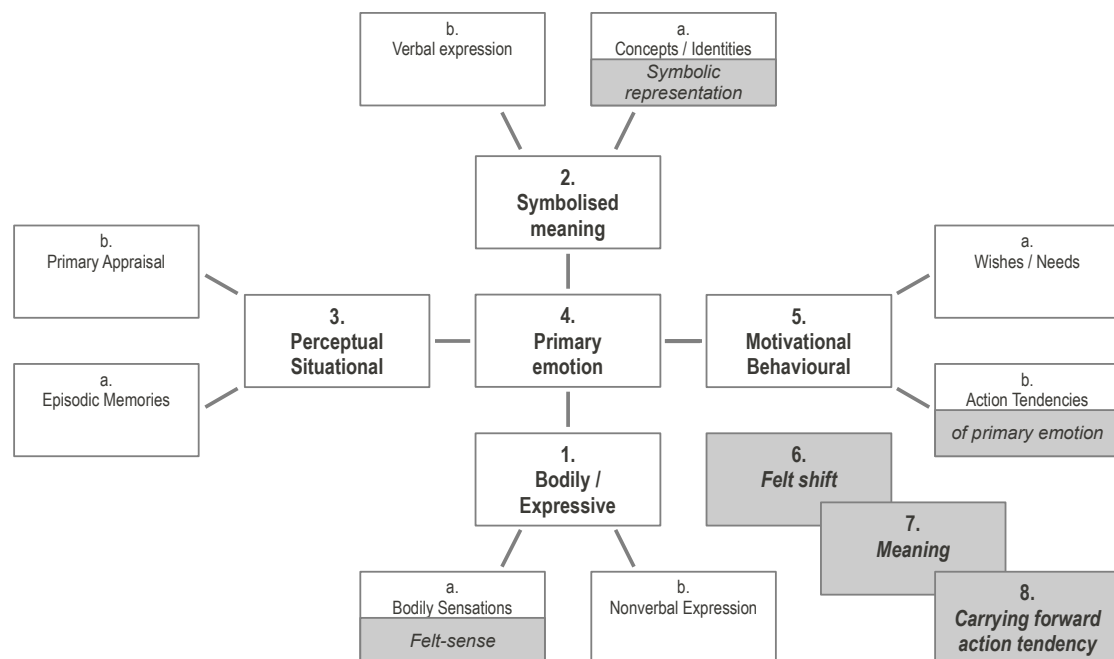


Figure 10.1. Elements of an emotion scheme with proposed re-ordering of elements.

Source: Elliott et al. (2004).

The process I refer to in this discussion is the observed *in session* processing of the young women's maladaptive emotion schemes. In this process, a young woman started with a description of an issue that we explored, for example via the bodily-felt sensations in a focusing. The bodily felt-sense was expressed in symbolic-conceptual terms and the perceptual-situational level was further explored. Once the primary emotion was aroused a link was made to the motivational-behavioural level culminating in a felt shift.

I will explain each element in turn and summarise how I observed each component contributing to the change. Some of the elements are more critical than others in optimising the process of change. I viewed this as a dynamic and often multilayered process where elements moved in and out of awareness to deepen the experience. There was also a movement backwards and forwards between the bodily felt sense, the episodic memory, the aroused emotion/s and the possible meaning

making. The key was to identify all the elements and facilitate processes that permitted them all to become active. The proposed stages 6 to 8 correspond to a recent formulation of advanced client “post-processing” put forward by Elliott (2006) which refer to bodily, symbolised meaning and action tendency emotion scheme aspects.

## **1. Bodily expressive.**

### ***a. Felt-sense.***

All four young women were able to identify a bodily *felt-sense* when directed to notice pressure and tension in their bodies. (See tables in Appendix V). The felt-sense, as previously described, is an important component of the PE-EFT work (Elliott et al., 2004). Identifying the marker, an unclear felt-sense for example, and initiating the task, by directing the client to *clear the space*, created a therapeutic focus. It assisted the young women to work productively with experiencing processes and facilitated them to enter a slightly altered semi-meditative state. I used the focusing and clearing the space, not only as the task for an unclear felt-sense, but also on the occasions when the young women were quite aroused and emotionally labile as it assisted them to ground themselves in the physical sensations within their body. It also provided a portal into unprocessed and unexpressed experiences that are *remembered* in the body (see Rothschild, 2000). The semi-meditative state generated by clearing the space also distanced the young women a little from their overwhelming emotions and allowed them to take an observer role, thus creating a situation where they were less likely to be flooded by memories and potentially re-traumatised. The pace of the exposure to the experience was regulated. I now also realise that it was important to ensure each young woman was grounded in her body. Simple techniques such as breathing and body awareness assist with this (see Rothschild, 2000). Where there was heightened arousal and distress it was evident I had more trouble dealing with their processing difficulties as was the case with Ava.

After setting up the focusing task I encouraged the young women to notice the *tension and pressure* in their bodies as a means of accessing body memories (Rothschild, 2000) that will potentially uncover suppressed experiences that are then able to be processed experientially. I attended to bodily felt-sense in the other tasks as

well as a way of uncovering suppressed experiences with the same aim. Using the felt-sense in this way I believe offers a means of deepening awareness of an experience by accessing often non-verbal or not yet fully spoken or understood experiential information. I drew on my own empathic attunement to track the process through my own felt-sense and to try to guide the young women to their most salient felt experience. Felt-sense descriptions mentioned by the young women in session included pressure and tension in the head, neck, shoulders, chest, solar plexus, constriction in the throat, sensation in the face, feelings of nausea, pressure in the stomach, and dryness in the throat.

According to Greenberg et al. (1993) it is useful therapeutically for the client to develop a symbolic representation for the felt-sense in the form of a label, metaphor or image. The felt-sense experience I suggest is a vital ingredient in the change process. Checking and rechecking back to the bodily felt sense provided an indication of whether the process was partially resolved or fully resolved. A *felt shift*, which I will discuss later, can be an indicator that change has occurred.

#### ***b. Nonverbal expression.***

By bringing attention to the nonverbal behaviours of the women I was able to encourage the young women to take notice of the information they were communicating with their bodies. Attending to the micromarkers of nonverbal expression is a valuable skill in PE-EFT (Elliott et al., 2004). Katie as she sat in her chair in Session 1 appeared child-like and small despite being quite tall, and she was able to recognise that there was power for her in being small and that she believed that people would look after her if she appeared small and helpless. This was a powerful insight for her. In Session 6 she found it difficult to express her anger towards her mother but was able to kick out with her foot toward an empty chair where she imagined her mother sitting. She was even able to push the chair over with her foot. Near the end of therapy her anger towards her mother became more evident and to her more understandable. It was as if the earlier session where she had managed to access a nonverbal bodily expression of her anger later allowed her to be freer in the verbal expression of that anger. For Ava the frenetic pulling at her hair and jumper were strong indicators of how anxious and distressed she was. She was also very angry

but couldn't quite access the anger overtly either. On another occasion she pulled her cardigan around her in attempt to feel safe. Whilst these non-verbal observations are important I placed more emphasis on felt-sense because I observed the felt-sense is a more critical element of the emotion scheme within the mechanism/s of change process.

## **2. Symbolised meaning.**

I conceptualise the symbolic-conceptual element of the emotion scheme as the verbal descriptions of the visual/symbolic representations of the felt-sense that were experienced in session. The verbal expression aspect of this element showed where the client was able to find words for her experience that had emerged in session, words that had been previously unavailable to her.

### ***a. Symbolic representation.***

Each of the four young women was able to symbolise their bodily felt experience to varying degrees (see Appendix V). Sarah and Chloe in particular were able to describe their bodily felt experience in symbols that were then described in words over 80% of the time. For example, Sarah noticed a sensation in her cheeks and a pressure in her chest. She described the pressure in her chest like an "orange rectangle with fuzzy edges." Another example from Sarah involved upper chest pressure being described as a "solid green cylinder" containing words that were "stuck." For Chloe the pressure and tension at the back of her neck and shoulders was identified as a black moulded armour which had been used as protection against the onslaught of her family and school friends. She also said there was black tar covering the positive side of things for her. Chloe at another time symbolised the pressure in her chest with a description of "red with black edges" that took up a great deal of space. This symbol emerged a number of times and seemed to develop over the time of the work. The blackness became a box with red edges with a light in the middle of it, "like a diamond in a glass cage." In a later session she described the sensation in her chest as "an old wooden gate covered in barbed wire that kept people out" but there was a rock-like crystal inside.

I view such body exploration as a very significant means of access to underlying experiential knowledge, and an alternative entry point to purely verbal expression. The synthesis of rational and experiential modes of processing information provides a richer understanding of self and self in the world. Thus the experiential knowledge that emerges by processing bodily felt experiences via symbolic representation is a vital component in the change process. Meaning is created from the dialectical synthesis of language/symbolic representation and inner experience (Watson & Greenberg, 1996a). In the focusing task, I aimed to identify a felt-sense in order to go into deeper processing or understanding, but finding or creating a verbal label or pictorial symbol for the nonverbal felt-sense is an important ingredient in the process of change in PE-EFT. The symbols can be visual or kinaesthetic or even actions, objects or situations. Clients often find it difficult to find words for their experiences or make meaning of them, and symbolising them enhances the potential to make meanings of those experiences (Elliott et al., 2004; Greenberg, 2011; Greenberg et al., 1993).

Fuller exploration of the felt-sense can lead to a *felt-shift* and resolution, which in turn can lead to new thoughts, feelings and actions. This was very evident for the young women who experienced felt shifts in sessions between 50% and 80% of the time. Whilst not everyone has the same natural ability to symbolise their experience in this way, Gendlin suggested that this can be taught (see Weiser Cornell, 1996). I argue that this symbolic representation appears to be an important component in facilitating the process of change.

#### ***b. Verbal expression.***

Symbolic representation in the form of language is informed by cultural and past personal and interpersonal factors (Whelton & Greenberg, 2000). It most often takes the form of verbal statements but can also include metaphorical qualities (Elliott et al., 2004). Each of the four young women was quite articulate when asked to tell her story from a cognitive perspective but there were many experiential elements that were not expressed coherently or understood. Throughout the sessions however they came to find words for the felt experiences and this in turn led to greater understanding. Describing an inner state in words is a fundamental means of symbolic expression, as

is the retrieval of a perceptual experience that has not yet been fully processed. The use of an internal experiential search aids in getting in touch with a vaguely felt meaning that is sensed as important but not yet made conscious (Greenberg et al., 1993). Thus finding words to describe the felt-sense is also a significant component in the change process.

### **3. Perceptual / situational.**

The perceptual-situational element comprises of a current trigger that connects to an episodic memory from the past. According to Rothschild (2000) “awareness of body sensations can be a superhighway to the past, a tool for helping the client connect not only with forgotten traumatic memories but also forgotten resources” (p. 118). I used the current body awareness to allow the emergence of the episodic memories that could then be reprocessed.

#### ***a. Episodic memories and b. Appraisals.***

All four young women were able to discuss a current event that concerned them, locate the bodily felt experience in relation to that current experience, allow an episodic memory to emerge and subsequently reprocess that past event. Sarah and Chloe were able to manage this most of the time in session, Ava sometimes and Katie a couple of times (see Appendix V). The most striking example of this involved the young woman Sarah’s flushing experience, where she was able to use a recent situation when she found herself flushing at her ballroom dancing class as she recalled people looking at her and appraised that they were judging her. She symbolised the sensation in her chest as “an orange rectangle with fuzzy edges”, and found that this appraisal and feeling of being judged was familiar to her. As she focused on the symbol the episodic memory of the punishment circle emerged and she connected with her humiliation and confusion.

Other poignant examples were the trauma repossessing experiences of Chloe. She was sad and disappointed by life and had been let down by people. She described pain in her head and shoulders as a black rectangular shape with unclear edges with a texture of hard dull plastic, and, when asked to focus on the sensation, she recalled the event when she was five and her then eight-year-old cousin rubbed himself up against

and “started to do things.” Her appraisal was that she was alone and unprotected, and in the session she connected with her deep hurt and sense of abandonment.

In getting in touch with their felt-sense and symbolising the sensation by describing it in linguistic or representational terms the young women were able to recall memories that emerged from that bodily sensation and we were able to reprocess these events. According to Hupbach and associates (2007; 2008), retrieved memories become malleable and constantly undergo revision because the process of retrieval and recollection leaves them open to reprocessing or *reconsolidation*. It seems that retrieving memory in this way provides a way of assisting clients to alter and make sense of those painful experiences in order to achieve a sense of acceptance and some wellbeing.

By evoking memories that carry traumatic emotional content and finding symbols for these in a guided therapeutic task such as a focusing, Chloe was able to gain control over her experience and see the experience from a new perspective. Greenberg and Paivio (1997) report that by evoking memories that carry traumatic emotional content and symbolising this in a safe environment, PE-EFT assisted clients to gain control over their experience and see the experience from a new perspective. Symbolising traumatic emotion memories in words promotes assimilation into a person’s ongoing self-narrative (Van der Kolk, 1993). Hurt needs to be experienced and expressed but having it symbolised into awareness is an important step towards this.

I will elaborate further in the next sections how getting in touch with primary emotions and accessing fundamental needs within these memories can lead to greater understanding. The research and writings of Greenberg, Elliott and associates support this assertion (Elliott et al., 2004; Greenberg, 2011; Greenberg et al., 1993).

#### **4. Accessing and expressing the primary emotion/s**

From my observations, once the episodic memory came to mind via the symbolisation of the bodily felt-sense, emotions were often aroused. The emotional expression might not be overt but was acknowledged as felt. Even a welling of tears or a recognition that an emotion was present was sufficient expression. At this point a couple of the women became quite vulnerable and so I saw that affirming, validation and providing



empathic understanding was necessary to encourage them to *stay with* the experience. Staying with the vulnerability and identifying the primary emotions that accompany the vulnerability is important in the process of change. The quality of the primary emotions is quite different from the maladaptive emotions. They are quick to arise and dissipate, with a natural rising and falling in intensity, they feel right for the given situation and have adaptive qualities. Once the primary emotion is expressed there is a sense of relief, a felt-shift, and often a deeper recognition of what has not been fully felt in the past. An opportunity for reflective processing becomes possible. A number of primary emotions may be experienced for any given experience.

Each of the young women was able to connect with her emotions to varying degrees. Secondary reactive sadness was most commonly expressed in the beginning of a session even though anger was often the emotion hidden underneath. This was true especially for Ava and Chloe. Tears would fall as they described their situations. This expression of tears was not surprising as it is considered far more socially acceptable for young women to cry than to be angry (Elliott et al., 2004; Greenberg et al., 1993). Sarah and Katie were more guarded when showing their emotions and did so less spontaneously. For Ava global distress was her predominant emotional presentation (Pascual-Leone, 2009; Pascual-Leone & Greenberg, 2007). For Sarah and Chloe, the processing of their experiences consistently in the manner outlined above, by focusing on their symbolised bodily felt-sense and recalling certain episodic memories, allowed the more adaptive primary emotion/s to emerge (See Appendix V). To highlight this I use the example of Chloe's memory of her cousin's inappropriate sexual behaviour towards her when she was five. She was able to visualise asking adult Chloe to support five-year-old Chloe in a confrontation of telling her mother and cousin what he did was not OK, that he "should have [been] punished... he should be sorry for what he did." Tears fell from her eyes. She wanted "them to listen and recognise and understand what happened and not to laugh." Afterwards, Chloe sighed with relief and reported her inner child was "a lot happier." A felt-shift resulted and a newer understanding of that experience became known to her. I will discuss the concept of the felt-shift later in this section.

Allowing the global distress to become more differentiated into primary emotions is an optimal aim in PE-EFT (Pascual-Leone & Greenberg, 2007), and this study

found that once processing had occurred, access to the primary emotions became possible in more than half the sessions for all the young women and up to ten of the twelve sessions for Sarah (see Appendix V for more details). Fear, anger, sadness, shame, disgust and surprise emerged as the most dominant primary emotions. This accessing the primary emotions as a vital component of the mechanism/s of change is already well documented in the PE-EFT literature (see Elliott et al., 2004; Greenberg, 2002, 2011; Greenberg et al., 1993).

***Emotional arousal, emotional expression and processing styles.***

Before I move onto the next element of the emotion scheme I want to elaborate on the emotional processing I noticed within the work with the four young women in more general terms. The opportunity for giving space, providing explanation, understanding and validation for their emotions was a significant aspect of the therapy for these young women, and I validated emotions generally and encouraged expression of specific emotions within sessions. Interestingly we did not directly ask about experienced emotions in the Change Interviews but spontaneous responses were made in relation to emotional processing generally. For example, "...I can actually express what I'm feeling... I am aware more of my emotions and I can express them and I definitely have a little bit more control over my emotions... I'm talking myself through the anxiety rather than just trying to get over it," "...telling me that it's okay to feel those things that yeah, just understanding that the things that I'm feeling are okay and... it's not bad to feel that way..." and "...this therapy has helped me to feel like, it's ok to feel, it so that's been a big help." A comment was also made that the "techniques... are good... to help bring up those emotions..."

Naturally individuals have different processing styles and can be more or less comfortable with expressing emotion. Not surprisingly, all four young women used various avoidance strategies to hold painful or frightening feelings or experiences at bay. Interestingly, each one exhibited a form of eating disorder ranging from overeating as a teenager and bingeing to extreme food restriction. Since the time of my research, two articles have been written specifically on eating disorders and PE-EFT (Dolhanty & Greenberg, 2007, 2009). One striking remark made by Dolhanty and Greenberg (2007) was that, for individuals with anorexia, "feelings are intolerable,

dangerous and to be feared, and must be ‘gotten rid of’ or avoided all together... starving numbs, binging soothes, vomiting provides relief...” (p. 98). They note that attempts at recovery are met with a resurgence of previously avoided feelings and so relapse is extremely common. Dolhanty and Greenberg (2007) wrote “...the wish for recovery and the logic of knowing what she should do are overridden by a desperate sense that ‘I’d rather die than feel’...” (p. 98). This was very evident with Katie who connected with her anger at her mother in the later sessions, but shut this down soon afterwards as she directed her energy to being admitted to hospital.

A second article by Dolhanty and Greenberg (2009) illustrated the effectiveness of PE-EFT by presenting a *good outcome* case study with a client who had had anorexia for eighteen months, and suggested three primary markers for tasks are self-criticism, self-interruption or blocking of feelings, and unfinished business with a significant other. When I read these articles I was pleasantly surprised to notice that my application of the PE-EFT tasks had been suitable for working with Katie’s anorexia and that, despite my not paying enough attention to promoting more emotional arousal or using the focus on the food issues as a means of exploring her underlying pain, I was intuitively on the right track but needed more time. For Katie her symptoms were, in PE-EFT terms (Dolhanty & Greenberg, 2007, 2009), her unconscious strategy to avoid feeling. I needed to increase her awareness of her emotions by focusing on bodily felt feelings to bring them into awareness, to utilise two-chair work to assist in softening the harsh critical “anorexic” voice, and to move beyond the idea that she’s ‘not ready to change.’ (Dolhanty & Greenberg, 2007, 2009). Ultimately, the aim is to replace the eating disorder as a means of managing affect with more adaptive emotional responses and to develop the capacity to self soothe.

Other avoidance strategies the young women used included valuing thinking over feeling, fearing their emotions were irrational and over concern with others’ opinions. Whilst Sarah and Katie were more cognitively driven and somewhat over regulated their emotions, Ava in particular was able to tap into her emotions quite readily when those emotions were recognised by me as valid and important. Katie had a more somatic representation of her emotions and was less able to express her emotions in session. She presented and told her story in a detached, story-telling fashion, and at times had little insight into her history and expressed little emotion. She did however,

near the end of therapy get in touch with her despair and some primary anger. Chloe and Ava perhaps under regulated their emotions and found containing their emotions the challenge. Valiant cognitive rationalisations by them did not render adequate regulation. Working with their emotional responses to various situations really supported them to feel more comfortable with the idea that emotions held important information to which they needed to pay attention (Elliott et al., 2004; Greenberg, 2002, 2011; Greenberg et al., 1993). In my opinion, the young women were more able to differentiate their feelings into discrete emotions by the end of therapy.

### **5. Motivational / behavioural.**

The motivational/behavioural elements of the emotion scheme include in the motivational domain such aspects as desires, wishes, needs and intentions but also involve action tendencies.

#### ***a. Wishes and needs.***

All four young women at the beginning of therapy tended to externalise their concerns by feeling disappointed if their needs were not met by others, or feeling misunderstood. By the end of therapy all four young women, to varying degrees, were able to communicate their needs more clearly by being more aware of those needs and by assertively articulating those needs and requesting support from appropriate sources. A key element in this was the differentiation of their global concerns to more specific events that were then addressed and reprocessed (Greenberg & Watson, 2006; Pascual-Leone, 2009; Pascual-Leone & Greenberg, 2007).

Symbolising pain and suffering can provide a sense of distance from, containment of, and mastery over, maladaptive feelings and such distancing can also encourage recognition of primary needs and subsequent compassion and empathy for oneself. Symbolisation of pain of loss helps create a distance from it that assists in making it comprehensible. Greenberg and Paivio (1997) state that by symbolising the feeling into language, attention can then be focussed on the need. For example the questions “what do you need?” and “what was missing?” can be answered and such recognition and articulation begins a process of reorganisation. The person feels entitled to the

need, or begins to recognise that they didn't previously feel so entitled and to question why this was so.

It appeared that all the young women were able to get in touch with their existential needs to varying degrees within the processing work. Needs for acceptance, understanding, reassurance, and safety were strong themes from the young women. Within the focusing task when an episodic memory emerged, I would ask "what does little ... need?" For example, when Chloe explained the difficulty she had learning to read and write: "[I] couldn't read or do up my shoelaces and she'd tell me I was stupid... she should've sat me down and taught me," I asked her to have an internal conversation with her step mother. After a period of deep reflective processing I enquired as to what was happening, and she replied, "they're listening to me now... I'm having a conversation with them... I'm telling them what I need." She sat more upright and breathed deeply, and experienced a felt-shift. The pressure in her head and heart was less.

In another example, Sarah recalled in a focusing task her grade six graduation and the failure of her father to attend and I encouraged her to have an internal conversation with her father about what she needed from him and to ask him to tell her he was proud of her. She sat silently as she reflected on this internal dialogue. A little later in the session a further body scan revealed that there was still the sensation of a pressure in her shoulders and chest that she believed connected to her father's absence at her graduation. She now acknowledged she had been upset at the time but had squashed it. She recognised that she needed her father to acknowledge her and say she was beautiful "I think I need him to actually say it."

***b. Action tendency of primary emotion.***

An important premise in PE-EFT is that the expressed *need* and the *action tendency* associated with the primary emotion lead to adaptive action (Greenberg & Watson, 2006). Contacting the fundamental need and realising the action tendency provide motivation and direction for change and an alternative way of responding. From a purely behavioural perspective, an action tendency is the operational definition of an emotion, however from an experiential perspective it is one facet of a complex experience that is laden with personal meaning (Paivio & Pascual-Leone, 2010).

Within the processing of an episodic memory, accessing the primary emotion and the corresponding action tendency associated with that emotion leads to adaptive action tendencies that help organise appropriate behaviour. Often the fundamental need has been suppressed and emerges within the recalled memory. For example, the child accesses suppressed anger at the parent perpetrating violations, or the child experiences sadness at the loss of the parent's attention and support, or fear in response to the danger of being hit or scolded.

Within the focusing task Chloe was able to access primary anger towards her mother for not protecting her from her cousin's inappropriate sexual advances. At different times throughout our work together Chloe expressed her anger through imaginary confrontations with her stepmother, father, mother, twin sister and cousin. She also accessed primary sadness at the loss of her father when her parents separated. Whilst engaging in the empty-chair enactment, Katie expressed her primary anger with a kick towards her mother for not noticing her. The liberation of these suppressed primary emotions leads to more adaptive action in the here-and-now.

#### **6. Felt-shifts experienced by client and observed by therapist.**

Once the client's emotion scheme has been activated and the primary emotion felt, mobilising the action tendency of that primary emotion, full resolution is possible. I found the most useful indicator that a full resolution had been achieved to be the client's experience of a *felt shift*. This may take the form of a bodily felt shift or Ah-Ha experience, or a change in the symbolic representation. This constellation of elements can give us an indication that we have achieved a full resolution of the particular issue the client was working with.

I noticed and recognised the significance of these felt-shifts and changes in the symbolic representation in the sessions I had with the young women and saw the felt-shift as an indicator that a change in understanding had occurred. My observations corroborate the work of Gendlin (1962, 1981, 1996) and Elliott, Watson et al. (2004) that suggests such shifts not only indicate that a shift in awareness has occurred but are quite possibly mechanisms for change. The movement of awareness and symbolisation of the bodily felt-sense through to the cognitive meaning making processes culminating in a felt shift signifies a change in awareness and

understanding. In other words, a full exploration of the felt-sense can lead to a felt-shift and resolution that in turn can lead to new thoughts and feelings. I found that facilitation of these felt shifts in the majority of sessions helped strengthen the clients' sense of self and contributed to a feeling of wellbeing and an unfolding self understanding and meaning. The felt-shift, with its accompanying bodily relief, seemed a peak moment when change and growth were possible. The client often seemed to get a direct sense of authenticity, autonomy, or rightness that could be used to validate choice and responsibility. The awareness that emerged was new, gratifying, and offered a more differentiated and more holistic perspective.

These findings accord with much of the literature on PE-EFT. According to Mathieu-Coughlin and Klein (1984), the client's ability to focus experientially is the main *event* of experiential psychotherapy and "everything else flows from, builds on, is grounded in and validated by the client's capacity for felt referent" (p. 224). Experiential therapy requires attending to an embodied felt sense, symbolic representation and interpreting that emerging feeling in the context of a person's expectations, language and self-concept. According to Paivio and Pascual-Leone (2010), language plays an essential role in constituting one's emotional experience: how one verbally formulates one's feelings also influences those feelings. The more readily a client can *sit with* her experience the greater the therapeutic potential. Greenberg (2011) added emotion to the mix because he was "convinced that emotion was central in therapeutic change" (p. 24), and that change occurred by facilitating an individual's emotion scheme activation in session and guiding the process of that experience.

In my work with the young women I was keen to facilitate body awareness and symbolisation through identifying and exploring bodily felt-sense to assist them to find understanding and meaning. As the therapist, I utilised the felt-sense bodily awareness where possible in all the tasks because it seemed something they could respond to and use productively, and I viewed a change in the symbolic representation as a guide to whether I was facilitating processing of the most salient issue. As a researcher, I was interested to see whether symbolic representation, together with verbal articulation was a key determinant of change. I was interested also to notice whether the symbols were repeated from session to session or were unique each time.

I also hypothesised that if the client/participant noticed a change in the symbol, for example, if the symbol altered slightly or quite dramatically, or disappeared, this might indicate a felt-shift. I have tabulated each client/participant's symbolic representation and felt-shifts in order to identify whether one or both are needed to facilitate change (see Appendix V). From the data I tabulated it became evident to me that not only is a change in the symbolic representation an indicator of change but so is a felt-shift with its emotional release. These components together indicated to me that change had occurred.

### **7. Meaning creation.**

Whilst meaning creation was not a specific focus within the original emotion scheme model it is implicit within the dialectical constructivist epistemology of PE-EFT. It belongs here in my discussion because assisting the young women to make sense of their experiences resulted in a sense of relief from the distress and confusion that not understanding brings. I see meaning as arising from the symbolisation of the felt sense, retrieval of the episodic memory, arousal of the primary emotion, and expression of the fundamental need (see Figure 10.1). As human beings we need to make sense of our experience and everything is filtered through that need for understanding and meaning making.

Meaning is created from the dialectical synthesis of language/symbolic representation and inner experience (Watson & Greenberg, 1996a). We are motivated to seek meaning and understanding of our experiences and ultimately to find some meaning in our life (Frankl, 1959; Greenberg, 2011). This was quite evident in the work I did with these four young women. They wanted to know why they were feeling the way they were and to make sense of their experiences. Greenberg et al. (1993) suggests we can assist clients to find that meaning by "conscious, controlled processing acts to create meaning by attending to and symbolising what has occurred both internally and externally" (p. 57). I encouraged the young women to find meaning by taking them on an internal journey of self-discovery.

I am reminded of the writings of Gendlin (1962) who stated that meaning "...is formed in the interaction of experiencing and something that functions symbolically. Feeling without symbolisation is blind; symbolisation without feeling is empty" (p. 5).



This fits with my observations of the experiences of the young women in therapy. In order to make sense of their worlds, they had previously been encouraged to emphasise the logical and rational way of understanding concepts and to put less value on experiential knowledge. All four of the women were taught to value their logical processing and yet it let them down. Thinking about a solution to a problem didn't resolve their emotional reactions to that problem. They often found themselves slaves to their emotionality.

Often it is difficult to find words for our experiences or to make meaning of them, so encouraging the young women to symbolise those experiences potentially enhanced their ability to make meanings of those experiences. Gendlin (1962) says that we cannot know what a concept means or use it meaningfully without the *feel* of its meaning, its *felt meaning*. He says that without the symbol there cannot be a felt meaning, and without felt meaning, symbols would have no function. Symbols function as markers and depend on felt meaning for meaning but also have meaning in and of themselves. The precious diamond symbolically located in Chloe's chest offered her a representation of her internal strength and brightness. I found that processing Sarah's experience of the punishment circle experience through her bodily felt sense provided her with a memory and an explanation of her non verbal flushing expression of shame.

The young women in this study appeared to demonstrate the innate growth tendency in people as described by Rogers, which according to Greenberg, Rice, and Elliott (1993) relies on awareness and symbolisation of the emotional meaning of experience in order to operate effectively. "People are constructive-information processors continually creating emotional meaning by symbolising inner experience. Attending to inner experience is most helpful in guiding people in an adaptive, self-enhancing fashion... because self-awareness is necessary for any self-regulatory process" (Greenberg et al., 1993, p. 65).

These findings also support Greenberg et al.'s (1993) notion that symbolising emotional experience into words aids in meaning creation. I noticed that for the young women their ability to reprocess emotion by attaching words to feelings introduced new elements of meaning; such symbolisation provided a handle on the feeling and thereby modified it. According to Greenberg and Paivio (1997)

symbolisation promotes the generation of new meaning and a stronger sense of self, and the young women in this study certainly reported they felt stronger within themselves. In naming a feeling an act of separation from it occurs, and a new perspective is possible that may contribute to a new experience of a coherent sense of self. The absence of verbal-symbolic or experiential elements in a person's processing of their emotional experience leads to a dysfunction in that processing of their experiences (Greenberg et al., 1993). This had been quite evident for the young women as they struggled to understand their inner worlds.

My observations in this therapy support the claim that symbolising feelings brings the emotion from the domain of sensation and action into the mental domain and integration of *head* and *heart* can begin (Greenberg, 2002). The young women reported valuing the fact that they learnt to feel what their bodies were telling them rather than blindly letting impulses determine their actions. This seems very much in line with Greenberg's (2002) claim that "becoming aware of and symbolising... emotional experience in words provides access to both the information and to the action tendency in the emotion. It also helps people make sense of their experience and promotes the assimilation of this experience into people's ongoing self-narrative" (p. 60). Such symbolising of emotion into awareness by these clients promoted reflection on the experience to create new meaning and helped the young women to develop new narratives to explain those experiences (Greenberg & Pascual-Leone, 1997; Pennebaker, 1990; Watson & Greenberg, 1996a; Whelton & Greenberg, 2000). Putting emotion into words thus allowed previously unsymbolised experience in emotion memory to be assimilated into their conscious, conceptual understanding of the self and the world, where it could be organised into a coherent story. I found that symbolic representation appeared to be a vital component in facilitating change, and this finding is supported by and confirms the research and writings of Greenberg, Elliott and associates.

Finally, changing emotion schemes involves a number of general factors (Greenberg et al., 1993). The combination of safety and process facilitation offered within the Rogerian principles provides the conditions necessary for schematic change. Further, the therapeutic relationship provides interpersonal safety that leads to an increased processing capacity for the client, which in turn promotes an inward

attending to self-experience. The broadening attentional focus, the facilitation of memory reorganisation and meaning construction, and the provision of new emotional and relational experiences all contribute to the potential for change (Greenberg et al., 1993). The young women in this study all reported that they felt they understood themselves and others much better. This supports the observations of Elliott, Greenberg and associates (2004) who also found a shift in awareness that enables clients to own or accept previously ignored aspects of self and to understand themselves and others more clearly.

### **8. Carrying forward action tendency.**

There is an action tendency associated with the concept of *carrying forward* (Gendlin, 1962, 1981, 1996). The action of carrying forward the implications of the work is where clients move from personal reflection to considering how the change in awareness can be translated outside of therapy (see Elliott et al., 2004; Greenberg et al., 1993). Clients' action tendencies associated with accessing emotion and need can be directed outward and revealed in behavioural tendencies and interpersonal interactions, or the action tendencies can be inner directed and revealed in the interpersonal orientation and treatment of themselves (Greenberg & Watson, 2006). The reporting of more self-care by three of the young women is an example of this more adaptive way of functioning.

The action tendencies arising from emotional processing work with these young women enabled them to be more active participants in their lives and become more empowered. Each of the young women was, to varying extents, able to translate their experiences in session into their world outside of therapy. They reported feeling more mature and became more confident and assertive in asking for their needs to be met. I observed these changes in them and therapy: their relationship to me, and their Change Interviews all supported their claim that their interpersonal relationships improved. The processing with Sarah described above, for example, led to her contemplating having a face-to-face conversation with her father and saying "that's what I need to do." There was shift for her from squashing her needs and wants to having a desire to assert herself and being able to take appropriate action in her life. The three women in relationships were more assertive with their boyfriends.

The research on PE-EFT and depression has already found for adult clients that, in depression, contacting the need and realising the action tendency provide motivation and direction for change and an alternate way of responding (Greenberg & Watson, 2006). For a person with depression “action replaces resignation and motivated desire replaces hopelessness” (Greenberg & Watson, 2006, p. 113). These findings support that research and extend it to the case of at least some young women.

### **Comparisons between the Findings in this Study and Previous Research**

A number of PE-EFT outcome studies for depression were presented in Chapter 4. These comprehensive studies concluded that PE-EFT was an effective treatment for depression for older adults (Goldman, Greenberg, & Angus, 2006; Greenberg, Goldman, & Angus, 2001; Greenberg & Watson, 1998; Watson et al., 2003). The BDI was the inventory used for pre- and post-treatment depression assessment in these studies. The case studies (Goldman, Watson, & Greenberg, 2011; Watson, Goldman, & Greenberg, 2011) presented in Chapter 4 focused on outcome and commented on the reduction of depression symptoms indicated also on BDI scores. “David” dropped from 20 to 0, “Gayle” from 33 to 0, “Anna” from 17 to 0 (Watson, Goldman, & Greenberg, 2007) and “Eloise” reduced from 40 to 0 at the end of treatment (Goldman et al., 2011). Each of the four women in this current study presented with depression in the *severe* range (29 to 63), with their BDI-II scores ranging from 43 to 31. At the conclusion of therapy Sarah and Katie had a BDI-II score in the minimal range, (6 and 3 respectively), Chloe was in the mild range, 16, whilst Ava remained in the severe range, 36 at Session 12 and 30 at Session 14. The minimum range is 0 to 13. As in previous case studies, the BDI-II scores suggest that the PE-EFT treatment was effective for three of these depressed young women. In comparison to these cases my client/participants began with more severe levels of depression, and their symptoms did not reduce to zero as in these published studies.

Whilst this present study corroborated that PE-EFT was apparently an effective treatment for three of the four of the young women according to the BDI-II scores it was too small a sample to offer a definitive answer to the question of efficacy for this

younger population. However, when the broader concept of clinical significance (Kazdin, 1999, 2003) was examined to ascertain whether change as a result of a treatment makes a real difference in the everyday life of these young women, there was some evidence that PE-EFT had been an effective treatment for all four young women. For all the young women including Ava, the changes that were acknowledged by them had practical value, which were indicators of clinical significance (see Chapter 8). For instance as noted in more detail below Ava said she was doing better, was more confident and her relationships had improved. As well, it is important to note that in the outcome research and the case study research described in Chapter 4, the clients underwent 15 to 20 sessions of PE-EFT, while my clients only had 12 and in Ava's case 14 sessions.

The outcome research and the case study research listed above also used a battery of other quantitative or self-report inventories for accessing interpersonal problems, and self-esteem and a symptom checklist amongst others. Overall, the older adults who received PE-EFT showed greater improvement in self-esteem, had fewer interpersonal problems, increased confidence, greater self-acceptance and improved affect regulation (Greenberg et al., 2001; Greenberg & Watson, 1998; Pos, Greenberg, Goldman, & Korman, 2003; Watson et al., 2007; Watson et al., 2003). Qualitative investigations were not carried out except in the good outcome case of Eloise where a post-therapy assessment interview (not a Change Interview) was also conducted (Goldman et al., 2011). Each of the four young women in this present study reported improvements like those of the older groups, but these were described in the context of the Change Interviews rather than on the self-report measures used in the above studies. It can be argued that for young people whose sense of self and identity are just forming these aspects of developing self-esteem, enhanced emotion regulation and improvement in interpersonal skills are even more crucial.

The working alliance, assessed using the WAI-S, appeared to be an overarching factor in the success of PE-EFT in this study, which aligns with research on older adults in the outcome and case studies (Greenberg et al., 2001; Greenberg & Watson, 1998; Pos et al., 2003; Watson et al., 2007, 2011; Watson et al., 2003). My findings support those of these researchers who found that for those clients in the PE-EFT groups it was *both* the relationship and the addition of the specific active PE-EFT tasks

at appropriate moments within the sessions that seemed to hasten and enhance recovery. I am reminded that research by S.A. Baldwin, Wampold, and Imel (2007) found that therapists who formed better alliances also had better outcomes. In my work with the four young women, developing good relationships was not only an aim, but, I believe, a core factor in their positive experience of therapy, and when combined with the PE-EFT tasks potentiated the best outcome possible. For Ava, the process of developing that trusting relationship took longer than for the other three young women.

While this current research offered further support to the claim that the working alliance was an important change factor, it was also evident that *both* the working alliance and the PE-EFT tasks facilitated the changes for this young group as well as for the older adults researched previously. Goldman, Greenberg, and Angus (2006) were even as bold as to state that

In relation to the debate on common and specific factors, it appears from this study that a large proportion of outcome variance is accounted for by the relational conditions. The addition of specific, more process-guiding emotion-focused methods, however, does appear to enhance this effect (p.546).

The issue of maintenance of therapeutic gains then becomes an important question. Ellison, Greenberg, Goldman, and Angus (2009) provided support for the hypothesis that the addition of PE-EFT interventions to the relational conditions of client-centred therapy would lead to increased maintenance of therapy gains (reduced depression) across follow-up assessments at six-, twelve- and eighteen-months. In their study, PE-EFT clients maintained treatment gains of minimal or non-depressive symptoms for a significantly longer period than the client-centred group, and appeared to have more active and effective ways of dealing with emotional distress in the follow-up periods. In the case of Gayle (see Watson et al., 2007), an 18 month follow-up indicated that her changes had held over that time. Each of the young women in the present study also reported better emotional regulation and maintained other improvements in the follow-up periods of six and twelve months post-

treatment. The BDI-II scores at twelve-month follow up follow up were: Sarah 12, Katie 0, Ava 14 and Chloe 5.

In the current study one of the key things to emerge regarding the process of change was that Sarah and Chloe were able to engage in the tasks, when a marker was identified, more readily than Ava and Katie and their sessions seemed more productive and their progress seemed steadier. This was consistent with findings in the Watson and Greenberg (1996b) study which investigated the use of interventions matched to highly specific problem formulations. The researchers reported that significantly deeper emotional and internal experiencing and greater problem resolution for splits and unfinished business was found when interventions were used, guided by the markers, than when splits and unfinished business were attended to by client-centred reflections. These findings again support the concept that specific interventions have a significant role in the change process (Greenberg & Safran, 1987, 1989; Watson, 1996). Sarah said she felt the changes she experienced were cumulative and Watson and Greenberg (1996b) stated that small in-session changes, as well as the ability to symbolize and reflect on experience, appeared to result in intermediate changes that may accumulate over the course of treatment.

Emotional processing abilities seemed to have been an important component in the treatment for the four young women. Despite my not measuring the level of emotional processing, it was very evident to me that for Sarah and Chloe being able to access their primary emotions in processing of their experience was a key factor in their movement towards positive change. This is consistent with the study by Pos, Greenberg, Goldman, and Korman (2003) which explored the importance of early and late emotional processing during the development of treatment, in relieving depressive and general symptomatology, improving self-esteem and interpersonal problems.

This current research provided indirect support for the Pos, Greenberg, and Warwar (2009) model of change in experiential therapies for depression. These researchers found that emotional processing in the working phase predicted reductions in depressive symptomatology most directly and accurately and could predict early gains in self esteem. In their study, increasing clients' emotional processing was found to be directly related to good outcomes in experiential therapy

for depression. Put simply emotional processing is a core change process, and the working alliance facilitated emotional processing (Pos et al., 2009), a finding consistent with this research.

Research into cases of poor outcome concludes that not every client can benefit from short-term PE-EFT treatment, some require longer treatment especially where there is a lack of trust in the process that therapy will be effective, where there is a lack of trust in the therapist or that trust is slow to build, or where effective emotional processing skills and an ability to self-focus need to be learnt (Watson et al., 2007, 2011). In this study, while Ava's BDI scores suggested she did not make significant progress in relation to her assessed depressive symptomatology, the final score was taken in the context of a miscarriage and the loss of a relationship. Ava took longer to form a strong alliance, and found it difficult to trust the process of therapy, engage in the PE-EFT tasks or believe that therapy would assist her. However, Ava reported that she did achieve positive outcomes such as improved ability to regulate her anxiety and enhanced interpersonal relationships. I believe longer treatment would have supported Ava in working through the grief at her loss, and enabled her to consolidate some of the changes she reported in her Change Interview and to achieve some independence from her mother. Whilst Ava's depression scores post therapy were still in the severe range it is useful to look at working with her more holistically and in the context of her experience. She left therapy with skills to manage her emotions more effectively and had gained courage and strength to achieve things that had not been considered achievable prior to therapy.

This study contributes to the current body of knowledge by corroborating the findings of research that the working alliance and the incorporation of PE-EFT tasks at appropriate moments within session increase the likelihood of change for clients. Whilst emotional processing in general, and depth of emotional processing specifically, were not examined as variables in this study, these factors are indicated as important contributing change factors in the positive outcome for clients. This study does contribute to the change process research by looking more closely at the moment-by-moment processes within the tasks, such as the facilitation of felt-sense experiences culminating in felt-shift releases.



## The Pascual-Leone and Greenberg (2007) Emotional Processing model

In Chapter 3, I discussed research conducted by Pascual-Leone and Greenberg (2007), which demonstrated that emotional processing was an important component in the eventual recovery from depression. Their model is depicted in Figure 10.2 and gives useful insight into the findings from this study. All four young women presented with undifferentiated emotional expression or global distress. Chloe and Ava were in a state of high expressive arousal but struggled to understand the reasons why. Their feeling of being overwhelmed and of despair was expressed with tears and crying.

Of the two potential pathways identified by Pascual-Leone and Greenberg (2007) in the process for differentiating emotions, none of the women in this study presented predominantly with *rejecting anger*, a generic, undifferentiated type of emotion, which is characterised by protest and hate, with high arousal and an action tendency of either distancing or destruction. All four women presented with maladaptive fear and shame and experienced themselves as inadequate and isolated, with a sense of feeling “I am bad” or “I am weak,” and action tendencies of closing down or withdrawing. For them enduring autobiographical memories perpetuated these self-concepts. When I asked in the focusing task what they needed, all four young women were able to express their existential need for acceptance and protection. To feel accepted and safe are core needs every child wants from their caregiver.

What emerged next in their process follows Pascual-Leone and Greenberg’s model closely, as they considered they were deserving of such acceptance and protection. Again all four young women were then able to reach an understanding that they were indeed deserving, and subsequently they became more assertive about their needs. For Ava who had become unexpectedly pregnant and miscarried, this was particularly difficult. Yet her determination became very apparent in the year following our work together when she was able to resist the suggestion that she needed antipsychotic medication. All of them became more able to calm themselves when distressed by sitting with their emotional discomfort and reassuring themselves. This was true even of Ava who did not show as much improvement on her BDI-II and DASS scores.

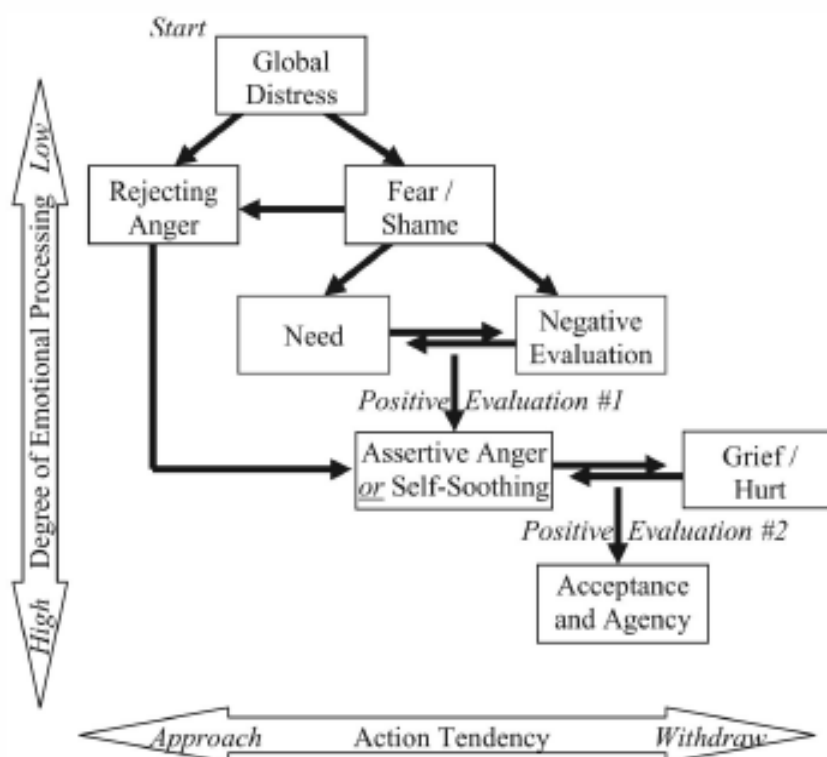


Figure 10.2. Rational/empirical model: A state-transition diagram for the emotional processing.

Source: Pascual-Leone & Greenberg (2007).

According to this model, grief and hurt emerges as the realisation that fundamental needs were not met in childhood. For Sarah and Chloe the liberation that was experienced when deep primary sadness was felt, led to a deeper acceptance of self and agency. For Katie and Ava their maladaptive fear and shame kept them from going fully into their primary sadness. I suspect they may have done so in time. However, despite not fully expressing their deep hurt and grief they did touch on it at times throughout the sessions. It is clear to me that this process required a certain readiness and willingness to go to the depth of their pain. In PE-EFT there is an assumption that when recovering from depression “the only way out is through” (Hunt, 1998, p. 361). For some clients there is a disconnect between current issues and past events, a reluctance to accept that past events have any relationship with the present, and so a

reticence to explore the past. All four women were surprised that their present day issues had some link to the past. For some clients the sense of acceptance and safety created by the therapist and trust in the process may take longer to create and this in turn affects their readiness. This was particularly true for Katie and Ava. However, emotional flexibility was achieved to varying extents for all four of them and they all reported feeling more comfortable within themselves and more able to take charge of their lives.

Pascual-Leone and Greenberg's model seems particularly useful for explaining the course of emotional processing. The model emphasises that *experiencing*, the process of exploring and verbally symbolising subjective internal feelings, thoughts, images, and/or bodily sensations and constructing new meaning, is both a change process and a key intervention principle (Paivio & Pascual-Leone, 2010). It also shows that if the therapist uses *both* bodily felt-sense experiential processing and cognitive information processing strategies, a dialectical synthesis emerges that includes the embodied felt-sense and the interpretative meaning. In a small way my findings support these assertions because by capturing the experiences of the young women in sufficient detail I was able to follow and map their processes along this pathway.

### **Dose-Effect Model of Change**

I chose twelve PE-EFT counselling sessions because this was the number of sessions suggested by Medicare Australia as sufficient to deal adequately with such issues as anxiety and depression. For Sarah the twelve sessions were sufficient but for the other three more sessions would have potentially enabled a more sustained outcome. Sarah targeted her sessions very deliberately and, despite a mini setback six-months post therapy, continued to do well. Katie needed long-term (18 to 24 months) counselling in relation to her eating disorder. Ava needed more time to recover from her miscarriage and more opportunities to deal with the issues around her relationship with her mother (see page 386). Trauma repossessing was a vital component of the work with Chloe, as I considered trauma was a significant contributor towards her depression, and I believe she too would have benefited from more sessions. This small

scale study does suggest that Medicare Australia's most recent session allowance of ten sessions per calendar year may not be adequate in such cases.

## **Therapist Effects, Therapeutic Presence and Relational Depth**

In Chapter 2 I introduced the concept of therapist effects, where the question was raised "are some therapists more effective than others?" In naturalistic settings some therapists have been shown to be more effective than others (Lutz, Leon, Martinovich, Lyons, & Stiles, 2007; Wampold & Brown, 2005) and therapists who formed better alliances had better outcomes (Baldwin et al., 2007). As I was the only therapist in this study it is not possible to comment on this, other than to ascertain whether I had developed good working alliances with the four young women. According to the WAI-S scores I did develop strong working alliances, which potentially optimised the benefits the young women might achieve from counselling.

Concepts such as therapist *presence* and *relational depth* have been proposed as an essential for the therapeutic stance (Cooper, 2005; Geller & Greenberg, 2002; Geller, Greenberg, & Watson, 2010; Mearns & Cooper, 2005). Rogers (1957) asserted that the therapist's ability to be congruent, unconditionally positive and accepting and empathic was necessary and sufficient for psychotherapeutic change but in his later years he began writing about another characteristic that exists which has been referred to by client centred writers as *presence* (Geller & Greenberg, 2002; Geller et al., 2010). Presence has been perceived as a distinguishable fourth condition that provides a foundation for and encompasses all of the three core conditions and is an essential step in building and maintaining a therapeutic relationship (Geller & Greenberg, 2002; Geller et al., 2010).

*Relational depth*, on the other hand, consists of a feeling of profound contact and engagement with a client, where high and consistent levels of empathy and acceptance are offered to the client, and the client experiences receiving that empathy, acceptance and congruence, either explicitly or implicitly (Cooper, 2005; Knox & Cooper, 2010; Mearns & Cooper, 2005). Whilst these concepts were not measured in this study, the four young women said in the Change Interviews that my way of being with them was open, trustworthy, understanding, warm and real. I was experienced by the young

women as genuinely caring and interested in their welfare both within and outside of sessions and I exhibited an earnest desire to understand them and their dilemmas. I attempted to minimise the power differential by being patient and earning the right to relate and sometimes to direct their experience in the sessions. These are factors reported by clients in a study conducted by Knox and Cooper (2010) which explored the qualities of the therapeutic relationship associated with profound moments of interpersonal connectedness, i.e. relational depth. I sought an in-depth relationship with these four young women as a way of respecting their journeys, and tried to maximise their positive change by being as effective a therapist as I could be despite my inexperience. Interestingly, according to Knox and Cooper (2010)

In order to facilitate the emergence of a moment of relational depth, therapists, it would seem, do not have to be perfect – in fact it might be preferable if they are not. More important is their humanness, with all the frailties and uncertainties that being human involves (p. 255).

## **Adherence to the Manual**

I asked Dr George Wills, my original principal supervisor, to assess my competence in following the PE-EFT model by viewing segments of my counselling work with the four young women. (See Appendix V where I have tabulated the results of Dr Wills' assessment and ranked his responses). Dr Wills assessed the entire set of sessions on a checklist for each client. The conclusion I draw from Dr Wills' quantitative analysis is that I was appropriately and consistently emphatic and affirming. I accurately reflected thoughts, feelings and behaviours as they presented and was at all times respectful, authentic, open and genuine. I maintained a safe working alliance throughout and supported the re-telling of traumatic experiences. I nearly always assisted and supported emotional expression that may have been difficult to express. When it came to the process tasks, I facilitated the use of the tasks competently more often than not, although in my work with one of the young women Dr Wills reported that I initiated appropriate focusing strategies less than half the time.

Dr. Wills' feedback was somewhat critical of my chair work and I think this was valid. As mentioned in Chapter 5, I had had about 6 months training in the PE-EFT model at the commencement of the study and, as a therapist in training, still had much to learn. Les Greenberg (2010a) stated in his four day training workshop in Toronto that I attended that it takes up to two years of practice with regular supervision with a PE-EFT supervisor to become truly competent in the model. Whilst I was a novice therapist when I conducted the counselling with these young women, I now continue to apply the strategies discussed here to my current work with my clients. When I reviewed the videos I noted that I was somewhat nervous in front of the cameras and I was certainly very eager to assist these young women. However, when I observed and critiqued my own work with these young women I was pleased to identify a particular style that is still with me now. It seems I am able to be *present* to my clients in a way that puts them at ease and encourages them to share their painful experiences with me and to feel heard and acknowledged. I enter their world gently and with curiosity. In my work now, over six years on and thousands of hours later, I notice I am less eager, more patient, I can *trust the process* more comfortably and I take the approach that *less is more*. I speak less and attend to the content less and follow the process more carefully. I am more unconsciously competent at facilitating the tasks. These qualities and skills I recognise develop over time with experience and supported practice.

## Research-Practice Gap

By undertaking research that was *experience-near* (Schneider, 1999) I wanted to present my research findings in a form that practising therapists can easily use. I wanted to offer evidence-based practice that is supported by *practice-based evidence* and driven by research-practitioner initiatives. Despite the reticence of practitioners to read outcome research it can influence therapeutic practice in a number of indirect ways (Timulak, 2008). Such research can contribute to the therapist's certainty that they are practising within an evidence-based model. This evidence may be communicated at the beginning of therapy thus potentially allowing the client to form realistic expectations about the benefits or limitations that therapy can have. Using

screening and monitoring instruments developed from outcome research can also test the effectiveness of certain interventions or therapeutic approaches and monitor client progression. Applying a routine outcome assessment tool could be considered good practice when evaluating therapy (Stinckens, Elliott, & Leijssen, 2009; Timulak, 2008) as long as the client is in agreement, and does not feel objectified and it does not harm the working relationship.

Process research may be easier for practitioners to assimilate. It can support the therapist to be able to reflect systematically on her own therapeutic practice, which should be an ethical goal (Stinckens et al., 2009). The development of the scientist-practitioner attitude to gathering information about process and outcome can be useful to foster deeper understanding of the therapy process. There is an obvious link between process research and therapeutic practice because of the similarity to everyday practice. The PE-EFT model is a good example of how research studies of therapeutic episodes resulted in a step-by-step approach to working with specific processes in therapy. Such process research informs therapeutic practice. My research adds to the evidence about what works in PE-EFT by illuminating the clients' and therapist experiences within the process of therapy. I also offer PE-EFT practitioners some elaboration of the model for processing the focusing task to provide a way of working with difficult or traumatic memories (see below).

### **Sequence Model of Change for the Focusing Task**

The focusing task I employed as part of processing the four young women's experiences, an elaboration on the task documented by Greenberg et al. (1993) and Elliott, Watson et al., (2004), is graphically depicted in Figure 10.3, which provides a sequence model for this task.

The marker for the task of focusing, typically used for processing an unclear felt sense is broadened here to include the reprocessing of painful or traumatic events. There are a number of pathways within the focusing task. Pathway 1, as depicted as the vertical pathway in Figure 10.3, is the classic focusing pathway as described by Gendlin (1962, 1981, 1996) and later by Elliott, Greenberg and associates (2004; 1993). The sequence of symbolisation of the bodily felt-sense culminates in an internal

processing where there is a sense of easing or a feeling shift and a readiness to apply new awareness outside of therapy. This sequence is well documented elsewhere (see Elliott et al., 2004; Gendlin, 1981, 1996). The second pathway includes the processing loop as depicted in Figure 10.3 and is the extended version I present here.

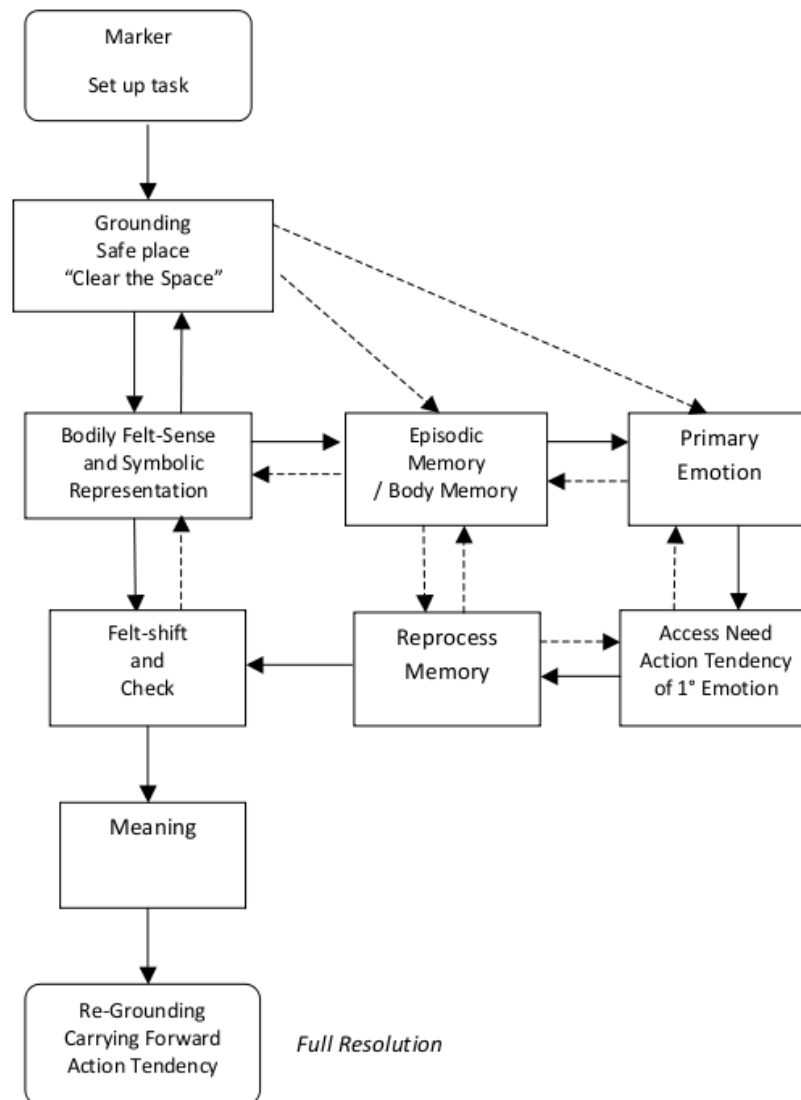


Figure 10.3. Sequence model of change for the focusing task.



### **Development of the focusing model.**

In constructing this model I followed the underlying principles and philosophies within the PE-EFT model but incorporated other processing components informed by trauma theory (e.g. Rothschild, 2000). I was drawn to the work of Babette Rothschild (2000, 2004) who asserts that the body has a memory. As PE-EFT is an integrative model I believe it was quite appropriate to incorporate concepts and philosophies from other leading theorists in the field so as to best support and facilitate our clients' change processes. I also noticed in my work with trauma clients that, if a traumatic memory is accessed within a focusing task via bodily felt-sense in conjunction with emotional arousal and activation of other schematic elements, it is possible to reprocess the event in such a way that the person is no longer plagued by the painful aspects of it and is not *retraumatised* by the re-remembering that occurs when asked to retell their story. If the person is able to express the appropriate primary emotion and articulate their needs within the remembered experience, the associated painful emotional charge is lessened (Elliott et al., 2004; Greenberg et al., 1993; Rothschild, 2000). The event is remembered as having occurred but the emotional intensity is greatly reduced. This reprocessing of the traumatic event is more than a desensitising of that traumatic experience.

According to Greenberg (2011), the degree to which emotional responses become subsequently disorganized and resistant to change by alternative life experiences depends on how early they were experienced, how intensely, and how frequently they and the situations activating them occurred. In some cases the more highly aroused the emotion, the more the evoking situation is remembered (McGaugh, 2000) but in others the traumatic memories are suppressed (Paivio & Pascual-Leone, 2010; Rothschild, 2000). A vital ingredient in the idea that episodic memory can be reprocessed comes from recent neuroscience findings. There is now strong evidence that reactivation of a long-term memory returns it to a fragile and labile state, initiating a restabilisation process termed *reconsolidation*, which allows for updating of the memory (Hupbach et al., 2007; Hupbach et al., 2008). Hupbach and associates showed that at times of reconsolidation, new input could alter the original memory, which was then consolidated, incorporating new material into the old memory. Reactivating a previously "stored" memory can lead to the creation of a new version of

that memory (Hupbach et al., 2007). This, according to Greenberg (2011), suggests that the memory associated with an emotion scheme can be changed by new emotional experience. Reconsolidation is an important mechanism for understanding plasticity, potentially explaining how organisms build on prior experience while incorporating new information (Hupbach et al., 2007).

The model derived from the findings in this study illuminates the current research by Dr Richard Lane (as cited in Jancin, 2011) who claimed in his PhD thesis that automatic dysfunctional emotional processes arising from traumatic childhood experiences can be altered by activating the problematic memories, generating new adaptive emotional responses, and then storing the changed memories in stable fashion. This is what I noticed when repossessing past distressing events, particularly with Sarah and Chloe. I have personally questioned Greenberg in 2010 and Pavio in 2011 as to whether they used the focusing task to process trauma and they responded that they did not.

### **The sequence in the model.**

Identification that a client is ready and willing to work on a painful or traumatic event is the marker for this focusing task. In order to process painful or traumatic events it is essential that the client be equipped to manage this processing (Rothschild, 2004). Part of this management involves clients being *grounded* in their bodies and not exhibiting dissociative symptoms. Grounding is achieved by creating body awareness, noticing your back against the back of the chair, your feet on the floor etc and noticing your breath and which reduces physiological arousal (Rothschild, 2000, 2004). Clients need to be confident that their flow of anxiety, emotion, memories and body sensations can be contained at will and have the ability to move in and out of distressing states. Also creating a *safe place* before or within the clearing of the space process is useful as it acts as another grounding mechanism or anchor the client can return to if she becomes overwhelmed or hyperaroused. For highly traumatised clients developing the grounding and safe place assists them to manage the movement in and out of the painful or traumatic memories. I have tabulated the process see Table 10.1. This process was observed by me in session with the young women and has been corroborated within my subsequent clinical work.

Table 10.1. Sequence model of change for the focusing task.

Step	Description
Identify marker	Unclear felt sense, overwhelm, blank, hyperarousal OR Reprocessing memories of painful or traumatic events
Set up the task	Invite client to participate in task
Grounding	Check client is grounded in their body <b>often</b> throughout the process Particularly important if client is highly aroused or dissociative – highly traumatised clients may find this very difficult  Invite client to close eyes (optional) and to become comfortable in their chair Relax by taking a few deep breathes – notice the in-breath and the out-breath Notice back against chair, legs on seat of chair and feet on floor, hands in lap etc.
Safe place	Encourage client to create an imaginal space or remember a real place where they felt safe, truly relaxed where no one wanted anything from them. Assists in reducing arousal Can be alone or with others Allow time to experience this fully by exploring and describing the scene in detail  Highly traumatised clients may not have a safe place and therefore not get past this stage. Build up slowly with grounding  Can be used for anxiety/stress reduction Gauge level of anxiety/stress on a scale of 1 to 10 with 10 being very high and 2-3 being within normal levels. Ground the client into their body sitting in the chair Ask them to go to safe place. With each breath slowly reduce the anxiety/stress until within normal ranges Breath out pressure and tension and breath in calming and relaxing energy Encourage client to practise regularly and when anxiety or stress increases

Step	Description
Clearing a space	<p>Aims to develop an adequate internal working space for experiential processing</p> <p>Induction of a <i>state change</i> by inviting client to turn inward</p> <p>Talk in a slow and steady voice, pausing regularly to enable client to assimilate the instructions.</p> <p>Check-in with the client to ensure they are following you and ask them to respond verbally or nonverbally</p> <p>Ground if necessary – may need to be done many times especially if client is dissociative</p> <p>Ask client to imagine an opening or a space in their mind / mind's eye</p> <p>Encourage them to allow this space to grow gradually over a number of steps</p> <p>If thoughts, objects or people enter let them move across 'as if on a movie screen'</p> <p>Encourage the space to be so large that reaches the edges of their awareness and then if comfortable go beyond the edges of their awareness</p>
Felt-sense	<p>Facilitate development of an internal felt-sense</p> <p>Encourage the client to tune into their body sensations</p> <p>Scan body for areas of tension or their unclear feeling</p> <p>Notice where the most pressure and tension is located</p>
Symbolic representation	<p>Ask the client to locate and describe the sensation or feeling – it can be a bodily sensation, a symbol, an image, a memory, a hope, a sound etc</p> <p>Offer exploratory questions to fully search for descriptors e.g. where is it, does it have shape, colour, texture, temperature etc.</p> <p>Reflect descriptors back to client – avoiding interpretation</p> <p>Check the accuracy of the symbol / descriptors</p> <p>Ask open-ended questions</p> <p>Encourage the client to be open to spontaneous awareness</p>
Episodic memory retrieval	<p>Encourage client to focus in bodily felt sense</p> <p>Thoughts or memories may emerge</p> <p>Ask client to be as specific as they can about the memory</p> <p>OR</p> <p>Get a sense of how long has the bodily felt sensation been there for?</p> <p>What was going on at that time...?</p> <p>Memory emerges</p>
Primary emotion	<p>Emotion may emerge that can be differentiated into primary emotion by allowing space and safety</p> <p>The emotion that had been suppressed may now be expressed</p> <p>A number of primary emotions may be experienced for any given experience.</p>
Access fundamental need	<p>For example the questions "what do you need?" and "what was missing?" can be used and validate the need to be safe, accepted, loved, cared for etc ...</p>

Step	Description
Action tendency of primary emotion	<ul style="list-style-type: none"> <li>• Anger at violation mobilises fight and defence of boundaries</li> <li>• Sadness at loss mobilises reparative grief by either seeking comfort or withdrawal in order to conserve resources</li> <li>• Fear in response to danger mobilises flight, fight or possibly freezing</li> <li>• Disgust organises an impulse to spit out or reject some noxious experience – often seen with childhood sexual abuse</li> <li>• Shame precipitates a sense of wanting to hide from the scrutiny of others</li> </ul>
Reprocess memory	<p>Imaginal restructuring process</p> <p>Bring in the adult/supportive caregiver/deity/ to advocate for the child and/or</p> <p>Remove the child from the traumatic scene –take the child to the safe place</p>
Felt-shift and Check	<p>Monitor: Move back and forth from the bodily felt-sense or feeling to the thoughts or memories associated with it</p> <p>Notice <i>felt shift</i>: Felt-shifts deepen understanding because of the consonance between the felt experience, emerging symbols and emerging meaning</p> <p>Clients may get a sense of relief, describe an ‘aha’ moment, a deeper understanding</p>
Meaning	Stay with: Encourage client to stay with new or emerging experience and understating
Re-Grounding	<p>Bring client back to their awareness of their body in the chair in the room</p> <p>Invite client to notice their breath – notice the in-breath and the out-breath</p> <p>To become aware of their body in the chair – their back against chair, legs on seat of chair and feet on floor, hands in lap etc</p>
Carrying forward action tendency	<p>Having a deeper understanding of the insights gained by the focusing, the client may begin to imagine what in their life or situation needs to be changed</p> <p>This may take the client further into exploration, offer insight into action strategies or provide a sense of achievement and completeness</p>
Full resolution	May occur in session or out of session

I noticed in my work with the young women and later in my clinical work that processing past painful events through a focusing task might take a number of iterations until a complete felt-shift occurred. There might also be movement backwards and forwards between the elements. A careful check is needed to ascertain if there has indeed been a shift in the bodily sensation or a change in the symbol that would indicate that the experiencing process is complete and fuller meaning has

emerged. At times a process may only be partially resolved within a session (see Elliott et al., 2004; Greenberg et al., 1993) and a fuller resolution may occur hours/days later or in a subsequent session. It is important to re-ground the person back into their body to ensure they are fully present to their current surroundings and thus able to reengage with the world outside the therapy room (Rothschild, 2000, 2004). This re-grounding also ensures that any processing that has occurred can be integrated, makes further meaning making possible and enhances the carrying forward action tendency.

There is a third and fourth pathway in the model I have proposed based on my clinical practice, as depicted by the dotted arrows coming from the Grounding/Safe place/Clear the Space stage on Figure 10.2. When setting up the task in this way an episodic memory or a primary emotion may surface spontaneously. If this occurs it is possible to continue in the processing loop in the clockwise direction shown by the arrows on the model, remembering to ground the client in their body if they become overwhelmed or dissociative.

## **Limitations and Strengths of this Study**

Unfortunately, only four young women volunteered for the research and there were no males in the sample. Therefore, as acknowledged previously, this small sample is of course not representative of the greater population of young people. However, the young women, although all suffering severe levels of depression, were sufficiently different in other presenting issues, individual differences and style of processing to offer an interesting and informative insight into the process of therapy. The young women have been described in relation to their life circumstances, and recording the information-rich cases enabled me to conduct in-depth investigations into their inner worlds and the therapy process. It was not my aim to generalise my findings but there are sufficient themes emerging that may stimulate other research with added refinements.

There is also scope to provide the practitioner with some practical ways to implement PE-EFT tasks in their clinical practice. I had intensive contact with each of the young women which enabled me to develop a therapeutic relationship based on genuineness and trust and also a research relationship that ensured an increased

chance of legitimate responses to the questionnaires and interviews I asked them to undertake. Nevertheless, despite asking questions (both on the HAT Form and in the Change Interviews) about hindering aspects of our work together, I don't believe I searched actively enough for negative experiences within the therapeutic work or for alternative explanations for change. However, having developed a satisfactory level of triangulation I was able to crosscheck much of the data and feel satisfied that the young woman provided a true account of their experiences in therapy and that these were validated by the quantitative measures. I was able to check both factual accuracy and interpretative sensitivity by encouraging the young women to read drafts of the cases and provide input.

It might be considered that I deviated from the standard PE-EFT practice by initiating a task as early as session 1. According to Elliott et al (2004) as a matter of good practice, active tasks are generally not initiated until session 3 or 4. As I conducted an extensive intake interview I had already begun to develop a working relationship with the young women and thus I suggest it was appropriate to implement tasks in the early stages of the work. Active task work continued into the twelfth session and a review of how the therapy was experienced was not done by me. However, Dr Wills conducted a Change interview after the twelfth session as a way of bringing the work to a close. In addition, I only had twelve sessions in which to work with these young women instead of the suggested 16 to 20.

I am hopeful that the thick description within each case and subsequent analyses provide a context so that judgments can be made as to whether findings for these clients can be of use in working with others. Using the design framework suggested by Elliott and Zucconi (2005, 2006, 2010) enables some reproducibility of this research. All the inventories, questionnaires and interview structures are readily accessible. I chose the design specifically with the idea of reproducibility in mind. Whilst the use of the Personal Questionnaire provided data for the concern ratings the guidelines for proper construction of the items were not administered accurately according to its manual. Thus items were stated as problems instead of goals. This is an unfortunate limitation as valuable data was not collected.

I am very aware that I was not an objective observer in this research but I believe I have represented my findings in such a way that the reader can judge the adequacy of

those findings. In my writings and analyses I have been critical of my work both as a therapist and as a researcher and I believe I have highlighted those inadequacies. My choice of Dr George Wills, my original principal supervisor, may not be seen as the most appropriate choice to conduct the Change Interviews because, as my teacher and mentor with an interest in the outcome of this work, he may not have been as objective an interviewer as perhaps might have been required. Yet I chose Dr Wills because not only was he my supervisor, he was also considered one of the most competent and experienced PE-EFT practitioners in Australia before his retirement due to ill health. I recognise that his feedback was both critical and affirming, and value it greatly.

## **Ethical Issues**

There are multiple dimensions of ethical sensitivity when conducting case study research. Such research involves a high degree of moral risk because for a client in a case study her life is being examined (McLeod, 2010). It is not only the client who may be identifiable but also their family and friends. I am reminded of a quote from McLeod (2010) that “ethical research is good research” (p. 55) because it enables all participants, including myself as the therapist to feel safe enough to make a maximum contribution. However, on the other hand I wanted some flexibility that is often present in a naturalistic setting so that the young women or myself didn’t feel encumbered by too many procedures and restrictions.

Intensive research on the therapeutic process can sometimes be more demanding for the client than outcome focused research. Filling out forms repeatedly and being interviewed about the therapy process can be problematic as issues of privacy and confidentiality emerge. The research itself invades the client’s privacy. Clients may feel vulnerable about expressing themselves, as they may not be fully aware of where and in what context this information may be presented, despite thorough discussions. In addition, the amount of information gathered needs to be balanced. Filling in too many inventories may tire a client already vulnerable after a session, but too little information gathered may render the research study lacking in data. I tried to balance



the amount of information I gathered after each session and in the Change Interviews with simplicity and time effectiveness.

In all aspects of this research I followed the Australian Psychological Society Code of Ethics (2007) for research and practice. I was also guided by the National Health and Medical Research Council (NHMRC) guidelines regarding the ethical conduct of research in Australian Universities.

I ensured that I practised PE-EFT within the ethical guidelines of my profession as a psychologist, and that the consent of my participants was informed and ongoingly verified. I set out to avoid harm and implement moment-by-moment ethical decision-making by checking in and ensuring that each young woman felt comfortable enough about completing the inventories, and by requesting Dr Wills to ask them how their experiences of counselling had been for them. I endeavoured to keep the research as collaborative as possible. Fortunately all four young women decided to remain within the research and did not wish to withdraw. Had one of them wished to terminate the research aspect of the project this would not have affected their therapy as I would have continued to counsel them. The fact that none dropped out of the research might indicate that I had succeeded in my endeavour to support the young woman adequately through the research aspects of the project.

Another means of ensuring my practice was ethical was partaking in researcher reflexivity and supervision. I sometimes was aware that there was a vested interest for me that these young women progress in a manner that was supporting a positive outcome. As a therapist I had a duty to the client, but as a researcher I had a duty to collect data and make a contribution to professional knowledge and understanding. I was aware as I was analysing the data that I needed to take each piece of disconfirming evidence and place as much significance on it as I did on the confirming evidence. Supervision reminded me to put the needs of my clients before the research. At times this created a tension in me but it was clear where my focus needed to be. I was mindful of the relationship I had developed with these young women and they were for me far more than sources of data. I have attempted in all instances to be transparent with the young women about the ethical procedures and have followed that through by the documentation of those procedures in the write up of this thesis.

I felt it was very important for me to be respectful, uphold confidentiality and privacy and be non exploitative. It was particularly important to de-identify each of the young women to maintain confidentiality. I changed their names, their profession, family details, and health issues but I wanted to keep enough of the essence of each young woman alive to make their story authentic and vivid. In the writing process I wanted always to keep each of the young women in mind as the readers of this work. They read drafts of their cases and so I feel confident that I have not revealed things that they were uncomfortable to share. I also agreed with my supervisors that some sensitive material was drastically altered or removed entirely for ethical reasons, even when this was material that was of great interest to me as a researcher.

An important ethical and design question arises. “Should the researcher also be the therapist?” In a purely positivist paradigm it might be confounding to have the researcher as the therapist but as this was a professional doctorate aimed at looking at change processes within a therapeutic context the therapist becomes an integral part of that context. In this case it is actually appropriate for the researcher to be the therapist. The therapist reflections are an important part of the investigation and are more accurate when the therapist is also the author. As the therapist I bring an embodied knowing of the process of the therapy which enriches the insights rather than reducing them to implementation of certain tasks. This research is contributing to practice based evidence from a collaborative subjective stance and not a purely objective one.

Having attempted to ensure ethical practice throughout, the concept of *deference* did occur to me. Deference is commonly defined as “the submission to the acknowledged superior claims, skill, judgment, and so forth of another person” (Rennie, 1994, p. 428). Being deferential to the therapist has been suggested as the client’s way of protecting and fostering the alliance. I certainly recognised there may have been times when the young woman deferred to me but, on the whole, the fact that they could say they weren’t comfortable about participating in the PE-EFT tasks indicated to me a healthy ability to resist me. More subtle deference may certainly have been present however but I had no way to measure or identify it.

Despite the focus on this study being on young women with depression it is evident that these young women experienced mixed anxiety-depression and also

eating difficulties and/or disorders. Whilst it was beyond the scope of this project to adequately address all these concerns and it was fortunate that underlying principles of PE-EFT support a holistic approach to the work enabling improvements in a number of domains.

I also became acutely aware of the impact of writing this thesis on me as a therapist. I agonised at times about the extent to which I should reveal myself in what I wrote. However, despite my reservations, I want to honour the journeys of these fine young women as well as highlight their experiences of what worked for them using PE-EFT. The journey of critiquing and presenting my own work has been arduous but rewarding.

Finally, I recently read a wonderful piece co-written by Akira Ikemi, a leading Japanese advocate of focusing and Mick Cooper, who is associated with a relational person-centered stance (Cooper & Ikemi, 2012). A number of points seemed relevant to this thesis. In Ikemi's contributions to the dialogue he pointed out that Rogers and Gendlin emphasised that there needs to be an *openness to being changed* in the client *and* the therapist. In addition, Ikemi stated that Rogers opposed imposing concepts and schemes on the client's experience: Rogers did not intend to change the other without being changed himself. Cooper responded by wondering if in a focusing the words that the other explicates changed his experience (Cooper & Ikemi, 2012). He stated

It is when the therapist's words can serve to carry the client forward. It is not something that the client just does alone – that would be self-reflection: the therapist becomes part of that process. But in relational depth, the client's words, or being, also act to carry the therapist forward in some way. So the explication process becomes co-joined. Two people begin to follow one path (p.133).

In order to facilitate such an *openness to being changed* the provision of unconditional positive regard, listening and a willingness to disclose one's own felt sense were posited as necessary in a way that the other, the client, feels they can draw on for their own self-development. A stance of *indefiniteness* is also important for facilitating

dialogue as well as one in which we as *growing* therapists feel that we have something to learn from our clients – an *openness to being changed by them* (Cooper & Ikemi, 2012). This journey provided an opportunity for change not only for the young women but also for me.

## Chapter Eleven • Conclusion and Recommendations

This study has attempted to add to the *change-process* research in four cases of young women undergoing Process-Experiential/Emotion-Focused Therapy (PE-EFT) for their depression. I have identified, described, and attempted to explain some of the processes that bring about therapeutic change over the course of therapy, in the hope of providing useful understandings to the therapist in the field. In analysing the Process-Experiential/Emotion-Focused Therapy used with the four young women with depression and other comorbid conditions, such as anxiety and eating difficulties, over twelve sessions in a naturalistic setting, I asked four questions: 1) did any change/s occur, 2) what evidence was there that therapy was responsible for the change/s, 3) which processes in therapy might have been responsible for the change/s and 4) what alternative explanations are there for the change/s? I used a series of qualitative techniques and quantitative measures to elicit answers to these questions.

I found this research provided tentative support that PE-EFT was an effective treatment for young women with depression. Three of the young women showed improvement on the analyses of quantitative data and all four women showed clinically significant improvement across the analyses of qualitative data. In the Change Interviews the young women reported a decrease in their presenting symptoms of depression and anxiety and improvement in their interpersonal and social skills, greater self-esteem and confidence and better emotional regulation. All of them were able to express themselves more and stand up for themselves more assertively. There was a sense of feeling better about themselves and more compassion and acceptance for self and other.

This research offered further support to earlier findings that both the working alliance *and* the PE-EFT tasks facilitated the changes, since this applied for this young group as well as for the older adults researched previously. Emotional processing was also identified as an important change factor also in line with previous research (see Pos, Greenberg, & Warwar, 2009). My observations also support the claims in the literature that symbolising feelings brings the emotion from the domain of sensation and action into the mental domain and integration of *head* and *heart* begins. The

young women reported valuing the fact that they learnt to feel what their bodies were telling them, to notice and reflect on this, rather than blindly letting impulses determine their actions. Essentially what I noticed in the work with the young women was that when an emotion scheme was activated in session through the pathway of bodily felt-sense, as in a focusing task for example, the symbolic representation of that felt sense potentially generated some episodic memory retrieval. This in turn enabled the young woman to experience a primary emotional release and articulate a need and ultimately facilitated a felt-shift. New understandings emerged and meaning was generated. The appropriate implementation of the PE-EFT tasks facilitated an optimal environment for the felt-shifts and meaning creation to occur. These findings enabled me to adapt a PE-EFT model to reflect the processing of painful and traumatic events.

Although these results need to be interpreted in the light of the fact that this was a small sample of participants and I was relatively inexperienced as a therapist at the time of the study, they could potentially be useful to both practitioners and researchers. These findings could be useful for practitioners by providing an in-depth account that illuminates some of the processes that occurred within each session for both the client and therapist. Indeed, this data is the first to examine change processes when PE-EFT is used in young women with depression. These results could be useful for other researchers by offering constructive information about what qualitative and quantitative measures were valuable in identifying whether change had occurred and the types of changes that occurred. Indeed specific recommendations for future research and practice are presented below.

## **Recommendations for Further Research and for PE-EFT Practice**

While I recognise my therapeutic work is unique because of my personal style, another therapist could conduct a similar piece of research quite simply and extend our understandings of PE-EFT in practice. The inclusion of additional inventories to measure emotional processing (Pos, Greenberg, & Warwar, 2009) or relational depth (Knox & Cooper, 2010) or therapeutic presence (Geller, Greenberg, & Watson, 2010) would add further dimensions to the results. Analysing data from Greenberg's York study clients might be a worthwhile starting point to confirm my observations of the

proposed key elements of change, if appropriate data could be made available. Further, an investigation including young men would be valuable as a way to extend and check my findings. Studying the applicability of PE-EFT to adolescents and young children might be another worthwhile endeavour.

Further research could be conducted to corroborate the amendments to the change model based on the emotion scheme that I have suggested, since my client pool of four is insufficient to verify it or make conclusions as to its applicability. It might be useful to explore whether the various components of the proposed model could be operationalized, and in-depth process research could identify their finer nuances. Whilst it appears that all the components are necessary, perhaps some elements are more important than others.

The significant impact of trauma is becoming more widely understood as a very important area of specialised therapeutic work, but when working with depression and complex trauma the number of sessions required is always hard to predict (see Watson, Goldman, & Greenberg, 2007, Paivio & Pascual-Leone, 2010). Suggestions of weekly sessions over a period of two to five years have been made for clients with complex trauma (see Greenberg, Watson, & Lietaer, 1998), so investigations might explore the number of sessions required to achieve a good outcome using the proposed model, considering the severity of depression or the degree of trauma impact. Further investigations might compare the proposed model to other trauma treatments. It might also be useful to ascertain not only effectiveness but also client experiences of safety, pace and processing usefulness. Research such as this might provide evidence to inform government agencies and insurance providers that 10 to 16 sessions for people with serious mental health issues such as complex trauma may not be sufficient.

## Conclusions

Despite only four young women volunteering for the study, the thick description within each case study here offers an insight into the complexity of the therapeutic processes. Without oversimplifying the processes, the case study method has still allowed some themes of similarity to emerge. From detailed accounts of the therapy, I

was able to identify patterns, draw inferences, discover themes and generate hypotheses where appropriate and these have been highlighted throughout the thesis. I consider that the *key* factors in creating change for these four young women were the combination of the relationship and the implementation of the PE-EFT tasks that led to bodily-felt symbolising, emotional expression, experiential exploration and the subsequent felt-shifts in experiencing.

It was an important consideration for me to personalise each of the young women's stories and to bring their stories to life. A very early and fundamental aim of this work was to write up the cases in such a way that the reader could resonate with each of the young woman's stories and also be able to judge the accuracy of my conclusions, thus gaining a deeper understanding and appreciation of the therapeutic process. As a humanistic person-centred researcher I felt it vital to disclose my personal values, interests and theoretical orientations well in advance. In the thesis too I have allocated space for my reflections throughout and provided my own analysis of my work with the young women based on my understandings of PE-EFT theory and my clinical experience. I value the attempt to work *in-mode* and I have endeavoured to display this in every aspect of this work. I recognise that writing is also a process of interpretation and have attempted to present my understandings in a way that is authentic, fair, balanced and even-handed. For me, the young women were not research subjects but individuals struggling with significant life issues. I value them as people and as contributors who have allowed me and the reader to look into their lives and psychological processes in order to understand better the intricacies that occur inside the therapeutic experience.

Broadly speaking it was *both* the therapeutic relationship and the tasks that were reported by the young women as the change agents, although they found it difficult to articulate the *how* of change. However, by looking more deeply I suggest that when the emotion scheme is activated within a session we optimise the possibility of change by paying attention to all the elements of the emotion scheme and processing the previously unresolved aspects through bodily felt symbolising and emotional expression. This was particularly evident when using the focusing model for painful and traumatic events, as the PE-EFT model provides a map for working with the



person's experience systematically and holistically. I think Sarah explained it well by saying

It's like the realisation and acceptance... yes I think it wasn't just that session it was an accumulation... or just everything... talking about something maybe completely different had a flow on effect in some other area... when it happened that *click*... it was like a relief feeling I can't really I explain it... it just happened because of what I think was the accumulative effect of the therapy.

## **What I Now Know**

As a PE-EFT practitioner I know there is a pathway that can lead my clients to a fuller understanding of themselves and an alleviation of their distress. My role is not only to provide support but to also minimise long-term distress, through illuminating that pain into awareness to facilitate movement through it. Having previously journeyed through my own pain as a client I know I can touch and meet the pain of my clients so that we sit together in their emotional pain, both open to what that meeting might bring. Important too, is the fact that I can facilitate an active process aimed to create a shift in their felt sense of themselves. We hope not only to understand the experience more, but also each other. Each client's journey will be slightly different in terms of willingness, readiness, pace and depth. For Sarah her journey was deliberate and focused. Katie's need to control her environment also meant controlling her willingness to attend or engage once there. Ava was more cautious and often in crisis and her tentativeness and vulnerability left us less focused. For Chloe the relationship connection was highly valued as was being able to symbolically process her experience. So I was opened and became curious as a journeyed with Sarah, Katie, Ava and Chloe and we were all positively changed by the experience of that encounter despite our differences.



## Appendices

Refer attached CD.

Change processes in therapy: Case studies in Process-Experiential / Emotion-Focused Therapy

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