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Application of Emotion-focused Therapy as a Treatment of Generalised Anxiety Disorder: Analysis of Eight Case Studies

Thesis presented to the School of Psychology,

University of Dublin, Trinity College, for the degree of

Doctor of Philosophy

by

James McElvaney

2014

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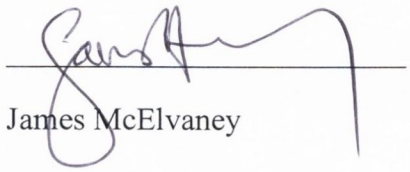

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Abstract

Aims: The aim of the current study is to develop an effective variant of Emotion-focused Therapy (EFT) for Generalised Anxiety Disorder (GAD), which can be delivered within the same time-frame as currently accepted, empirically supported treatments of GAD, which could, if shown to have promising results, be further validated in a randomized clinical trial (RCT). The aim is then to benchmark the results of the current study against the findings of other research studies which have investigated the efficacy of psychotherapeutic treatments of GAD. The study will also collect qualitative data on the outcomes of therapy as well as helpful and unhelpful aspects of the therapy process.

Method: This was a mixed methods study. Client/participants in the research study (n = 8), were recruited from an urban primary care centre. Clients' suitability for participation in the research was based on their initial intake assessment at the primary care centre and their score on the Generalised Anxiety Disorder- 7 (GAD-7; Spitzer, Kroenke, Williams, & Löwe, 2006) and the Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Patient Edition. (SCID-I/P; First, Spitzer, Gibbon & Williams, 2002). Clients underwent 16-20 sessions of therapy (although in some cases this was extended for clinical reasons), which were audio and video recorded. Quantitative pre-post-outcome measures were completed pre, mid, post and at six month follow-up. Qualitative data were collected at the end of each session and at the end of treatment. Descriptive analyses and t-test for dependent samples were carried out on quantitative data. Effect sizes were calculated which were standardised pre-post differences. Qualitative data were analysed in accordance with a descriptive and interpretive qualitative research method described by Elliott and Timulak (2005).

Results: Findings indicate that the pre-post difference in mean scores for the treatment group was statistically significant, with large effect sizes, across all measures, and suggests that findings are comparable and frequently better than results for other currently accepted, empirically supported treatments of GAD. In terms of qualitative outcomes, our findings are broadly consistent with the literature on the qualitative aspects of humanistic and experiential therapies to date (Timulak & Creaner, 2010). While the current study supports the notion that worry is the avoidance strategy most commonly associated with GAD, it disputes the role and character assigned to worry by other contemporary (mainly CBT) theories.

Conclusion: From a review of the first eight cases, the results of the current study appear promising, suggesting that both EFT theory of GAD, and EFT theory of treatment of GAD warrant further examination. An examination of qualitative and quantitative results indicates that therapy appears to have been effective, to varying degrees across all cases. A significant amount of material concerning therapy process in terms of case conceptualisation and emotion transformation has contributed to the development of EFT as a treatment of GAD.

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Preface

The current study presents an analysis of the outcome of eight cases of Emotion-focused therapy (EFT) for Generalised anxiety disorder (GAD) and is part of a wider project (EFT for GAD Study) which will consist of 14 cases upon completion. The aim of the current study (and also the wider study) is to develop a variant of EFT for GAD that could be, if shown to have promising results, further validated in a randomized clinical trial.

The dissertation begins with a description of GAD, comprising its history as an evolving diagnostic category in the DSM suite of Axis I disorders, its prevalence across clinical and community samples, comorbidities and its cost to society in terms of the human and economic burden. This dissertation will discuss current empirically supported psychotherapeutic models, and their treatments, of GAD. The dissertation will then look at Emotion-focused therapy as a contemporary form of psychotherapy, enjoying increasing empirical support, in terms of emotion theory, theory of dysfunction, and therapy process. A brief examination of anxiety from a general EFT perspective will be presented followed by current EFT thinking on GAD in particular.

Eight single-case studies will be presented, followed by a cross case analysis of same, focusing on qualitative and quantitative findings. Discussion of qualitative findings will synthesise material regarding case conceptualisation and emotion transformation across cases, to illuminate common underlying processes, and explore both the similarities and differences between an EFT understanding of GAD and its treatment, and that of empirically well-established approaches to GAD. Quantitative outcomes will be tentatively benchmarked against those reported in other studies focusing on treatment of GAD, and should they appear promising when compared to existing treatments, it is hoped that this will support further investigation of a brief-EFT treatment of GAD.

1.0 Introduction

This literature review aims to provide a background to, and rationale for, the current research, specifically the perceived necessity of developing a new psychotherapeutic treatment of generalized anxiety disorder (GAD). Accordingly, its initial focus is preoccupied with the emergence and development of GAD as a discrete diagnostic category within the DSM suite of diagnostic manuals. Attention is then paid to prevalence rates; incorporating a review of both community-based and clinical epidemiological studies, which establishes GAD as one of the most prevalent of the mood disorders across multiple settings. The notably high prevalence of GAD at primary care centres (Roy-Byrne & Wagner, 2004) informed the choice of host centre for the current study. Analysis of the economic, social and human cost of the disorder is presented and clearly illustrates the necessity of developing alternative and new means of addressing GAD, given the relatively modest recovery rates enjoyed by currently prescribed psychological treatments of GAD (Brown, Barlow & Liebowitz, 1994).

In the analysis of current treatments, the choice of treatment models (mainly cognitive-behavioural) examined reflects the fact that as GAD has evolved as a discrete diagnostic entity in successive versions of the DSM suite of diagnostic manuals, it has done so along broadly cognitive-behavioral principles, reflecting the current dominance of that paradigm within the field of psychotherapy. In the case of GAD, this is reflected in the gradual replacement of the somatic and arguably vague Freudian notion of 'free-floating anxiety' with the current definition of GAD, which places an emphasis on the more cognitive process of worrying (Heimberg, Turk & Mennin, 2004). Research suggests that CBT as a treatment of GAD has been found to be superior to no treatment, analytic psychotherapy, non-directive therapy, placebo and pill placebo therapy (Borkovec & Ruscio, 2001). This has led to CBT being recognized as the only psychological therapy which currently meets the criteria of an empirically supported treatment of GAD, which, in turn, has led to CBT

becoming the default, high intensity treatment prescribed by policy makers and health organisations (c.f. NICE, 2011).

The sections pertaining to EFT focus initially on the particular role of emotion and of contemporary emotion theory as it relates to the theory and practice of EFT. This draws on EFT's broad program of research, conducted over the last 30 years, in order to explicate certain theoretical constructs, peculiar to EFT, which are intended to facilitate understanding of aspects of treatment and treatment development which are important for full appreciation of the case studies presented later. These include EFT's core constructs, including emotion schemes, primary and secondary emotions and adaptive and maladaptive emotions. Attention is paid to the principles of emotional change and the phases of treatment in EFT and a discussion of case conceptualization is provided.

The concluding sections of the literature review discuss current EFT thinking on anxiety, and propose a tentative model of emotion transformation as it relates to GAD from an EFT perspective. The paper explores the role of the case study in the development of EFT theory and outlines the rationale for the use of case studies in the current research. The literature review concludes with a discussion of the rationale for the current study and outlines its research aims.

1.1 Introduction to Generalised Anxiety Disorder

While anxiety disorders have increasingly become the focus of investigation in psychiatric and psychological literature in recent years, (Cox, Wessel, Norton, Swinson & Direnfeld, 1995; Norton, Cox, Asmundson & Maser, 1995) it is fair to report that historically, within this broader trend, generalised anxiety disorder (GAD) has been relatively under-examined (Dugas, 2000; Mennin, Heimberg & Turk, 2004). This is attributable, in the main, to early conceptual confusion regarding GAD's status as a discrete diagnostic entity, leading

to a somewhat impoverished view of the disorder as a residual category within which to classify individuals whose anxiety features were such that they might not adequately be described by other Axis I anxiety disorders (Mennin, Heimberg & Turk, 2004). By the time of the publication of DSM-III (APA, 1980), in which GAD was first recognized as a distinct, non-residual category with worry as its central and defining feature, the diagnosis had a poor reputation amongst clinicians and researchers. As a result of this, Barlow (1988) was able to report that despite a reportedly high prevalence of individuals presenting with seemingly chronic generalized anxiety features at primary care centers across the United States, clinicians still struggled to accurately diagnose and classify these persons as GAD sufferers.

1.1.2 Brief History of GAD

The first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I; American Psychiatric Association [APA], 1952) was influenced by Freudian thinking, and as a result, early conceptualizations of GAD were strongly influenced by psychoanalytic theory (Mennin, Heimberg & Turk, 2004). Mennin and colleagues (2004) draw attention to Freud's (1920/1966) distinction between *anxiety neurosis*, which would include current understandings of GAD and panic disorder and *phobic neurosis* which would contain agoraphobia, social phobia and specific phobia. It is recognized that Freud's description of *anxious expectation* matches the phenomenon currently referred to as *worry* (Rickels & Rynn, 2001). Mennin and colleagues, however, observe that while contemporary theories of GAD focus on the *cognitive load* of worrying, the Freudian position lends its self to viewing worry as "diffuse and somatic, appearing as "free floating anxiety" (Mennin, Heimberg & Turk, 2004; p. 4).

The conditions which allowed for the gradual emergence of GAD as a discrete diagnostic category were influenced by two key developments. First, the discovery that

Imipramine was successful in treating the symptoms of panic disorder, but had little impact on symptoms associated with a more generalized anxious presentation, suggested that the two disorders might be more distinct than had previously been assumed (Klein, 1964). Second, a general trend was emerging which privileged atheoretical, scientific and empirical methods in the proposition and establishment of diagnostic categories, rather that the theoretically driven formulations of the past which were dismissed as speculative and out of step with prevailing trends in modern medicine (Mennin, Heimberg & Turk, 2004). It is apparent that in comparison to the other diagnostic categories which comprise the DSM suite of Axis I disorders, the currently recognized GAD diagnosis is both a relative newcomer and has undergone a number of substantial revisions in recent, consecutive editions of the DSM from its original, formal inception in DSM-III (American Psychiatric Association, 1980) to its current incarnation in DSM-IV (APA, 1994) (Roemer, Orsillo & Barlow, 2002).

1.1.3 DSM and ICD Diagnostic Criteria

The Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association (DSM-IV-TR; APA, 2000) defines GAD according to the following criteria. GAD is characterized by excessive anxiety and worry (apprehensive expectation), which the sufferer describes as difficult to control, occurring more days than not for a period of at least six months. For a diagnosis of GAD to be made the anxiety and worry must be associated with at least three of the following six symptoms: (i) restlessness or feeling keyed up or on edge, (ii) being easily fatigued, (iii) difficulty concentrating or mind going blank, (iv) irritability, (v) muscle tension, (vi) sleep disturbance (difficulty falling or staying asleep, or restlessness unsatisfying sleep). The focus of the anxiety ought not to be related to features of another Axis I disorder (i.e. worry about having a panic attack (panic disorder), worry about being embarrassed in public (social anxiety) etc.). The anxiety, worry, or physical symptoms must cause distress or impairment in social, occupational, or other

important areas of functioning. The condition must not be due to the direct physiological effect of a substance (i.e. drugs or medication), or a general medical condition, and must not occur exclusively during a mood disorder, a psychotic disorder, or a pervasive developmental disorder (APA, 2000).

While the ICD-10 is similar to the DSM-IV, insofar as it characterizes GAD as being defined by anxious tension and worry, experienced over a six month period and related to every day issues, there is some variation over symptoms, with the ICD-10 requiring four out of a possible twenty two symptoms of which at least one must come from the following list of four autonomic symptoms, (i) palpitations or pounding heart, or accelerated heart rate (ii) sweating, (iii) trembling or shaking, (iv) dry mouth (not due to medication or dehydration). Andrews and Slade investigated the common assumption that DSM-IV and ICD-10 diagnoses are equivalent and found that the DSM-IV requirement that worry be excessive resulted in fewer diagnoses of GAD, than were diagnosed under ICD-10 criteria. They also found that DSM-IV only cases of GAD had significantly higher levels of disability, leading them to conclude that while prevalence rates for both classification systems were largely the same, it appeared as though they were diagnosing different groups of people. (Slade & Andrews, 2001; Andrews & Slade, 2002).

The DSM-IV's removal of the 'unrealistic' criteria in relation to worry, and its replacement with 'difficult to control', along with the minimum duration criteria of six months, reflects the recognition that GAD is a chronic condition, quantitatively distinguishable from non-clinical worry (i.e.in terms of worry frequency and intensity) rather than qualitatively distinguishable from it, as had been implied by 'unrealistic' worry (Dugas & Robichaud, 2007). This recognizes that persons suffering from GAD generally worry about the same things as everybody else, however it is the degree to which they do so which characterizes their worry as pathological (Barlow & Wincze, 1998). The removal of a large

number of the somatic symptoms from the diagnostic criteria in DSM-IV has increased the discriminant construct validity of the diagnosis by reducing unhelpful co-morbidities. For example, prior to the removal of symptoms related to autonomic hyperactivity, the distinction between GAD and panic disorder was frequently obscured by a focus on autonomic arousal, which is not necessarily a feature of GAD (Andor, Gerlach & Rist, 2008). The current study employed DSM-IV TR criteria in diagnosing and recruiting participants. The DSM-V was published as the research was being conducted; however no changes were made to the GAD diagnostic criteria (APA, 2013).

1.1.4 Prevalence of DSM GAD

In establishing lifetime prevalence rates for GAD, it is important to acknowledge variation which may be attributed to different research methodologies, changes to GAD diagnostic criteria across successive editions of the DSM (APA, 1980, 1987, 1994& 2000) and the existence of two distinct classification systems: the DSM and the ICD (Roemer, Orsillo, & Barlow, 2002). For example, the DSM system requires that anxiety be excessive whereas the ICD system does not, and the DSM incorporates a hyper-vigilance syndrome which the ICD does not (Kessler, Keller, & Wittchen, 2001). It is significant, however, that despite the numerous alterations to the DSM diagnostic criteria over recent years, and the differences between the ICD and DSM codes of classification, the reported lifetime prevalence rates for GAD are quite consistent when compared to other disorders (i.e., depression) (Wittchen, 2002).

1.1.4.1 Community Based Epidemiological Studies

Large-scale community studies, in the United States, Australia and Germany, provide the following prevalence rates for GAD. In the United States, The Epidemiologic Catchment Area (ECA), which examined the responses of 8,537, 18-65 year olds using DSM-III criteria,

places the one-year and lifetime prevalence rates for GAD at 2% - 3.6% and 4.1% - 6.6% respectively (Blazer, Hughes, George, Swartz, & Boyer, 1991). Also in the United States, The National Comorbidity Study (NCS), which examined the responses of 8,098, 15-54 year olds using DSM-III-R criteria, places the one-year and lifetime prevalence rates for GAD at 3.1% and 5.1% respectively (Wittchen, Zhao, Kessler, & Eaton, 1994; see also Kessler, Dupont, Berglund & Wittchen, 1999). The Australian National Survey of Mental Health and Well-Being, which analyzed the responses of 10,641 participants over 18 years of age, using DSM-IV criteria, places the one-year prevalence for GAD at 3.6% (Hunt, Issakidis, & Andrews, 2002). The German National Health Interview and Examination Survey, Mental Health Supplement, was the first nationwide, epidemiological study of mental health in Germany (Wittchen, Mueller & Storz, 1998b). Participants were assessed for DSM-IV disorders with the 12-month version of the Munich Composite International Diagnostic Interview. The prevalence rate for 12-month threshold DSM-IV GAD was estimated to be 1.5%, with approximately 3.6% of respondents presenting with sub-threshold GAD over the previous 12 months (Carter, Wittchen, Pfister & Kessler, 2001).

Other epidemiological studies, conducted outside the United States, have revealed similar patterns; for example Bijl, Ravelli, & Van Zessen (1998) in the Netherlands Mental Health Survey and Incidence Study (NEMESIS: n=7076; 18-64 years) which, using DSM-III-R diagnostic criteria, found lifetime and 12-month prevalence rates of 2.3% and 1.2 % respectively. Offord and colleagues, in a sample of 9,950, 15-64 year olds in Ontario, Canada found a 1-year prevalence rate of 1.1% (Offord, Boyle, Campbell, Goering, Lin, Wong & Racine, 1996). Faravelli, Degl'Innocenti, and Giardinelli, (1989) in an Italian sample (n=1000; 16-61+ years), revealed prevalence rates for current and lifetime GAD, based on DSM-III-R criteria to be 2.8% and 5.4% respectively; while Bhagwanjee and colleagues in South Africa found a current prevalence rate of 3.7% in a study of a rural sample (n=354;

18+years) using DSM-IV diagnostic criteria (Bhagwanjee, Parekh, Paruk, Petersen, & Subedar, 1998). In Iceland, Stefansson and colleagues in a sample of 862, 55-57 year-olds using DSM-III diagnostic criteria found lifetime prevalence rates of GAD to be 21.7% (Stefansson, Líndal, Björnsson & Guðmundsdóttir, 1991). In Shatin, Hong Kong, Chen and colleagues, in a sample of 7,229, 18 to 64 year-olds, found lifetime prevalence rates for DSM-III GAD to be at 7.8% for males and 11.1% for females (Chen, Wong, Lee, Chan-Ho, Lau & Fung, 1993). In the UK, Jenkins and colleagues (1997, 2003a, 2003b) in the British Psychiatric Morbidity Study, found current prevalence rates for ICD-10 GAD among a 10,108 strong sample of 16 to 64 year olds, at 3.4% (Jenkins, Lewis, Bebbington, Brugha, Farrell, Gill, & Meltzer, 1997; Jenkins, Bebbington, Brugha, Farrell, Lewis, & Meltzer, 2003a; Jenkins, Lewis, Bebbington, Brugha, Farrell, Gill, & Meltzer, 2003b).

Epidemiological studies indicate that the high prevalence of GAD is not restricted to primary care settings (Kessler, Brandenberg, Lane, Roy-Byrne, Stang, Stein, & Wittchen, 2005; Lieb, Becker, & Altamura, 2005; Ormel, von Korff, Ustun, Pini, Korten, & Oldehinkel, 1994; Sartorius, Üstün, Lecrubier, & Wittchen 1996; Spitzer, Williams, Kroenke, Linzer, de Gruy, Hahn, Brody, & Johnson, 1994; Weiller, Bisserbe, Maier, & Lecrubier,1998; Wittchen, et al., 1994), and suggest that that the relatively low prevalence levels of GAD in community based studies in comparison with clinical studies may be attributed to a number of factors, including stigmatization of mental illness, which results in non-reporting of symptoms by respondents and difficulties in obtaining an accurate diagnosis on the part of clinicians.

1.1.4.2 Clinical Studies

Research suggests that GAD is highly prevalent among patients in primary care settings (Hoffman, Dukes and Wittchen, 2008; Ormel et al., 1994; Schonfeld, Verboncoeur, Fifer, Lipschutz, Lubeck, & Buesching, 1997). Barrett, Oxman, & Gerber (1988) reported

that GAD is the most frequently occurring anxiety disorder, and the second most common of all mental health presentations, in primary care settings. Wittchen and colleagues (1994) reported that fifty percent of respondents in the National Comorbidity Survey (NCS) study had sought help in primary care settings. Roy-Byrne and Wagner (2004) found rates of GAD to be between 2.8% and 8.5%, which is at least twice the rate reported in community-based epidemiological studies such as the NCS. Ansseau and colleagues in Belgium conducted a large scale study, the Generalized Anxiety and Depression Impact Survey (GADIS I), in which primary care physicians, comprising three hundred GPs in Belgium and Luxemburg, were asked to screen 50 consecutive patients each (Ansseau, Fischler, Dierick, Mignon, & Leyman, 2005). Out of 13,677 patients who were subsequently analyzed, 8.3% were diagnosed with GAD. In a follow up study (GADIS II) conducted in 2008 they found a higher prevalence, in a comparable sample (13.4%), than in their earlier study (Ansseau, Fischler, Dierick, Albert, Leyman, & Mignon, 2008).

The World Health Organization (WHO) Psychological Problems in General Health Care study (PPGHC) estimated current prevalence of GAD (Using ICD-10 criteria) across primary care settings to be approximately 8% of all primary care attendees (Ustun & Sartorius, 1995). Participating centers in this international study were in Ankara, (Turkey); Athens, (Greece); Bangalore, (India); Berlin, Mainz (Germany); Groningen, (the Netherlands); Ibadan, (Nigeria); Manchester, (England); Nagasaki, (Japan); Paris, (France); Rio de Janeiro, (Brazil); Santiago, (Chile); Seattle, Washington, (USA); Shanghai, (China); and Verona, (Italy). Subsequently, Maier and colleagues (2000), analyzing the same data set, reported that GAD was common in nearly all countries with an estimated one-month prevalence rate of 7.9%. Interestingly, 25% of patients attending primary care settings for psychological difficulties presented with pure GAD, without any comorbidities (Maier, Gänsicke, Freyberger, Linz, Heun, & Lecrubier, 2000). Wittchen (2002) observes that in the

PPGHC study, while the overall, current prevalence of GAD in primary care attendees is 8.5%, a further 4.1% of patients experience sufficient distress to qualify for a diagnosis of sub-threshold GAD. These findings have been confirmed in a study of GAD, based on DSM-IV criteria, across 20,000 primary care patients (Generalized Anxiety Disorder and Depression Study: GAD-P), which provides a point prevalence of GAD at 5.8% and suggests that 50% of all anxiety presentations qualified as GAD (Hoyer, Krause, Hofler, Beesdo, & Wittchen, 2001; Wittchen Krause, Hoyer, Beesdo, Jacobi, Hofler, & Winter, 2001; Wittchen, Kessler, Beesdo, Krause, Höfler, & Hoyer, 2002).

In a study of 256 individuals, randomly selected from primary care medical clinics at a public medical center in Louisiana (United States), Brantley and colleagues (1999) reported current and lifetime prevalence rates for DSM-IV GAD at 3.5% and 14.5 % respectively (Brantley, Mehan, Ames, & Jones, 1999). While acknowledging that the figure for current GAD is consistent with other studies, they recognize that the rather high figure for lifetime GAD may have been influenced by socio-demographic features, in that the sample was predominantly female (77.7%) and low-income, with 56% unemployed, all of which are risk factors that increase the likelihood of meeting the diagnostic criteria for GAD at some point in their lives. In a study of 119 'distressed' (where levels of elevated distress were identified using the SCL-90), high utilizers of medical care, aged between 18 and 74, Katon and colleagues reported current and lifetime prevalence rates for DSM-III-R GAD at 22% and 40% respectively (Katon, von Korff, Lin, Lipscomb, Russo, Wagner, & Polk, 1990). This is consistent with results found in Africa by Hollifield and colleagues who reported the prevalence of current DSM-III GAD among 126 randomly selected outpatients, in an outpatient clinic in Lesotho, at 29% (Hollifield, Katon, & Morojele, 1994).

1.1.4.3 Impact of Diagnostic Issues on Prevalence Rates

Research has shown that variation in the assumptions regarding the criteria pertaining to *duration* and *excessiveness* of GAD symptomatology, impacts on prevalence rates. The original minimum duration requirement for GAD in DSM-III was one month, which led to confusion regarding the status of GAD as an independent diagnostic category, due to excessive comorbidity with other anxiety and mood disorders (Breslau & Davis, 1985b). Recognition that comorbidity decreased with duration (Breslau & Davis, 1985a), led to GAD duration criteria being increased to six months in DSM-III-R (APA,1987) which also facilitated clearer distinction between genuine cases of GAD and more situation-specific, stress reactions (Barlow & Wincze, 1998).

Kessler and colleagues analyzed data from the United States National Comorbidity Survey Replication (NCS-R) (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005; Kessler, Berglund, Demler, Jin, Koretz, Merikangas, & Wang, 2003; Kessler & Merikangas, 2004), a large, community, epidemiological survey of GAD (n=9282) using DSM-IV diagnostic criteria, carried out between 2001 and 2003. NCS-R diagnoses were based on the WHO Composite International Diagnostic Interview (CIDI) (Kessler & Ustun, 2004) which diagnoses according to ICD-10 and DSM-IV criteria. Their findings showed estimated lifetime, 12-month and 30-day prevalence rates for DSM-IV GAD to be 6.1%, 2.9% and 1.8% respectively. However, when the duration criteria was dropped from six months to one month, the estimated prevalence rates more than doubled, to 12.7%, 5.5% and 2.6%. Andrews and colleagues observed that reducing the threshold to a 3 month duration would significantly increase the prevalence of GAD by "recapturing clinically significant cases" excluded by the six month threshold, and could further increase diagnostic reliability by "decreasing discrepancies in informant recall" (Andrews, Hobbs, Borkovec, Beesdo, Craske, Heimberg, Rapee, Ruscio, & Stanley, 2010).

Issues arising in relation to the diagnostic concept of *excessiveness* recall previous debates concerning the diagnostic necessity that worry be *unrealistic* (Abel & Borkovec, 1995; Barlow & Wincze, 1998). Ruscio and colleagues, analyzing data from the NCS-R found that the estimated lifetime prevalence of GAD increases by approximately 40% when the excessiveness requirement is removed (Ruscio, Lane, Roy-Byrne, Stang, Stein, Wittchen, & Kessler, 2005). Further difficulties arise over how worry might be objectively appraised as excessive and indeed, who might be in a position to make such an appraisal. Wittchen and colleagues, in a study of DSM-III-R GAD criteria, found that the removal of the excessiveness criterion greatly improved inter-rater reliability (Wittchen, Kessler, Zhao, & Abelson, 1995). Andrews et al. (2010) estimate that removal of the excessiveness criterion might result in an increase in prevalence rates of GAD between 27-40%, encompassing clients with milder, though still clinically significant, symptoms. It has been noted that in community samples, respondents who met ICD-10 criteria for GAD did not meet DSM-IV requirements because they failed to satisfy the excessiveness criterion (Slade & Andrews, 2001). Ruscio and colleagues (2005) reported that estimated lifetime prevalence of DSM-IV GAD increased by up to 40% when the excessiveness requirement was eliminated.

1.1.5 Onset, Course and Prognosis

Evidence from retrospective accounts provided by participants in community epidemiological surveys (Burke, Burke, Rae, & Regier, 1991; Kendler, Neale, Kessler, Heath, & Eaves, 1992) and clinical studies (Barlow, Blanchard, Vermilyea, Vermilyea, & DiNardo, 1986; Rogers, Warshaw, Goisman, Goldenberg, Rodriguez-Villa, Mallya, Freeman, & Keller, 1999) suggests that the onset of GAD typically occurs between the late teens and the late twenties (Ruscio, Chiu, Roy-Byrne, Stang, Stein, Wittchen, & Kessler, 2007).

Childhood onset occurrences of presentations with GAD features are often classified as overanxious disorder of childhood, which has implications both for overall prevalence rates for GAD and for the estimated age of onset (Kessler, Walters & Wittchen, 2004).

Research suggests that GAD is a chronic and enduring condition which the majority of sufferers describe as unremitting in nature (Angst & Vollrath, 1991; Blazer, Hughes, George, Swartz, & Boyer, 1991; Mancuso, Townsend &Mercante, 1993; Noyes, Holt & Woodman, 1996; Noyes, Woodman, Garvey, Cook, Suelzer, Clancy, & Anderson, 1992). While prevalence estimates for GAD among older adults range from 1.2% (Gum, King-Kallimanis & Kohn, 2009) to 7.3% (Beckman, Bremmer & Deeg et al, 1998), late onset GAD is considered by some commentators to be uncommon (Wolitzky-Taylor, Castriotta, Lenze, Stanley, & Craske, 2010). However, other researchers, for example, Le Roux, Wetherell, and Loebach (2005), have reported a bimodal distribution amongst older adults with GAD, with data indicating that, although 57% of patients reported early onset, 43% reported late onset (i.e. over fifty years of age). This suggests that there may, in fact, be two distinct subtypes of GAD, with earlier and later onset, and evincing specific causal and expressive features. Further evidence of this is provided by Blazer, Hughes and George (1987) and Brown, Barlow and Liebowitz (1994) who propose that late onset GAD may be triggered by a significant life stressor or trauma (see also Hoehn-Saric, Hazlett, & McLeod, 1993), compared with early onset GAD which is not necessarily precipitated by a dramatic or significant event and may have a more gradual onset, with sufferers reporting early childhood fears, disturbed home environment and a history of avoidant behaviour (Cole, Peeke, Martin, Truglio, & Seroczynsci, 1998; Sprujit-Metz & Sprujit-Metz, 1997). Hoehn-Saric and colleagues (1993) in a study of a clinical sample, reported that 64% of patients experienced early onset GAD, and that 15% of those reporting early onset GAD first experienced symptoms before the age of 10 (with the rest describing onset between 10 and 19). With

regard to the late onset group, 43% reported onset between 20-29 years of age, 31% between 30-39 years of age and 22% at 40 years of age or above (Hoehn-Saric, Hazlett, & McLeod, 1993).

Lifetime prevalence of GAD among the elderly has been reported as 3.6% (Kessler et. al., 2005) which suggests that GAD may be chronic and stable over time. However, studies which examine GAD prevalence across different age groups commonly report that it decreases with age. For example, Gum, King-Kallimanis and Kohn (2009), comparing GAD prevalence across the lifespan, found a 2.8% 12-month prevalence for 18–44 year olds, a 3.2% prevalence for 45–64 year olds, 1.4% prevalence for 65–74 year olds, and 1.0% prevalence for those aged 75 and older. Nevertheless, for those individuals with GAD, the chronic and enduring nature of their condition is expressed in Woodman and colleagues' (1999) paper, comparing patients with panic disorder and patients with GAD, which found that GAD sufferers were more likely to meet full criteria for the disorder and less likely to be in remission (or indeed, to have even experienced a period of remission in the preceding five years).

The Harvard/Brown Anxiety Research Program (HARP: Warshaw, Keller & Stout; Yonkers, Massion, Warshaw & Keller, 1996), a longitudinal follow-up study of 711 participants with one or more of five DSM-III-R anxiety disorders from 11 sites in the United States reported that, of patients who have been followed for five years, only 15% experienced remission for two months or longer in the first year after baseline, increasing to 25% in two years (Yonkers et al., 1996) and 38% after five years (Yonkers, Dyck, Warshaw & Keller, 2000). Kessler et al., (2004) draw attention to the consistency between the results from the Epidemiologic Catchment Area (ECA) study (Blazer et al., 1991) and the findings of the HARP study which both indicate that DSM-III GAD is chronic in nature. Dugas and Robichaud (2007) draw attention to the high levels of patient relapse in the HARP study to

illustrate the tenacity and aggressivity of GAD symptoms and the chronic and enduring nature of the disorder.

1.1.6 Socio-Demographic Factors

1.1.6.1 Gender

A considerable amount of research suggests that GAD is more commonly found among women than men in community studies (Carter et al, 2001). The National Comorbidity Survey (NCS) and the Epidemiologic Catchment Area (ECA) study report one-year prevalence rates of 4% for women, compared with rates of 2% for men (Blazer et al., 1991; Wittchen, Zhao, Kessler, & Eaton, 1994). In clinical samples GAD is also found to be twice as high among women as men (Woodman, Noyes, Black, Schlosser, & Yagla, 1999; Yonkers, Warshaw, Massion, & Keller, 1996). This is consistent with findings for other anxiety disorders, with women evincing higher prevalence rates in the NCS for panic disorder, agoraphobia without panic disorder, social anxiety disorder and simple phobia (Dugas & Robichaud, 2007). Indeed, Kessler et al., (1994) report that prevalence rates for having any anxiety disorder range from 22% to 30% for women compared to 12 % to 20% for men. However Bhagwanjee and colleagues (1998) study in South Africa which found higher prevalence rates among men suggests that findings may be culturally specific.

1.1.6.2 Age

Age has a more complicated relationship with GAD prevalence rates than gender. While some commentators place the highest rates of GAD between the ages of 35 and 55 and the lowest rates among adults over 55, (Blazer et al., 1991; Wittchen et al., 2002), evidence exists which challenges these findings. Beekman and colleagues (1998), in a report from the Longitudinal Aging Study Amsterdam, found that while the overall prevalence of anxiety

disorders was 10.2%, GAD was the most common disorder at 7.3%. Moreover, viewed across thirty years, post fifty five years of age, six month prevalence rates for GAD were revealed at 4.0% (55 – 64 years old), 11.5% (65 – 74 years old) and 6.9% (75 – 85 years old) demonstrating that rates of GAD increased rather than decreased during this period (Beekman, Bremmer, Deeg, Van Balcom, M., Smit, De Beurs, et al., 1998; see also Carter, et al., 2001). On the other hand, studies have shown that adults over 75 were less worried than those in the 65 to 75 year bracket (Doucet, Ladouceur, Freeston, & Dugas, 1998). A variety of suggestions have been proffered to explain these discrepancies, generally focussing on diagnostic issues, variations in the socio-demographic composition of samples, and the increased possibility of physical health issues amongst this age group which may obscure accurate diagnosis.

In the United States' National Comorbidity Survey (NCS), features associated with an increased risk for GAD included having been previously married (which carried a higher risk than associated with currently married, or never married, respondents); similarly affected were homemakers and those confined to the home through disability, unemployment or early retirement. Interestingly there appeared to be no discernible connection between race, income levels, education, religion or urbanicity and susceptibility to developing GAD (Roemer, Orsillo & Barlow, 2002).

1.1.7 Comorbidity

1.1.7.1 Comorbidity of GAD with DSM Axis-I Disorders

While acknowledging that the DSM-IV and DSM-IV-TR allow for greater specificity in achieving diagnoses of GAD than previous formulations of DSM diagnostic criteria, it is still the case that under this nosological system, clients are likely to receive multiple diagnoses (Menin et al., 2004); i.e. comorbidity, defined as the "co-occurrence of at least two

different disorders in the same individual" (Brown and Barlow, 1992; p. 835). These high levels of comorbidity, with both general medical and other psychiatric diagnoses, have often obscured the accurate recognition, diagnosis and treatment of GAD and furthermore, have even called into question its right to exist as a discrete diagnostic category (Van Der Heiden et al., 2011). For example, it was the high levels of comorbidity found in clinical samples of GAD, based on DSM-III criteria which led to the expansion of the one month duration criteria to six months in ensuing editions of the DSM (Breslau & Davis, 1985a). Interestingly, Heimberg, Turk and Mennin (2004) draw attention to the fact that much of this early data was derived from clinical samples and note that when community samples are examined (i.e., Wittchen et al., 1994) the degree of comorbidity between GAD and other DSM disorders is found to be not disproportionally greater than that of any other anxiety or mood disorder. For example, the lifetime comorbidity of National Comorbidity Survey (NCS) DSM-III-R disorders is calculated at 91.3 % for dysthymia, 99.4% for mania, 91.3% for GAD and 92.2% for panic disorder. Nevertheless, the majority of subjects who have been diagnosed with a principal anxiety disorder meet the criteria for one, or more, current anxiety or mood disorders (Brown & Barlow, 1992; Brown, Campbell, Lehman, Grisham, & Mansell, 2001). Comorbidity can be viewed in both clinical and epidemiological samples and can be analysed with reference to lifetime occurrence or current status (Goisman, Goldenberg, Vasile, & Keller, 1995).

1.1.7.2 Clinical Samples

In an analysis of data from the Harvard/Brown Anxiety Disorders Research Program (HARP), relating to the comorbidity of anxiety disorders across multiple clinical treatment centres, Goisman and colleagues (1995) reported that participants with lifetime GAD had an additional diagnosis of panic with agoraphobia (48%), social phobia (33%) and simple phobia (21%). They found that subjects with a diagnosis of GAD were the most likely (90%)

to have a lifetime history of a comorbid anxiety disorder. Noyes (2001) reported that in clinical samples in the United States, 45-98% of GAD patients met diagnostic criteria for lifetime, comorbid anxiety, depressive or substance use disorders. In a study of 109 adult patients with a primary diagnosis of DSM-III-R GAD (excluding those with concurrent major depressive episode), 46 patients (42%) had experienced at least 1 major depressive episode during their lifetime (Brawman-Mintzer, Lydiard, Emmanuel, Payeur, Johnson, Roberts, Jarrell, & Ballenger, 1993). In a study of 1,448 psychiatric outpatients in a Greek sample, using DSM-IV diagnostic criteria, Garyfallos and colleagues reported that 5.6% received a diagnosis of GAD. They noted that 65% of them had a comorbid Axis I diagnosis, (which increased to 78% when lifetime psychiatric diagnoses were recorded). The most frequent comorbid diagnoses were panic disorder, dysthymia, major depression, and social phobia (Garyfallos, Adamopoulou, Karastergiou, Voikli, Milis, Donias, & Parashos, 1999).

In a naturalistic, prospective study of anxiety disorder, examining the impact that comorbid disorders have on the course of GAD, Bruce and colleagues followed 300 patients over eight years; 179 of whom had GAD at intake, 12 who had a past history of GAD, and 109 patients who experienced a first episode of GAD during the course of follow-up. They found that 39% of patients that presented with GAD at intake had a comorbid diagnosis of major depressive disorder; this increased to 65% at 4 years and 74% at the 8 year follow-up (Bruce, Machan, Dyck, & Keller, 2001). Their research showed that patients with a diagnosis of GAD at intake were particularly at risk for developing comorbid conditions over time, noting that the increased comorbidity (with MDD and PD with agoraphobia in particular) reduced the likelihood of remission from GAD. Interestingly, Zbozinek and colleagues, in an investigation of DSM-IV-TR GAD and major depressive disorder in a primary care sample, (n=1218) concluded that a considerable degree of comorbidity may be attributable to

diagnostic symptom overlap (Zbozinek, Rose, Wolitzky-Taylor, Sherbourne, Sullivan, Stein, Roy-Byrne, & Craske, 2012).

1.1.7.3. Community Samples

Carter et al., (2001) in a general population study (German National Health Interview and Examination Survey, Mental Health Supplement (GHS): n=4181) in Germany, report that over 90% of people who meet the criteria for lifetime GAD in a given year will have at least one other DSM-IV diagnosis, suggesting that comorbidity of mood and anxiety disorders may represent a defining feature of the GAD construct (Judd, Kessler, Paulus, Zeller, Wittchen, & Kunovac,1998; Ninan, 2001). Data from The Australian National Survey of Mental Health and Wellbeing suggests that the prevalence of comorbid DSM-IV disorders for persons with one-month GAD is 67.8%. Specifically, individuals with GAD are 39.3% likely to have comorbid major depression, 17.7% likely to have comorbid dysthymia, 21.2% likely to have comorbid social anxiety disorder and 13.9% likely to have comorbid panic disorder (Hunt, Issakidis, & Andrews, 2002). Data from the Mental Health Supplement of the German National Health Interview suggests that the prevalence of comorbid DSM-IV disorders for individuals with one-year GAD is 93.1%. Specifically, individuals with GAD are 59.0% likely to have comorbid major depression, 36.2% likely to have comorbid dysthymia, 28.9% likely to have comorbid social anxiety disorder and 21.5% likely to have comorbid panic disorder (Carter et al., 2001). The degree of comorbidity increases with duration.

Data from the National Comorbidity Study shows that 90% of people with a lifetime GAD diagnosis have a lifetime history of one or more DSM diagnoses (Wittchen et al., 1994). Of NCS respondents with current (the six month period prior to interview) GAD, 66% met the criteria for any comorbid DSM Axis I disorder, 38.6% met the criteria for major

depressive disorder, 24.5 % met the criteria for simple phobia and 23.2 met the criteria for social anxiety disorder (Wittchen et al., 1994). In a survey which analysed data from the National Comorbidity Survey (NCS; 15–54 years) and the Midlife Development in the U.S. Survey (MDUS; 25–74 years) for 12-month GAD and major depression, using DSM-III-R diagnostic criteria, Kessler and colleagues observed that of respondents with GAD, 70% had experienced an episode of major depressive disorder over the previous year (Kessler, DuPont, Berglund, & Wittchen, 1999). The patterns described above can also be seen in the German National Health Interview and Examination Survey-Mental Health Supplement which found that 40% of 12-month GAD cases had current depression (i.e., occurring within the preceding 30 days), 59% had experienced an episode of major depressive disorder within the previous 12 months, and 56% satisfied diagnostic criteria for any other anxiety disorder within the previous 12 months (Carter et al., 2001; Wittchen, Carter, Pfister, Montgomery, & Kessler, 2000). Brawman-Mintzer and colleagues (1993) studied patients (n=109) with a primary diagnosis of GAD, determined by SCID for DSM-III-R criteria, finding that 42% of respondents had experienced one major depressive episode in their lifetime.

1.1.7.4 Comorbidity of GAD with DSM Axis-II Disorders

Some researchers have suggested that the GAD diagnosis may in fact be more accurately be understood as describing a disturbance of personality (Beck, Stanley & Zebb, 1996; Newman and Erickson, 2010). Przeworski et al, (2011) draw attention to research which highlights the overlap between maladaptive interpersonal functioning and conceptualizations of personality disturbance (Przeworski, Newman, Pincus, Kasoff, Yamasaki, Castonguay, & Berlin, 2012; Pincus, 2005; Sullivan, 1953). Research has shown that up to 50% of patients with GAD meet the criteria for Axis-II personality disorders (Sanderson, Wetzler, Beck, & Betz, 1994; Garyfallos et al., 1999). Przeworski and colleagues (2011) observe how research indicates that, in common with Axis-II personality disorders,

GAD has a lifelong duration (Kessler et al., 2005; Rapee, 1985), chronic course (Kessler et al., 2005; Wittchen & Hoyer, 2001; Blazer et al., 1991) and onset in early adulthood (Ruscio et al., 2007; Hoehn-Saric et al, 1993).

In an examination of the relationship between personality disorders and anxiety disorders, Sanderson and colleagues (1994) administered the Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders-III-Revised (DSM-III-R) Axis II Disorders to 347 outpatients with a principal diagnosis of an anxiety disorder at intake. Findings showed that 49% of patients who met the criteria for GAD also met the diagnostic criteria for a personality disorder. The majority of the personality disorders came from the anxious/fearful cluster (Cluster C), with avoidant and obsessive-compulsive personality disorder being most common. In their study of Greek psychiatric outpatients, Garyfallos and colleagues (1999) reported that 53% of the GAD patients met the criteria for DSM-IV Axis II personality disorder. In findings which are consistent with those of Sanderson et al., (1994), they reported that their GAD sample most commonly manifested personality disorder from Cluster C, with obsessive-compulsive and avoidant personality predominating. These findings are also consistent the current study, which found that all participants met the criteria for avoidant personality disorder.

1.1.7.5 Non-Psychiatric Medical Comorbidity

A significant aspect of GAD, which contributes not only to personal suffering, but also adds to the social and economic cost of the disorder, is the degree to which sufferers are often simultaneously afflicted by chronic pain symptoms such as backache, headache/migraine, gastrointestinal issues and joint pain (Puca, Genco, Prudenzano, Savarese, Bussone, D'Amico, & Marabini, 1999; Juang, Wang, Fuh, Lu, & Su, 2000; Sheftell & Atlas, 2002; Brenes, 2003; Bensenor, Tófoli, & Andrade, 2003; McWilliams,Cox, & Enns,

2003; Zwart, Dyb, Hagen, Ødegård, Dahl, Bovim, & Stovner, 2003; Grothe, Scheckner, & Albano, 2004). Perhaps this is not unusual, given the large percentage of GAD sufferers who seek treatment in primary care settings, are high utilizers of medical services and report long-term somatic complaints (Allgulander, 2012; Hazlett-Stevens, Pruitt, & Collins, 2009). Headaches and gastrointestinal problems appear to be the most common complaints. Research shows that 14% of patients suffering from episodic cluster headache (Jorge, Leston, Arndt, & Robinson, 1999), and 45% of patients with tension headaches (Puca et al., 1999) also have a diagnosis of GAD. It appears however, as though gastrointestinal problems are more associated with GAD than any other non-psychiatric complaint (Sareen, Cox, Clara & Asmundsen, 2005; Kennedy & Schwab, 1997). Kennedy and Schwab (1997) reporting on the levels of utilization of medical specialists by 80 anxiety disorder patients and 14 'normal' adults (18–65 years) over a five year period, observed that although patients with panic disorder saw the greatest number of specialists overall (in comparison to OCD and GAD), patients with GAD saw the greatest number of gastroenterologists. Tollefson and colleagues report that in a clinical sample of GAD sufferers, 37% met the diagnostic criteria for irritable bowel syndrome (IBS) (Tollefson, Tollefson, Pederson, Luxenberg, & Dunsmore, 1991), while 34% of a sample of medical patients with IBS met lifetime diagnostic criteria for GAD (Lydiard, 1992, 1997, 2001). GAD is also associated with sleep disturbance (Belanger, Morin, Langlois, & Ladouceur, 2004). Monti and Monti (2000), drawing on sleep laboratory and epidemiological studies reported that between 60% and 70% of GAD sufferers also experience some degree of sleep disturbance; noting that sleep disturbance associated with mild-to-moderate GAD is sleep-maintenance insomnia, and to a lesser extent, sleep-onset insomnia.

1.1.8 Cost/Impact of GAD

The impact of GAD, in terms of disability and interference, has been interpreted as both a human and an economic burden (Kertz & Woodruff-Borden, 2011). In a paper discussing the humanistic and economic burden of GAD in North America and Europe, based on a review of the literature (1987-2010), Revicki and colleagues reported that GAD was associated with increased impairments in psychosocial functioning, role functioning, work productivity and health related quality of life (HRQL) (Revicki, Travers, Wyrwich, Svedsäter, Locklear, Mattera, Sheehan, & Montgomery, 2012). They note that degree of life impairment remained present even when controlling for comorbid disorders such as depression. They recognize both the significant HRQL cost to sufferers and the economic cost to society associated with the diagnosis and treatment of GAD. The paper provides a thorough overview of the area but is somewhat limited in so far as it is restricted to papers written in English and excludes papers referring to non-pharmalogical interventions. Given that GAD is the most frequently occurring anxiety disorder in health care and is chronic in nature, the implications in terms of cost for society and the individual cannot be underestimated, particularly in light of the demographic shift towards increasingly large elderly populations in North American and European societies (Allgulander, 2012).

1.1.8.1 The Human Burden of GAD

In a comprehensive review of studies which examine GAD, comprising general population studies, primary care studies, mental health studies and clinical trials, Hoffman, Dukes and Wittchen (2008) define the impact of GAD on the individual, i.e. human burden, as comprising: impairment in, (a) social, family and occupational functioning, (b) perceived emotional and physical health status, and (c) satisfaction with aspects of daily life; expressed by the terms *role functioning* and *quality of life* (QOL). In their review of 34 studies reporting original quantitative data on associations between GAD and role functioning, and QOL, (also examining economic costs) using DMS-III-R, DSM-IV, and ICD-10 DCR

diagnostic criteria for GAD, they reported that GAD sufferers (both with and without a comorbid mental disorder) described significant physical and emotional problems. They reported that role and QOL impairments attributable to GAD were comparable to those of other anxiety disorders, somatoform disorders, major depression and medical conditions.

Kessler (2002) notes that a combined analysis of data from the National Comorbidity Study and the Midlife Development in the United States Survey reveals DSM-III-R GAD to be as disabling as pure major depression, with the highest levels of disability occurring when GAD was comorbid with major depression (Kessler et al., 1999). Similar findings are reported by Wittchen et al., (2000) using DSM-IV diagnostic criteria, in the German National Health Interview and Examination Survey. In a study of 67 individuals (GAD: n=17; Panic Disorder: n=23; Social Phobia: n=27) at the University of Houston Anxiety Disorder Clinic, Barrera and Norton (2009) noted a marked impairment of quality of life in individuals across all three disorders, as measured by the Quality of Life Inventory (Frisch, 1994, 2004). Maier and colleagues (2000) report that in instances where ICD-10 GAD has been present for one month, the level of disability experienced by the sufferer is equivalent to chronic somatic disease including, diabetes, arthritis, cardiovascular disease, cancer, tuberculosis, asthma and HIV.

1.1.8.2 The Economic Burden of GAD

Hoffmann and colleagues consider the economic burden of GAD in terms of decreased work productivity, increased health care utilization, referrals to specialists, diagnostic tests and medication (Hoffman, Dukes, & Wittchen, 2008). Their findings indicate that GAD patients are more likely to report fair/poor health than non-GAD patients. In addition GAD sufferers are found to be more likely to present at emergency rooms than non-GAD sufferers (Jones, Ames, Jeffries, Scarinci, & Brantley, 2001), are more likely to be

unemployed/on government assistance (Leon, Portera & Weissman, 1995), and evince greater work-related absenteeism than non-GAD sufferers (Olfson, 2000).

Wittchen (2002) provides a thorough overview of the cost of GAD to society, noting that the level of disability associated with GAD is comparable to that of chronic somatic disease. Wittchen assesses the cost of GAD to society in terms of its impact on work productivity, health care utilization and general economic burden. Analysis of data from the GHS study which evaluated levels of disability by examining reductions in work productivity found that 34% of patients with 12-month pure GAD and 48% of patients with comorbid GAD and depression exhibited a 10% reduction in work productivity (Wittchen, 2002). Eleven percent of respondents with pure GAD reported a reduction of up to 50% in the past month (Wittchen, Carter, Pfister, Montgomery, & Kessler, 2000). In Australia, Andrews and colleagues reported that mental health issues were the third greatest burden after heart disease and cancer, and that among mental health issues, the most problematic were GAD and depression (Andrews, Issakidis, & Carter, 2000).

In terms of economic burden, Wittchen (2002) draws on data from across research studies by Du Pont and colleagues (1996), Greenberg and colleagues (1999), and Rice and Miller (1998) to report that the annual cost of anxiety disorders in the United States was between $42 and $47 billion in 1990 (Dupont, Rice, Miller, Shiraki, Rowland, & Harwood, 1996; Greenberg, Sisitsky, Kessler, Finkelstein, Berndt, Davidson, & Fyer, 1999). Of this figure, 54% was attributable to non-psychiatric medical intervention, 31% was attributable to psychiatric treatment and 10% represented workplace costs (Greenberg et al., 1999). The 10%, ($4 billion), comprising workplace costs, refers to diminished productivity at work rather than absence from work. Simon and colleagues in a study of overall health care costs associated with DSM-III-R depression and anxiety among 1,962 primary care patients, report that patients presenting with anxiety and depressive disorders were associated with

considerably higher health care costs ($2,390 per patient, compared to $1,397 per patient with sub-threshold diagnoses), which were attributable to higher utilization of services rather than relative expense of treatment (Simon, Ormel, Von Korff, & Barlow, 1995).

It is well established that GAD sufferers are particularly high utilizers of medical services, with recent studies indicating that GAD sufferers are more likely to present at primary care centers rather than at mental health clinics (Maier et al., 2000; Roy-Byrne & Wagner, 2004) with prevalence rates at primary care centers ranging from 3.7% to 14.5% (Olfson et al., 1997; Olfson, 2000). Witchen and Hoyer (2001) reported that GAD is the most commonly occurring of the anxiety disorders presenting at primary care settings, accounting for 50% of all anxiety cases. In a study of a primary care sample in which 558 primary care physicians were surveyed, comprising over 20,000 patients, it was revealed that patients with GAD made twice as many visits to primary care centers as patients with depression (Wittchen et al., 2002). Judd and colleagues, in an analysis of data from the National Comorbidity Study, report that up to one third of GAD sufferers look for medical assistance for their somatic complaints (Judd, Kessler, Paulus, Zeller, Wittchen, & Kunovac, 1998). As has been discussed in the previous section on non-psychiatric comorbidity, GAD sufferers are prone to a variety of somatic, maladies including gastroenterological complaints and headache/migraine amongst others, which leads to GAD patients becoming highly engaged with medical services, and frequently with a number of specialists. Kennedy and Schwab (1997) noted that 50% of the GAD patients had seen 1-2 specialists, not including their general practitioner, while 10% had seen 3-5 specialists, which gives some indication of the level of demand placed on medical services by GAD patients.

In their study of the human and economic cost of GAD in a primary care sample, Kertz and Woodruff-Borden (2011) draw attention to the prevalence of sub-threshold GAD presentations in primary care settings (see also Wittchen, 2002). While acknowledging the

relative paucity of the data on the topic, they report that sub-threshold GAD and major depression are the most common presentations in primary care (Pini, Perkonnig, Tansella, & Wittchen, 1999; Rucci, Gherardi, Tansella, Piccinelli, Berardi, Bisoffi, & Pini, 2003). Carter and colleagues (2001) reported that 3.6% of patients reported sub-threshold GAD symptoms in the past year while 7.8% identified a period of at least one month during which they experienced elevated worry, tension or anxiety. Kertz and Woodruff-Borden (2011) point out that in Rucci and colleagues' (2003) analysis, sub-threshold GAD is in fact, a more common presentation than GAD itself. Kertz and Woodruff-Borden's (2011) analysis of a sample of 329 primary care patients, from a University-based urban ambulatory internal care medical clinic, assessed for GAD using the Primary Care Evaluation of Mental Disorders (PRIME-MD: Spitzer, Williams, Kroenke, & Linzer, 1994) broadly confirmed the above research findings, suggesting that GAD is indeed associated with significant human burden, but also, importantly, that sub-threshold GAD (which may also be viewed as a precursor to GAD (see also Rucci et al., 2003) causes substantial impairment in its own right and frequently goes unrecognized by physicians (see also Pini, Perkonnig, Tansella, & Wittchen, 1999; Wittchen, 2002).

1.2 The Nature and Role of Worry in GAD as Conceptualized by CBT

In DSM-III, worry was recognized as but one of many symptoms characteristic of GAD (Chelminski & Zimmerman, 2002), however by DSM-III-R, chronic, excessive worry had become identified as the central, defining feature of the disorder (Roemer, Orsillo & Barlow, 2002), with high frequency and self-perception of uncontrollability becoming increasingly recognized as the hallmarks of the form of pathological worry found among GAD sufferers (Borkovic, Shadick & Hopkins, 1991). The bulk of research into GAD has been conducted from within the cognitive-behavioural paradigm, which has led to the elevation of the cognitive component of worry to the point where it has become the defining

feature of GAD. The perceived central role of worry in the GAD construct led Andrews et al. (2010) to consider the proposition that in DSM-5, GAD be renamed Generalized Worry Disorder, Major Worry Disorder, or Pathological Worry Disorder.

Worry was originally investigated as a component of test anxiety (cf. Deffenbacher, 1980), however the formal investigation of the construct of worry itself grew out of Borkovec and colleagues' research into the role of worry in insomnia (Borkovec, 1982, 1985; Borkovec, Robinson, Pruzinsky, & DePree, 1983). Borkovec and colleagues (1983) offer an early, partial conceptualization of worry as "a chain of thoughts and images, negatively affect-laden and relatively uncontrollable. The worry process represents an attempt to engage in mental problem solving on an issue whose outcome is uncertain, but contains the possibility of one or more negative outcomes. Consequently, worry relates closely to fear process." (Borkovec et al., 1983; p. 10). Roemer and colleagues (2002) draw attention to Borkovec's observation that while the primary stage of problem solving is successfully achieved, namely generating the problem, the secondary stages of coping with, or resolving the problem, are not (Borkovec, 1985). Subsequent research suggests that worry, in both non-clinical and GAD populations, may involve mainly linguistic/verbal processes rather than imaginal ones (Borkovec, 1994) which are involved in the generation of a wide range of potentially catastrophic future situations.

Roemer and colleagues (2002) note that GAD sufferers "worry more frequently, excessively and uncontrollably than their non-anxious counterparts, but not necessarily about dramatically different topics" (p. 484). They further observe that patients with GAD do not report worrying about a specific content area, but rather, are beset by worries concerning a broad range of possibilities. Both GAD sufferers and non-clinical populations reporting high levels of worrying, and describe difficulty in arresting the worry process once it has commenced (Tallis, Davey & Capuzzo, 1994). Breitholz, Westling and Ost (1998) used semi-

structured interviews to record the most recent anxious thoughts of patients with diagnoses of either GAD or panic disorder. Three eventual categories emerged: (a) Physical catastrophe such as injury, illness or death, (b) mental catastrophe, such as loss of control or inability to cope and, (c) other, such as shame. They noted that GAD sufferers were more likely to report worries pertaining to mental catastrophe and other categories than those with panic disorder who were mostly concerned with physical catastrophe. Their findings suggest that GAD patients are likely to be most concerned with potential negative future events related to interpersonal difficulties, challenges to self-esteem and one's sense of being able to cope (Roemer et al, 2002).

Many researchers have investigated the function of worry, and there is considerable diversity among the various, proposed, explanations regarding why individuals should engage in this particular activity. Distinctions have been made between constructive and maladaptive worry (Wells, 1999), which views constructive worry as a form of problem solving; whereas other researchers (Borkovec, 1994), maintain that worry ought to be distinguished from problem solving, insofar as effective cognitive resolution of problematic issues might be more accurately be described as preparatory coping, rather than worry.

1.2.1 Psychological models of GAD

It is clear from reviewing the literature that, in terms of developing models and treatment, cognitive-behavioral approaches to GAD are by far the most comprehensively researched and empirically investigated in relation to the disorder. Differing treatments for GAD over time reflect the shifts in diagnostic criteria from DSM-III (APA, 1980) to DSM-IV-TR (APA, 2000), which have increasingly centralized and refined the worry construct in such a manner as to shift the emphasis from the emotional/physiological focus of 'persistent anxiety' to the more cognitive focus of 'excessive worry' (Robichaud & Dugas, 2009).

Interestingly, Robichaud and Dugas (2009) observe that generic cognitive-behavioral approaches encompass a broad range of therapeutic elements and foci which only partially engage with the diffuse and continually evolving symptomatology found in GAD, adding that, insofar as GAD sufferers frequently report worrying about *everything*, treatment of specific fearful stimuli is often not possible given the broad range of possibilities, which in turn leads to efforts aimed at management of anxiety rather than attempts to engage with the elements driving the underlying, fear-based, causal structure.

It has been argued that research into GAD has been both insufficient and misdirected. In a recent review of research into GAD and other anxiety disorders, Dugas and colleagues (2010) draw attention to the fact that in the period 1980 to 2005 fewer papers were published on GAD than any other anxiety disorder (with the exception of acute stress disorder) (Dugas, Anderson, Deschenes, & Donegan, 2010; Boschen, 2008). Dugas and colleagues (2010) observe that in the period covering 1980 to 1997, data reveal that 57% of GAD publications focused on descriptive issues (i.e. epidemiology, prevalence rates), 31% dealt with treatment issues (i.e. clinical trials, meta-analyses), while only 10% attended to process issues (i.e. cognitive vulnerability, interpersonal functioning). Dugas et al., (2010) argue that research on the etiology of a specific disorder ought to precede research into its treatment, and state that this has clearly not been the case with research into GAD. More recent research has focused on the development of treatment approaches which are individually tailored to target the specific processes which are considered to underlie GAD and are characterized by psychological models which attempt to identify and explain these processes (Robichaud & Dugas, 2009; Behar, DiMarco, Hekler, Mohlman, & Staples, 2009). This paper will address a number of disorder-specific, evidence-based treatments for GAD.

1.2.1.1 The Avoidance Model of Worry of GAD (AMW)

Some of the most important early research into GAD and the role of worry has been carried out by Borkovec and colleagues, who, since the 1980's have worked on the development of an Avoidance Model of Worry and GAD (AMV; Borkovec, 1994; Borkovec, Alcaine & Behar, 2004), which essentially describes worry as an attempt to avoid future threats and potential aversive emotional experiences. It conceptualizes worry as a verbal linguistic, cognitive activity (Borkovec, 1994; Behar, Zuellig & Borkovec, 2005; Borkovec & Inz, 1990) which facilitates the inhibition, or avoidance, of intense imaginal experience, thereby decreasing the possibility of experiencing any of the somatic or emotional arousal potentially associated with it, leaving sufferers "stuck in chronic, habitual modes of multi-system interactive responding, with each occurrence of the process functioning as a defensive reaction to threat and resulting in a sequence of anxious responses that acquires greater habit strength from repetition" (Borkovec and Costello, 1993; p.611). Paradoxically, this experiential avoidance, when successful, makes it impossible for the GAD sufferer to process fear in the manner necessary to allow for movement through and beyond the feared experience, by denying them access to 'corrective information', thereby maintaining them in a state of anxiety (Foa & Kozak, 1986).

Typically, the worry is negatively reinforced by the perceived diminution of the feared imagery. This process is then further strengthened by positive beliefs regarding worry, for example, that it contributes to problem solving; beliefs which are in turn positively reinforced if the feared event is either effectively coped with, or fails to occur. Borkovec and Costello (1993) acknowledge that GAD sufferers experience the complex interaction of a number of systems ("attentional, conceptual, imaginal, physiological, affective and behavioural" (p. 611) and draw attention to a number of features which may distinguish GAD from other anxiety disorders. These include less obvious triggers of anxiety, bias towards

multiple threat cues with instantaneous cognitive avoidance on detection, verbal-linguistic worry which suppresses fear-related imagery, somatic arousal and emotional processing.

The treatment prescribed by the AMW proceeds along broadly cognitive behavioral lines and is summarized in Behar (2009), as including: (a) self-monitoring, (b) relaxation techniques, (c) self-control desensitization, (d) gradual stimulus control, (e) cognitive restructuring, (f) worry outcome monitoring, (g) present-moment focus and, (h) expectancy-free living.

Empirical Support for the AMW model and AMW based treatment of GAD

Evidence suggests that GAD sufferers are prone to holding positive beliefs regarding worry and that it may be employed in order to avoid emotional processing (Borcovec & Roemer, 1995; Davey, Tallis, & Capuzzo, 1996). Research supports the idea that worry is a primarily verbal-linguistic, rather than an imagery based process (Behar & Borkovec, 2005; Borkovec & Inz, 1990; Freeston, Dugas & Ladouceur, 1996; Hoyer, Becker, & Roth, 2001; Behar, Zuellig, and Borkovec, 2005; Hirsch, Hayes, Mathews, Perman, & Borkovec, 2012), and that it seems to contribute to the dampening of somatic arousal at rest (Hoehn-Saric & McCleod, 1988; Hoehn-Saric, McLeod &Zimmerli, 1989, Lyonfields, Borkovec & Thayer, 1995, Thayer, Friedman & Borkovec, 1996). Interestingly, some research suggests a greater occurrence of insecure attachment styles among GAD sufferers, in comparison to a non-clinical control group, (Eng & Heimberg, 2006), while both college undergraduates (Viana & Rabian, 2008) and adolescents (Hale, Engels & Meenus, 2006) with GAD report a degree of estrangement from parents and peers. This is consistent with research which suggests that GAD sufferers expend a great deal of their time worrying about interpersonal difficulties (Roemer, Molina & Borkovec, 1997).

Empirical support for the efficacy of the AMW is found in Borkovec and Costello (1993), where non-directive (ND), applied relaxation (AR) and cognitive behavioral therapy (CBT: Essentially the AMW model) were compared. Although the ND condition produced the deepest level of emotional processing, the CBT condition was found to have the best results according to outcome measures. RCT support has been reported for the Avoidance Model of Worry in Borkovec and colleagues (2002) study, in which clients received (a) applied relaxation and self-control desensitization, (b) cognitive therapy, or (c) a combination of these methods. Clients in all conditions experienced clinically significant gains, however, no significant differences in outcome were found between treatments (Borkovec, Newman, Pincus, & Lytle, 2002). In Newman and colleagues' (2011) RCT which assessed whether whether cognitive-behavioural therapy (CBT) could be augmented with the addition of a module targeting interpersonal problems and emotional processing, reported that while all conditions experienced clinically significant improvement across a range of measures, there was no evidence to suggest that the introduction of the supplementary module had any clinically significant impact (Newman, Castonguay, Borkovec, Fisher, Boswell, Szkodny, & Nordberg, 2011).

1.2.1.2 The Intolerance of Uncertainty Model of GAD (IUM)

This model proposes that intolerance of uncertainty (IU) is the principal underlying agent, at the core of GAD, in so far as GAD sufferers find ambiguous situations with uncertain outcomes difficult to tolerate and experience intense and chronic worry as a result (Dugas & Robichaud, 2007; Dugas, Letarte, Rhéaume, Freeston, & Ladouceur, 1995; Dugas, Buhr & Ladouceur, 2004; Dugas, Gagnon, Ladouceur, Freeston, 1998; Freeston, Rhéaume, Letarte, Dugas, & Ladouceur, 1994). IU has been defined as "the tendency to react negatively on an emotional, cognitive and behavioral level to uncertain situations and events" (Dugas et al., 2004, pp. 143-144).

In common with the AMW, the IUM proposes that intolerance of uncertainty promotes worry by enhancing cognitive biases, as GAD sufferers: (a) hold *positive beliefs* regarding the utility of worry, (believing that it may help them to cope more effectively with future events and may even serve to prevent those events from occurring at all (Borcovec & Roemer, 1995; Davey, Tallis, & Capuzzo, 1996), (b) endure *negative problem orientation* and (c) experience *cognitive avoidance.* Negative problem orientation involves: (a) a lack of confidence in one's ability to solve problems, (b) a tendency to interpret problems as threatening, (c) low frustration tolerance when dealing with problematic issues and, (d) lack of optimism regarding the possibility of achieving positive outcomes for specific difficulties (Koerner & Dugas, 2006). Cognitive avoidance describes an effort made on the part of the individual in order to prevent or, at least reduce, cognitive arousal and the occurrence of upsetting thoughts or images by deploying a variety of avoidance strategies, (including: thought suppression, thought replacement, mental distraction, avoidance of triggers) (Dugas & Koerner, 2005).

Treatment in the IUM focuses on developing an increased tolerance for uncertainty (Robichaud and Dugas, 2006), and includes self-monitoring, psycho-education regarding intolerance of uncertainty, evaluation of worry beliefs, improving problem orientation and processing core fears (Behar, 2009) It is argued that the IUM is based within schema theory and as such, Fisher and Wells (2009) posit that "intolerance of uncertainty (like a danger schema) may be the consequence rather than the cause of worry" (p.231) which has implications for treatment.

Empirical support for the IUM and IUM based treatment of GAD

Two studies have investigated the degree to which the four principal components of the IUM (Intolerance of uncertainty, positive beliefs about worry, cognitive avoidance and

negative problem orientation) are specific to GAD sufferers (Dugas, Marchand & Ladouceur, 2005; Ladouceur, Dugas, Freeston, Rhéaume, Blais, Boisvert, & Thibodeau, 1999), with both studies finding that of the four items, only intolerance of uncertainty was specific to GAD alone, among anxiety disorders. Interestingly, in a recent study, while clinical groups (comprising GAD sufferers (GAD) and individuals with other anxiety disorders (ANX)) reported greater concern over negative, positive and ambiguous situations than the control group (no psychiatric condition), the GAD group did not report greater levels of concern over ambiguous situations than the ANX group, with both groups reporting similar levels of concern, questioning the specificity of the IU construct to GAD (Anderson, Dugas, M. J., Koerner, Radomsky, Savard, & Turcotte, 2012). This is consistent with studies of OCD groups (Holaway, Heimberg, & Coles, 2006; Steketee, Frost, & Cohen, 1998; Tolin, Abramowitz, Brigidi, & Foa, 2003) which suggest that intolerance of uncertainty occurs to a similar degree in both GAD and OCD groups. While there is evidence to suggest that GAD sufferers experience high levels of positive beliefs regarding worry, cognitive avoidance and negative problem orientation (Buhr & Dugas, 2002; Dugas, Gagnon, Ladouceur, & Freeston, 1998) there is less evidence to support their specificity to GAD (Behar et al, 2009).

RCT support for treatment of GAD, based on the Intolerance of Uncertainty Model, can be found in a number of studies (i.e., Dugas et al., 2003; Ladouceur et al., 2000; Dugas, Brillon, Savard, Turcotte, Gaudet, Ladouceur, & Gervais, 2010; Van der Heiden, Muris, & Van der Molen, 2012). Dugas and colleagues' (2003) analysis of small-group, IUM based, CBT for GAD indicated that the treatment group evinced the greatest post-test improvement (in comparison to waitlist) on all measures. Dugas and colleagues' (2010) RCT of IUM based CBT and applied relaxation (AR), for adult GAD sufferers found that at post-test, CBT was superior to AR and waitlist, although CBT and AR were found to be comparable. Ladouceur and colleagues' RCT of IUM based CBT for GAD found that the treatment produced

clinically and statistically significant gains, with 77% of participants no longer meeting the diagnostic criteria for GAD upon completion of treatment Ladouceur, Dugas, M. Freeston, Leger, Gagnon, & Thibodeau, 2000). Van der Heiden and colleagues' RCT on the effectiveness of metacognitive therapy (MCT) and IUM based CBT for GAD found that both of the CBT treatments produced statistically significant improvement with large pre-post effect sizes (Van der Heiden, Muris, & van der Molen, 2012).

1.2.1.3 The Metacognitive Therapy Model of GAD (MCM)

The Metacognitive Model was developed by Wells (1995, 1999, 2001, 2004, 2006, 2009, 2013) and is grounded in information-processing theory of self-regulation in psychological disorder (Wells & Mathews, 1994, 1996). The model distinguishes between *Type 1 worry* which refers to worry about external events and internal non-cognitive issues and *Type 2 worry* or *metaworry* which comprises troubling and negative thoughts regarding worry as uncontrollable and harmful (Wells, 1995; Fisher & Wells, 2009). The essential proposition of the MCM is that due to worry (Type 1) being construed as harmful, the individual feels threatened which, in turn, elevates his anxiety and leads to further worry (Type 2). Further conflict is experienced as the individual attempts to integrate both positive and negative beliefs regarding worry.

Wells (2005) maintains that it is negative beliefs about worry and the ensuing metaworry which distinguishes between GAD sufferers and non-clinical worriers, further proposing that metaworry leads to the adoption of a variety of unsuccessful coping strategies such as reassurance seeking, behavior checking, thought suppression and distraction which are intended to help the individual avoid worry (Wells,1999, 2004). The individual's attempt to prevent worrying by avoiding situational triggers limits their chances of discovering that worry is harmless and can be managed, thereby maintaining them in the cycle (Wells, 2005).

In terms of treatment, given that the focus of the MCM is to target Type 2 worry it is logically consistent that attention is paid to challenging the individual's dysfunctional beliefs and (presumed) distorted cognitive processes regarding worry in their day to day lives. Strategies involve case formulation in order to explore the worry fully, socialization, discussions regarding the perceived uncontrollability of worry, worry as dangerous and positive belief in worry (Wells, 2006).

Empirical Support for the IUM and IUM based treatment of GAD.

There is considerable support for many of the central features of the MCM, with a number of studies suggesting that GAD sufferers report holding negative beliefs about worry and engaging in metaworry (Cartwright-Hatton & Wells, 1997; Davis & Valentiner, 2000; Ruscio & Borkovec; 2004, Wells & Carter, 2001). Whilst the foregoing studies support the contention that GAD sufferers experience greater levels of negative beliefs about worry and metaworry than non-anxious individuals, they also provide evidence which indicates that levels of distress in these domains are similar for GAD sufferers and individuals with OCD (Cartwright-Hatton & Wells, 1997) and panic disorder (Wells & Carter, 2001), which has implications for specificity.

RCT support for the MCM, as a treatment of GAD, comes from Wells et al. (2010), Wells and King (2006) and Van der Heiden et al., (2012). Wells and colleagues (2010) pilot-RCT of MCM based treatment (MCT), versus applied relaxation (AR) in the treatment of adults with GAD, revealed that MCT was superior to AR at post treatment with recovery rates that matched the earlier performance of MCT in Wells and King (2006). Wells and King (2006) open trial of MCT for GAD reported that all patients were significantly improved at post treatment assessment. Van der Heiden and colleague's 2010 study found that both the

MCT and IUM conditions produced clinically significant change in clients, with findings indicating that the MCT produced better results overall.

1.2.1.4 The Emotion Dysregulation Model of GAD (EDM)

The Emotion Dysregulation Model of GAD (Mennin, Heimberg, Turk & Fresco, 2005, Mennin, Heimberg, Turk & Fresco, 2002; Mennin, Turk, Heimberg, & Carmin, 2004) derives from Borkovec and colleagues' contention that worry is a means of avoiding unpleasant emotions, and utilizes the literature on emotion theory and emotional regulation (Ekman & Davidson, 1994; Gross, 1988) in order to conceptualize GAD, and explore why some emotions are so aversive that individuals seek to avoid them through worry. The model proposes that GAD sufferers experience emotional arousal, both positive, and especially negative, to a greater extent than non-clinical persons. It further assumes that individuals with GAD have difficulty in understanding their emotional experience, are more likely to interpret emotionality in a negative light, and engage in coping strategies which leave them worse off than before (Turk, Heimberg, Luterek, Mennin & Fresco, 2005; Mennin et al., 2004). Mennin and colleagues (2002, 2004) assert that GAD sufferers evince poor affect regulation and seem overly dependent on cognitive methods of managing emotional experience, such as worry.

In terms of treatment, the EDM relies on a combination of CBT treatment principles, such as self-monitoring, relaxation exercises, principles which address emotion regulation such as increasing emotional awareness and exposure, and elements particular to the model such as belief reframing, psychoeducation around emotion, emotional skills training and experiential work around emotion (Mennin, 2004; Fresco, Mennin, Heimberg & Ritter, 2013).

Empirical Support for the EDM and EDM based treatment of GAD

There is a degree of contradiction in the evidence regarding the central propositions of the EDM. While there is research in support of the claim that individuals with GAD experience negative emotions with greater intensity than non-clinical controls (Mennin et al., 2005), and subjects with psychopathology (including depression) (Mennin, Holaway, Fresco, Moore & Heimberg, 2007), other studies contradict some of the principle features of the model. Novick-Kline and colleagues (2005), for example, reported that there were no significant differences between GAD sufferers and controls in their ability to identify and describe emotions, while acknowledging, however, that this may be due to the fact that the study was based on clinicians' ratings rather than client self-report (Novick-Kline, Turk, Mennin, Hoyt, & Gallagher, 2005). No RCTs have been conducted to assess the efficacy of EDM based treatment of GAD.

1.2.1.5 The Acceptance Based Model of GAD (ABM)

Roemer and Orsillo's Acceptance Based Model of Generalized Anxiety Disorder (2002, 2005) adopts Borkovec's (Borkovec, 1994; Borkovec, Alcaine, & Behar, 2004) theory of worry as emotional avoidance and allies it to Hayes and colleagues' model of Experiential Avoidance (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). The model proposes that the individual experiences difficulty with internal experience (thoughts, feelings, and bodily sensations) as a result of, (a) negative response to internal experience and, (b) fusion with internal experience. The former entails negative reactions to internal experience which make it difficult for the individual to identify, tolerate and understand emotional experience, while the latter suggests that the individual fuses with their temporary negative response in the mistaken belief that it is permanent and somehow defines them (Behar, 2009).

Treatment features an acceptance-based behavioural therapy comprising three main components, (a) psycho-education regarding the ABM model, (b) mindfulness and acceptance exercises and, (c) behaviour change and valued actions (Roemer & Orsillo, 2005)

Empirical support for the ABM and ABM based treatment of GAD

Research suggests that problematic emotion regulation is positively associated, and that mindfulness is inversely associated, with GAD symptom severity in a non-clinical sample (Roemer et al., 2009; Study 1), while GAD sufferers reported greater problems with emotion regulation and less mindfulness than non-clinical controls (Roemer et al., 2009; Study 2) (Roemer, Lee, Salters-Pedneault, Erisman, Orsillo, & Mennin, 2009). Experiential avoidance, difficulties with emotional regulation and negative reactions to emotions have been associated with severity on GAD related outcomes in non-clinical samples (Roemer, Salters, Raffa and Orsillo, 2005; Roemer et al., 2009; Salters-Pedneault, Roemer, Tull, Rucker, & Mennin 2006).

Empirical support for the treatment based on this model comes from Roemer, Orsillo & Salters-Pedneault, (2009), who found that ABM based treatment led to statistically significant reductions in clinician-rated and self-reported GAD symptoms at post treatment and 9-month follow-up and Treanor, Erisman, Salters-Pedneault, Roemer & Orsillo, (2011) who found that clients in the ABM based treatment group reported significantly fewer difficulties in emotion regulation, greater tolerance of uncertainty, and perceived control over anxiety than waitlist.

1.2.2 GAD Treatment Guidelines

Low intensity psychological interventions for GAD are proposed as the primary treatment for individuals experiencing mild to moderate anxiety symptoms and are

considered integral to stepped models of mental health care (NICE, 2011). The majority of these low intensity interventions are based on CBT principles and include such activities as: Individual non facilitated self-help, individual guided self-help, psycho-education al groups and relaxation training (NICE, 2011). High intensity psychological interventions, on the other hand, are advised for individuals suffering from moderate to severe symptoms, and are generally considered preferable to medication (Prins, Verhaak, Bensing, & van der Meer, 2008). These interventions include cognitive-behavioural therapy, applied relaxation psychodynamic therapy, non-directive therapies and combined psychological and pharmacological treatments (NICE, 2011). CBT for GAD has been comprehensively examined and, in the main, has been demonstrated to be more effective than wait-list, non-specific control conditions or treatment as usual (Borkovec & Ruscio, 2001; Hunot, Churchill, Teixeira, Silva de Lima, 2007; NICE, 2011), leading it to become the default, psychological treatment of choice for GAD.

This is not, however as straightforward as it seems. Although there is evidence to support the therapeutic benefit of CBT, research suggests that not all clients benefit from it. In one study, only 50% of patients reached high functioning following treatment (Provencher, Dugas, & Ladouceur, 2004) and in another, only 40% recovered at the end of the treatment (Westen & Morrison, 2001). When CBT was compared with waitlist control (across eleven studies), there was a statistically significant large improvement in clinician-rated anxiety scores and a moderate improvement in self-rated anxiety scores (NICE, 2011). CBT also produced significant reductions in worry symptoms compared to waitlist controls, which is perhaps unsurprising, given the centrality of the worry construct to cognitive –behavioural conceptualisations of CBT and the emphasis on symptom reduction in CBT protocols.

Given the foregoing it appears as though cognitive behavioural therapies are the only recognised empirically supported therapies according to APA guidelines (Chambless &

Ollendick, 2001), hence the NICE guidelines recommendation that the recommended psychological therapy treatment for GAD should be either CBT or applied relaxation. Nevertheless, studies from within the CBT paradigm (i.e. Newman et al., 2011) indicate that attempts are being made within the broader CBT community to integrate interpersonal and emotion focused components in order to augment existing treatment protocols, suggesting an awareness that existing treatments are not all that they could be.

1.3 Emotion-Focused Therapy (EFT)

1.3.1 Introduction to Emotion-Focused therapy (EFT).

Emotion-Focused Therapy (EFT) positions itself as the successor to a tradition of free-thinking characterised by 19th century writers such as Blake, Rousseau and Kierkegaard (Elliott et al., 2004). In much the same way as these writers resisted "the domination of human experience by rationalism, social convention, religious conformism and industrialisation" (Elliott et al., 2004; p. 21), contemporary humanistic practitioners challenge the dominance of the medical model with its insistence on the biological origins of mental distress (and corresponding pharmacological treatment) alongside attempts standardise and control the number and nature of therapies available to clients (Elliott et al., 2004).

Emotion-focused therapy (EFT) is an empirically supported therapy with roots in the person-centred, gestalt, experiential and existential therapies (Greenberg, Rice & Elliott, 1993; Greenberg, 2002; Rogers, 1957, 1959; Perls, Hefferline & Goodman, 1951; Gendlin, 1969, 1996). It has evolved gradually over twenty five years through a systematic program of psychotherapy research and in its current incarnation, incorporates elements of contemporary cognitive and emotion theory (Greenberg, 2011; Elliott & Greenberg, 2007). The particular evolution of EFT is directly attributable to its origins in a research-based investigation of change processes in psychotherapy (Greenberg, 1979, 1986; Rice & Greenberg, 1984), in

tandem with a curiosity regarding the role of emotion (Greenberg & Safran, 1987). This program of research led to the recognition that a combination of particular tasks in therapy, occurring within a facilitative relationship characterised by Rogerian (1957, 1959) relational conditions, in turn, led to different types of change and change processes. Awareness of this specificity allowed for the development of EFT as a marker-based and task-oriented form of psychotherapy, where therapists facilitate clients' attempts to resolve emotional difficulties by addressing identifiable markers with specific tasks. Early tasks subjected to such analysis included systematic evocative unfolding and the two-chair dialogue for the resolution of splits (Greenberg, 1979; Rice & Greenberg, 1984).

1.3.2 Research on EFT

One of the defining characteristics of EFT as a psychological therapy is the extensive research program which has been conducted to examine and explore its therapeutic components with a particular interest in understanding change processes in therapy (Greenberg, 1979, 1986; Rice & Greenberg, 1984). EFT has also been demonstrated to be an effective psychological therapy for both individuals (Elliott, Greenberg and Lietaer, 2004) and couples (Johnson, Hunsley, Greenberg & Schindler, 1999) in a number of randomised controlled trials (RCTs). EFT has been shown to be effective in the treatment of depression (Goldman, Greenberg & Angus, 2006; Greenberg & Watson, 1998; Watson, Gordon, Stermac, Kalogerakos & Steckley, 2003) and was also found to be effective in preventing relapse (Ellison, Greenberg, Goldman & Angus, 2009). The York I Depression Study (Greenberg and Watson, 1998) compared the effectiveness of EFT with Client-centred therapy; findings suggested that the addition of certain EFT tasks at specific points in therapy accelerated and improved recovery. The York II Depression Study (Goldman, Greenberg & Angus, 2006) replicated the York I study and then combined the samples to increase statistical power, revealing that the addition of emotion-focused interventions improved

outcomes to a statistically significant degree over Client-centred Therapy. Watson (2003) ran an RCT between EFT and CBT for Depression which, while indicating that both conditions improved in relation to depressive symptomatology, revealed no significant differences in outcome between the conditions.

In addition to research on depression, EFT has conducted numerous investigations into the nature of Complex Trauma and the resolution of interpersonal injuries from the past using empty chair dialogue (Greenberg & Foerster, 1996; Paivio & Greenberg, 1995; Paivio, Hall, Holoway, Jellis and Tran, 2001). Paivio and Pascual-Leone (2010) have developed Emotion-focused Therapy for Complex Trauma and have demonstrated positive results in treating adult survivors of childhood abuse, which were maintained at nine month follow up (Paivio & Niewenhuis, 2001; Paivio et. al., 2001).

Rather than focusing exclusively on adapting EFT as a treatment of specific disorders based on DSM diagnostic criteria, a great deal of work in the EFT research program has focused on examining the change processes underlying human dysfunction and on evaluating the EFT interventions developed to target them. Greenberg (2011) refers to a number of studies outside of the experiential tradition, which demonstrate the connection between facilitating clients in becoming aware of, and processing their emotion, and therapeutic change, irrespective of therapeutic modality. For example, Coombs, Coleman & Jones, (2002), as part of the National Institute of Mental Health Treatment of Depression Collaboration Research Program, reported that *collaborative emotional exploration* was significantly related to positive therapeutic outcome. Jones and Pulos, (1993), in a comparison of therapy process between brief psychodynamic (PDT) and cognitive-behavioural (CBT) therapies, reported that PDT promoted the evocation of affect and bringing difficult feelings into awareness, while CBT rather sought to control negative affect through the use of intellect. Greenberg (2011) also draws attention to the connection between

the depth of emotional experiencing and therapeutic gain in experiential, dynamic and cognitive therapies (e.g., Castonguay, Goldfried, Wiser, Raue & Hayes, 1996; Goldman, Greenberg & Pos, 2005; Orlinsky & Howard, 1986; Silberschatz, Fretter & Curtis, 1986). Watson & Bedard (2006) compared clients' emotional processing in good and poor outcome cases in cognitive-behavioural (CBT) and process-experiential therapies (PET), to investigate whether clients' emotional processing increased over the course of therapy. Results indicated that clients in the good outcome and PET groups evinced higher levels of emotional processing than those in the poor outcome and CBT groups respectively.

The importance of working with emotion in EFT was explored in the York Studies of EFT as a treatment of Depression. Pos (1999) using a hierarchical regression analysis, reported that while early differences in emotional experiencing, in treatment of depression, did predict outcome, (and that an increase in depth of experiencing across therapy, was predictive of good outcome) the level of experiencing reached upon the conclusion of therapy was the only significant predictor of positive change. High, mid-term, emotional arousal, combined with a capacity for reflection on it (Greenberg & Warwar, 2000), also predicted good outcome, along with deeper emotional processing later in therapy (Pos, Greenberg, Goldman, & Korman, 2003). Pascual-Leone and Greenberg have developed a '*sequential model of the optimal therapeutic processing of core emotional pain*' (2007), through the qualitative analysis of observable, '*moment-to-moment steps*' in emotional processing as they took place in therapy (Pascual-Leone & Greenberg, 2005, 2007; Pascual-Leone, 2009) and have continued to explore the role of emotional processing as a vital mechanism in, and predictor of, change in therapy (Greenberg & Pascual-Leone, 2006).

The various interventions, specific to EFT, which are believed to facilitate client change in therapy, have also been subjected to rigorous empirical scrutiny. The *two chair dialogue for conflict splits* (Greenberg, 1979, 1980, 1983, 1984a, Greenberg, Rice & Elliott,

1993), was originally informed by Perls' (e.g., Perls, 1969; Perls, Hefferline and Goodman, 1951) writings on polar aspects of the self (in which a coercive, evaluative '*top dog*' aspect of self, oppresses the experiencing aspect of self) and disruptions to healthy organismic functioning, and has been shown to follow Greenberg's (1983) three stage model of resolution comprising 'opposition-merging-and integration' (Mackay, 1996).

Based on the gestalt principle of *unfinished business* in which unmet needs do not just disappear from awareness (Perls et al., 1951), the *empty chair dialogue for unfinished business*, was validated as a task resolution model in EFT by Greenberg & Foerster (1996), who compared successful and unsuccessful resolution of unfinished business. They identified four components, (a) intense expression of feeling, (b) expression of need, (c) shift in representation of other, and (d) self-validation or understanding of the other as predictive of resolution. The model was demonstrated to be more effective than empathy alone (Greenberg & Foerster, 1996), was found to be more effective than focused, psycho-education group-work (Paivio & Greenberg, 1995) and deemed to be capable of producing significant improvement across a range of variables including symptom distress and interpersonal problems (Greenberg & Malcom, 2002; McMain, Goldman & Greenberg, 1996). Greenberg and Malcom (2002), in a study relating the process of the resolution of unfinished business with a significant other to therapeutic outcome, reported that clients who expressed previously unmet interpersonal needs to the significant other, and who experienced a shift in their view of the other, had significantly better outcomes. They also reported that resolution in empty-chair dialogues was a better predictor of outcome than working alliance (Greenberg and Malcom, 2002).

Other interventions/processes employed by EFT which have been subjected to scrutiny include *systematic evocative unfolding of problematic reactions*, which was originally developed by Rice (e.g., Rice and Saperia, 1984) and is used when a client

experiences a "*problematic reaction*". Watson and Rennie (1994) analysed clients' reports of their experience of engaging in systematic evocative unfolding tasks and found two main categories of activity emerged, (a) *symbolic representation of experience*, and (b) *reflexive self-examination*. Watson, (1996) subsequently reported that sessions which led to resolution were characterised by vivid descriptions of the difficult situation during which clients were able to differentiate an emotional response to the situation, followed by a shift in affect. Other processes which have been investigated include *focusing* (Gendlin,1969, 1996; Iberg, 1996; Leijssen, 1998,1996,1990, Leijssen, Lietaer, Stevens & Wels, 2000), and *narrative processes* (Honos-Webb, Stiles, Greenberg, & Goldman, 1998; Honos-Webb, Surko, Stiles, & Greenberg, 1999; Levitt, & Angus, 1999; Stiles, Honos-Webb, & Lani, 1999; Angus, Levitt, & Hardtke, 1999; Angus & Greenberg, 2011).

1.3.3 The Adaptive Role of Emotion in EFT

EFT "provides a distinctive perspective on emotion as a source of meaning, direction and growth" (Elliott & Greenberg 2007, p. 41). Contrary to traditional conceptualisations of emotion which regard emotion with suspicion, as a source of disruption, and as something to be controlled, EFT recognises emotion as a central component in the formation of the self and a vital agent in the process of self-organisation (Greenberg, 2004, 2008). Considered at the most fundamental level, emotion is construed as an evolutionarily adaptive source of information which allows the human organism to orient to, and engage successfully with, its environment (Greenberg, 2013; Greenberg & Paivio, 1997; Greenberg & Safran, 1987; Frijda, 1986).

EFT draws on contemporary research in the area of affective neuroscience to support its claims regarding the role of emotion in human functioning. Emotion theory in EFT is informed by LeDoux's (1996) study of the emotional brain which illustrates how the brain

might experience the emotional significance of a stimulus before it has been interpreted by the perceptual system. LeDoux (1996) proposes that as the amygdala pathway transmits information twice as quickly as that involving the neocortex, it becomes apparent that emotional responses can occur so instantaneously that the thinking brain is powerless to stop them. This has an adaptive function in that it allows people to respond immediately to stimuli without the delay implicit in the involvement of higher order cognitive processing. The significance of this for psychotherapeutic purposes is that one must now acknowledge that people are capable of responding emotionally to stimuli without engaging cognitive processes. One might have an emotional experience without an associated and identifiable train of thought (Greenberg, 2008; Damasio, 1994).

EFT theory challenges the notion of the primacy of cognition, drawing on the work of LeDoux (1996) and Zajonc (1980) to support its' proposition that emotion frequently plays an important role in many cognitive processes, such as decision making, and that transforming emotion can result in a corresponding change in cognition. Recognising the immediacy with which the amygdala forms emotional memories in response to perceived threats, Greenberg (2004) observes that the challenge facing any form of psychotherapy is to transform amygdala reactions so that reminders of past events are not negatively re-experienced in the present

1.4 EFT Emotion Theory

1.4.1 Emotion schemes

"Emotion schemes are at the base of our emotional response system" (Greenberg, 2011, p.39); and "provide an implicit higher order organisation for experiencing" (Elliott et. al., 2004; p.25). Emotion schemes are regarded as processes which may contain linguistic components but more frequently are comprised of preverbal elements (e.g. bodily sensations)

and are not immediately available to awareness. Greenberg (2011) describes them as "[...] internal emotion memory structures that synthesise affective, motivational, cognitive and behavioural elements into internal organisations that are activated rapidly, out of awareness, by relevant cues." (p.38). Emotion schemes capture our interpretation of events and the emotional impact of them upon us into what cumulatively evolve over time into "core emotion schematic autobiographical memories with an internal narrative structure" (p. 38; Angus & Greenberg, 2011). Significantly, these emotionally-motivated processes occur out of awareness (being only indirectly accessible through the experiences they generate) and impact upon subsequent conscious processing. As a result, despite its essentially flexible and adaptive nature, this form of emotional schematic learning opens up the possibility of generating maladaptive emotional responses. For example, whilst one might experience an adaptive protective anger in the face of a boundary violation, one may also experience maladaptive fear or shame when criticised by a significant other (Greenberg, 2011).

According to EFT theory, in order to identify an emotion scheme one must first elicit an item of episodic memory which must then be explored experientially before being expressed, or symbolised with language, before being reflected upon (Greenberg & Safran, 1987). An individual may experience any number of emotion schemes at any given time and these take the form of 'voices' which may co-occur with other voices, either in harmony or in disagreement (Elliott & Greenberg, 1997). Elliott and colleagues (2004) stress the importance of the therapist recognising this "multiplicity of self-organisations or voices" as they are an integral component of adaptive human functioning (p. 26).

1.4.2 Emotion Response Forms

In order to facilitate process diagnosis, EFT classifies emotion responses into four distinct categories: *Primary adaptive emotion* (which is functional), exists alongside *primary*

maladaptive emotion, *secondary reactive emotion* and *instrumental emotion* (which are dysfunctional) (Greenberg & Safran, 1987; Greenberg & Paivio, 1997; Elliott et. al., 2004; Fosha, 2000; Greenberg, et. al., 1993).

1.4.2.1Primary adaptive emotions

Primary adaptive emotions are states for which the adaptive value seems clear and appropriate; they represent the only emotional response form which is fully functional. It is natural, for example that one might experience sadness in the face of loss or that one might feel angry in the face of a boundary violation. These uncomplicated responses enable us to react appropriately to given situations, are evolutionarily adaptive and have a sense of feeling 'fit for purpose'. If one did not experience fear in the face of a dangerous situation, for example, one might not be mobilised to take the appropriate course of action and one's safety might become compromised. Greenberg and Paivio (1997) subdivide this category into three subcategories: (a) *discrete emotions*, (b) *feelings* and, (c) *emotional pain*. While feelings, which include a bodily sense of one's felt-experience (Gendlin, 1964), and emotional pain, which alerts the body to an awareness that trauma is impacting the system as a whole, are valuable sources of adaptive information, discrete emotions, such as fear, anger and shame not only inform us but contain *action tendencies*. To illustrate; a primary adaptive discrete emotional response such as anger cannot be broken down any further, it is a core response to a situation, and provides not only adaptive information but activates an action tendency which might, in this instance, be an aggressive defence of a threatened boundary. Therapeutically it is important to work with primary emotions because they represent the individual's initial and immediate response to a given situation, which is of particular significance when working with primary maladaptive emotions (Greenberg and Paivio, 1997).

1.4.2.2 Primary maladaptive emotions

Primary maladaptive emotions are direct responses to situations which are based on learning and are embedded in learning schemes but have become dysfunctional. These responses do not help the individual cope with current circumstances and frequently interfere with functioning. They are often based on past traumatic experiences of neglect, abuse or humiliation and while they might originally have been adaptive, such as learning to fear emotional warmth as it may have been followed by abuse or humiliation, continuing to respond this way in adult life may be harmful or self-defeating. They are considered primary in that they cannot be broken down into sub-components (Elliott et. al., 2004; Greenberg & Paivio, 1997). Greenberg (2010) describes them as old, familiar feelings that we experience repeatedly and have a sense of being stuck in. "They are feelings, such as a core sense of lonely abandonment, the anxiety of basic insecurity, feelings of wretched worthlessness, or shameful inadequacy which plague one all one's life" (p.34). Whereas primary adaptive emotions are accessed in therapy and utilised for their adaptive information and for the action tendencies contained in them, primary maladaptive emotions require accessing in order that they be regulated and transformed (Greenberg, 2010).

1.4.2.3 Secondary reactive emotions

Secondary reactive emotions are generally a response to primary, internal, emotional or cognitive processes but conceal their origins by displacing their source (Greenberg et al., 1993). From an emotional perspective, a male client might experience a strong a primary adaptive emotion, such as fear, however for any number of reasons (perhaps a sense that fear is somehow not acceptable in a male), he may become angry instead (either at himself or at the external source of the fear) and thus the secondary reactive emotion takes precedence.

From a more cognitive perspective an individual may become depressed after ruminating over failure in life (Elliott et. al., 2004; Greenberg & Paivio, 1997).

In their delineation of secondary reactive emotions, Greenberg and Paivio (1997) further distinguish between *bad feelings* and *complex feelings*, recognising that both are the product of a complex interaction between cognition and emotion. They observe that the therapeutic significance of being able to distinguish between primary and secondary emotion enables the therapist to either bypass or explore secondary emotions in order to access more adaptive alternative primary emotions. They give the example of an individual who feels secondary emotions of sadness, and hopelessness (bad feelings) at the end of a relationship. Through therapy the individual is able to access primary adaptive emotion such as sadness over loss of personal identity and anger at their partner for having been controlling of them. Furthermore, it is possible to identify an individual's response to having an emotion, where the emotion itself is not experienced, but rather the emotional reaction to having that emotion, i.e. one might be angry at one's fear, ashamed of one's sadness etc. These defensive reactions can be maladaptive and are typically used to avoid feeling other deeper, primary emotions and ultimately frustrate any possibility of processing those emotions. Further complexity derives from one's capacity to experience complex self-reflective reactions to one's own emotions. For example, the individual who becomes depressed following the end of a relationship, who is intolerant of and angry with themselves for being depressed and unable to shift this feeling, thereby becoming more depressed and filled with self-loathing over time. Greenberg and Paivio (1997) then describe more complex feelings such as "gloating or humility" which, while secondary, are not always experienced negatively or feelings of "pride or joy or hope" which, while secondary, are not maladaptive.

1.4.2.4 Instrumental emotions

Instrumental emotions generally occur when an individual's emotional response to a situation is intended to influence or in some other way exert control over others (Greenberg & Safran, 1987). They are frequently a learned response to a specific type of situation and may be consciously intended to either control the behaviour of others or to present oneself in a particular light. For example, one may express anger to dominate others or alternatively, sadness in order to gain their sympathy; consequently these emotions are sometimes referred to as *manipulative* or *racket feelings* (Greenberg, 2011. P. 44). Whether or not these emotions and their intent are open to awareness for the individual their purpose is either to control the individual's environment or the perception of the individual in relation to their environment (i.e. one might cry at a funeral because one knows, and wants to show others that one knows, that it is the socially appropriate thing to do). These emotions are often considered to be "shown" or displayed, rather than truly experienced or felt, due to the specific gain involved in presenting them to others. They are rather considered as a "communication device" and as somewhat manipulative (Greenberg & Paivio, 1997).

Greenberg and Paivio (1997) make the point that this does not imply that only primary emotions are real; they stress that all emotions are real in that they are 'felt'. However, it is clinically important to distinguish between different categories of emotion in order to accurately identify and address issues which contribute to complex emotional functioning. Given EFT's view of emotion as fundamentally adaptive, insofar as it facilitates the processing of complex situational material, is central to human functioning, and affords the capacity to effect change, it follows that an understanding of emotion processes is considered essential for conducting effective therapy. EFT further understands this from a broader *dialectical constructivist* position which acknowledges that humans actively and continuously construct their reality, utilising complex and dynamic *self-organising systems*

which synthesise information to produce experience (Greenberg, 2011; Greenberg & Pascual-Leone, 1995, 2001; Greenberg and Safran, 1987, Pascual-Leone, 1991).

1.5 Dialectical constructivism and EFT

Dialectical Constructivism maintains that by the very process of acquiring knowledge of a thing, both the nature of one's knowledge and the thing itself are necessarily changed. This suggests that 'facts' are perhaps more accurately described as a joint construction of, or interaction between, the thing itself and the process of knowing (Greenberg et. al., 1993; Elliott et. al., 2004). This notion requires both distinguishing between, and facilitating meaningful dialogue between, opposing sides. The essence of this is that unlike computational models which input data and output meaning in a static conversion process, dialectical constructivism recognises the manner in which the individual is engaged in a fluid process of simultaneously reacting to and integrating various elements of experience.

EFT proposes a dialectical constructivist model of self-functioning (Pascual-Leone, 1976a, 1976b, 1976c, 1980, 1983, 1987, 1991) which integrates biology and culture (Greenberg et.al., 1993; Greenberg & Pascual-Leone, 2001, Greenberg & Pascual-Leone, 1995; Elliott & Greenberg, 2002). Rather than being constrained by an explicitly structural view of a stable self-concept, the opportunity presents to engage with a more complex, on-going dialectical process (Greenberg et. al., 1993; Pascual-Leone, 1991). EFT's position in relation to dialectical constructivism has been influenced by constructivist psychotherapy (Guidano, 1991), narrative views on psychotherapy (Greenberg & Angus, 2004; Angus & Greenberg, 2011; Angus & McLeod, 2004), and explorations of the creation of personal meaning through cognitive processes, driven and organised by affect (Greenberg & Pascual-Leone, 1995, 1997, 2001; Greenberg, 2011).

Greenberg and colleagues (1993) draw attention to the fact that a dialectically constructed interpretation of meaning making allows for a more dynamic understanding of how humans function in relation to their environments than that originally explicated by Rogers and Perls in their early writings and is, in fact, more consonant with their later theorising (i.e. Rogers, 1961, 1975; Perls,1973). Greenberg (2011) observes that human brain anatomy provides two important brain processes, namely, the ability to have emotion and the ability to subsequently reflect on it. This provides the context in which "organismic emotional experience is seen as largely being created automatically by modular emotion schemes and by sensorimotor responses in order to guide action" (Greenberg et al., 1993; p.61). The former, modular emotion schemes, occur automatically, out of awareness without language, and provides the impetus for Rogers (1959) *organismic valuing process*. The second process is a language-based reflection on the information gleaned from the first process. We utilise this second order process to establish whether or not we should trust the information provided by the primary source as a guide, and it is this point where we evince the opportunity for agency or choice (Greenberg, 2011)(See also: Taylor, 1990). As Greenberg observes; "Without emotion there is no action, but without conscious organisation there is no coherence" (Greenberg, 2013; pp. 525). In terms of the implication for therapy, clients are therefore construed as "[...] an active agent in a dialectical synthesis creating meaning from immediate experience" rather than being labelled as incongruent, in denial or subject to distortion (Greenberg et al, 1993; p.62).

The significance of this for therapy lies in the acknowledgement that we actively create our sense of self by symbolising in language that which we discover in ourselves. The implication for EFT is the realisation that change is not achieved by a self-concept's incorporation of experience, but rather by a "*change in the modular self*"at the level of emotion schemes (Greenberg et al., 1993; p. 62). "EFT thus involves an interpersonal,

dialectical process involving a synthesis of biology, culture, emotion and reason that situates the client in a less radically independent, interior position *vis à vis* the construction of new story meanings and self-understanding" (Angus & Greenberg, 2011; p. 19)

1.6 Theory of Self in EFT

In terms of expressing a theory of self, EFT provides a broadly integrative approach with the added perspective of having adopted a Humanistic/Neo-Humanistic view of the person with all of the implicit values contained therein. As described above, EFT operates from a developmental, dialectical constructivist perspective which affords the individual the opportunity to act reflectively and creatively in relation to experience which allows for the opportunity to achieve greater, organised complexity, thereby attaining improved adaptation, need-satisfaction and self-actualisation. It acknowledges the two key adaptive motivational issues which concern the essentially self-organising individual; (a) the relevance of the nature of attachment to others (c.f. Bowlby, 1969/1982) and, (b) ones capacity for exploration and mastery of the environment (c.f. White, 1959, 1966) with a view to achieving the most from available resources.

In this context the individual is viewed as an "[...] integrated cognitive/emotional/motivational/relational action system in which the perceiving and appraising of stimuli, the experience of affect and the generation of action tendencies or motivational potentials are all part of a holistic dialectical relational system in operation" (Greenberg et. al., 1993; p. 78). Over time the individual is exposed to situations which provoke affective responses that eventually produce a 'self-in-the-world' emotion scheme. Multiple schemes are formed in relation to multiple situations and eventually these blend to produce an emerging sense of self. The self, however is in flux and as Greenberg (2011) observes "'At any one time, a person is organized by a tacit, dialectical synthesis of a number

of co-activated emotion schemes into one of many possible self-organisations, such as feeling confident, insecure, worthless, angry, sad or ashamed, which can change from one moment to the next" (p. 33).

Accordingly, EFT eschews the notion of a permanent, static, 'true' self, rather recognising that the relational, modular self, described above, is in a constant and on-going process of constructing itself as a *centre of initiative* (Greenberg et. al., 1993). Referring to the ways by which infants acquire a sense of themselves as an integrated whole, Greenberg and colleagues (1993) propose that the adult view of an integrated self is similarly constructed and has the potential for occasionally breaking down. They posit that when needs are met in development, one acquires an ability to regulate one's self that forms the basis of future stable self-organisations in relation to the environment. This allows clients to recognise that the 'self' is fluid and in a continuous state of construction and, being composed of multiple self-organisations rather than one fixed singular entity, can then understand current problematic experience as a temporary situation involving part of their totality rather than their whole being (i.e. "part of me feels hurt" rather than " I am hurt").

1.7 EFT Theory of Dysfunction

In EFT, dysfunction is regarded as being the potential result of a number of factors including "lack of awareness or avoidance of internal states, failure in emotion regulation, maladaptive responding based on traumatic learning or developmental deficits, protection against injury to one's self-esteem (shame), internal conflict, and blocks to the development of meaning" (Greenberg, 2011; p. 53). EFT recognises that it is important to distinguish between the different sources of dysfunction in order to effectively deploy differential interventions. Greenberg observes that while EFT has a broadly integrative approach to understanding dysfunction and has assimilated Roger's ideas around

congruence/incongruence, Gendlin's notion of blocked process, Gestalt ideas of disclaimed experience, existential theories around loss of meaning, learning theories around traumatic learning and psychodynamic interpretations of developmental deficits, it has redefined them in constructivist terms such that they are now more compatible with EFT's overarching process-experiential, dialectical-constructivist stance (Greenberg, 2011).

Dysfunction can appear under a variety of circumstances and in a number of manifestations. Given ETF's reluctance to diagnose whole persons in terms of disorders, it is incumbent upon the EFT practitioner to attend to a form of process-diagnosis of emotion states as they emerge during the course of therapy and then to focus on these states as the locus of intervention. Greenberg (2011) identifies four main processing difficulties: (1) lack of emotional awareness, (2) maladaptive emotional responses, (3) emotion dysregulation and, (4) problems in narrative construction and existential meaning (p. 53). Greenberg and colleagues (1993) categorise and describe dysfunction somewhat differently in that two main processes related to emotional meaning and dysfunction are identified: (1) a dialectically constructive process featuring the on-going conscious construction of meaning by synthesising and symbolising experience in awareness and, (2) an automatic process involving scheme activation wherein experience is automatically generated for potential synthesis in awareness. Greenberg's (2011) discussion of dysfunction is slightly broader in its scope and captures the core features of dysfunction, which is the reason its structure is more closely followed in the following sections, however, Greenberg and Paivio (1997) provide an even more inclusive taxonomy of the sources of dysfunction which includes stress, traumatic emotional memory, cognitive error and over-emphasis on beliefs.

1.7.1 Lack of emotional awareness

Lack of emotional awareness refers to the inability to symbolise bodily-felt experience in awareness (Greenberg, 2011Grenberg et al., 1993). It is a state in which the individual is cut off from emotion and the only way in which they can cope is by attempting to avoid feeling, by distorting, denying or ignoring experience. To be thus deprived of valuable, adaptive emotional information results in the individual becoming unable to identify needs and have them met, or to activate appropriate action tendencies. It follows that this can result in difficulties in interpersonal functioning and a diminished sense of mastery for the individual over their environment. For example, someone who is unaware, or cannot accept that they may feel anger cannot activate assertive/protective anger to set appropriate boundaries and as a consequence, may become confused and upset over repeated intrusions or violations perpetrated upon them by others in their environment. In generalised anxiety disorder, for example, worry may be experienced as a dysfunctional attempt to protect the individual from more primary emotions such as shame or fear/terror, which then paradoxically maintains them in a state of distress.

Many strategies can be deployed by the individual to further the goal of keeping emotional experience from awareness. Individuals may strive to feel emotions which they believe are socially desirable but which conflict with their own experience (the grieving individual who presents a stoic front); one may deliberately avoid certain situations which are anticipated to provoke unpleasant emotional experience (withdrawal to avoid embarrassment in social anxiety). Individuals may distract themselves from unpleasant emotions through keeping busy or always keeping the radio on, the transformation of emotions into somatic complaints such as 'stress headaches', or the numbing of emotional experience with drugs, alcohol or a range of other self-harming behaviours (Greenberg, 1997). Greenberg (2011) makes the interesting point that experience in this instance is not repressed or forgotten;

rather it has been disowned or disclaimed. The goal of EFT, therefore, is not to reveal to the client the contents of their unconscious, but rather to facilitate them in a process of reclaiming or taking ownership of previously unacceptable experience, and through assimilating it into existing meaning-structures, develop a more integrated and coherent sense of self (Angus & Greenberg, 2011, Greenberg, 2011, Greenberg & Paivio, 1997).

1.7.2 Maladaptive Emotion Schemes

Maladaptive emotion schemes form in a variety of ways but are most frequently the result of interpersonal situations that produce strong primary emotional reactions to particular circumstances or sets of circumstances. It appears as though that which is now intrapersonal was once interpersonal. If adaptive needs are continually unmet during development it is likely that the individual will develop a portfolio of core maladaptive emotion schemes, rather than the adaptive, resilient ones required for successful interpersonal functioning and self-coherence. For example, if in childhood the secure base is perceived to be a source of threat, the child cannot internalise compassion and develop the capacity for self-soothing. The resulting feelings of rejection and existential isolation may lead to the development of emotion schemes organised around anger, fear, and shame which mitigate against the possibility of forming close relations with significant others in later life (Greenberg, 2011; Greenberg & Watson, 2006).

In the above case, current triggers in the individual's life may activate old patterns of response, based on such historical, maladaptive emotion schemes and vulnerable self-organisations, which are then acted out in the present, thereby depriving the individual of the opportunity to learn new ways of responding in an adaptive and healthy manner. A fear of attachment, as someone attempts to become close to the individual may trigger the old self-

organisation, activating feelings of fear, rage and worthlessness, leading to hostile rejection of the other and an ensuing feeling of hopelessness and despair.

1.7.3 Emotion Regulation and Dysregulation

Emotion regulation and dysregulation reflects the notion that many difficulties in human functioning are, put simply, the result of having too much or too little emotion. It is frequently the regulating process governing emotion (in terms of, say, duration or intensity) that is the source of difficulty rather than the specific emotion itself. Anger which cannot be regulated may escalate to an inarticulate fury which in turn leads to fear about the possible consequences of experiencing anger, even if it is appropriate to the situation. This manifests in the therapy room when clients present as either overwhelmed by painful emotion expressed as rage, or inarticulate and unreachable crying, or on the other hand, are completely numb and disconnected from their emotional experience, either inappropriately cheerful or relating their own experience as thought they were a character in a story, divorced of affect. EFT interprets many of symptomatic presentations encountered in the therapy room, such as depression, substance abuse, anxiety etc. as dysfunctional attempts on the part of the client to achieve some form of emotional regulation in the face of chronic and enduring suffering (Greenberg, 2011). Recognising that the individual's ability to regulate emotion is mediated by conditions surrounding early attachment relationships in which caregivers act as *emotion coaches* Greenberg (2011; p. 59) states that "the secure self is formed primarily through the dyadic regulation of affect, and failure in this leads to an insecure sense of self" (See also Fosha, 2000, Schore, 1994).

EFT recognises that while cognitive and emotional processes are mutually regulating in an automatic process which mostly takes place out of awareness, emotion is both automatically and deliberately regulated. Rather than seeing emotion as a rogue element,

something to be feared and which needs to be controlled or constrained, EFT views emotion as something which is there to be tolerated if initially painful, explored for its inherent adaptive meaning, transformed if necessary but never avoided or repressed.

1.7.4 Narrative Construction and Existential Meaning-Making

Narrative construction and existential meaning-making acknowledges that a considerable amount of psychological difficulty for people can be attributed to the way in which they make sense of their existence and the way in which this is then re-presented as an over-arching self-narrative. This is quite distinct from *irrational thinking* as proposed by other theoretical modalities but rather is reflective of the existence of complex cognitive-affective structures operating at a core level, which renders them difficult to access superficially. "Narrative incoherence is a sign of the chaotic nature of self-organisation, where people are unable to create a stable sense of self "(Greenberg, 2011; p. 61)". As part of therapy, Angus and Greenberg (2011) describe the processing strategy of clarifying and organising needs, self-experience and thoughts, as they are symbolised in language, into a coherent narrative. This allows for complex experience to be organised into an understandable story in which individuals can make sense of and come to understand their active role in their own lives. "Clearly, it is important to symbolise and express emotions in a narrative context (p. 61). By this means, for example, narratives of humiliation or pain which were previously problematic can be transformed such that individuals can attain a new understanding of either their own role or the intentions/behaviours of others. The abused child who for many years felt small, weak, ashamed and victimised may through therapy reconstruct an alternative narrative which honours him/herself as a survivor, (accessing previously unavailable self-compassion), recognise the contemptible nature of the abuser (activating protective anger) and move, gradually towards a more integrated sense of narrative and self-coherence (Paivio & Pascual-Leone, 2010) How people describe their

experience necessarily influences their experience; such that one may move from a passive, victim stance with a chaotic self-narrative to a more stable position characterised by greater agency and narrative coherence.

1.8 The Therapy Process in EFT

1.8.1 Treatment Principles

EFT operates from an established set of six treatment principles that guide and inform the manner in which the therapist relates to and engages with the client. These can be divided into *relationship principles* and *task principles* (Greenberg et. al., 1993; Elliott & Greenberg, 2007). EFT holds that the "Relationship principles are crucial and are to be given logical and temporal priority over the task principles" (Greenberg et. al., 1993; p. 101).

1.8.1.1 Relationship principles

Relationship principles are a prerequisite for conducting therapy from an EFT perspective and are strongly influenced by humanistic values. EFT offers a relationship which is genuinely prizing of the client. It is authentic, respectful and is characterised by a genuine and non-judgemental therapeutic presence. Such an affirming relational stance allows for engaging in tasks, particular to EFT, in a safe environment where clients are able to access core emotional experience (Greenberg et. al., 1993; Elliott et. al., 2004; Elliott and Greenberg, 2007; Geller & Greenberg, 2012). Relational principles outlined below are adapted from Greenberg and colleagues (1993).

Principle 1: Empathic attunement: Contact and be empathically attuned to the client's internal frame of reference.

This process, wherein the therapist tracks the client's in-session experience as it evolves, develops as a result of the therapist's *presence* and is driven by the therapist's

genuine curiosity regarding his/her client's inner world. Empathy is an empirically validated process in psychotherapy (Bohart, Elliott, Greenberg and Watson, 2002) and involves the therapist's adoption of a particular relational stance towards the client, incorporating a willingness to enter the client's frame of reference and intuit that which is most pertinent or salient for the client at any given moment. Empathic attunement allows for the following of specific client pathways and frees up the possibility of systematically unpacking the client's experience.

Principle 2: Therapeutic bond*: *Communicate Empathy in a Genuine, Prizing Relationship.

This refers to the connection formed by the therapist's effective communication of accurate empathy, prizing and therapeutic presence to the client. The therapeutic bond is, in and of itself, a healing factor (Rogers, 1957; Norcross, 2002; Orlinsky, Rønnestad & Willutzski, 2004) involving three related elements: (a) understanding/empathy, (b) acceptance prizing, and (c) presence/genuineness. The therapeutic bond develops as the therapist is not only empathically attuned to the client, but communicates this empathetic awareness to him/her, in order that they feel genuinely understood at all times (Greenberg et al., 1993; p. 105). By successfully adopting a way of being in relation to the client which incorporates these factors, the therapist and client may experience a relationship/bond which is characterised by authenticity (congruence) and transparency (openness) and is infused by the therapist's genuine presence (Greenberg et al., 2003, Gellar & Greenberg, 2002, 2012, Lietaer, 1993).

Principle 3: Task collaboration: facilitate Mutual Involvement in Goals and tasks of Therapy.

This refers to the client and therapist collaboratively engaging in therapeutic tasks which are consistent with overall treatment goals and within-session therapeutic activities. Greenberg (2002; p. 55) volunteers the notion of therapist as *"emotion coach"*, to capture the nature of the relationship between client and therapist EFT recognises that, while the therapeutic bond as expressed by person-centred facilitative conditions was necessary and might be sufficient, it could not be considered efficient (Elliott, 2012; Watson, 2007). In EFT, client and therapist collaborate in identifying and carrying out tasks which facilitate the achievement of therapeutic goals, which has been demonstrated to be predictive of outcome (Watson & Greenberg, 1996)

1.8.1.2 Task principles

While the relationship principles described above capture the essence of an optimal relationship between client and therapist, EFT theory elaborates on a further three principles which guide the therapist's efforts to facilitate the client's journey towards resolving emotional dysfunction.

Principle 4: Experiential processing: Facilitate Optima, Differential Client Processes.

This refers to EFT's recognition that clients are adaptive and flexible in their approach to therapy and that the effective therapist must be aware of these *modes of engagement* (Elliott et al., 2004) and assist the client in engaging with salient *micro-processes* as they emerge, mindful of the fact that clients may 'work in different ways at different times' (Elliott and

Greenberg, 2007; p. 250). Elliott and Greenberg (2007; pp.250-251) list the following modes of engagement:

- Attending – focusing on that which is accessible to consciousness.
- Experiential search – exploring experience to identify and clarify.
- Active expression – enacting inner experience.
- Interpersonal contact – exposing ones internal world to an other.
- Self-reflection – reflecting on experience to understand and create new meaning.
- Action planning – anticipating how one may act think or feel in the future.

EFT is a marker-driven therapy and within certain given tasks, micro-processes suggest to the therapist what may be the optimal form of engagement to enhance the client's experience of therapy, and facilitate change.

Principle 5: Foster Client Growth and Self-determination (Growth/Choice).

This refers to the EFT therapist's commitment to enhancing the client's natural movement towards responsibility and empowerment. Theoretically consistent with EFT's humanistic stance, this reflection of an existential position where clients are encouraged to assume ever greater responsibility for their actions both in and outside of therapy in a gradual movement towards ever greater autonomy. Choice is continually proffered to clients in the awareness that one inevitably commits to something in a more meaningful way if one feels a sense of ownership of it, be that in relation to a specific task or the entire process of therapy

Principle 6: Task completion/focus: Facilitate Completion of Specific Therapeutic Tasks.

This describes the requirement that the therapist, being aware of the way in which resolution may be achieved, and cognisant of the fact that clients often struggle to complete tasks in the early stages, facilitates the client in overcoming avoidance, interruptions and

blocks which threaten to derail therapy. The therapist is *process-directive*, guiding the client towards resolution; the degree of direction offered is related to the level of client dysregulation (more dysregulated clients may initially favour a greater provision of structure). The therapist does not, indeed cannot and should not attempt to, force resolution. However by adhering to the framework the EFT therapist can, through adopting a dialectical constructivist position of leading and following, facilitate the client in their journey towards the eventual allowing or acceptance of experience. In this context change is facilitated by the dynamic self-organisation undergone by the client as a result of their acceptance and moving on (Greenberg, 2011).

1.8.2 Principles of Emotional Change in EFT

Greenberg (2002, 2008; Greenberg & Watson, 2005) proposes five empirically based principles for understanding the manner in which emotion processing relates to clinical change: (a) emotion awareness, (b) emotional arousal and expression, (c) emotion regulation, (d) reflection on emotion and, (e) emotion transformation), a sixth principle (f) corrective emotional experience, is added in Greenberg (2010, 2011).

(a) Emotion Awareness

Increased *emotion awareness* is the foundation for emotional change; therapists therefore aim to facilitate their clients in approaching, tolerating and accepting their emotions. Only when a client can access their core emotional experience and express it in language can they employ the adaptive information and action tendencies contained therein. When we know and accept what we feel, we are in a position to identify our needs and move towards having them met. Greenberg (2011) stresses that we are not thinking about feeling, we are in fact "feeling the feeling in awareness" (p.74) and that only when emotion has been felt, can its symbolisation in language be of therapeutic benefit.

(b) Emotional arousal and expression

As Greenberg (2011) observes, *emotional arousal and expression* does not refer to the indiscriminate "venting" of secondary emotion but rather describes a process whereby clients can access and express hitherto unavailable primary emotions, thereby facilitating adaptive emotional and behavioural responses (p. 75). Noting the manner in which emotional expression "mobilises the affect system, changes physiology and neurochemistry, overcomes inhibition and changes interpersonal interaction", Greenberg (2008; p. 52) cites numerous studies which confirm the role played by emotional arousal in predicting outcome across a number of treatments and conditions. He cautions, however, that arousal alone is not necessarily sufficient for progress and that it be qualified in terms of its productivity, where productivity is understood in terms of regulation, agency and emotional processing (Greenberg, 2008; Auszra, Greenberg & Herrmann, 2007). Clients need to learn to allow and tolerate being in "live" contact with their (frequently painful) emotional experience (Greenberg, 2011; p. 73).

(c) Emotion regulation

Emotion regulation refers to the "processes by which people influence which emotions they have, when they have them, and, most importantly, how they experience and express these emotions" (Greenberg & Watson, 2005; p. 79); a necessary component of any therapy is an ability to identify which emotions need regulation and how this may be achieved. EFT provides a safe, affirming and empathic environment which contributes towards regulating or soothing under- or dys-regulated secondary and maladaptive primary emotion. Greenberg (2011) draws attention to emotional self-regulation skills outlined by Linehan and utilised in Dialectical Behaviour Therapy (DBT: Linehan, 1993), which include identifying and labelling emotions, allowing and tolerating emotions, establishing a working

distance, increasing positive emotions, reducing vulnerability to negative emotions, self-soothing, breathing and distraction as a means of tolerating acute distress and acquiring some distance from otherwise crushing feelings of hopelessness and despair. DBT, along with other therapies acknowledges that emotion regulation requires more than cognitive strategies, arguing that problems may be attributable to deficits in implicit forms of emotional regulation, confirming the EFT position that clients benefit from interpersonal validation along with regulation strategies and distress tolerance skills (Greenberg, 2011, 2010; 2008; Greenberg & Watson, 1998, 2006; see also: Fosha, 2000; Linehan, 1993; Schore, 2003).

(d) Reflection on emotion

Reflection on emotion recognises that not only is it essential to symbolise emotion in language, but individuals must also reflect on their emotional experience in order to attain a sense of narrative coherence. The manner in which we interpret our emotional experience, in a sense, defines us. Reflection on experience allows individuals to create new meaning and to develop new narratives to explain ourselves to ourselves (Greenberg, 2011, 2010, 2008, 2007, 2002; Greenberg and Pascual-Leone, 1997; Greenberg and Angus, 2004, 2011) Greenberg states "Therapy thus involves change in both emotional experience and change in the narratives in which they are embedded" Greenberg, 2008; p. 53)

(e) Transformation

Transformation is one of the concepts most central to EFT in so far as it introduces the novel concept of transforming one emotion with another. This process refers to the transformation of primary maladaptive emotions such as fear or shame with more adaptive emotions. Greenberg (2002, 2008) argues that as thinking usually changes thoughts, feeling usually changes emotions. Rather than attempting to reason with emotion, or think one's way out of distress, EFT proposes that clients access maladaptive emotions, not as a source of

adaptive information or action tendencies, as would be the case in primary adaptive emotion, but in order to transform them with a more adaptive alternative. To illustrate this point, Greenberg (2008) refers to Frederickson's (2001) study which suggests that certain aspects of positive emotions are incompatible with negative ones and noted that resilient individuals displayed an ability to recruit positive emotions in order to regulate negative emotions (Greenberg, 2008; p. 54). Greenberg highlights the paradox inherent in this as, in order to effect emotional change, one does not attempt to change but, rather, must accept painful emotion experience. "One cannot leave a place until one has arrived at it" (Greenberg, 2011; p. 78). EFT theory proposes that unlike other therapeutic strategies which operate on emotion from the basis of habituation, extinction, exposure or catharsis EFT is quite distinct in that one emotion is used to undo or transform another (Greenberg, 2010, 2011).

In the sense that negative emotions may be changed by the introduction of more adaptive, positive emotions, so maladaptive emotions are open to transformation by the introduction of dialectically opposite adaptive emotions (i.e. maladaptive anger can be transformed by accessing adaptive sadness). The therapist may facilitate this process by bringing subdominant emotions to greater awareness. For example, the therapist may encourage the client to focus on the need implicit in their core pain thereby activating a novel emotional response to an otherwise old and worn emotional pathway (A client who accesses their core sadness and abandonment may identify the need for connection and provide this through self-soothing). Alternatively, fear in the face of historical threat (perhaps an abusive parent) has an action tendency of withdrawal and running away. If fear is replaced with protective/assertive anger, which has the action-tendency of moving forward and is therefore incompatible with running away, the client may access the possibility of standing up to the parent; an opportunity afforded by access to a new emotional possibility.

(f) Corrective Emotional Experience

Corrective Emotional Experience occurs when a new lived-experience with another person (often the therapist) changes an old way of feeling. For example, if a client experiences shame in session and is met with the therapist's acceptance and understanding, rather than the expected disgust and rejection, it is possible the client's pathogenic belief may be undone by this new sense of being accepted or soothed.

1.8.3Therapeutic Phases in EFT

EFT is delivered across three phases of treatment: *bonding and awareness*, *evoking and exploring* and finally *transformation* (Greenberg, 2011). Although linear, these are not necessarily followed sequentially and therapy can move between phases. Each stage includes a combination of relational principles, task principles and techniques to facilitate therapeutic progress (Greenberg & Watson, 2006; Elliott & Greenberg, 2007). The following phases are adapted from Greenberg and Watson (2006).

Phase1. Bonding and Awareness

This primary and foundational phase of therapy aims to establish a safe, working relationship between client and therapist, characterised by trust and understanding. It facilitates orienting the client towards greater awareness of their emotional processes and allows for collaborative agreement on a focus for therapy. While these objectives will be developed and enriched throughout the course of therapy, initial attainment of them allows for progression to phase two. Establishing a relationship requires attending to, empathising with and validating the client's feelings and current sense of self, providing a rationale for working with emotion, promoting awareness of internal experience and establishing a collaborative focus (Greenberg & Watson, 2006).

Phase 2. Evoking and Exploring

This phase captures the experiential dimension of EFT as clients are encouraged to fully engage with and experience their difficulties rather than simply describe them in the abstract. Clients are encouraged to, and guided in, the re-claiming of experience which has previously been disowned, or dis-allowed. In this phase the EFT therapist acts as an in-session, process-facilitator, helping clients to access their core pain, which is expressed through activating core emotion schemes. Clients are facilitated in accessing, and staying in contact with (i.e. tolerating), previously unacceptable, disclaimed experience. This involves establishing support for emotional experience, evoking and arousing problematic feelings, undoing interruptions of emotion, helping the client access primary emotions or core maladaptive schemes (Greenberg & Watson, 2006).

Phase 3. Transformation: Generating New Emotions, Creating New Narrative Meaning

Working from the principle that clients cannot leave a place until they have arrived at it, Phase 3, a transformational phase, facilitates clients in transforming, or leaving the place they arrived at, or reclaimed in Phase 2. Clients are facilitated in accessing new, adaptive responses and in constructing new meaning in relation to their experiences. Change is produced as clients, in a dialectical process of synthesising new experience, redefine themselves by generating new emotional responses to transform core maladaptive schemes, promoting reflection to make sense of experience and validating new feelings and supporting an emerging sense of self (Greenberg & Watson, 2006).

1.9 Case Conceptualisation in EFT

Case conceptualisation (or formulation) in EFT finds expression as a collaborative act of co-construction between therapist and client, a context-sensitive, process-orientated activity wherein therapists endeavour to remain attentive and responsive to the client's moment-to-moment, in-session experience (Greenberg, 2011; Greenberg & Watson, 2006;

Greenberg & Goldman, 2007; Watson, 2010). While it originally focused on responding to in-session markers, with the application of specifically developed experiential tasks in order to achieve therapeutic aims (Rice & Greenberg, 1984; Greenberg et. al., 2003; Elliott et. al., 2004; Greenberg, Rice & Elliott, 1993), EFT currently explicates an over-arching, comprehensive and theoretically informed approach to case formulation. Eight steps have been developed which provide the framework for case-formulation in EFT (Greenberg & Goldman, 2008). Case formulations are held tentatively by the therapist and are subject to revision and development as therapy progresses. The relative fluidity of EFT case formulations is facilitated by the eight steps which provide a process by which the therapist can engage reflexively in therapy with the client, adapting the formulation as the need arises. The eight steps, which were developed with the treatment of depression in mind, but have a general application, are as follows:

1. Identification of the presenting problem.

In this stage the therapist attends to that which brought the client to therapy, the presenting issue, and also, collaboratively arrives at a focus for treatment with the client. In the early stages, as therapy progresses, the client's presenting issue is re-presented to him/her, in terms of problematic emotion schemes, consistent with EFT's aim of making the therapist's tacit knowledge more explicit and providing a rationale for future task-based interventions (Watson, 2010). In the spirit of collaboration, clients may be asked for their own theories regarding presenting issues which not only provides an opportunity for shared understanding of the issue but may also flag future therapeutic issues regarding client insight, processing style, etc. (Paivio & Pascual-Leone, 2010).

2. Listening to, and exploration of, the client's narrative about the presenting problem.

Here the therapist listens attentively to the client's narrative style in order to identify how clients express themselves in order to inform future interventions. Therapists wish to elicit information regarding how clients treat themselves and others, how they allow themselves to be treated, and the meanings they attach to this. Therapists wish to gauge how distant clients are from their emotional experience or if in fact they are quite aware of it (Watson, 2010). Clients may present themselves here as externally focused, disconnected from their emotional experience, intellectual and overly rational, looking to external factors as indicators of how they should feel and behave (Elliott et al., 2003). Angus and Greenberg (2011; p. 73) identify four types of narrative style commonly encountered in therapy: (a) *the same old story*, which has a rehearsed, pre-planned quality, (b) *empty stories*, in which clients disclose salient or painful material which emotional activation or experiential engagement are absent, (c) *unstoried emotions*, where painful emotional states are expressed without being embedded in a narrative context or, (d) *broken stories*, in which the client experiences a discrepancy between two plotlines, the "expected, or hoped" for versus "the emerging or actual plotline"; which may manifest as emotional and/or narrative incoherence.

3. Observe and attend to the client's style of processing emotions.

From the commencement of therapy, the therapist observes the client's processing style in order to assess how he/she engages with their emotional experience. They gauge how aware clients are of their emotional experience and how they regard and evaluate it. They assess whether clients are emotionally under- or over-regulated; whether, lacking the ability to symbolise their experience in language, it emerges in non-verbal ways (laughing, fidgeting); or the degree to which they can differentiate between the various flavours of emotional experience; i.e. assertive/protective anger or hurt/rejecting anger (Greenberg &

Watson, 2006). During in-session observation of the client's narrative processes the therapist may determine whether the client is experiencing and expressing primary, secondary or instrumental emotion, and emotion may be further assessed in terms of its level of arousal and degree of productivity (Goldman, Greenberg & Pos, 2005; Klein, Mathieu, Gendlin & Kiesler, 1969; Carryer & Greenberg 2010; Greenberg, Auszra, & Herrmann, 2007).

From the point of view of case-formulation, this allows the therapist to assess the various coping strategies employed by clients in order to regulate their affect. Such coping strategies are learned from caregivers as ways of soothing oneself in the face of overwhelming or aversive emotional experience and may be behavioural or cognitive in nature, may involve reflecting on or distracting from emotional experience and may be self- or other-orientated in nature. The therapist may then focus on eliciting primary emotion and either transforming or regulating it as required.

4. *Gather information about clients' early attachment, identity-related histories and current relationships.*

EFT theory proposes that dysfunction is frequently attributable to issues concerning affect regulation due to maladaptive or unprocessed emotional experience. Given that emotion schemes are generally based on, (a) significant attachment relationships (past and present) and, (b) personal identity experiences, involving issues around meaning-making and construal, and which are current and developmentally relevant; it follows that information concerning these issues is vital to meaningful case-formulation. EFT aims to provide a safe therapeutic environment under which clients can access emotion schemes for further processing and, if necessary, restructuring (Elliott et. al., 2003). Information regarding how and when emotion schemes were formed is required in order to activate them and to subsequently work with them therapeutically.

5. Identify and respond to the painful aspects of the clients' experience (core pain).

Greenberg and Watson (2006; p. 144) describe how, in order to successfully formulate cases, it is necessary for the therapist to develop a *pain compass* which allows them to accurately track their clients' emotional experience. Given that the therapist wishes to access and work with narrative information that is emotionally charged, it follows that therapists allow themselves to be drawn to the most therapeutically productive regions of their clients' stories by using the pain compass to guide them towards attending to that which is most painful or poignant in the client's narrative. That pain is likely to be at the core of the client's maladaptive emotion scheme, comprising (for example) feelings of loss, humiliation, rejection or fear and, in terms of case formulation, suggests itself as an appropriate focus for therapy.

6. Identify markers when they arise; suggest tasks appropriate to the problem state.

As a therapy, EFT is distinguishable by its adherence to applying specific in-session, marker-driven tasks in order to resolve clients' cognitive affective difficulties. Markers are an empirically validated component of EFT theory that guide the work of therapy (Elliott et al., 2004; Greenberg et al., 1993). Main markers may relate to, interpersonal issues involving emotional pain related to past or current, featuring unresolved issues in relation to a significant other (requiring empty-chair) work, and empathic exploration and, examination of self-self-relations (self-treatment) which reveals how clients treat themselves (i.e. harsh, punitive, neglectful, contemptuous) and how they process emotion (requiring two-chair work).

7. Focus on emerging thematic intrapersonal and interpersonal processes and narratives.

Attending to client accounts of relations and interactions with caregivers and significant others, whether expressed in narrative or through experiential tasks, over the course of therapy provides the therapist with valuable information regarding clients' perceptions of how others treat them and also how they treat themselves (Elliott et. al., 2004; Watson & Bohart, 2001). These accounts may take the form of experiential re-enactments of the presenting issue offering the therapist the opportunity to explore and address maladaptive emotion schemes, 'live', in session. Intrapersonal processes are identity-focussed and may involve feelings of shame or worthlessness while interpersonal processes are attachment-focussed and may involve feelings of abandonment or rejection.

8. Attend to clients' moment-by-moment processing to guide interventions within tasks.

As case formulation in EFT is a fluid and ever-evolving concept it is incumbent upon the EFT therapist to pay close attention to the client's, in-session, moment-to-moment processing as a guide to further action. Therapists are alert to *micromarkers*, verbal or non-verbal behaviours exhibited by clients, which indicate the degree to which clients are in touch with their emotional experience and may provide information regarding the state of the therapeutic alliance (Greenberg & Watson, 2006). Attending to micromarkers is an important component of developing the pain compass described earlier as the therapist homes in on the most poignant aspects of the client's story. Verbal micromarkers would include the language clients use to describe their experience, for example: are narratives vague or is there specific detail, is language vivid and personal or is it bland and impersonal, does the client resort to cliché or humour or is their narrative direct and meaningful? Nonverbal markers include pauses, level of emotional arousal, vocal quality and body language (Greenberg & Watson, 2006).

1.10 Model of Emotion Transformation

In an analysis of how emotional transformation occurs in therapy, Pascual-Leone and Greenberg (2005) developed a sequential model of the optimal therapeutic processing of core emotional pain, through the qualitative analysis of observable, moment-to-moment steps in emotional processing as they occurred in therapy. The emotional processing model which emerged from this analysis, suggested that clients with successful therapeutic outcomes moved from an initial position of undifferentiated *global distress* and secondary emotions to maladaptive primary emotions such as fear or shame featuring strong negative self-evaluations. The model then proposed that by the identification and expression of a previously unmet need, the client may then, through a process of accessing adaptive sadness, protective anger and a hitherto unavailable capacity for self-soothing, achieve a position of acceptance and agency in relation to their emotional states (Pascual-Leone & Greenberg, 2005).

The coding system in the model of emotion transformation (Classification of Affective-Meaning States: CAMS; Pascual-Leone & Greenberg, 2005) was developed to track the 'flow of emotions' as they occur and in the sequence in which they present. It recognises previous research which acknowledges that some emotions are more productive than others (Greenberg, Rice & Elliott, 1993; Greenberg & Paivio, 1997) and anticipates future research in that area (Greenberg, Auszra & Herrmann, 2007). It also considers the level of emotional arousal which is optimal for effective emotional processing (Warwar & Greenberg, 1999; Missirlian, Toukmanian, Warwar & Greenberg, 2005). The models ten key categories are, briefly, as follows (adapted from Pascual-Leone and Greenberg, 2005).

Global Distress

Global distress may also be referred to as *undifferentiated distress* in so far as it is an emotionally reactive response to an underlying hurt in which negative emotions are fused and obscure the client's attempts to access the deeper emotional difficulty. As they do not capture a specific emotional response or the action tendency contained therein, the client is left feeling confused and in pain without access to resolution. Frequently clients state that they simply do not know why they are feeling so distressed (Pascual-Leone and Greenberg, 2007). Pascual-Leone and Greenberg (2005) describe this stage as "being of high expressive arousal and low meaningfulness in regards to some personally sensitive theme" (p. 10). Typical of early presentations in therapy the client at this stage experiences being in a state of suffering with high expressive arousal, lacking in agency with no sense of direction or clear internal referent of experience. In this state clients experience themselves as passive victims and describe themselves as hopeless, helpless, resigned, confused (i.e. *"I feel hopeless, lost, sad and discouraged"* or *" I could just cry forever"*). Some psychodynamic literature conceptualises global distress as a mini-dissociative defence position (Fosha, 2003). Pascual-Leone and Greenberg (2005) observe that when clients begin to differentiate their experience they move either towards fear/shame or rejecting anger.

Specific maladaptive fear and shame

Specific maladaptive fear and shame describes the next stage of the model captured by Pascual-Leone and Greenberg (2005) as "...the emotional expression of a core underlying concern, which is the source of deep and enduring personal pain" (p. 19). They characterise this state as being one of high arousal and high meaningfulness due to the idiosyncratic nature of the (generally self-oriented) pain being expressed, which the client experiences as an old and familiar way of feeling (i.e. "I am worthless", "I am defective/bad"). The

autobiographical nature of the memory provides an affective meaning state infused with recollections of repeated occurrences within a specific context (Angus, Lewin, Bouffard & Rotundi-Trarisan, 2004). In comparison to global distress, these emotions are quite differentiated and specific and although they have associated action tendencies (withdrawal, escape, closing down) the crushing familiarity of these emotion states suggests to the client that they will never break free of them, inducing hopelessness (*"I still feel it's my fault...I deserve to be punished"*).

Generic rejecting anger

Generic rejecting anger refers to the client's angry rejection of some external object, is frequently expressed from the position of victimhood and may be seen as a defensive reaction to avoid pain. It is characterised by feelings of repulsion, hate or disgust and is commonly expressed with high arousal such as angry tears, shaking a fist. Its action tendency is one of distancing and sometimes even one of destroying (Pascual-Leone & Greenberg, 2007). Although it can occasionally have an initially adaptive quality, in that it appears to be an agentic rejection of an aversive experience, it is more commonly maladaptive, leaving the client in a *stuck* position due to its essentially reactive character and its potential for maintaining the client in an *underdog* role from which they may easily collapse back into global distress. Lacking in idiosyncratic meaning it focuses more on the noxious aspect of the other rather than divining personal, subjective information from the experience which might facilitate adaptive emotional schematic processing.

Negative evaluation

Negative evaluation occurs when the client makes a statement which suggests any one of the following, (a) I am not loveable, (b) I am worthless, (c) I will be destroyed and (d) I will be abandoned and unable to survive on my own (Pascual-Leone & Greenberg, 2005; p.

38). Such a statement may be conceptualised as a core negative belief, and as such, while not an actual emotion, the therapist may be confident that this is an accurate expression of meaning with regard to the client's distress.

Existential need

Existential need, and the expression of same, reflects the identification in language of an adaptive need which the client requires to have met in order to achieve healthy functioning (i.e. *"I want protection"* or *"I need to be loved"*). The expression of need may be prompted by the therapist (*"What do you need here?"*), or may occur spontaneously. Such statements of need are often accompanied by aroused emotion as they frequently occur after the client has expressed their core negative belief (i.e. *"I am unlovable"* may be followed by *"I just need to feel loved"*). Pascual-Leone and Greenberg make the interesting distinction that the expression of need at this point is not accompanied by a sense of entitlement (which would make it closer to assertive anger); rather, it is expressed as a statement of novel self-discovery (Pascual-Leone and Greenberg, 2005).

Specific self-soothing

Specific self-soothing describes a reflexive process whereby the client moves from a passive to an active position in relation to themselves and engages in a form of self-treatment which is characterised by tenderness, caring and understanding. Self-soothing, or *self-nurturing*, may be viewed as an active form of nurturing the self; 'compassion for the self' made explicit, or operationalized.

Specific and adaptive assertive anger

Specific and adaptive assertive anger reflects a sense of empowerment as the client manifests self-assertion with regard to either personal boundaries (i.e. *"I will not allow you to*

speak to me like that!") or adaptive need (i.e. *"That's not enough anymore. I need your support!"*). The tone of his expression reflects the client's growing self-confidence and is sufficiently differentiated as to implicitly contain some form of positive self-appraisal (i.e. I deserve better than this; I am loveable). These statements may contain a dimension of *ethical righteousness* (i.e. *"I cannot accept the way you treat me"*) and being generally high in both arousal and meaningfulness are considered to be adaptive in terms of both self-valuation and mobilisation towards a positive and healthy state of being. In contrast to rejecting anger, which is concerned with driving away something noxious, assertive anger is more concerned with "setting boundaries and engaging in a fight for one's rights and/or existential needs" (Pascual-Leone & Greenberg, 2007; p. 879)

Specific adaptive grief/hurt

Specific adaptive grief/hurt captures a very genuine and highly authentic sense of loss, which is considered adaptive in the sense that it is an appropriate response, grounded in the real and infused with an acceptance of things being the way they are. Unlike global distress, the affective meaning state of grief/hurt is distinguished by the absence, in its emotional tone, of blaming, self-pity or resignation. Further evidence for the adaptive nature of this affective-meaning state lies in the way that it mobilises the client towards *letting go* of certain memories or aspects of their past, or may involve a profound acknowledgement of the significance of past injuries in such a way that they can be woven into a new and developing sense of narrative coherence.

Relief

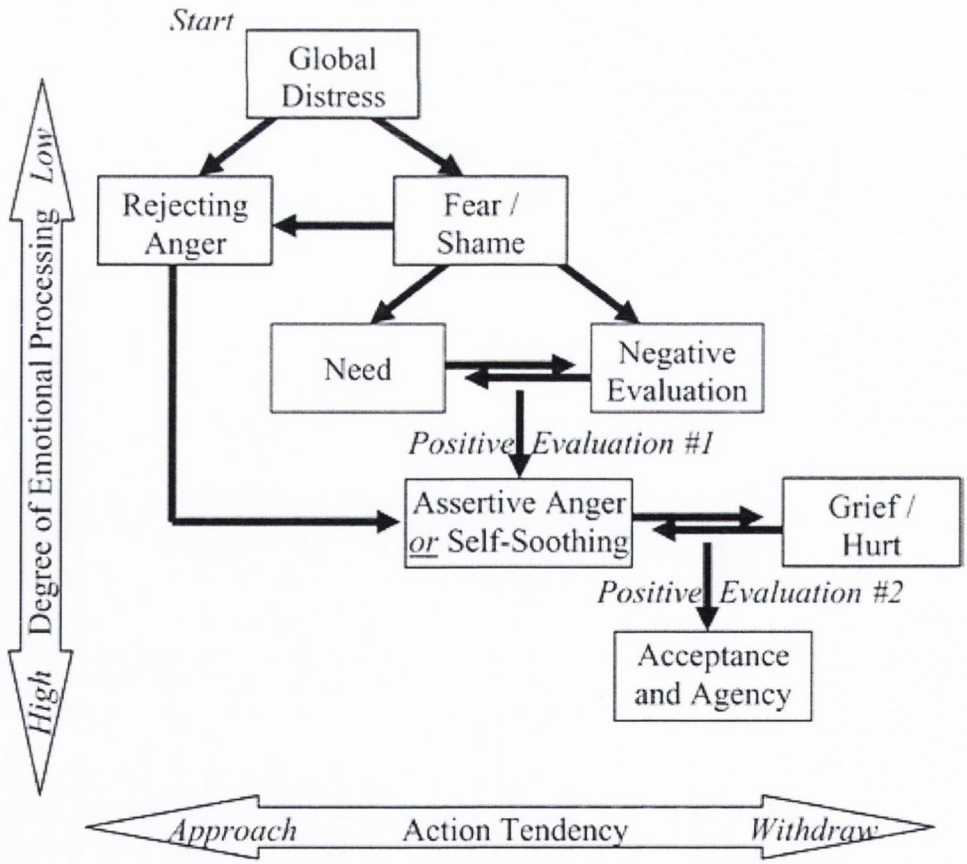
Relief occurs when clients, reflecting on recent processes in which they have been engaged, note that tension has been reduced (which may be felt in the body) and acknowledge, in a kind of meta-awareness that some form of emotional shift has taken place.

Pascual-Leone and Greenberg (2005) draw attention to Fosha's (2000) observation on "the experience of the experience" noting that while the actual emotional transformation may be painful, the overall experience of that transformation, on reflection, may be positive.

Acceptance and agency

Acceptance and agency refers to the resolution of distress; a state characterised by high meaningfulness and low arousal. It suggests a state of calm in which the client is largely free of the elements which contributed to previous upset and is able to accept both themselves and their situation.

Figure 1. The State-Transitional Model (Pascual-Leone & Greenberg, 2005)



1.11 EFT and Anxiety

It is fair to say that historically that, amongst researchers of person centred and experiential therapies, anxiety has been somewhat neglected as a profitable field of inquiry (Elliott, 2013). This is no less true in the case of EFT which, arguably, has focused primarily on depression, albeit with considerable success (Greenberg & Watson, 2006; Elliott, Watson, Greenberg, Timulak & Freire, 2013). It is notable that recently EFT has broadened its scope to include investigations of the application of EFT to such diverse areas as eating disorders (Dolhanty & Greenberg, 2009), complex trauma (Paivio & Pascual-Leone, 2010; Paivio, Jarry, Chagigiorgis & Ralston, 2010), borderline personality disorder (Pos & Greenberg, 2012; Warwar, Links, Greenberg & Bergmans, 2008), deliberate self-harm (Kimball, 2009) and, indeed, has always had an interest in couples therapy (Greenberg & Johnson, 1988; Johnson & Greenberg, 1985; Johnson, 2009, 2004; Greenberg & Goldman, 2008).

It is perhaps consistent with EFT's neo-humanistic, process orientated approach to case formulation that past research has concerned itself not so much with fitting therapy to specific diagnostic categories, but rather with examining the underlying features which contribute to dysfunction and the change processes which lead to their resolution. In recent years EFT has strengthened its position as an empirically supported therapy, consistent with APA Division 12, Empirically Supported Treatments (APA: Div. 12 SCP, 2013); a position which necessarily (politically) requires validation of therapeutic efficacy in terms of specific populations.

Significant work has been produced recently by Elliott and colleagues (MacLeod & Elliott, 2012; MacLeod, Elliott & Rodgers, 2012) investigating the application of EFT as a treatment of social anxiety, while work by Timulak and colleagues, including the current study, has focused on generalised anxiety disorder (O'Brien, Timulak and McElvaney, 2012;

Keogh, Timulak and McElvaney, 2013; Crowley, Timulak and McElvaney, 2012; Hughes, Timulak and McElvaney, 2013; Murphy, Timulak and McElvaney, 2013). Elliott (2013) outlines a compelling rationale for engaging with the treatment of anxiety disorders on the part of humanistic therapies, based on recognition of historically proven success rates. He notes that, (a) the high levels of co-morbidity between depression and anxiety suggest that humanistic therapies are already being successfully applied to populations suffering from anxiety, (b) humanistic therapies are commonly applied to 'mixed' populations which are statistically likely to contain anxious members, and, (c) critically, central formulations concerning human dysfunction held by humanistic therapies may be understood as explicitly pertaining to anxiety (Elliott, 2013).

Typically, EFT conceptualises anxiety in terms of *anxiety producing splits* in which clients makes themselves anxious by means of a process in which the catastrophiser (critic) impacts on the emotional experience of anxiety (experiencer), which approximates the "experience of the symptomatic anxiety" (Greenberg, 2010; p. 104). The powerful critic impacts upon the vulnerable and collapsing experiencer who is unable to withstand the onslaught, becoming compromised and fearful; unable to have their basic needs met (Elliott, 2013, Elliott et. al., 1998, Paivio & Pascual-Leone, 2010, Greenberg, 2011). EFT acknowledges the manner in which, beneath the presenting anxiety split, there is a deeper, more profound anxiety split characterised by the critic's fear of what may befall the experiencer should it attempt to have its hitherto unmet needs met, rendering itself vulnerable in the process. Greenberg notes that this represents the core maladaptive emotion scheme and is frequently centred on fears of abandonment or the shame of inadequacy. He proposes that these schemes be activated in unfinished business work and may be resolved by accessing protective/assertive anger and self-soothing/self-compassion (Greenberg & Pascual-Leone, 2005; Pascual-Leone, 2009; Greenberg, 2011).

Timulak and the author of the current study are currently in the process of developing a model for understanding GAD from an EFT perspective, which, while informed by the classical EFT theories of case conceptualisation and EFT views on the nature of anxiety, is further informed by the recent research in EFT on emotional transformation and emotion processing by Greenberg and Pascual-Leone (Pascual-Leone & Greenberg, 2005, 2007 and Pascual-Leone, 2009). This approach to conceptualising change processes in anxiety has been expanded on through further work by Timulak and colleagues (O'Brien et al., 2012; Keogh, et al., 2013; Crowley, et al., 2013; Hughes, et al., 2013; Murphy, et al., 2013) providing an elaboration on the existing EFT model.

1.12 Emotion Transformation Model of EFT and GAD

Timulak (2012) elaborates on the connection between the emotion transformation model (Pascual-Leone and Greenberg, 2005), and classic EFT case conceptualisation, by drawing on information derived from studies produced by the Trinity College Dublin psychotherapy research group (Keogh, 2010; Timulak et al., 2012; O'Brien et al., 2012; McNally et al., 2012; Dillon et al., 2012; Crowley et al., 2013; Keogh et al., 2013; Murphy et al., 2013; Hughes et al., 2013). Following a successful application of the model of emotion transformation to cases of EFT as a treatment of depression (Keogh, 2010; McNally et al., 2012; Dillon et al., 2012), it was felt that results warranted an application of the model to emerging data from cases of EFT as a treatment of GAD. O'Brien and colleagues analysed the early sessions of therapy, in cases where EFT was offered as a treatment of GAD (39 sessions across 5 participants), with a view to capturing the core emotional pain of clients with GAD, providing an enriched understanding of client progression through the early stages of therapy (O'Brien et al., 2012). This facilitated the development of a conceptual

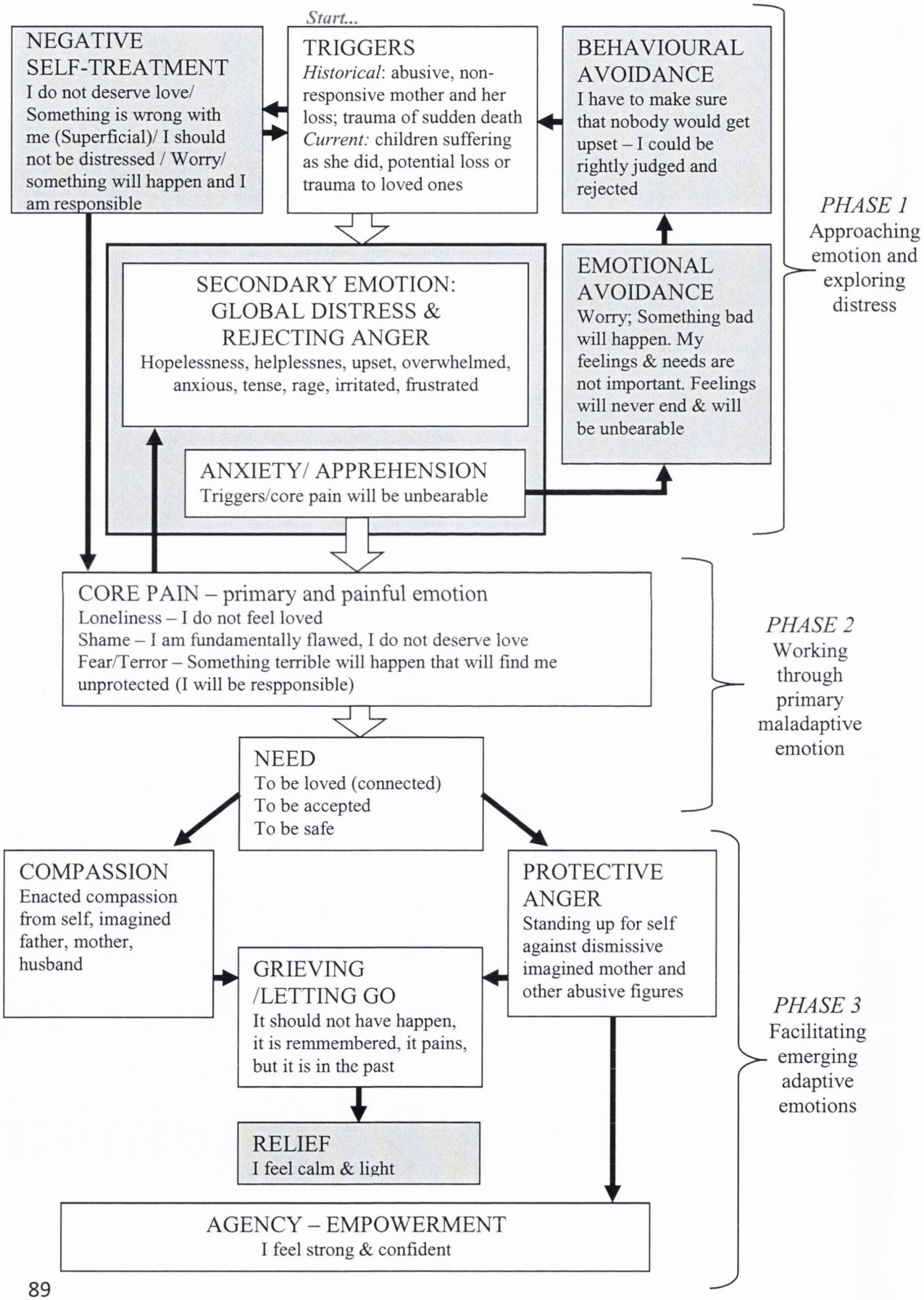
framework through which the therapist might, by attending to client narrative (including verbal and non-verbal markers), elicit the clients' core emotion schemes (including core pain), triggers, manner of self-treatment etc. in a manner consistent with standard EFT practice. By applying the conceptual framework the therapist may then intuit which actions might be required, at a particular point in time, to facilitate the client in achieving optimal change-processing at specific points in therapy. The framework might thus be used by the therapists, not only as a structure for reflecting on the session, but also as a guide in their moment-to-moment, in-session interactions with clients.

Timulak (2012; Timulak & Pascual Leone, 2014) proposes that the client's global distress is most frequently a response to current and past (generally interpersonal) triggers, which, signify instances when client needs were catastrophically unmet, producing core painful emotions which in turn are so unbearable and so seemingly unresolvable that the client collapses into a state characterised by hopelessness and helplessness. This situation is then maintained by certain emotional and behavioural avoidance strategies as clients seek to escape from future suffering by either avoiding their own emotional experience, or by avoiding situations which may contain further, painful triggers Timulak (2012; Timulak & Pascual Leone, 2014) notes that clients may exacerbate their situation through their style of self-treatment, or self-relating; which is frequently self-blaming.

Timulak (2012; Timulak & Pascual Leone, 2014) (see figure 1.12.1) acknowledges the significance of triggers, actual or perceived behaviours of significant others, which activate emotion schemes (shame, loneliness/sadness and terror/fear based) containing unbearable feelings of rejection, humiliation, shame, invalidation, neglect etc. They may be current or historical in nature, but generally resonate with developmental interpersonal injury which occurred at a time in the past when the client was unable to organise effectively towards having their needs met, leading to collapse into hopelessness and helplessness.

Consistent with Pascual-Leone and Greenberg (2005), Timulak (2012; Timulak & Pascual Leone, 2014) recognises global distress as an undifferentiated state of high arousal and low meaningfulness, where the therapist encourages the client to attend to their experience in order to develop a pain compass which may guide them to eliciting the underlying core pain. Timulak (2012; Timulak & Pascual Leone, 2014) notes the manner in which the client's self-treatment interacts with the interpersonal trigger in a manner, which contributes to distress by either encouraging avoidance of painful feelings or by responding negatively to the self through self-contempt, self-judgement or self-criticism. The latter are frequently recognised as hostile introjects from significant others in the past, while the former are often expressed in the manner of rules for living, which paradoxically maintain the client in a state of unresolved

Figure 1.12.1. The model of Emotion Transformation in therapy which can serve also as a case conceptualisation framework for GAD cases.



distress (i.e. "*If I constantly worry I can avoid future catastrophe.*" or "*Always be nice to others so that they will like me.*").

Self-interruption (emotional and behavioural avoidance) (see figure 1.12.1) is a form of obstructive self-treatment where the client, fearing the possibility of experiencing future pain engages in avoidant behaviour in order to minimise risk. This may find expression in behavioural avoidance where clients avoid standing up for themselves for fear of evoking hostile criticism (*"If I don't let him have his way he may criticise me"*), or emotional avoidance where they attempt to avoid emotional experience lest it occasion pain (i.e. *"I'd better not go there – it may be painful"*). It is commonly suggested (see section 1.2) that clients with a GAD presentation engage in worry as an attempt to manage the possibility of avoiding future painful experience. The unfortunate and unintended consequence of such self-interruption is that it paradoxically frustrates the client's ability to process painful emotion and develop more adaptive emotion schemes; thereby prolonging unresolved emotional distress and promoting a sense of hopelessness (Timulak, 2012; Timulak & Pascual Leone, 2014).

(Anticipatory) fear features prominently in the anxiety disorders and while it is less significant than the core fear associated with trauma, it plays a major role in driving emotional and behavioural avoidance. A distinction is made between anticipatory fear and a deeper core emotion. For example a client with social anxiety may avoid a presentation due to an anticipatory fear that the outcome will not be good and they will receive painful criticism, which would bring feelings of shame. In terms of the overall goals of therapy, it is more important therefore, that the client be able to tolerate and process their feeling of core shame, rather than resolve a specific and somewhat superficial anxiety regarding the presentation. In terms of the model, it is only when the core scheme is activated (in this case, shame) that the adaptive need can be accessed, and only then can protective anger and self-

soothing can be mobilised in order to promote healing. It is often necessary, however, to facilitate the client in overcoming this anticipatory fear in order to enable deeper processing, as its perceived protective function may obstruct the possibility of achieving greater emotional depth.

As can be seen from the foregoing, the model proposed by Timulak and Pascual-Leone (2014), combines features of classic EFT case formulation (Greenberg and Goldman, 2008; Watson 2010, Greenberg & Watson, 2006) and combines them with features of Pascual-Leone & Greenberg' (2005) Emotion Transformation Model. In this new form, the model no longer solely functions as a purely descriptive account of client's sequential change processes in successful therapy. Rather, in its inclusion of new elements (such as triggers, emotional/behavioural avoidance, self-interruption processes and anticipatory fear), it now appears to function more like a heuristic, a road map of how therapy may evolve incorporating not only the aspects of a successful therapy but also processes which may interfere with, yet are frequently found to occur in, therapy.

1.13 Case Study Research and EFT

In light of the developments outlined in Section 1.12, the current study aims to contribute to the development of an EFT model of treatment of GAD by presenting a series of case studies (of the first eight clients to complete treatment), followed by a cross-case analysis of those studies. Case studies have been an important part of psychotherapy since Freud (1901, 1909, 1910) and have always been part of the development of humanistic psychotherapy, informing inquiry into the processes and outcomes of experiential and person-centred therapies (Farber, Brink & Raskin, 1996). Case studies are a form of practice-based evidence that have been crucial in generating knowledge in psychotherapy research, contributing to theory, practice and training (McLeod, 2010).

As McLeod (2010) observes, while one successful case of the application of a given treatment of a particular disorder, proves little more than the fact that one person responded positively to treatment, whereas, the development of a model of that treatment, allows for the testing of that model against other cases, facilitating subsequent refinement of the model. The current study aims to contribute to the development of EFT as a treatment of GAD by providing a quantitative and qualitative evaluation of an emerging model by analysing the first eight completed cases, in a wider project, from a theory building perspective (Stiles, 2007), paying attention, not only to the outcomes and clients perspectives, but also to the psychotherapeutic processes implicit in case conceptualisation and emotion transformation. The current study is further inspired by Iwakabe and Gazzola's (2009) discussion of meta-synthesis of qualitative studies as a means of theory building and development. In particular this informs the qualitative cross-case portion of analysis in the current study, which focusses on identifying common themes across the eight cases, utilising Elliot and Timulak's (2005) descriptive interpretive approach to qualitative data analysis, with a view to uncovering the underlying constructs and processes which characterise clients' progression through therapy from the perspective of their therapists, client experiences of therapy and their outcomes, as well as accumulated pre-post outcomes captured by traditional quantitative instruments.

Three main limitations have, historically, stood out in relation to case studies: (a) the 'data problem', where data are perceived to be unreliable, (b) the data 'analysis problem', where analysis of data lacks validity and, (c) the 'generalizability problem', where, even if data are reliable and analysis is valid, one cannot generalise beyond the particular case (Midgley, 2006). These limitations imply that it is impossible to recall accurately everything that has occurred during the course of a session without losing vital information and that inevitably, such recollections will be influenced by the assumptions and biases of the therapist. Data gathered in this way suffer from the absence of triangulation, in so far as the

views of the client (the other half of the therapeutic dyad) are seldom considered. There is often uncertainty regarding the interpretation of data in terms of whether it has been analysed in rigorous, systematic and comprehensive way (McLeod, 2010). Spence (1986, 1989, 2010) has referred to this process as *narrative smoothing* and McLeod (2010) has observed that the issue has been compounded by the use of extracts from cases to illustrate points rather than publication of entire cases.

A response to this has been the development, since the mid 1960's, of a more rigorous approach to case study research which has led to the development of a more systematic approach to the genre (McLeod, 2010). McLeod and Elliott (2011) attribute this development to two factors; first, an emerging appreciation of the limitations inherent in establishing an evidence-base on Randomised Controlled Trials (RCT) alone, as this places limitations on both the potential sources, and categories, of data available for consideration. Secondly, recent advances in case study methodology (including process and outcome measures and an increased number of recorded therapy sessions) have allowed for increasingly systematic and rigorous analyses of data by persons other than the therapist (McLeod & Elliott, 2011).

To allow for some degree of generalisation, case study research requires a rich and comprehensive body of evidence, covering complete case studies comprising good and poor outcome (McLeod, 2010). This thorough, systematic approach to psychotherapy research is reflected in Watson, Goldman and Greenberg's (2007) presentation, of multiple single case studies of brief-EFT as a treatment of depression. Arguing that there is learning to be found in comparing good and poor outcome cases, they analyse and present three cases of each, taken from three different RCTs, comparing EFT, CBT and client-centred therapy in the treatment of depression (Goldman, et al., 2005; Greenberg and Watson, 1998; Watson et al., 2003). From this analysis, they were able to extrapolate common factors which through their presence or absence impact on the outcome of therapy. Watson and colleagues outline three

main objectives in conducting this type of analysis; (a) to enrich understanding of how various EFT tasks and client objectives can be integrated to promote good outcome, (b) to focus on poor outcome cases of therapy in order to better understand the factors which impede client progress in resolution of issues, and (c) to identify client factors contributing to successful outcome in brief-EFT for depression (Watson et al., 2007).

Iwakabe and Gazzola (2009) describe three types of case studies, (a) clinical case studies, defined as "...therapists narrative accounts of what happened during the treatment along with interpretations based on the therapeutic work with their own clients" (p. 602), (b) experimental case studies, described as "rigorous methods for testing hypotheses about treatment effects and may be considered alternatives to large scale outcome research" (p. 602) and, (c) naturalistic/systematic case studies. Naturalistic or systematic case studies (see also pluralistic case studies; McLeod, 1998), are representative of the approach to research adopted by the current study which is somewhat inspired by Elliott's (2002) hermeneutic single case efficacy design HSCED, and to a lesser extent, by Stiles' (2007) theory building case studies. The influence of the HSCED approach is discussed in detail below, while the influence of Stiles' theory building case studies is evident in two case studies with which the author of the current research was involved (Keogh, Timulak & McElvaney, 2013; Crowley, Timulak and McElvaney, 2013), which effectively took the form of therapy transcript studies, exploring process analysis of emotional change across a course of EFT as a treatment of GAD, although not specifically in terms of Stiles' assimilation model.

Iwakabe and Gazzola (2009), observe there are two main aspects of this form of research which redress the methodological issues described above. First, multiple sources of data (i.e., in the case of the current study: Outcome measures, observer ratings, client interview, therapist perspective, client post-session qualitative measures) which produces a rich and contextualised account of therapy. The data can then be triangulated to check for

coherency. Second, the work is generally conducted by a research team (as in the case of the current study) rather than being the sole preserve of the therapist, which allows for the checking and challenging of biases in pursuit of consensus.

Robert Elliott has recently employed his HSCED (Elliott, 2002) as a scientific tool for exploring the processes involved in EFT as a treatment of various anxiety disorders, including social anxiety (MacLeod & Elliott, 2012; MacLeod, Elliott & Rodgers, 2012) and panic disorder (Elliott, et. al., 2009). While the intention of the current study is to present the first eight cases of EFT as a treatment of GAD in an open trial format, it has incorporated a number of elements of the HSCED approach, in order to provide the reader with an enriched experience of engaging with case study material. Accordingly, data were collected by standardised self-report outcome measures (GAD-7, BDI-II, CORE-OM etc.), a personal questionnaire, administered at the beginning of each session in which the client wrote down problems they wished to address in therapy (Target Complaints), an open-ended questionnaire soliciting important helpful and unhelpful events in therapy was administered at the end of each session (Helpful Aspects of Therapy form) and an interview investigating client experience of change was administered at the mid-point and end of treatment (Client Change Interview). All of these measures are described in full in the method section and were augmented in the results section by the therapist's process account of the progression of therapy. The current research deviates from HSCED methodology in so far as there was insufficient time to conduct the 'quasi-judicial review' proposed by Elliott (2002) as a means of structuring the inquiry process in such a manner that the qualitative outcome of the case might be determined in a manner consistent with legal procedures, thereby placing the conclusion 'beyond reasonable doubt'. This lengthy and complex process was beyond the scope of the current research, which presents eight case studies, however the attempt to gather as much information as possible, from multiple perspectives, lends the cases in the

current study a degree of authenticity and is consistent with Rennie's (2000) notion of Methodical Hermeneutics, in terms of being coherent, systematic, replicable and transparent.

The Trinity College Psychotherapy Research Program applied Greenberg and Pascual-Leone's (2005) model of emotion transformation, initially to APA recordings of Greenberg conducting therapy (Keogh et al., 2010; Keogh et al., 2011) and subsequently to cases from the York I Depression Study (Greenberg & Watson, 1998) (Dillon et. al., 2012; McNally et. al., 2012). Encouraged by their findings O'Brien (2012) applied the model in an analysis of 39 early sessions, from five cases of EFT of GAD, from the current research project. Single case study research was conducted, which builds on these findings (Crowley et. al., 2013; Keogh et. al., 2013). The current study intends to develop this further, as the next step in developing a model of EFT as a treatment of GAD.

1.14 Rationale for the Current Study and Research Aims

The current study presents an analysis of the outcome of eight cases of Emotion-focused therapy (EFT) for Generalised anxiety disorder (GAD) and is part of a wider project (EFT for GAD Study) which will consist of 14 cases upon completion. The aim of the current study (and also the wider study) is to develop a version of EFT for GAD that could, if shown to have promising results, be further validated in a randomized clinical trial. The therapy presented is a brief version of EFT (i.e. up to 20 sessions) which can be applied specifically to the treatment of GAD. This is consistent with our aim of developing a form of therapy which can be delivered within the same time-frame as currently accepted, empirically supported treatments of GAD (which have emerged mainly from within the CBT paradigm).

The aim of this study was to contribute to the development of EFT as an effective treatment of GAD, through cross-case analysis of eight case studies. It evolved through the accumulation of case studies which were built into, and presented in an open trial format. The

current study presents the first eight completed case studies from which research team wished to learn. The primary research team consisted of the Principal Investigator, Dr. Ladislav Timulak (Trinity College Dublin) and two co-investigators, the author James McElvaney, (PhD. Candidate; Trinity College Dublin), and Professor Leslie Greenberg (York University Toronto). Although the broader study now contains 13 completed cases, and involves four therapists, the current study comprising the first eight completed cases, features the work of the first two therapists to engage with the project (Dr Timulak and the author).

The study will examine the impact of treatment across all eight case studies in terms of pre-post outcome, measured on quantitative outcome measures (i.e. GAD-7, GADSS, PSWQ, BDI-II, CORE-OM, and PSWQ-PW). The aim is then to benchmark the results of the current study against the findings of other research studies which have investigated the efficacy of psychotherapeutic treatments of GAD. The study will also collect qualitative data on the outcomes of therapy as well as helpful and unhelpful aspects of the therapy process. This will involve collating and analysing data from clients' retrospective recall of the entire treatment (Client Change Interviews) and post-session helpful and unhelpful aspects of therapy (Helpful Aspect of Therapy form) along with the therapists' retrospectively recalled perspectives on case conceptualisation and emotion transformation (i.e. therapeutic change), which will, in some cases, be supplemented by an observer perspective provided by the findings of related studies which examined portions of the same data set.

The current study hopes to establish a preliminary assessment of the potential efficacy of EFT for GAD and the various processes that may or may not contribute to it, by exploring both the similarities and differences between an EFT understanding of GAD and its treatment, and that of empirically well-established approaches to GAD. It is hoped that this will be achieved by tentative benchmarking of quantitative findings against those reported in other studies focusing on treatment of GAD, and, following cross-case analysis of case-

conceptualisation and case transformation, by comparison with existing models of treatment of GAD. It is hoped that the findings from the current study, should they appear promising when compared to existing treatments, will support further investigation of a brief-EFT treatment of GAD. The triangulation of data sources also provides an opportunity for clients to comment on their experience of therapy, and hopes to address the question of whether clients feel that therapy has brought meaningful change to their lives, and if so, what in particular has been helpful about being in therapy? Data from therapists gives an insight into how they conceptualise GAD from an EFT perspective and how they view the process of emotion transformation in EFT for GAD. The current research draws upon the findings of four pieces of research carried out on a sub-section of the data set and with which the current author was involved; they are described in further detail in Section 1.14.1.

1.14.1 Additional Studies drawn on to supplement analysis.

In total the author of the current study drew on four additional pieces of research with which he was involved to supplement case study analysis. The first two pieces of research took the form of single case studies, and investigated the process of emotional transformation in two separate treatments which employed EFT as a treatment of GAD. The studies viewed the treatments through the lens of the State-Transitional Model of Emotional Processing (Pascual-Leone and Greenberg, 2007), and, through a careful examination of the transformation of emotion, across an entire treatment, in comparison with change processes proposed by the model, hoped that research would suggest refinements which could be incorporated to the model which would become increasingly specific to EFT as a treatment of GAD. Both studies found that broadly speaking, the model was adhered to, however refinements were suggested which enhanced its specificity as a treatment of GAD; in

particular, concerning the role of the worry agent and the nature of GAD-specific forms of avoidance.

The first of these studies (Keogh, Timulak, & McElvaney, 2013). *Treating generalised anxiety disorder with emotion focused therapy: A case study investigation of emotional transformation processes* was presented as a paper at the 43rd Annual conference of the Psychological Society of Ireland, Sligo, Ireland. This piece of research sought to qualitatively describe the transformation in emotional processing across sixteen sessions of a successful Emotion-Focused Therapy (EFT) treatment for GAD, using a qualitative, observational, single case study research design. As mentioned above, it employed a theoretical framework derived from the EFT model of in-session emotional transformation (State-Transitional Model of Emotional Processing: Pascual-Leone and Greenberg, 2007) as a basis for qualitative analysis, which was further enhanced by employing the Classification of Affective-Meaning States, the Classification of Emotion Arousal Scale-III, and the Classification of Emotion Productivity Scale-Revised, to observe and describe moment-by-moment shifts in client affective-meaning states, emotional arousal and emotional productivity, respectively. In order to achieve triangulation, independent raters were trained in the use of these observational measures and their findings were triangulated with the findings of the research team.

The research team met on 8 occasions (lasting approximately 2 hours each) in order to qualitatively analyse the first 6 sessions of therapy. The remaining 10 sessions of therapy were then analysed by the primary researcher (Dr. Keogh) who continued to meet with members of the research team in order to audit findings. Further triangulation was provided by employing independent raters (trained in utilization of the scales (CAMS, CEPS-R and CEAS-III) by Dr. Timulak). The qualitative analysis component of the research involved tracking the client's process of emotional transformation across the entire course of treatment

(16 sessions using the framework developed from Pascual-Leone and Greenberg' work (2007) which had been demonstrated as being effective in capturing the process of emotion transformation in therapy by members of the research team in the past (Keogh et al., 2011; O'Brien et al., 2012; Timulak et al., 2012).

The second of the studies (Crowley, Timulak, & McElvaney, 2013): *Emotion transformation in generalised anxiety disorder: A case study of emotion focused therapy* was presented as a paper at the 43rd Annual conference of the Psychological Society of Ireland, Sligo, Ireland. This study, like the one above, was a single case study which sought to examine whether the process of emotion transformation in emotion focused therapy for generalised anxiety disorder was consistent with the sequence of emotion transformation proposed by the State-Transitional Model of Emotional Processing (Pascual-Leone & Greenberg, 2007). In terms of design, this study was also a single case study with a qualitative observational design which examined an entire course of treatment (comprising 24 sessions of therapy).

The research team met weekly, over a period of 9 months to analyse the first 7 sessions of therapy; thereafter the primary researcher (Dr. Crowley) presented his analysis of subsequent sessions to Dr. Timulak for auditing. The same process was followed as in Keogh, Timulak, & McElvaney (2013) with regard to utilizing scales (CAMS, CEPS-R and CEAS-III) in order to track moment-to- moment emotional processing and identical methods of triangulation were employed.

Two other papers were drawn on by the researcher in the analysis of cases presented in in the current research. Unlike the two papers presented above these draw on a different methodology (Task Analysis) in order to investigate specific aspects of the process in EFT treatment of GAD.

The first study (Murphy, Timulak & McElvaney, 2013): *Working with worry in clients with a diagnosis of GAD: A task analysis of two chair work* was presented as a paper at the 43rd Annual conference of the Psychological Society of Ireland, Sligo, Ireland. This was an observational, multiple case study design which studied 12 dialogues across 3 clients utilising a task analytic method (Greenberg, 1977; 1983; 1984; 1992; 2007; Greenberg, & Foerster 1996; Pascual-Leone Greenberg & Pascual-Leone 2009), with a view to proposing a tentative model of chair-work for working with the worry process in clients with GAD. The study used qualitative and quantitative methods to analyse therapist interventions and client processes involved in two chair work for worry. Each of these mini-case studies contained four dialogues between the client (experiencer) and an imagined representation of the construct of worry experienced by the client (the Worry Agent). These dialogues form mini-case studies for intensive analysis. The primary aim of the research was to study the process of resolution of the worry process in two chair dialogues.

Moment-by-moment analysis of worry dialogues, extracted from therapy sessions from three clients (the first three clients to complete treatment in the wider project), was conducted over a period of six months, and was informed by the utilisation of four additional scales; (Degree of Resolution Scale (DRS), CAMS, CEPS-R and CEAS-III)) to facilitate the tracking of emotional processing. Six sessions were watched by Dr Murphy and Dr Timulak, four by Dr Murphy and the author of the current study and two by Dr Murphy alone. When all 12 individual worry dialogues had been analysed and individual models of each worry dialogue had been created, individual worry dialogue models were condensed in order to form an overarching model that could be applied across the board to all dialogues. This analysis was audited by Dr Timulak and the author of the current study throughout the research process, and feedback was incorporated into the results section.

The fourth study (Hughes, Timulak & McElvaney, 2013) *Transforming Emotional Injury with a Developmentally Significant Other through a series of Unfinished Business Dialogues in Clients with Generalised Anxiety Disorder: A Task Analytic Approach* was presented as a paper at the 43rd Annual conference of the Psychological Society of Ireland, Sligo, Ireland. This study employed a multiple mini-case study, observational, qualitative design in order to investigate stages of emotion transformation within and across unfinished business dialogues (UBDs) with a developmentally significant other in clients with GAD. It performed a task analysis (Greenberg, 1977; 1983; 1984; 1992; 2007; Greenberg, & Foerster 1996; Pascual-Leone Greenberg & Pascual-Leone 2009) of 4 – 6 dialogues across three clients (the first three clients to complete treatment in the wider project) and also employed four additional scales; (Degree of Resolution Scale (DRS), CAMS, CEPS-R and CEAS-III)) to further enable the tracking of emotional processing.

As in Murphy and colleagues' (2013) study, the analysis protocol involved the research team meeting to conduct a detailed moment-by-moment analysis of the UBDs. Eight sessions were watched and analysed by Dr. Timulak and Dr. Hughes, three were analysed by Dr. Hughes and the author of the current study and three were analysed by Dr. Hughes alone. Analysis focused on therapist interventions, client processes, and therapeutic alliance alongside emotional arousal, emotional productivity and classification of emotions. Findings suggested that successful transformation of emotional injury required multiple engagements in UBDs with the developmentally significant other leading (in a non-linear fashion) eventually to the emergence of a new view of the self and a new view of the other.

2.0 METHOD

2.1 Introduction

The current study presents an analysis of the outcome of eight cases of Emotion-focused therapy (EFT) for Generalised anxiety disorder (GAD). It is part of a wider project (EFT for GAD Study), which will consist of 14 cases upon completion, being conducted by the author of this dissertation and Dr. Ladislav Timulak (Trinity College Dublin) in collaboration with Professor Leslie Greenberg (York University Toronto). The current study presents the first eight completed cases, drawn from the wider project, in an open trial format; the remaining six cases were incomplete at the time of submission. The cases are presented in chronological order (i.e. Client 001 "Tina", was the first client to engage with the project and complete treatment, Client 002 "Jackie was the second, and so on). In keeping with the open trial format, the clients are neither randomised, nor is there any control group.

The aim of the study (and indeed the wider study as well) is to develop a demonstrably effective, empirically supported variant of EFT (a brief version – up to 20 sessions), which can be applied specifically to the treatment of GAD. The research is funded by a grant from the Health Research Board (HRB). The principal investigator on the project is Dr. Timulak, the author (James McElvaney), a PhD. candidate of Dr Timulak's is a co-investigator on the project, as is Professor Greenberg, who is providing EFT training, supervision and is checking adherence to EFT protocols. Elaine Martin, a Counselling Psychologist is hosting the project in an urban, primary care centre.

As stated above, this research presents the first eight cases in the project which have been brought to conclusion and will present them in the order in which they were completed. Individual case analyses are informed by the principles guiding HSCED (Elliott, 2002) in so far as an attempt is made to provide an analysis of the case on the basis of a rich data record

with a specific focus on outcomes and the processes responsible for them. In the case of this dissertation, eight individual analyses are further supplemented by a cross-case analysis, informed by Iwakabe and Gazzola's (2009) writings on metasynthesis of single-case studies.

2.2 Participants

2.2.1 Client/participants

All of the client/participants in the research study (n = 8), and indeed, in the wider study, were recruited from an urban primary care centre. Clients' suitability for participation in the research was based on their initial intake assessment at the primary care centre and their score on the Generalised Anxiety Disorder- 7 (GAD-7; Spitzer, Kroenke, Williams, & Löwe, 2006). Those deemed suitable for the research were asked if they wished to participate, and if they were interested, were presented with a comprehensive information sheet and consent form. If they elected to proceed with the research, a further round of assessment commenced, which is described fully in the Procedure (2.4) section. For inclusion, all clients were required to meet diagnostic criteria for DSM-IV-TR GAD. Exclusion criteria comprised, (a) the client posing a risk to self or others, (b) psychosis, (c) substance abuse, (d) concurrent treatment or, (e) organic brain syndrome.

The sample in the current study (n = 8) consists of the first eight clients to have participated in the wider study and was composed of six females and two males. Their ages ranged from 23 to 56 with a mean age of 34. Of the eight participants represented here, all were resident in the catchment area for the primary care service and had been referred into the service by their General Practitioner (G.P.). All of the clients participated voluntarily in the research and none was offered any financial incentive to do so. Participants were aware that they could withdraw from the study at any point during the proceedings, without

prejudice, and in the knowledge that they would be referred back into the primary care service, at the top of the waiting list, to receive treatment as usual (TAU).

During the screening procedure, two potential participants were excluded from participation in the study. In the case of one potential client it was decided after concluding the SCID interview (conducted by the author of the current paper) that GAD was not the primary diagnosis, in so far as it was preceded by current and past major depressive disorder. It was felt that best practice necessitated immediate treatment of the primary diagnosis and therefore the candidate was not in a position to engage with the research. In the case of the second potential participant, it became apparent during the course of the SCID interview (conducted by the author of the current paper) that the potential client was suffering from PTSD related to a traffic accident, which had gone undetected at intake at the service, and manifested as a panic attack during assessment. As with the first client, it was felt that the client's needs were best met by attending to their most significant presenting issue and the candidate was not invited to participate in the research.

During the course of the study, two participants expressed suicidal ideation. On both occasions this was precipitated by certain life events which, combined with the clients' own fragile processes, activated suicidal thinking. Neither client had reported any hint of suicidal ideation during the intake process and as such did not warrant exclusion from the study at the outset. The information provided by the research team for each participant, prior to commencing therapy, included the following statement regarding the nature of therapy: "As in any psychologically therapy, the effects may not be achieved. Small numbers of people get worse while in therapy. The research procedure may be time consuming. The therapy or research procedure may stir difficult emotions. All of those hindering aspects are responded to by the availability of qualified professionals and by respecting your preferences for treatment and/or research participation". In keeping with the spirit of this passage, and in line

with best practice, all possible steps were taken to ensure the safety and security of the two participants until such times as the crisis had passed and therapy could resume.

2.2.2 Therapist/participants

Dr Timulak, the principal investigator (PI) on the project was therapist for six of the eight clients (Tina, Ann, Laura, Mark Susan and Fiona). Dr Timulak is a counselling psychologist and fully trained EFT therapist. James McElvaney, the author, acted as therapist for two of the clients in the study (Tony and Jackie) and also served as coordinator of the project as a whole. Mr McElvaney is a counselling psychologist, and received extensive training in EFT from Dr Timulak and Professor Greenberg. In addition to checking adherence to EFT protocols, Professor Greenberg provided supervision to Dr Timulak, who in turn, supervised the author. The wider project utilises another two therapists, both counselling psychologists. As they started to see their clients at a later stage of the wider project their cases are not part of the thesis.

2.3 Measures

2.3.1 Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Patient Edition. (SCID-I/P; First, Spitzer, Gibbon & Williams, 2002)

In its various incarnations over time, The Structured Clinical Interview for DSM-IV-TR (SCID), reflecting the evolutionary changes to diagnostic criteria across successive editions of the DSM series, is one of the most frequently used interview protocols in the assessment of Axis I psychiatric disorders (Keane & Barlow, 2002). It is administered by a clinician or trained mental health professional who has a working knowledge of the DSM-IV classification system. There are two versions of the SCID-I, for researchers and clinicians, in order to reflect the different, respective needs of both groups. The Research Version (the one

used in this study) is longer than the Clinician Version, containing more disorders, subtypes and generally offers more opportunities for gathering detailed information. The SCID- I/NP is for use with non-psychiatric patients and is particularly common in community based studies or studies using primary care populations. In general it is considered to be both systematic and comprehensive, however it has been criticised for its dichotomous rating of symptoms (present or absent) which overlooks the dimensional nature of psychological symptoms as they occur in practice (Keane & Barlow, 2002)

2.3.2 Structured Clinical Interview for DSM-IV-TR Axis II Disorders (SCID-II; First, Spitzer, Gibbons & Benjamin, 1994)

The SCID-II and its companion the SCID-I are considered to be the gold standard in assessment of DSM psychiatric and personality disorder. The SCID-II is designed to enable standardised, accurate and reliable diagnosis of the 10 DSM-IV Axis II personality disorders. The respondent completes a self-report questionnaire, which is then used by the researcher to guide a semi-structured interview which determines the presence or absence of personality disorder. Recent research shows excellent inter-rater reliability (both categorical and dimensional) for the SCID-II (Lobbestael, Leurgans &Arntz, 2011).

2.3.3 Generalised Anxiety Disorder-7 (*GAD-7*; Spitzer et al., 2006)

The GAD-7 is a 7-item self-report questionnaire which is employed to ascertain the level of severity of GAD symptoms experienced by the client over the preceding two weeks. Items are scored from 0 to 3, where 0 = not at all, 1 = several days, 2 = more than half the days, 3 = nearly every day. The cut off scores within this measure are 5 (mild anxiety), 10 (moderate anxiety), and 15 (severe anxiety). A criterion standard study performed in fifteen primary care clinics across the United States (n = 965) suggested that the GAD-7 had good reliability, as well as criterion, construct, factorial, and procedural validity. The measure has

been found to have a sensitivity of 89% and a specificity of 82% for GAD, when 10 is taken as the cut off score. The study concluded that the GAD-7 was both valid and efficient in screening for and assessing the severity of GAD in clinical and research settings (Spitzer et al., 2006; Kroenke, Spitzer, Williams, Monahan, & Löwe, 2007). For the purposes of this study a cut-off score ≥10 was used to determine a clinical range on the measure (Kroenke et al, 2007), and in terms of establishing the reliable change index (RCI), a movement of 5 points would be required to demonstrate reliable change, which was calculated with Jacobson and Truax's (1991) formula using Kroenke et al.'s (2007) data.

Evidence also supports the reliability and validity of the GAD-7 as a measure of anxiety in the general population (Löwe et al., 2008); it has been demonstrated to adequately detect the presence of GAD in drug and alcohol users (Delgadilo, Payne, Gilbody, Godfrey, Gore, Jessop, & Dale, 2012) and has potential value for assessing and exploring the level of disability experienced by primary care attendees (Ruiz, Zamorano, García-Campayo, Pardo, Freire, & Rejas, 2011). In a recent comparison between the Penn State Worry Questionnaire and the GAD-7 measuring response during therapeutic treatment of GAD, while both measures were sensitive to change, the GAD-7 appeared to be more sensitive to change which may suggest greater utility in both clinical work and research settings (Dear, Titov, Sunderland, McMillan, Anderson, Lorian, & Robinson, 2011).

2.3.4 Generalised Anxiety Disorder Severity Scale (GADSS; Shear, Belnap, Mazumdar, Houck and Rollman, 2006).

The GADSS was developed as a simple DSM-IV based rating scale, using a model based on the Yale-Brown Obsessive Compulsive Scale (Goodman, Price, Rasmussen, Mazure, Fleischmann, Hill, Heninger, & Charney, 1989) in order to facilitate the assessment of GAD symptom severity by researchers and clinicians in primary care settings (Shear et al.,

2006). In terms of structure, it begins with a target worry list (i.e. future, health, family etc.) and then continues with six items which explore the identified target worry in terms of, (a) frequency of worry, (b) distress due to worry, (c) frequency of associated symptoms, (d) severity and distress of associated symptom, (e) impairment in work and, (f) impairment in social function. Scoring is based on a five point scale ranging from 0 = *none*, to 4 = *very severe*; cut off scores on this measure are as follows: 1-6 (mild levels of GAD), 7-12 (moderate levels of GAD), 13-18 (severe levels of GAD) and 19-24 (very severe levels of GAD) (Shear et al., 2006).

Although the validation of the measure, conducted by Shear and colleagues (2006), was carried out by telephone rather than face to face, research indicates that valid, reliable results can be achieved by this means (Kobak, Greist, Jefferson, Mundt, & Katzelnick, 1998). Results suggest that the measure has good internal consistency ($\alpha = .90$), good convergent and discriminant validity, and displayed sensitivity to change, with treatment, in a primary care sample (Shear et al., 2006). The results of a subsequent investigation, which focused on applying the GADSS to a geriatric population ($n = 134$ over 60 year olds with GAD, $n = 33$ over 60 year old healthy controls and $n = 186$, 18 – 60 year olds with GAD) who met DSM-IV diagnostic criteria for GAD, showed a high internal consistency (raw Cronbach's $\alpha = 0.76$), along with good convergent, concurrent, and discriminant validity (Andreescu et al., 2008). Similar findings occurred in a study which used the GADSS in a trial of agomelatine versus placebo for the treatment of GAD (Stein et al., 2009). Caseness for this measure is put at 7 (Craske, Stein, Sullivan, Sherbourne, et al., 2011), however, we were unable to calculate an RCI as no published studies of GADSS provided test-retest reliability.

2.3.5 Penn-State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990).

The PSWQ is a 16-item self-report measure, developed through factor analysis of a data set derived from 1,580 college students and is the most commonly used measure to determine the presence of generalised anxiety and pathological worry in clinical and non-clinical populations (Meyer et al, 1990). It is generally believed that it accurately captures the main features of pathological worry: (a) the generality of worry over time and situations, (b) the intensity/excessiveness of worry and, (c) the uncontrollability of worry (Molina & Borkovec, 1994). The form is scored on a five point Likert scale which ranges from 1 ("not at all typical of me") to 5 ("very typical of me"). Typical questions on the scale are "Many situations make me worry" and "I've been a worrier all my life".

The scale has been shown to demonstrate good internal consistency with samples consisting of older adults with GAD (Beck, Stanley, & Zebb, 1995), community subjects (Brown, Antony, & Barlow, 1992), and undergraduates (Meyer et al., 1990). It has also demonstrated good test-retest reliability over 4 weeks (Molina & Borkovec, 1994) and 8-10 weeks (Meyer et al., 1990). The scale evinces good convergent and divergent construct validity in so far as it is more positively correlated with other self-report measures of worry (e.g., Beck et al., 1995; Davey, 1993; van Rijsoort, Emmelkamp and Vervaeke, 1999) than with measures of anxiety or depression (Molina and Borkovec, 1994). For the purposes of the current study a cut-off point for clinical caseness was established at 46 (Fresco, Mennin, Heimberg, & Turk, 2003) and RCI was calculated at 9 using available data from Behar, Alcaine, Zuellig and Borkovec (2003).

A great deal of research has been carried out using the PSWQ and the vast amount of normative data available on the scale has led to it being recognised as the "gold standard" test

for assessing trait worry (Dugas and Robichaud, 2007). However, the fact that it measures trait worry may impact on its sensitivity to therapeutically induced change, with Dear and colleagues demonstrating that the GAD-7 evinces greater sensitivity with a clinical sample of GAD sufferers (Dear, Titov, Sunderland, McMillan, Anderson, Lorian, & Robinson, 2011). (For the purposes of the current study, therefore, the Penn State Worry Questionnaire – Past Week (*PSWQ-PW*; Stöber & Bittencourt, 1998) was introduced, in the hope that it might better capture weekly variation in worry. It was introduced for the first time in the post-treatment assessment of participant 001, "Tina").

Interestingly, Van Rijsoort and colleagues observe that although the PSWQ is proven to be unidimensional, their results suggest that, overall, the inverted questions contributed less to the establishing of the general factor (Van Rijsoort, Emmelkamp, & Vervaeke, 1999). Indeed, the negative items are also remarked upon by Dugas and Robichaud (2007) who observe that the inclusion of five negatively keyed items may serve only to confuse respondents, or catch out the inattentive. This is consistent with the findings of the research team who frequently observed participants struggling with the wording and ultimately, meaning, of the inverted questions.

2.3.6 Penn State Worry Questionnaire – Past Week (PSWQ-PW; Stöber & Bittencourt, 1998)

The PSWQ-PW was developed by Stöber & Bittencourt (1998) and is an adapted version of the PSWQ which aims to capture changes in levels of worry symptomatology during therapeutic treatment. The authors acknowledge that while the psychometric qualities of the PSWQ have been well established in relation to assessing trait-like worry, there is a question mark over its' suitability as a measure of short-term change. They argue that the phrasing of the PSWQ's questions, which ask the respondent to answer in terms of how

typical their experience of worry is, implies a degree of stability which is impervious to recognising week by week change. As Stöber and Bittencourt (1998; p. 3) state: "The respondent may still consider dysfunctional worry as typical and characteristic, even though his/her level of worry has recently changed significantly".

The original PSWQ (Meyer et al., 1990) was adapted in a number of ways to accommodate the new objective. Questions were reconstructed to reflect the one week assessment time frame. Accordingly, respondents were encouraged to reflect on the past week when addressing the items, which were now phrased in the past tense. Items were now scored on a seven-point rating scale which ranged from 0 = *Never* to 6 = *Almost always*. To maintain theoretical consistency PSWQ Item 12 ("I've been a worrier all my life") was dropped because the trait-like phrase "worrier all my life" was no longer consistent with the 'past-week' range of the revised measure.

In their investigation of the psychometric properties of the PSWQ-PW, involving weekly assessment of 28 non-clinical, high worriers in a brief treatment study, Stöber & Bittencourt's findings suggested that the measure was "highly reliable" (Cronbach's alpha of 0.91) and "substantially valid" in assessing both the week-to-week status of worry, and treatment-related changes in worry (1998).While it was not possible to establish a clinical cut-off point for this measure, its RCI was calculated at 28 based on information (available standard deviations and test-retest reliability) from Stöber and Bittencourt (1998).

2.3.7 Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996).

The BDI-II is a 21 item, multiple choice, self-report measure of depression, and is a revision of the Beck Depression Inventory (BDI). The revised version reflects changes in the DSM diagnostic criteria for depression between DSM-III-R and DSM-IV. Respondents are invited to score items on the measure in the degree to which they are affected by them;

examples of items include, hopelessness, irritability, sleep disturbance. Respondents score each item on a scale value of 0-3, the scores are summed and the total score is used with the following cut-offs to assess the severity of the respondent's depression: 0-13: minimal level of depression; 14-19: mild level of depression; 20-28: moderate level of depression; and 29-63: severe level of depression (Beck et al., 2006).

Research suggests that the BDI-II has high internal consistency (α=.91) (Beck, Steer, Ball & Ranieri, 1996), and has high one-week test–retest reliability (Pearson r =0.93) (Beck, Steer & Brown, 1996). Caseness for this measure is set at 10 (Beck et al., 1996), while the RCI used is 9 (Cuijpers, Sijbrandij, Koole, Huibers, Berking, Andersson, 2014)

2.3.8 Clinical Outcomes in Routine Evaluation– Outcome Measure (CORE-OM; Evans et al., 2002)

The CORE-OM is a thirty four (34) item self-report questionnaire designed to measure a 'pan-theoretical core of clients' global distress' over the previous week, which is then expressed as an average score and can be used pre- and post-therapy to evaluate (clinical) change (Evans, 2003). This distress is calculated across four domains; subjective wellbeing (4 items), commonly experienced problems/symptoms (12 items), life/social functioning (12 items) and the level of risk to self/others (6 items) and is scored on a 5-point scale from 0 = *not at all*, to 4 = *all of the time*. Test items include such questions as "I have felt terribly alone and isolated" and "I have felt able to cope when things go wrong". The CORE-OM is commonly used in primary care settings as it is brief and can be scored by hand (Evans et al., 2000); its reliability and validity have been established across multiple settings. The clinical cut-off is 1.19 for men and 1.29 for women (Evans, Connell, Barkham, Margison, McGrath, Mellor-Clark, & Audin, 2002). RCI for this measure is at 0.48 (Evans et al., 2002).

2.3.9Target Complaints (TC: Battle et al., 1966)

The Target Complaints (Battle et al., 1966) is an idiographic self-report instrument which gives respondents the opportunity to identify and rate their particular presenting issues. Clients are asked to identify and write down the three problems which are causing them the most distress, and each problem is then rated on a scale which ranges from 0-13. The instrument can be used to guide discussion regarding the clients presenting issues as well as being used as a rating tool (Timulak, 2008).

2.3.10 Helpful Aspects of Therapy Questionnaire (HAT; Llewelyn, 1988)

The HAT (Llewellyn, 1988) is a brief, open-ended, questionnaire which is filled out by the client at the end of each therapy session. This form asks the respondent to identify a helpful event from the recently finished therapy session, to explain how the event was helpful, when it occurred in the session, how long it lasted for and to assign a quantitative value to it, indicating the degree to which the event was helpful or hindering. They are also asked to supply information concerning any other helpful or hindering events which may have occurred in the session. On the provided scale, 1, 2, 3and 4 represent, respectively: extremely, greatly, moderately and slightly hindering, while 6, 7, 8 and 9 represent slightly, moderately, greatly and extremely helpful respectively; 5 represents neutral.

2.3.11. Therapists' Perspectives on Case Conceptualisation

As a part of capturing an evolving understanding of their clients, therapists were asked to write a brief, retrospective account of their understanding of each case, based on recall and session notes, from the perspective of case conceptualisation.

2.3.12. Therapists' Perspectives on Emotion Transformation

As a part of capturing an evolving understanding of their clients' emotion transformation (change) in therapy, therapists were asked to write a brief, retrospective account of their understanding of each case, based on recall, session notes and notes taken in supervision, from the perspective of case transformation.

2.3.13 Client Change Interview Schedule: Version 5 (CCISv5; Elliott, 2008)

The CCISv5 (Elliott, 2008) is developed from Elliott's (2000) *Client Change Interview Protocol*, and is a semi-structured interview schedule which aims to capture the clients' experience of change in therapy. Clients are further asked to describe what they attribute the change to, and are invited to suggest any helpful or hindering processes which may have occurred in therapy. Elliott (2008) describes the implementation of the semi-structured interview as "a relatively unstructured empathic exploration of the client's experience of therapy". He suggests that the interviewer adopt a stance of curiosity, with the aim of facilitating the client in telling their story of therapy, utilising both the questions suggested by the schedule along with empathic responses, to allow the client to fully express their narrative. Elliott offers two principal guidelines for interviewers, (a) to ask the client to provide as many details as possible, and (b) to utilise the probe "anything else?" in an encouraging way until the client has provided all the information they can on the subject (2008).

2.4 Procedure

2.4.1 Data Collection

As outlined in section 2.2, Clients' suitability for participation in the research was based on their initial intake assessment at the primary care centre and their score on the

Generalised Anxiety Disorder-7 (GAD-7: Spitzer, Kroenke, Williams, & Löwe, 2006); a cut-off score ≥10 was used to determine a probable DSM-IV diagnosis of GAD (Kroenke et al., 2007). If clients satisfied these criteria, they were invited to meet with a member of the research team who conducted a Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Patient Edition. (SCID-I/P; First, Spitzer, Gibbon & Williams, 2002), and a Structured Clinical Interview for DSM-IV-TR Axis II Disorders (SCID-II; First, Spitzer, Gibbons & Benjamin, 1994) with them in order to confirm their suitability for participation in the research, (i.e., meeting the inclusion criteria of a diagnosis of DSM-IV GAD).

Upon satisfying these criteria, clients next met with a member of the research team who presented them with a detailed information package describing the project, and who then spent approximately one hour discussing the nature and purpose of the research with them. Clients were then invited to take home a consent form, consider in their own time whether or not they wished to participate in the research, and if they chose to do so were invited to return the signed consent form, and an initial appointment with their therapist would be arranged.

At the initial meeting, prior to the commencement of therapy the author, in the role of research assistant, would present the participant with a battery of pre-post-outcome measures comprising, (a) Generalised Anxiety Disorder – 7 (*GAD- 7*; Spitzer, Kroenke, Williams, & Löwe, 2006), (b) Generalised Anxiety Disorder Severity Scale (*GADSS*; Shear, Belnap, Mazumdar, Houck and Rollman, 2006), (c) Penn-State Worry Questionnaire (*PSWQ*; Meyer, Miller, Metzger, & Borkovec, 1990), (d) Penn State Worry Questionnaire – Past Week (*PSWQ-PW*; Stöber & Bittencourt, 1998), (e) Beck Depression Inventory (*BDI-II*; Beck, Steer, & Brown., 1996), (f) Clinical Outcomes in Routine Evaluation– Outcome Measure (*CORE-OM*; Evans et al., 2002).

This battery of pre-post-outcome measures would be repeated at the mid-point of therapy, and then again upon the conclusion of therapy. The measures would then be subsequently administered at six-month follow-up. In addition to these measures, from the mid-point of therapy on, clients were invited to participate in a semi-structured interview, the Client Change Interview Schedule: Version 5 (CCISv5; Elliott, 2008), conducted by a member of the research team. This was also administered at the end-point of therapy and at six-month follow-up. The Structured Clinical Interview for DSM-IV-TR Axis II Disorders (*SCID-II*; First, Spitzer, Gibbons & Benjamin, 1994) was first introduced and administered from the second client onward. The Penn State Worry Questionnaire – Past Week (*PSWQ-PW*; Stöber & Bittencourt, 1998) was first introduced to the research project at the time of the first client's post-treatment assessment.

Before commencing each session of therapy, clients were requested to complete a Target Complaints (*TC*: Battle et al., 1966) form and upon the completion of each session they were asked to fill out a Helpful Aspects of Therapy Questionnaire (*HAT*; Llewelyn, 1988). All therapy sessions were video recorded, and audio recorded, when possible. In certain cases, due to technical mishaps, one or other of the devices failed to record. Consequently, for some sessions, there exists solely either an audio or video record. Data were stored on an encrypted external hard drive. On the conclusion of therapy, each therapist provided a retrospectively written, brief account of their work with each client from the perspective of case conceptualisation and emotion transformation.

2.4.2 Data Analysis

2.4.2.1 Quantitative Pre-Post Therapy Data Analysis

Data from pre-post-outcome measures was collected presented for each individual participant and also for the group of eight participants as a whole using the IBM SPSS

Statistics software package. Descriptive analyses and t-test for dependent samples were carried out. Effect sizes were calculated, which were standardised pre-post differences (Cohen's d).

2.4.2.2 Qualitative Retrospective Recall (CCISv5) Data Analysis

Qualitative data, derived from an analysis of process measures, was presented for each, individual client. Data from the CCISv5 (Elliott, 2008) was examined and analysed, in order to facilitate cross-case analysis, using a descriptive and interpretive qualitative research method described by Elliott and Timulak (2005). This systematic, yet flexible, method facilitates checking and auditing of the analytic process through a process of "careful archiving" (p. 152). All of the transcribed interviews were read by the author, who removed any "obvious redundancies, repetitions, and unimportant digressions" (p. 152). Data were then split into discrete *meaning units* under the premise that their intrinsic meaning would be clear to the reader, even if viewed out of context. The coding process involved recording the meaning units in terms of the participant who produced them and the order in which they were produced. By this means, an *audit trail* was produced, which could be followed, for auditing purposes, at a later stage in the analysis. All steps of the analysis were audited by the supervisor of the dissertation.

Emerging *domains* which structured the participants' responses were identified, and in this instance, were broadly suggested by the questions on the semi-structured interview tool employed. Meaning units were then ascribed to the appropriate domains, and under this wider grouping, were clustered into sub-groupings, referred to as *categories*, based on their perceived similarity of meaning. Categories were therefore derived from the content of the meaning units provided by the participants. This is described as a subjective/interactive process in so far as, while the author attempts to organise the information in a manner which

is congruent with and representative of the client's meaning, he is aware of and explicitly recognises the potential impact of his own theoretical knowledge on the coding process.

2.4.2.3 Qualitative Data Analysis of in-Session Helpful Aspects of Therapy

Data from clients' completed HAT forms were subjected to a similar process of analysis as was applied to ***CCISv5*** (see section 2.4.2.3). Data were organised into meaning units, which were then grouped into categories, based on their perceived similarity of meaning. These categories were then further grouped under the broader domains of "Helpful Events" and "Helpful Impacts".

2.4.2.4 Qualitative Data Analysis of Therapists' Perspectives on Case Conceptualisation

Case conceptualisation analysis was achieved by the author receiving and editing the therapists' retrospective recall of case conceptualisation for each client. For the purposes of cross-case analysis, all cases were reviewed individually and then collectively, in order that commonalities and patterns might be identified. Cross-case analysis in terms of case conceptualisation, therefore represents the author's attempt to synthesise the data from individual cases and present a tentative, general model for explicating the generation and maintenance of GAD from an EFT perspective.

2.4.2.5 Qualitative Data Analysis of Therapists' Perspectives on Emotion Transformation

Analysis of data pertaining to therapists' perspectives on emotion transformation was achieved in a similar fashion to the process described in section 2.4.2.1. The author received and edited the therapists' retrospective recall of emotion transformation for each client. These retrospective reports of emotional transformation were then investigated for commonalities and patterns which were reported in the cross-case analysis as the author's attempt to describe

a model of emotion transformation across therapy, which simultaneously captured both the individual journey of each individual client, yet managed to describe a process of transformation which was common to all (incorporating any variation due to individual differences).

2.4.2.6 Supplementary data

The therapists' case conceptualisation and emotion transformation perspectives (and consequently their cross-case analyses) were, in case of five clients (the first five clients), supplemented by information about case conceptualisation of the GAD dynamic present in those cases, from work accomplished in a separate study (O'Brien, Timulak, & McElvaney, 2012) led by a partially overlapping research team (O'Brien, Timulak, and McElvaney) working with the same data set.

In case of two clients (the first two clients), data analysis also used information accomplished by separate studies (Keogh, Timulak, & McElvaney, 2013 and Crowley, Timulak, McElvaney, 2013) which studied emotion transformation in the process of therapy and were led by partially overlapping research teams (respectively, Keogh, Timulak, and McElvaney and Crowley, Timulak, and McElvaney). In case of three clients (the first three clients), data analysis also used information accomplished by a separate study (Hughes, Timulak, & McElvaney, 2013) that examined the transformation of interpersonal injury in the unfinished business dialogues. This study was led by a partially overlapping research team (Hughes, Timulak, and McElvaney). Finally, in the case of the same three clients (first three clients) data analysis also used information accomplished by a separate study (Murphy, Timulak, & McElvaney, 2013) that examined the worry dialogues in the process of therapy. This study was led by a partially overlapping research team (Murphy, Timulak, and McElvaney).

The studies cited above, which supplement the case studies presented in this paper utilised a number of measures to obtain quantitative data which was used to further the analysis. The measures used were, (a) the Client Expressed Arousal Scale - III (*CEAS-III*; Warwar & Greenberg, 1999), a seven point ordinal scale developed to assess the intensity of observable expressed emotion, based on the evaluation of audio or videotapes of psychotherapy sessions, (b) the Client Emotional Productivity Scale - Revised (*CEPS-R*; Auszra, Greenberg & Herrmann, 2010), a decision-tree instrument designed to determine whether client emotional processing in therapy is productive or unproductive, and (c) The Classification of Affective Meaning States (*CAMS*; Pascual-Leone & Greenberg, 2005), a measure used to categorize client emotional processing events in terms of discrete affective-meaning states as described in the State-Transitional Model of in-session emotional processing proposed by Pascual-Leone and Greenberg (2007).

Table 2.1 displays all available data that were used for the case analyses. This data was in some cases (first 2-5) cases supplemented with the conclusions of related analyses conducted by a broader team of researchers that are involved in the investigation of EFT for GAD projects.

Table 2.1 Quantitative and Qualitative Data Sources

Quantitative pre-post	Qualitative pre-post	Helpful and hindering aspects of therapy	Case conceptualisation	Theory of change (Emotional Transformation)
GAD-7	Target Complaints	Client Change Interview	O'Brien et al (2012)	O'Brien et al (2012)
GADSS	HAT form	HAT forms	Keogh et al (2013)	Hughes et al (2013)
PSWQ			Crowley et al (2013)	Murphy et al (2013)
PSWQ-PW			Therapist Recall	Therapist Recall
CORE-OM				
BDI-II				

As said before, the presentation of individual case analyses was inspired by the HSCED format (Elliott, 2002). The cases were then cross-analysed to provide a picture of commonalities and differences between the cases.

2.4.3 Ethics

All efforts were taken to safeguard and respect the ethical integrity of participants in this research. First of all a detailed outline of the research proposal was submitted to the Health Service Executive (HSE) in order to gain ethical approval from the body holding clinical governance over the clients; this was awarded (See appendix A). A formal ethics submission was then drawn up and submitted to the University regulatory body; this was also granted (See appendix B).

As described in Section 2.4, all clients were provided with detailed information concerning the research, both verbally and in writing, which confirmed important issues such as confidentiality and anonymity (the cases that follow are presented in a disguised manner – e.g., age characteristics, family situation, work circumstances, aspects of individual stories, etc. have been altered). On completion of the interview, clients were presented with a debriefing sheet which gave contact details of all therapists should any participants feel the need to discuss any aspects of the process, or if taking part in the research had raised any painful or unresolved issues. Furthermore, Clients were informed from the beginning that if, for any reason, they wished to withdraw from the research they would immediately be reinstated at the top of the queue for treatment as usual at the primary care service. No clients availed of this.

During the course of therapy, one client expressed suicidal ideation. This situation was managed by the therapist, research team and host organisation. The client was retained in

the study, as this was deemed to be clinical best practice, and continued to successfully complete the course of therapy.

3.0 RESULTS

3.1 Case Study 1, "Tina"

3.1.1 Introduction

Participant 001, who, for the purposes of this study has been assigned the pseudonym "Tina", is a 56 year old female, Caucasian who was referred to the primary care service by her General Practitioner (GP). Initial intake at the service concluded that she was suffering from chronic and debilitating anxiety, coupled with some depressive features. Consequently she was asked if she would be interested in participating in the study.

Tina currently lives at home with her husband and their three children. At intake, she reported difficulties in her relationships with her children. Although intermittently employed in her late teens and twenties, Tina has devoted the majority of her adult life to raising her family. Recently, however she has taken on part-time work which she finds rewarding, although it is occasionally anxiety provoking. Four months prior to commencing therapy, Tina's G.P. prescribed Citalopram, a Selective Serotonin Re-uptake Inhibitor (SSRI) to assist her in coping with a number of psychological and behavioural disturbances associated with anxiety/depression.

Tina lost her father when she was five, and this event is one of her earliest memories. For a brief while, she was an only child, however, her mother later remarried and had two further children. Tina described having had a positive relationship with her step-father, while he was alive, however, she believed that this relationship became increasingly complicated, as her mother was jealous of their closeness. Tina recently lost her mother, with whom she had a difficult relationship, and it was this loss which precipitated the crisis that brought her into therapy. Tina engaged in 16 sessions of therapy with an experienced EFT therapist.

Prior to commencing therapy, Tina completed a Structured Clinical Interview for DSM-IV-TR Axis I Disorders; Non-Patient Edition: Research version. SCID-I/NP-R. Her

results indicated that she met the DSM-IV-TR diagnostic criteria for Current GAD. She also met the criteria for Dysthymic Disorder with atypical features and Recurrent Major Depression. Her score on the Global Assessment of Functioning scale was 55, suggesting *moderate* symptoms, (e.g. flat affect and circumstantial speech, occasional panic attacks), or moderate difficulty in social, occupational, or school functioning (e.g. few friends, conflicts with peers or co-workers) (SCID-I/P; First, Spitzer, Gibbon & Williams, 2002). At this point in the research, the team did not have access to a SCID-II for assessing DSM-IV-TR Axis II personality disorders; accordingly, SCID-II was not carried out with this participant.

3.1.2 Therapist's Interpretation of Therapy, Case Conceptualisation and Emotion Transformation

Therapist Perspective

The therapist reported that therapy with Tina was quite smooth, despite the fact that it was his first therapy in the service, which took some getting used to (e.g., the premises were not particularly comfortable and the building itself was demolished before the end of the project). He attributed the 'smoothness' of their work to the fact that the Tina was quite compliant and prepared to follow any suggestions in therapy. The therapist also felt that she bonded with him quite early on in treatment, expressing to him; *"You get me"*. On the other hand, she was quite emotionally avoidant (which showed in her low emotional arousal in session) and she was quite rigidly self-critical, which took some time to shift.

Nevertheless, the therapist felt that therapy went well, and that a great deal was accomplished in 16 sessions. Tina moved from being suicidal, highly distressed and constantly worrying, to being relatively self-accepting. She had felt unloved by her mother her all life (indeed, the main reason for her seeking help was the death of her mother a few

months prior to commencing therapy), nevertheless, in one of the later sessions she was able to forgive her mother, and in an unfinished business dialogue (as the imagined mother), was able to express love towards the self.

Case Formulation

The analysis of case formulation for Tina was based on the reflections of the therapist and was also informed by a study to which the author of the dissertation contributed (O'Brien, Timulak, & McElvaney, 2012). O'Brien and colleagues' (2012) case formulation was based on the qualitative analysis of the narrative and emotion events in the first half of Tina's therapy, incorporating quantitative scales, such as the Client Emotional Productivity Scale - Revised (CEPS-R; Auszra, Greenberg & Herrmann, 2010), the Client Expressed Arousal Scale - III (CEAS-III; Warwar & Greenberg, 1999) and the Classification of Affective Meaning States (CAMS; Pascual-Leone & Greenberg, 2005), and also used Pascual-Leone and Greenberg's (2005) emotional processing model as a starting point for the qualitative analysis.

Tina described her anxiety as being defined by constant worry and anticipatory fear. She reported that she was "*...always waiting for something to blow up*". She described experiencing a range of somatic complaints including exhaustion, stomach tension, tightness in the shoulders and grinding teeth. Tina expressed hopelessness and occasional suicidal ideation, *"A hopelessness deep inside me body"; "I just think to myself if, if I could just take some tablets and go to sleep".*

A number of triggers, past and present, contributed to Tina's distress. In the past she had endured a difficult relationship with her mother, who shamed her and frequently put her down; a situation which remained much the same up to the point of her mother's death. Tina worried about her husband's recent unemployment and expressed fears for his health. She

reported finding her children rude, and disrespectful towards her; referring to frequent arguments in the house. Despite enjoying her new part-time job, Tina worried that she might, in some unspecified way, mess things up and be exposed as incompetent. She reported hyper-vigilance in an attempt to guard against this possibility. Tina reported that the most devastating trigger of all was the recent death of her mother.

Tina's core emotion scheme was described as being dominated by loneliness, incorporating feelings of rejection and abandonment; shame, incorporating feelings of being unlovable and worthless; trauma, related to her father's suicide and mother's psychiatric condition; and loss, of both her mother and stepfather. These were all complicated by behavioural and emotional avoidance (mostly visible in her worrying about potential triggers that might bring about the feared pain), which, up to the point of commencing therapy, had made it almost impossible for Tina to come into contact with her core pain without collapsing into either global distress or secondary, rejecting anger (the anger being mainly directed at her mother, but also at her children or husband).

Tina's need to feel loved, accepted, safe and ultimately to be able to adopt a more compassionate stance in relation to herself was frustrated by past and current experiences. Her situation was exacerbated by her inability to access and process core pain, due to pervasive worrying, and was further complicated by a self-treatment style which was harsh, critical and dismissive (similar, in fact, to the way she was treated by her mother).

Emotion Transformation

The analysis of Tina's emotion transformation was expanded upon on the basis of the therapist's reflection and also by information provided by a study to which the author of the dissertation contributed (Keogh, Timulak, & McElvaney, 2013), which tracked Tina's emotion transformation using qualitative analyses of emotion events and narratives,

supplemented by ratings from quantitative scales (CEAS-III, CEPS-R, CAMS). The qualitative analysis was based on a theoretical framework derived from the EFT model of in-session emotion transformation (Pascual-Leone and Greenberg, 2007).

Tina's initial sessions were characterized by emotional avoidance and overall, undifferentiated, (global) distress. As therapy progressed, she moved to the stage of being able to access core painful feelings (particularly feelings of worthlessness, of not being loved by her mother, intense loneliness, fear of mother, and others, who might attack her) mainly through utilizing empty chair and two chair dialogues (at this point she was still extremely self-critical). Tina would say things like "*I always sort of feel like that even though I'm married and even though I have my children now. I don't feel ... I still feel sort of isolated. You know? It's weird. It's there.*" With regard to her mother, she would say: "*She wasn't even there for anything you might have done at school or if you achieved anything she'd just...*" Over time, she became increasingly able to access self-compassion towards the small, hurt (lonely, unloved, terrified) little girl inside. Compassion came from the imagined caring other, such as her deceased father, a paternal grand-mother, and self (although this was a struggle as she was extremely self-rejecting). This reached a climax in session 13, in which Tina enacted the imagined mother and expressed: "*I know, I know I was wrong to you in a lot of ways but you know I love you really don't you.*" These were words she had never heard from her mother in reality.

Throughout the sessions Tina articulated her unmet needs, for instance, to her mother: *"I didn't do anything. I was only a little child"*, towards the critical self (which to a large extent appeared to have been introjected from her mother): "*I am a good person and I deserve to have time for myself.*" These were then expressed in protective anger, which she became increasingly able to access as therapy progressed, for instance saying to her critic: "*I have my power, shut up!*" The progress afforded by compassion and protective anger was

followed by grieving, which had a letting go quality, in the later sessions; e.g., in speaking about her mother: "*We had a bit of something going on there at the end definitely. But it's just a pity she couldn't sort of speak and tell me because I knew she wanted to tell me stuff.*" Tina's progress with regard to the transformation of her core painful feelings was mirrored by the progress she made in facing her worry process (see below).

Worry Dialogues. The analysis of Tina's emotional transformation was also informed by the available analyses obtained from a study to which the author of the current study contributed (Murphy et al., 2013); a study which tracked Tina across four of her worry dialogues using a task analytic approach (Greenberg, 1984; 2007; Pascual-Leone, Greenberg, & Pascual-Leone, 2009; 2013). Tina's progress in transforming her worry process was visible across the 4 dialogues. In the first two dialogues (between the worrying part, named the Worry Agent and the impacted part, named the experiencer), Tina appeared uncomfortable with the task and seemed to not fully understand it. In the third dialogue Tina's self-interrupting, avoidant, emotional processing style and her harsh, negative self-treatment became apparent, however in this sequence she was able to achieve partial resolution in so far as the Worry Agent (the part of the self that expresses the worry enacted in a chair dialogue) apologised for being so pushy and aggressive. The fourth session was characterized by Tina, as experiencer, assertively stating that she needed a break from worry, and the subsequent softening of the Worry Agent in relation to her.

Unfinished Business Dialogues (UBD). The case analysis of Tina's emotional transformation was also informed by the available analyses obtained from another study to which the author of the current study contributed (Hughes, et al., 2013). Hughes and colleagues (2013) examined four UBDs conducted between Tina and her deceased mother. This was consistent with Tina having identified *difficulties with her mother* as being a significant issue on her target complaints forms, and was further reflected in Tina's

comments on the helpful aspects of therapy (HAT) forms, completed after each session of therapy. Tina presented a clear marker for the appropriateness of the task, "*It's just always really the thing that I always focus on... I think is the relationship with my mum.*" In the first dialogue, Tina became aroused, and reported an almost instantaneous somatic response *"it is just like em I just want to choke almost. You know. It kinda comes up and..."* Tina was encouraged to attend to her internal experience when confronted by the imagined other. She was facilitated in staying with her core pain and in expressing this to the imagined other (rather than collapsing into global distress or expressions of rejecting anger); *"you are still very hurtful"* and "*I always felt afraid of you all my life*". Tina was facilitated in expressing previously unmet needs *"I missed the affection, the love, just what a mother should be doing."* While initially the imagined other was unresponsive, in the second and final dialogues, she provided a compassionate response. Importantly, Tina was also able to access protective/assertive anger *"you've no right to have treated me like you did"* which was empowering. Ultimately, Tina was able to offer an understanding and balanced appraisal of her mother's behaviour, leading to compassion and a degree of forgiveness, *"I can forgive you, of course I can".*

3.1.3 Measures

3.1.3.1 Analysis of Quantitative Pre-Post-Outcome Measures.

Tina's scores are presented for pre-, mid-, post-therapy and at her 6 month follow-up assessment in Table 3.1.1.

Table 3.1.1 Tina's Pre-Post-Outcome Scores

Scale	Caseness	RCI	Pre-Treatment	Mid-Treatment	Post-Treatment	6 Month Follow Up
GAD-7	10	5	16	11	0	8
GADSS	7	n/a	15	11	2	5
BDI-II	10	9	25	20	4	2
CORE-OM	1.29	0.48	1.17	0.85	0.23	0.94
PSWQ	46	9	67	63	51	42
PSWQ-PW	n/a	28	n/a	n/a	29	55

Note: Caseness = the cut-off for determining whether client is clinically distressed. RCI=Reliable Change Index; GAD-7 = Generalised Anxiety Disorder–7; GADSS = Generalised Anxiety Disorder Severity Scale; BDI-II = Beck Depression Inventory; CORE-OM = Clinical Outcomes in Routine Evaluation – Outcome Measure; PSWQ = Penn-State Worry Questionnaire; PSWQ-PW = Penn-State Worry Questionnaire (Past Week).

Immediately prior to commencing therapy, Tina was asked to complete a battery of tests comprising the GAD-7, GADSS, BDI-II, CORE-OM, and the PSWQ. This battery was repeated at the mid-point of therapy, at the end of therapy and at the six-month follow up assessment. By the time of her end of therapy assessment, the battery of tests completed by Tina now included the PSWQ-PW, which was introduced by the research team to provide a weekly measurement of worry. Of the five principal measures used by the research team to track Tina's quantitative outcomes as she progressed through therapy, two related specifically to GAD (GAD-7; GADSS), one measured worry (PSWQ), which is central, although not exclusive to, GAD and the last two comprised a clinical measurement of depression (BDI-II) and a pan-theoretical measure of global distress (CORE-OM).

On the GAD-7 measure, scores of 5, 10 and 15 are taken as the cut-off scores for mild, moderate and severe anxiety respectively; at the clinical threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for generalized anxiety disorder. At the beginning of therapy Tina's score on the GAD-7 was 16 which indicated that she was in the *severe* clinical range for GAD. By the mid-point of therapy Tina's score had reduced to 8, placing her in the *mild*, non-clinical range and upon the conclusion of therapy, her score was 0, indicating the absence of GAD symptomatology. Tina's pre-post difference of 16 suggested that reliable change had occurred and this, combined with the fact that she no longer met the criteria for caseness, suggested that she was *recovered*. Tina's score of 2 at her six month follow-up assessment suggested that she was still *recovered* on this measure.

On the GADSS, scoring is based on a five point scale ranging from 0 = *none*, to 4 = *very severe*; cut off scores on this measure are as follows: 1-6 (mild levels of GAD), 7-12 (moderate levels of GAD), 13-18 (severe levels of GAD) and 19-24 (very severe levels of GAD). Tina's scores on the GADSS followed a similar pattern to her scores on the GAD-7. Tina's pre-therapy, total score of 15 on the GADSS placed her in the *severe distress/impairment* range. At the mid-point of therapy, Tina's total score had dropped to 11, which placed her in the *moderate distress/impairment* range, and by the end of therapy her total score was 2, which placed her in the *mild distress/impairment* range, indicating that she no longer met the criteria for caseness and suggested remission of GAD symptomatology. Tina's total score of 0 at her 6 month follow-up assessment suggested that she was still in remission from GAD.

Tina's scores on the third measure associated with GAD, the PSWQ, were somewhat more ambiguous that those derived from the GAD-7 and the GADSS. The PSWQ is scored by summing the totals for all items. In her pre-treatment assessment, Tina scored 67 on the PSWQ which placed her in the clinical range. At the mid-point of therapy assessment she

remained in the clinical range with a score of 63, while at the end of therapy her score had fallen to 51. Tina's pre-post differential met the criteria for RCI, suggesting that reliable change had occurred, however her final score of 51did not meet the criteria for caseness, indicating that she had *improved* on this measure. A score of 42 at her 6 month follow-up assessment indicated that she was now *recovered* according to this measure.

It is perhaps worth noting at this point that Tina scores may have been impacted by a number of factors. First, as has been suggested above, the PSWQ is recognised as a measure of trait-anxiety and consequently Tina's scores may be a reflection of her self-perception as a "worrier". This may function as an enduring self-description even in the absence of, or relief from, the distress associated with worry, resulting from therapy. This is partially supported by Tina's scores on the PSWQ-PW measure, which are 29 at the post-treatment assessment and 16 at her 6 month follow-up interview. It is established that individuals may simultaneously hold both positive and negative beliefs regarding worry and thus it is possible that Tina's scores reflect a belief in the positive, or protective, function of worry. Finally in research interviews, Tina frequently expressed confusion regarding the wording of some items on the PSWQ and described being particularly confused by the inverted questions and, on occasion, the scoring system.

On the CORE-OM, Tina's score of 1.17 placed her just below the female clinical cut-off point of 1.29, suggesting that her level of distress was *non-clinical* in nature. At her mid-treatment assessment, her score had fallen to 0.85 and at her end of therapy assessment she scored 0.23 which placed her in the *non-clinical* range. Tina's pre-post differential score indicated that reliable change had occurred. Her score of 0.20 at the 6 month follow-up interview suggested that her level of distress remained *non-clinical* in nature on this measure.

The BDI-II uses the following cut-offs to establish the severity of depressive symptomatology: 0–13 = minimal depression; 14–19 = mild depression; 20–28 = moderate

depression; and 29–63 = severe depression. Tina's pre-treatment score of 25 on the BDI-II placed her in the *moderate* range of depression. Her mid-point assessment score of 20 also placed her in the *moderate* range of depression, while her score on the measure at the end of treatment was 4, which placed her in the *minimal* range of depression. Tina no longer satisfied the criteria for caseness, and her pre-post differential score suggested that reliable change had occurred, indicating that she had *recovered* according to this measure. Her score of 2 at her 6 month follow-up assessment suggested that she had stayed in remission from her depressive symptoms.

3.1.3.2 Analysis of Process measures

Target Complaints (TC)

On the first day of treatment, and subsequently, prior to each therapy session, Tina was asked to fill out a target complaints form, detailing the issues which were currently causing her the greatest distress and to rate how much they bother her on a scale ranging from 1 = not at all, to 13 = it couldn't be worse (See Table 3.1.2).

Table 3.1.2 Data from Tina's Target Complaints Forms

Complaint	**Pre-therapy**	**Mid-therapy**	**Post-therapy**	**Pre-post difference**
Feelings of distress related to my mother	7	3	0	7
Lack of confidence in myself	8	4	3	5
Overeating and sleeplessness	9	2	0	9

It is worth noting that of the three items that Tina listed in the TC, two of them, *self-confidence* and *issues related to mother*, featured prominently in her HAT forms while the third, overeating and sleeplessness, was not mentioned at all, despite being scored as the most distressing at the onset of therapy. It is possible to argue that the first two issues, being representative of core themes concerning shame, rejection and worthlessness, required and received attention in therapy while the third item, relating to rather secondary, behavioural difficulties was resolved over time as the core issues were addressed.

Helpful Aspect of therapy Form (HAT)

At the end of every session, Tina was asked to complete a Helpful Aspects of Therapy Form. This form asks the respondent to identify a helpful event from the recently finished therapy session, to explain how the event was helpful, when it occurred in the session, how long it lasted for and to assign a quantitative value to it, indicating the degree to which the event was helpful or hindering (See Table 3.1.3). On the provided scale; 1, 2, 3and 4 represent, respectively: extremely, greatly, moderately and slightly hindering, while 6, 7, 8 and 9 represent slightly, moderately, greatly and extremely helpful respectively; 5 represents neutral.

Table 3.1.3 Data from Tina's Helpful Aspects of Therapy Forms

Session	How helpful?	Helpful event	What made it helpful?	When in the session?	How long did it last?
1	7	Being able to open up. Felt more positive. Confidence building.	Built up self-esteem. Increased confidence.	At the beginning.	No Data.
2	7	Being able to talk openly	Sense of being listened to.	Almost straight away.	Nearly all of the session.
3	7	No Data.	Talking through my problems. Acting out the part of my mother.	The last 15minutes.	A few minutes.
4	8	Talking about confidence	Acting out myself talking	Most of it.	A lot of the session.

		issues. Making me accept myself.	to myself. Feelings of letting upsetting things go.		
5	7	Thinking that my mam did love me. Realising the sadness in me.	Very helpful getting it out of me. Talking is so good.	Near the end of the session.	Five minutes.
6	8	Growing in confidence. Letting the agitation out.	Very helpful. Relaxing tension.	No Data.	No Data.
7	9	Making me feel I'm worth it, that I'm not selfish.	Made me feel I deserve to look out for me.	Halfway through.	Lasted 15 minutes.
8	8	Going back to my early childhood. Bringing the bad memories out.	Acting out myself as a child. Feelings of being unwanted and unloved.	Middle	Half the session.
9	1	Talking about my feelings about myself.	Making me feel that I am not worthless. Telling myself that I am.	Halfway through.	The rest of the session.
10	No Data.	Growing in confidence. No crying.	Getting stronger. Don't feel so self-pitying.	Almost straight away.	Most of the session.
11	2	Being able to tell myself I am deserving. Near the end. Good feeling.	Therapist telling me to tell myself I am not worthless.	Near the end.	No Data.
12	2	Talking about my feelings as a teenager and the way my mother was with me.	Letting it all out. Relief to do that.	Near the end.	15 minutes.
13	1	I felt I could now discuss my mother in a confident way. My feelings are so much more positive. My therapist really has helped me to get where I	Letting everything out. The tensions released at each session.	All the way through.	No Data.

		am.			
14	1	Taking about my bossiness and learning to forgive myself.	My stressed feelings leave me in the session.	Most of the session.	All of it.
15	8	Facing up to my lack of confidence in myself. Talking about my attitude to others. Very helpful.	Realising I can do what I want without feeling guilty. Letting family do more for themselves. Feeling more able to deal with everything.	Most of the session.	No Data.
16	No Data	Feeling completely de-stressed. I feel calm and happy.	One- to- one session, where I am listened to.	No Data.	No Data.

It is interesting to note in the data extrapolated from these collated forms that there were occasional discrepancies between the quantitative score and the qualitative description of the event. For example the event in Session 9 is rated in between extremely and greatly hindering, however the description of what made the event helpful/important reports *"making me feel that I'm not worthless"*. Similarly, sessions 11, 12, 13, and 14 received scores denoting either extremely or greatly hindering experiences, whilst the qualitative descriptions referred to events such as *"Being able to tell myself I am deserving [...] Good feeling"* and *"My feelings are so much more positive. My therapist really has helped me to get where I am"*. These discrepancies, along with the fact that Tina twice failed to assign a quantitative score suggest that she may have had difficulty grasping some aspects of the scoring procedure.

Tracking through Tina's HAT forms it was possible to observe that in the early sessions (1, 2) she described a sense of feeling secure and confident in the therapy session which allowed her to talk openly about her experience, *"Felt more positive. Confidence-*

building." She described the feeling of being listened to as "helpful". While the helpful event in session 3 was not explicitly described, her comment on what made it helpful suggested that it involved chair work around unfinished business with other (in this case, her mother). Session four referred to work around confidence, self-acceptance and letting go while the description of what made the event helpful (*"acting out myself talking to myself"*), suggested that two chair work for evaluative conflict splits was used. In session 5, Tina referred to the realisation that her mother may have, in fact, loved her and also described a process of recognising and expressing emotion, *"realising the sadness in me"*, which she described as beneficial *"Talking is so good"*.

In session 6, Tina again referred to feelings of increased confidence and reduced tension, while in session 7 she reported improved feelings of self-worth and the beginning of a process of viewing herself more positively *"Made me feel I deserve to look out for me"*. Session 8 was described as involving in-depth exploration of painful early childhood experiences, involving feelings of being unwanted and unloved, while session 9 involved Tina exploring how she felt about herself and again, reaffirming that she had value *"Making me feel that I'm not worthless"*. Sessions 10 and 11 both developed the theme of emerging self-confidence *"Getting stronger. Don't feel so self-pitying"*, while in sessions 12 and 13 Tina described being facilitated in exploring her teenage years and her difficult relationship with her mother *"I felt I could now discuss my mother in a confident way"*. In both sessions Tina referred to a reduction in tension as a result of emotional expression. In sessions 14 to 16 Tina described increased self-awareness and self-acceptance *"Talking about my bossiness and learning to forgive myself"*, and described how interpersonal relations had improved by her relinquishing the need to control *"Letting family do more for themselves"*. In the final session (16) she reported that she felt quite at ease *"Feeling completely de-stressed. I feel calm and happy"*

Retrospective Recall of Helpful and Unhelpful Aspects, and Client Reported Changes (Client Change Interview).

In her post-treatment assessment, upon the conclusion of therapy, Tina described herself as "*doing very well*", she referred to a new-found sense of confidence and reported experiencing a sense of calm which had previously eluded her "*Feel content shall we say? I'm content.*" She described how she was initially worried about engaging in therapy because of feelings of inadequacy and lack of competence "*I didn't think I'd be able to do it*", but later felt that she had overcome this fear, stating, "*It's been, it's been great for me yeah. Very good,*" in relation to therapy.

In describing changes which she had noticed in herself since engaging in therapy Tina reported greater emotional regulation "*I've noticed that I'm not flying off the handle. Em, I'm handling situations better*", improved coping "*I'm more able now to deal with things*", and improved self-esteem "*I don't feel that I'm worthless. I feel that I'm worth something now*". In terms of self-treatment, she reported improved confidence and greater self-acceptance "*Yeah I'm feeling more confident now. I feel that I don't have to be... beat yourself up about things that...*" and "*Things...Things happen in life and it's... it happens to others not just to me. Things happen and to sort of get over it you know*". Tina reported having a greater understanding of her situation and an improved capacity for self-compassion "*Yeah absolutely, cause I just had no confidence and I would blame meself thinking everything was me own fault. Through what has happened to me as a child and that, it actually isn't me own fault*"

Reporting on her experience of the process of therapy, Tina referred to her relationship with her therapist as soothing *"very, very calming and he listens and he's just*

very good" and described how chair-work allowed her to work through issues her past to achieve symptom relief in the present "*The role playing thing is very good now* [...]*Talking about things from an early age and reliving all that stuff. I think that's really been good* [...] *It's sort of unknotted all the tensions in me*". She attributed these changes to guided chair-work which allowed her to access core emotion schemes "[therapist] *would listen to what you have to say and then he'd kind of dig at you more, if you like, to get to the root of the feelings*", the therapist's acceptance and supportive attitude "*And then he would em... tell you that it actually isn't your fault and that you are worth this, that and the other you know?*" and her own ability to channel these changes into enhancing her social life and relationships outside of therapy "*I'm having a better social life and everything now, yeah*" and "*I always walked around, you know, letting everybody think I'm confident but actually I wasn't but I do feel more confident now*".

In terms of changes in her interpersonal relations, Tina observed that as her anxiety reduced she felt less of a need for control over family members "*Just, in meself, not being em, so controlling. The therapy stopped me... maybe stopped to think that, you know, I'm not helping myself by bossing my people around in my family and that which I have said I've eased off and life's better because of it. I'm not as controlling now and that's through therapy you see*?" Tina pointed out that her friends have noticed her increased confidence "*Because I have a very close friend, a girl I met here when I first came to Dublin... And she's said, she said "God you're so different". She said "You know your confidence and I don't know why you ever weren't" and all this you know? She's noticed...*" She also reported that her husband has noticed that she is less vulnerable, and more able to stand up for herself "*And even me husband saying "Hold on!" you know? Because I tell him in no uncertain terms more you know...? I can stand me own corner now more*".

When reporting on helpful aspects of therapy, Tina described how therapy has helped her to regulate her emotional experience. She described how she moved from a position of being completely overwhelmed by everything to being able to accept herself, and her situation, with all its imperfections "*Em, well when I first came in I would be like ah... bursting into tears, very, very upset [...] Everything that was said to me but everything had just got on top of me so much...*". Eventually Tina described being able to "*get her head around*" her situation and accept things as they are "*Yeah I understand and I understand also that I don't have to have, like ,the perfect... clean house, through the house every day and stuff like that you know?*" Tina reported that therapy helped alleviate her feelings of worthlessness "*A feeling of worthlessness. Now I don't have that now... I used to just think I was useless and worthless.*"

Another area of therapy which Tina reported as being particularly helpful was the chair-work "*The thing that really stood out for me all the time was when I kept going swapping over the role-play. Really did it for me.*" She acknowledged how she was guided through "*role-plays*" which were frequently painful but effective "*...And you might be in bits and you're crying and everything else but you've really touched the spot.*" While Tina was unable to point out any areas of her therapy which were unhelpful or hindering, she was clear that she found the dialogues with her mother painful, although ultimately beneficial, "*And eh the relationship with me mother. Now I found that hard and... but I realized it had a lot of meaning like we had to talk about all that, you know. I just eh... Again I've come to terms with it now*".

3.2 Case Study 2, "Ann"

3.2.1 Introduction

Participant 002, who for the purposes of this study has been assigned the pseudonym "Ann", is a 46 year old female, Caucasian who was referred to the primary care service by her General Practitioner (G.P.). Initial intake at the service suggested that Ann was suffering from chronic anxiety and exhibited some features of depression. Consequently she was asked if she would be interested in participating in the study.

Ann is the mother of two adult children, both of whom live independently. She has a part time job as a cleaner but works primarily as a home maker, and lives at home with her husband, her elderly father, and a nephew. Ann is the youngest of seven children. Her mother, who struggled with alcohol and prescription medication dependency, died when she was 12 years old.

Although Ann's GP has prescribed anti-depressant medication for her in the past, she prefers not to take it, although she occasionally takes Xanax, to "*help with the nerves*". She reported almost constant worry regarding the health and safety of family members and described herself as deeply wounded by her own mother (now deceased) who was unable to meet her basic physical and emotional needs. Ann engaged in 25 sessions of therapy with an experienced EFT therapist.

Prior to commencing therapy, Ann completed a Structured Clinical Interview for DSM-IV-TR Axis I Disorders; Non-Patient Edition: Research version. SCID-I/NP-R. Her results indicated that she met the DSM-IV-TR diagnostic criteria for Current GAD and Current Major Depressive Disorder. Her score on the Global Assessment of Functioning scale was 55, which suggested *moderate* symptoms, (e.g. flat affect and circumstantial speech, occasional panic attacks), or moderate difficulty in social, occupational, or school functioning (e.g. few friends, conflicts with peers or co-workers) (SCID-I/P; First, Spitzer,

Gibbon & Williams, 2002). Ann also completed the SCID-II for assessing DSM-IV-TR Axis II personality disorders which indicated that she met the diagnostic criteria for Avoidant, Obsessive-compulsive and Depressive Personality Disorder.

3.2.2 Therapist's Interpretation of Therapy, Case Formulation and Emotion transformation

Therapist Perspective

The therapist believed that therapy went really well in this case. Initially, he reported, it took some time before Ann developed trust in the therapeutic process. She was quite skeptical and came across as not fully trusting of him, which he found difficult interpersonally. However, around session 10, upon her return to therapy after a brief break, taken following the death of a family member, he had a sense that she had settled in. She spontaneously commented that he "got" her; she thanked him at the end of the sessions, etc. He described noticing the progress that Ann was making in addressing her underlying issues (i.e. not feeling loved or supported by her mother, and then being traumatized by her death and loss associated with this) around session 13-17. By this time, Ann was able to access her core pain ever more easily; she was able to differentiate it and bring self-compassion and protective anger. He reported that they also did a number worry dialogues, and in time, Ann was eventually able to stand up to her worry agent. She remained extremely self-critical however, even towards the very end of therapy; nevertheless, she was able to stand up to her critic (as in session 19) and express pride in herself. The therapist remembered that by the end of therapy, Ann had signed-up for a course in her local community center; for the first time in her life she had looked after her own needs and felt good about it. He reported having a sense that it was a very successful therapy and that they had a very warm and easygoing relationship by the end of treatment.

Case Formulation

The analysis of Ann's case formulation presented here is based on the therapist's report and a study conducted by O'Brien, the author of the current study and Dr Timulak in 2012. The case analysis suggested that Ann's chronic anxiety had become increasingly difficult to tolerate and that she reported that she no longer felt that she can cope with the almost constant worry, anxious apprehension and hyper-vigilance which it entailed. Ann described how her mind was racing *"The head is doing ninety and... I just can't get a grip on things and I don't know why"* and noted that this was accompanied by somatic symptoms including bodily tension, palpitations, shortness of breath and a state of constant exhaustion. As set out in her Target Complaints forms, Ann was preoccupied with the possibility of death, illness or some other calamitous event befalling either herself or her family, exacerbated by her perceived inability to protect them. She was overwhelmed and frightened *"It's just not being able to cope with things when it's happening to me that's freaking me out"* and experienced bouts of low mood which were characterised by hopelessness and absence of joy in life.

Ann described past triggers which included a traumatic childhood in which she had to fend for herself *"I'm looking after myself since I'm about ten years of age"*, as her emotionally unavailable mother was abusing alcohol and died from heart failure when Ann was 12. More recently, her worries have focussed on her elderly father and her son and daughter, who have medical health issues. She described how the possibility that anyone close to her might suffer was almost unbearable, and worried constantly about the emotional well-being of both her immediate family and also that of her step-nieces and step-nephews, with whose experiences of neglect, loss and abandonment she found it all too easy to identify.

A great deal of Ann's core emotional pain was linked to her relationship with her mother, whose inability to meet her needs in childhood, and whose early death gave rise to feelings of rejection, shame, loneliness, sadness and abandonment (i.e. "*You didn't love me*", "*You died and left me*"," *It was my fault*"). Significantly, Ann's relationship with her mother, who suffered from depression, addiction to alcohol and prescription medication, and was twice psychiatrically hospitalised, was particularly fraught. It also introduced a huge element of fear into Ann's life as her mother was so frequently enraged that Ann reported being almost constantly terrified. This added a level of trauma to the formative GAD experience, as Ann experienced multiple, repeated, fearful incidents in childhood which terrified her and in the face of which, she felt quite helpless; unable to control or influence events.

Emotion Transformation

The account of emotion transformation was based on the therapist's report and was expanded upon by findings from Crowley, Timulak, and McElvaney (the author of the current study) (2013) who tracked Ann's emotional transformation using qualitative analyses of emotion events and narratives. Crowley and colleagues (2013) used the Emotional processing model (Pascual-Leone & Greenberg, 2007) as the basis of their qualitative analysis, which was supplemented by ratings from quantitative scales (CEAS-III, CEPS-R, CAMS). The therapist and Crowley et al. (2013) described the manner in which Ann employed worry as a means of avoiding her core pain, and how this further evolved into certain forms of behavioural avoidance, which over time, due to their protective function, became ingrained in personality and introduced a note of ambivalence when faced with therapeutic change that required a renunciation of these defences.

Ann's GAD dynamic prevented her from experiencing primary core feelings of loneliness/sadness, the trauma of witnessing the pain of others, and the shame associated with

feeling responsible for her own pain and the pain of others. Ann appeared to have internalised her mother's inability to tolerate vulnerability in herself or others.

Tracking Ann's emotional transformation across sessions, revealed how in the early stages of therapy she was frequently overwhelmed and bewildered by the intensity of her distress "*Sometimes I just wanna scream at the top of me lungs and for what I do not know*". Global distress was her dominant state and she frequently collapsed into maladaptive secondary emotions such as hopelessness and helplessness. Her desperate attempts to avoid her core pain resulted in an escalation of her worry process, resulting in both somatic and psychological distress and obstructing the possibility of her coming to terms with her painful emotional experience. By the middle stages of therapy, Ann appeared more able to tolerate core primary maladaptive emotion, was less avoidant and spent less time in secondary emotions such as hopelessness and helplessness. As this tolerance of core emotional pain evolved, Ann became increasingly able to address the hitherto unmet needs associated with it, for example, the need to be loved, accepted and protected.

As therapy progressed, Ann adopted an increasingly assertive position in relation to her worry agent *"... I need you to calm down a little bit and let the rest of me catch up with what you want me to do"* and it was during this phase of therapy that the inner critic began to soften. Ann also began to display greater insight at this point in therapy, a fact which was corroborated by her own comment in her HAT form "*Making me aware of myself more and my actions as well.*" [HAT: Session 15]. The softening of the critic and possibility for self-compassion facilitated a movement towards a deeper level of emotional processing.

In the final third of her treatment, Ann evinced a much greater ability to tolerate core pain experiences of shame, loneliness and trauma-related fear. There was a significant moment in Session 16 where the imagined mother softened and expressed a willingness to

help Ann (which did not actually happen in reality or, if it happened at all, occurred in a very limited way) and expressed caring feelings towards her. Ann was also able to let in this expressed compassion and experienced a rare moment of connection with her mother. Later Ann, with increased empathy towards her mother's difficult situation, acknowledged a subsequent improvement in her own circumstance: "*I do feel a hell of a lot better now. I have to be honest about it. I really do*". It was observed that Ann was now less inclined to collapse into global distress, and indeed, as she gained a degree of distance from her worry process, she was able to effect real change in the way she lived her life; for example, allowing her son to attend a hospital appointment on his own.

Worry Dialogues. The analysis of Ann's emotional transformation also drew on the available analyses obtained from a study to which the author of the dissertation contributed (Murphy et al., 2013). Murphy and colleagues (2013) tracked Ann across four of her worry dialogues using a task analytic approach (Greenberg, 1984; 2007; Pascual-Leone, Greenberg, & Pascual-Leone, 2009; 2013). Their analyses also drew on the Emotional Processing model and used quantitative measures, such as CEAS-III, CEPS-R and CAMS (mentioned above in the description of Crowley et al.'s study). Murphy et al. observed that Ann's first experience of chair work involved a worry dialogue in which the Worry Agent part of the self was enacted in an imaginary dialogue and its impact on the experiencer was explored and the experiencer's response to the worry was invited. While Ann was able to perform the task as far as expressing need to the Worry Agent, she collapsed into global distress and the task was changed, to better focus on addressing her core pain.

Ann's ability to engage in the worry dialogue task improved with each enactment. In Ann's third dialogue, when she once again expressed her need to an unyielding Worry Agent, that would not soften, the therapist intervened and provided compassion. By the time she

reached her fourth dialogue Ann was beginning to exhibit assertiveness, grounded in protective anger, which enabled her to demand the opportunity to prove herself.

Unfinished Business Dialogues (UBD). The case analysis of Ann's emotion transformation also drew on the available analyses obtained from another study to which the author of the dissertation contributed (Hughes, et al., 2013). Hughes and colleagues (2013) examined four UBDs conducted between Ann and her deceased mother. Hughes et al. (2013) also used the task analytic approach and their analyses also drew on the Emotional Processing model and used quantitative measures such as CEAS-III, CEPS-R and CAMS, as in Murphy and colleagues' (2013) study. Hughes et al. (2013) noted that fierce rejecting anger, in the initial dialogues, when elaborated upon and unpacked, allowed Ann to access the pain and hurt she felt, revealing a more complex blend of deep sadness and anger; *"It's heart breaking"*. In her enactment of the imagined mother, Ann's first three dialogues contained a hurtful message, contemptuous and dismissive, however the fourth dialogue represented a degree of softening.

Initially Ann struggled with receiving negative responses from the significant other and brief bursts of rejecting anger quickly gave way to a collapse into global distress. By the final dialogues, however, Ann had developed greater tolerance, and could move beyond rejecting anger to access her core pain. It is notable that each of the UBDs concluded with a positive emotional experience, mainly involving some variant of compassion. Initially taking the form of self-compassion, by the final UBD, a degree of compassion was provided by the imagined mother, affording Ann great comfort and relief.

3.2.3 Measures

3.2.3.1 Analysis of Quantitative Pre-Post-Outcome Measures.

Ann's scores are presented for pre-, mid-, post-therapy and at her 6 month follow-up assessment in Table 3.2.1.

Table 3.2.1 Ann's Pre-Post-Outcome Scores

Scale	Caseness	RCI	Pre-Treatment	Mid-Treatment	Post-Treatment	6 Month Follow Up
GAD-7	9	5	19	9	8	8
GADSS	7	n/a	19	10	6	5
BDI-II	10	9	12	16	4	2
CORE-OM	1.29	0.48	1.32	1.14	1.12	0.94
PSWQ	45	9	78	58	51	42
PSWQ-PW	n/a	n/a	n/a	48	47	55

Note: Caseness = the cut-off for determining whether client is clinically distressed. RCI=Reliable Change Index; GAD-7 = Generalised Anxiety Disorder–7; GADSS = Generalised Anxiety Disorder Severity Scale; BDI-II = Beck Depression Inventory; CORE-OM = Clinical Outcomes in Routine Evaluation – Outcome Measure; PSWQ = Penn-State Worry Questionnaire; PSWQ-PW = Penn-State Worry Questionnaire (Past Week).

On the GAD-7 measure, scores of 5, 10 and 15 are taken as the cut-off scores for mild, moderate and severe anxiety respectively. At the beginning of therapy, Ann's score on the GAD-7 was 19 which indicated that she was in the *severe* range for GAD. By the mid-point of therapy, Ann's score had reduced to 9, which placed her in the *mild*, non-clinical range, and upon the conclusion of therapy, her score was 8, which suggested that she was still non-clinical; in the *mild* range of GAD symptomatology. Ann's post treatment assessment revealed that this pre-post differential of 11 met the criteria for the RCI which suggested that reliable change had occurred. This, in conjunction with her post-treatment score of 8, which placed her below the cut-off for caseness, suggested that Anne had *recovered* on this measure.

Ann's scores on the GADSS followed a similar trajectory. Ann's pre-therapy total score of 19 placed her in the *very severe distress/impairment* range. By the mid-point of

therapy, Ann's total score had dropped to 10 which placed her in the *moderate distress/impairment* range, and by the end of therapy her total score had dropped to 6, which placed her in the *mild distress/impairment* range, which suggested remission of GAD, in that she has reached the cut-off (caseness) for non-clinical. Ann's total score of 5 at her six-month follow up suggested that she remained largely recovered.

Ann's scores on the PSWQ were less striking than those on the GAD-7 and the GADSS and described a significant shift towards improvement, although she remained in the clinical range. The PSWQ is scored by summing the totals for all items and then comparing them against a cut-off score of 45, which discriminates between clinical and non-clinical worry. At the beginning of therapy, Ann scored 78 which placed her firmly in the clinical range. At the mid-point of therapy she had a score of 58, which placed her in the clinical range and at the end of therapy her score was 51, which, while indicating considerable improvement remained in the clinical range. Ann scored 42 at her 6 month follow-up assessment which suggested that she was *recovered*. The PSWQ-PW was introduced to the research program at the mid-point of Ann's therapy; consequently there is no pre-treatment score for her on this measure. Ann's scores on the PSWQ-PW were 48 at the mid-point of therapy and 47 at the close of therapy; however they rose to 55 at the 6 month follow-up.

On other measures, the BDI-II and CORE-OM, Ann's scores also indicated improvement. Ann's pre-treatment score of 1.32 on the CORE-OM placed her in the clinical range of distress (female clinical cut-off point is 1.29). Her mid-point in therapy score was 1.14 which suggested she was no longer in the clinical range, as did her post-therapy score of 1.12. Ann's score of 0.94 at her 6 month follow-up assessment suggested that she had consolidated and improved upon the gains she made during therapy. Although Ann moved from the clinical into the non-clinical range by time therapy concluded, her pre-post

difference did not meet the criteria for the RCI, which indicated that she had *improved* according to this measure.

Ann's pre-treatment score of 12 on the BDI-II placed her in the *minimal* range of depression. Her mid-point assessment score of 16 placed her in the *mild* range of depression, while her post-treatment assessment score of 4 placed her in the lower end of the minimal range of depression. Her score of 2 at her 6 month follow-up assessment indicated that she had consolidated and improved upon the gains she made during therapy. Although Ann moved from the clinical to the non-clinical range on this measure, with regard to the Caseness cut-off score of ten, the fact that she failed to satisfy the criteria for RCI, in terms of pre-post difference, indicated that while she may have *improved*, she cannot be said to have *recovered* on this measure.

3.2.3.2 Analysis of Process Measures

Target Complaints (TC)

Prior to each therapy session, Ann completed a Target Complaints (TC) form. The information provided by this measure is presented in Table 3.2.2

Table 3.2.2 Data from Ann's Target Complaints (TC) Forms

Complaint	**Pre-therapy**	**Mid-therapy**	**Post-therapy**	**Pre-post difference**
Worrying	13	9	8	5
Fear of Death	6	9	8	-2
Something bad happening to my family	9	9	9	0

On the first day of treatment, Ann was asked to fill out a TC form, detailing the issues which were causing her the greatest distress and to rate how much they bothered her on a

scale ranging from 1 = not at all, to 13 = it couldn't be worse. It can be seen in the data provided in the HAT forms (see Table 3.2.3), that Ann seldom referred explicitly to the items listed in her TC when describing helpful events in therapy. Rather she focused on relational aspects, such as feeling understood and supported. Curiously, while she reported that her situation regarding worry had improved, it would appear from her self-report that her fear of death had increased while her fear of something bad happening to her family had stayed the same. This was somewhat at odds with other data reported upon the completion of therapy and with reported attitudinal and behavioural changes outside of therapy. Observing that Ann's score did not change on the TC, the therapist at one point asked her, whether she really felt the same? She responded that this was not actually the case, but that she felt that she needed to score the problems high, as she did not want to give impression that these were irrelevant thoughts, but were, on the contrary very important to her. For instance, she would feel very bad if she reported that something terrible happening to her family did not concern her. This showed that Ann's understanding of the purpose of the scale was somewhat different to how its purpose was intended by the researchers.

Helpful Aspect of therapy Form (HAT)

At the end of each session Ann was asked to fill out a Helpful Aspect of Therapy form, the data from which are presented in Table 3.2.3. As can be seen from Ann's responses, the section "How long did it last?" was frequently left blank, while the section "When in the session?" was commonly met with the answer *all through the session,* which suggests she may have been referring to a general process rather than a specific helpful event. In her quantitative rating of helpful events, however, she routinely scored either 7.5 or 8 indicating that she found the events between *moderately* and *greatly* helpful. On two occasions Ann scored 5, a neutral score; the first being Session 1, where she discussed her first experience of

death, while the second was Session 7, where no further data are provided other than the score.

Table 3.2.3 Data from Ann's Helpful Aspects of Therapy forms.

Session	How Helpful?	Helpful event	What made it helpful?	When in the Session?	How long did it last?
1	5	Talking about the first time I dealt with death	No data	Near the beginning	20 minutes
2	No data	Knowing that I am not taking up someone else's time and that I am not too much of a basket case.	Sense of relief	Half-way through	No data
3	8	Being told that I will be able to cope in the future, about problems that happen and I can handle it.	To be able to know that I am capable of getting on top of it and being told that.	Towards the end	No data
4	7.5	The therapist told me that it was ok to put things aside and that helped because I was able to not have them in my face, but they were still there.	The exercise in being able to put them to one side.	All through the session	No data
5	9	To know that I can get help to be able to cope and help my family as much as I can.	Knowing that this is real and that it can be fixed and I am going to	All through the session	No data

			be ok.		
6	7.5	That it is ok to be angry at the dead people in your life.	To recognise it and deal with it.	All through the session	No data
7	5	No data	No data	All through the hour	No data
8	7	The different ways people see me as a person	When you think about it and recognise what some people see	Half-way through	For some of the session
9	7	It helped to know that what I am feeling does happen to other people and that I am not on my own.	Knowing that someone understands what these feelings are.	All through the session	No data
10	No data	No data	No data	No data	No data
11	8	You helped me see that I can get through things with people's help and not be dependent.	Talking about it and seeing a different side to the situation	Towards the end of the session	Half of the session
12	7.5	I can see a bit clearer now and I know now that I am getting something out of the sessions.	Being able to say to someone that they get	All of the session	No data

			me as a person.		
13	5.5	That I need help with myself	Talking through the different sides of me myself.	The whole session	No data
14	8	Recognising some of my faults and problems	Talking about it to me and making me see it for real.	No data	No data
15	7.5	Making me aware of myself more and my actions as well.	That I could control my own behaviour. For myself.	All of the session	No data
16	7.5	Recognising and putting a label on some of the problems.	Being able to see some of the problem for what it is.	Near the end	No data
17	8	Seeing a difference in myself from the start	Can't pinpoint the event, just know it's there.	The whole session	No data
18	8	Letting me see I can take a different look at a problem and it can still work out.	Talking and thinking about it differently.	All through the session	No data

19	7.5	To recognise that I have to see the problem from all sides and find a way to deal with it.	Talking about it and discussing it from both sides.	All of the session	No data
2	7.5	Knowing that I am on the road to recovery and seeing things change as the weeks go by.	Discussing the problems I already had	All through the session	No data
21	8	Just understanding things better as the weeks go on	Talking things out and seeing things different	All of the session	No data
22	8	To see someone else recognise the change in me as well as myself.	For the other person to say it to me, so I know it is a real change	All through the session	No data
23	8	Knowing that the help is there for me, and showing me the way to deal with problems.	Recognising the problem	All of the session	An hour
24	8.5	Saying out loud that I can see the change in myself and being ok with it.	Knowing that the change is ok. Thank God.	All of the session	No data
25	No data	No data	No data	No data	No data

Initially Ann experienced relief (Session 2) as she began to realize that she deserved therapy and may not have been mad, as she had previously thought; *"knowing that I am not taking up someone else's time and that I am not too much of a basket case"*. Sessions 3, 4, and 5 were all linked thematically by Ann's appreciation of therapeutic support and a growing recognition that perhaps she might be able to cope more effectively in the future "*To be able to know that I am capable of getting on top of it and being told that*". In Session 6 Ann reported realizing that "*it is ok to be angry with the dead people in your life*" was helpful, and referred to overcoming a self-interruption process, which would have previously interfered with healthy emotional processing. In Session 8, Ann referred to her increasing self-awareness as she reported becoming aware of the various ways in which others may see her. Sessions 9 and 11 (Session 10 is missing data) both showed Ann beginning to appreciate the benefits of expressing her emotional experience to a receptive other, and her increased sense of feeling understood. In sessions 14 to 16 Ann reported becoming more aware of her own processes and of an emerging capability for accepting responsibility for herself without blame "*Making me aware of myself more and my actions as well*", combined with a nascent sense of agency "*...that I could control my own behaviour. For myself*".

In Session 17, Ann first remarked that she could recognise change in herself and this theme was pursued in the helpful events observed in the following four sessions "*Seeing a difference in myself from the start*" and "*Just understanding things better as the weeks go on.*" Her sense of gradual change was strengthened by validation from the therapist "*To see someone else recognise the change in me as well as myself*" and perhaps, for her, the real test was being able to articulate this and feel comfortable doing so "*Saying out loud that I can see the change in myself and being ok with it.*" Notably, other than the two mentions of *death* and *dead people,* in sessions 1 and 6 respectively, Ann scarcely referred to the items listed in her

target complaints throughout her completion of HAT forms in therapy, even though she had been primed (by rating them on a Target Complaints form) at the start of each session. Rather, she focussed on the benefits of therapeutic support and reassurance, improved self-awareness and acceptance, the possibility of positive change occurring, an emergent sense of agency and ultimately the ability to own and express change in terms of personal development.

Retrospective Recall of Helpful and Unhelpful Aspects, and Client Reported Changes (Client Change Interview).

At the conclusion of therapy, Ann reported that she felt she had benefitted from therapy, "*That's better than what I was, what I was*" and acknowledged that she no longer experienced things in the same manner as before, "*Yeah, I have felt it helped and improvement and I can see the difference in meself*"…"*I'm a lot calmer.*" She reported that not only did she recognize change, but "*Yeah, my family have noticed it as well.*" Ann identified the key change which had taken place for her since she began therapy; "*I'm not as highly strung…And I'm not as em, agitated.*" She noted that she could still occasionally become agitated, but never to the same degree as in the past.

When asked, Ann reported that nothing had changed for the worse since commencing therapy, and when asked if there was anything that she would like to change, she joked, "*less crying!*" Ann stated that she was surprised that therapy was able to bring about change, as she had not expected that she would have been able to move out of her comfort zones, "*Yeah, I was surprised because I took steps back… Steps back from situations that I would never take… And I felt alright about it.*" She reported being surprised that the experience "*didn't cause me any distress or it didn't cause me to go up into me head…… Saying, "I should have done this and I should have done that or I should have…" I just took the step back and I let it happen…*"

When asked whether she believed if it might have been possible to bring about change without therapy, Ann was resolute, "*It would never have happened*". She described the impact of therapy on her life as "*very significant*" and when pressed to elaborate upon what she believed may actually be responsible for the change in her, her answers were strikingly consistent with the data reported in her HAT forms throughout therapy; "*Em... from being able to em, realize the... I'm allowed feel the way I am, the way I was feeling... And I'm allowed have the anger... But.... I can ah... I'm allowed be me... And the anger comes with me and the sadness comes with me but I don't need to keep it all the time.*" Ann not only described a new level of self-acceptance but, proceeded to express a sense of assertiveness regarding it which was, hitherto, virtually non-existent, "*So I can... It doesn't... I'm not afraid of somebody turning around saying, 'Now you're not allowed cry and now you're not allowed be angry*'".

Strikingly, when asked if she felt that there were any particular personal attributes which she felt may have assisted her in therapy, Ann immediately stated "*I'm a stubborn pig...That made me get through the anger.*" She also described how the increased awareness she attained through therapy made it clear that she no longer wanted her husband and children to have to live with her as she was; "*The only thing that made it easier was em... I know who'd keep putting me husband and me kids through the difficulties that I was going through... And it was only when I was in the therapy, I realized how much I put them through.*"

In comments that chimed with the frequent references in her HAT forms to valuing the relational nature of the therapy, Ann described the importance of "*talking to somebody that em... that actually knows what I'm going through... And can understand what I'm going through... And can therefore say to me that it's alright for you to be going through this*", referring once more to the feeling of reassurance that she was not going mad "*...that was*

important to me because that made me realize that I wasn't going off me rocker". While reporting that there was nothing unhelpful or disappointing about the therapy, Ann acknowledged that certain aspects of it were painful, indeed the process itself was painful, "*Yeah. Just talking about things. That was hurtful*". Interestingly, when asked how it felt to be involved in the research project, Ann reported that *"...I didn't feel like I was in research... I just felt like I was coming and giving someone else me problems for a couple of... or for an hour.*"

3.3 Case Study 3, "Laura"

3.3.1 Introduction

Participant 003, who for the purposes of this study has been assigned the pseudonym "Laura", is a 27 year old female, Caucasian who was referred to the primary care service by her General Practitioner (GP). In the year prior to engaging with this study, Laura had availed of a brief course of cognitive-behavioural therapy offered by the primary care centre. At the time of engaging with the study Laura presented with generalized anxiety disorder and depression.

Laura is the eldest of five children. Her younger sister suffered from epilepsy, and growing up, Laura was frightened by her frequent and often violent seizures. In childhood, her father fell ill, and Laura's mother found it difficult to cope. While Laura herself does not suffer from any significant medical issues, she has struggled to control her weight since childhood. At the time of the research, Laura was living in rented accommodation with her partner, although this relationship ended four months after the conclusion of therapy, precipitating a return to the family home. Laura is not taking any medication and engaged in 19 sessions of therapy with an experienced EFT therapist.

Prior to commencing therapy, Laura completed a Structured Clinical Interview for DSM-IV-TR Axis I Disorders; Non-Patient Edition: Research version. SCID-I/NP-R. Her results indicated that she met the DSM-IV-TR diagnostic criteria for Current GAD and Current Major Depressive Disorder. Her score on the Global Assessment of Functioning scale was 60 which suggests *moderate* symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social occupational or school functioning (e.g. few friends, conflicts with peers or co-workers) *(SCID-I/P; First, Spitzer, Gibbon & Williams, 2002)*. Laura also completed the SCID-II for assessing DSM-IV-TR Axis II

personality disorders which indicated that she met the diagnostic criteria for Obsessive-compulsive and Depressive Personality Disorder.

3.3.2 Therapist's perspective on therapy, case formulation and emotional transformation

Therapist Perspective

The therapist reported that the work with Laura was, in general, very 'smooth and pleasant'. It was his belief that from early on they forged a good quality alliance. She was actively interested in EFT (and wanted to recommend it to friends) and was always diligent in attendance. Laura had some difficulty in accessing emotions in therapy. She could, however, touch on her core painful feelings of being on her own, being scared and feeling responsible (shame) for the unhappiness of people around her (particularly her mother). She was also in acute distress over a dispute at work, which somewhat activated her chronic sense of shame. She was bruised by being bullied at work and, historically, whilst at school.

Laura was very willing to bring these hurts into therapy and gradually developed the courage to face her bullies. She also gradually developed self-compassion. During the course of therapy she expressed fear regarding her sister's health difficulties, which had frightened her throughout her childhood. She also felt very panicky at work. Laura was capable of accessing protective anger in therapy, which helped her to face those fears with considerable resolve. Her worry process was also addressed in therapy. She realised that the worry was driven by her mistrust in her capability to cope with difficult situations (instilled by her mother) and she was eventually able to recognise and relate to the fear and tiredness the worry was causing, thereby reducing the worry process. She was also capable of recognising how much she needed to be free of worry and fear and, accordingly, stood up for herself

against the worry. As therapy ended she was badly hurt by the fact that her partner cheated on her and eventually abandoned her.

Case Formulation

The analysis of Laura's case formulation was based on the reflections of the therapist and was also informed by a study to which the author of the dissertation contributed (O'Brien, et al., 2012), which provided a qualitative analysis of the narrative and emotion events in the first half of Laura's therapy, and incorporated a number of quantitative scales (*CEPS-R/ CEAS-III/ CAMS*; see O'Brien et al., 2012). O'Brien and colleagues' (2012) analysis of Laura together with her therapist's perspective offers a portrayal of someone beset by constant apprehensiveness and worry in multiple domains (i.e. work, home) which has evolved to include somatic symptoms such as constriction across the back and chest with a sensation of suffocation *"it feels like an elephant sitting on my chest"*. Further GAD symptomatology includes sleep disturbance, loss of appetite and fatigue. In addition to her GAD symptoms, Laura had also recently begun to experience panic attacks which impacted on her functioning both socially and at work *"I just feel overwhelmed by the constant thoughts the constant worries... I can't think full thoughts; I can't keep my mind on one thing"*.

Laura referenced both recent and historic triggers. She felt vulnerable and threatened at work, had financial concerns due to her partner's chronic illness and inability to work, and was concerned about moving to a new apartment. Underlying these preoccupations, however, were deeper issues related to her mother, who was perceived as subtly judgemental and critical of Laura's physical appearance and mental health, all of which combined to leave her in a state of constant striving for validation, which was never realised.

O'Brien and colleagues (2012), in their analysis of Laura's core pain, identified her childhood experience of being overlooked *"Mom used to call me the forgotten child"*, as her

chronically ill sister received most of the attention from family and friends. Although Laura perceived her mother as pushing her into a position of responsibility in the family "*My mom relied on me to mind everybody, kind of to be the rock that everybody could go to*" she simultaneously felt judged and criticised for her appearance and behaviour. In childhood Laura felt the need to put up a front so as not to burden others with her pain; she hoped to gain approval through caring for others and the failure of this strategy left her with a sense of sadness and shame *"I tried to kind of please when I was younger, I tried to please you all of the time, and when I realised it wasn't happening I stopped"* [this was expressed in the imaginary empty chair dialogue]. Due to her constant perception of herself as undeserving of love and affection, Laura's harsh inner-critic was allowed to hold a dominant position in her various self-organisations, consistently reinforcing her sense of herself as being unlovable. In childhood, as in adulthood, Laura's needs, to feel loved, valued, heard etc., were seldom met.

In terms of her GAD dynamic, Laura evinced considerable emotional and behavioural avoidance. As a result of her upbringing, she perceived any feeling of vulnerability to be inappropriate and embarrassing; consequently she became critical and dismissive of her emotional experience. Behaviourally, she developed a pattern of coping by externalising, whereby, constantly attending to the needs of others, she managed to avoid the pain associated with her own unmet needs. This role of caretaker to others became central to Laura's identity. Her experience of being criticised in the workplace activated a shame-based core pain and a fear of rejection (in so far as she might lose her job). Laura's means of coping with these threats to her stability tended to be, (a) behavioural, in that she became perfectionistic in an attempt to defend against criticism and became withdrawn in general, and (b) emotional, in so far as she constantly worried about her situation and was overwhelmed by panic attacks.

As a result of these maladaptive coping strategies, Laura experienced exhaustion, hopelessness and helplessness. Her ability to access or mobilise assertive/protective anger on her behalf was interrupted by her self-assigned identity as the one who must always care for others; her fear that she will be caught unprepared for some eventuality meant that it was almost impossible for her to give up worrying, which she now believed to have a protective function. This was further complicated by Laura's fear of her own emotional experience, and the possibility that an inability to regulate her emotions may lead to her losing control, which would be shameful and contemptible. As a result, O'Brien and colleagues (2012) proposed that Laura was trapped in a pattern of avoidance and secondary emotion, maintained by specific factors which prevented her from processing her core primary pain which comprised fear of criticism, shame and loneliness.

Emotional Transformation

The therapy progressed quite well, although there were limitations to what could be achieved due to the client's strong emotional avoidance. Laura was not able to access emotions freely in the session. At one stage the therapist suggested to her that for homework she might watch a romantic movie and, once she got to the point of being moved she might allow herself to cry and be consciously aware of how she allowed the tears to flow. She tried this and it worked for her at home, however she was unable cry in session (although she was on the verge of tears on a number of occasions). Despite this, a good deal was achieved in therapy. Laura was able to access her core pain of feeling lonely, blamed (bullied) and her fear of facing frightening things (such as panic or her sister's illness). She was able to be compassionate towards the vulnerable part of the self (often through enacting her adult-self caring for the younger, lonely and bullied self in childhood in the imaginary dialogues). Compassion also brought more grieving, but this time it had more of a "letting go" quality.

Laura was able to stand up for the self in the imaginary dialogues with her problematic colleagues, with her mother, and also against the panic attacks and health difficulties of her sister (which were externalised and put to the empty chair). When she was cheated on by her boyfriend she was able to stand up for the self in the imaginary dialogues with him, which brought a sense of empowerment.

Both compassion and protective anger were also visible in the worry dialogues and the self-critic dialogues. Initially, Laura would undermine and criticise herself for not being able to be stronger and stand up for herself, but eventually she felt for the hurt-self and became increasingly able to stand up for herself, thereby freeing herself from shame of criticism and fear of catastrophe. All of this progression was slightly limited by the fact that her emotional experiencing was somewhat restricted and consequently one might speculate as to whether or not her emotion-schemes were fully activated in the sessions.

Worry Dialogues.

The analysis of Laura's emotional transformation also draws on the available analyses obtained from a study to which the author of the dissertation contributed (Murphy et al., 2013), a study which tracked Ann across four of her worry dialogues using a task analytic approach (Greenberg, 1984; 2007; Pascual-Leone, Greenberg, & Pascual-Leone, 2009; 2013). The progress in transforming her worry process was visible across the 4 dialogues. In early dialogues Laura was able to acknowledge the impact of the Worry Agent and to clearly express her need to be free of worry and fear and the tiredness that the worry brought. However, the worry agent failed to soften and the task switched to an unfinished business dialogue with her mother who had become identified as the internalised driving force behind the worry agent (i.e. mother believing that the world is dangerous). In later dialogues Laura, began to display the emergence of a protective anger in relation to both her mother and the worry agent, nevertheless her ingrained emotional avoidance was demonstrated by her

embarrassment at expressing compassion towards the tired self and her laughter when she became angry, both of which interrupted her ability to access and stay with her healing emotional experience. In the third and fourth dialogue the Worry Agent began to soften and in the fourth worry dialogue Laura was able to communicate her need not to be oppressed to the Worry Agent with conviction and a strong vocal quality.

Unfinished Business Dialogues (UBD). The case analysis of emotional transformation of this particular client also drew on the available analyses obtained from another study to which the author of the dissertation contributed (Hughes, et al., 2013). Hughes and colleagues (2013) examined six UBDs conducted between Laura and her mother across the course of therapy. Laura was initially inclined to understate the impact of the presence of the imagined mother, which was interpreted as suggesting the degree to which she was removed from her own emotional experience. Eventually, Laura became increasingly able to differentiate her emotional experience, and where, in the early dialogues she was prone to collapse into undifferentiated distress when dismissed by the imagined mother, as therapy progressed, she became increasingly able to differentiate her emotional experience, and express with greater accuracy her responses to mother (i.e. to mother: *"You hurt me by saying that"*). Over time Laura demonstrated an increased ability to tolerate and stay with her core pain, articulate her needs and eventually, allow for the emergence of a protective anger.

In later dialogues, Laura was able to generate and receive compassion, albeit with some difficulty, as she remained embarrassed when expressing positive emotions. At this stage, importantly, Laura was also able to access the grief associated with her mother's seeming inability to meet her emotional needs in terms of being loved and accepted. Through a process of meaning making she was also able to attribute motivation to her mother's behaviour (i.e. her mother's own vulnerability).

3.3.3 Measures

3.3.3.1 Analysis of Quantitative Pre-Post-Outcome Measures.

Laura's scores are presented for pre-, mid-, post-therapy and at her 6 month follow-up assessment in Table 3.3.1.

Table 3.3.1 Laura's Pre-Post-Outcome Scores

Scale	Caseness	RCI	Pre-Treatment	Mid-Treatment	Post-Treatment	6 Month Follow Up
GAD-7	10	5	14	9	3	6
GADSS	7	n/a	15	12	6	7
BDI-II	10	9	31	26	14	15
CORE-OM	1.29	0.48	2.50	1.29	1.02	1.58
PSWQ	45	9	57	64	55	53
PSWQ-PW	n/a	28	77	46	42	47

Note: Caseness = the cut-off for determining whether client is clinically distressed. RCI=Reliable Change Index; GAD-7 = Generalised Anxiety Disorder–7; GADSS = Generalised Anxiety Disorder Severity Scale; BDI-II = Beck Depression Inventory; CORE-OM = Clinical Outcomes in Routine Evaluation – Outcome Measure; PSWQ = Penn-State Worry Questionnaire; PSWQ-PW = Penn-State Worry Questionnaire (Past Week).

At the beginning of therapy Laura's score on the GAD-7 was 14, which suggested that she was situated towards the high end of the *moderate* range for GAD. By the mid-point of therapy, Laura's score had reduced to 9, placing her in the mild, non-clinical range, and by the time therapy was complete, her score had reduced to 3, which indicated the absence of GAD symptomatology. Laura's pre-post differential of 11 met the criteria for RCI and suggested that reliable change had occurred. This, in conjunction with her post-treatment score of 3 suggested that she had recovered on this measure. Follow-up data show that Laura's score on the GAD-7 at six months was 6, which suggested that she remained in remission from GAD.

Laura's scores on the GADSS followed a similar pattern. Her pre-therapy, total score of 15 placed her in the *severe distress/impairment* range. By the mid-point of therapy,

Laura's total score had dropped to 12 which suggested that she was now in the *moderate distress/impairment* range. By the end of therapy, Laura's total score had reduced to 6, placing her in the *mild distress/impairment*, which suggested remission of GAD symptomatology. Laura's score of 6 was also below the caseness score of 7 and therefore suggested that she no longer met the criteria for caseness on this measure. Laura's total score of 7 at her six month follow-up assessment suggested that she remained largely free of GAD symptomatology.

Laura's scores on the PSWQ displayed some variation on the pattern of response to treatment observed up to this point. In her pre-therapy assessment, Laura scored 57, which placed her in the clinical range; however by the mid-point of therapy her score on the measure had increased to 64. By the end of therapy, her score had reduced again, and at 55, while still in the clinical range exhibited some sign of improvement in relation to her mid-point of therapy score. In terms of her pre-post differential, however, no reliable change had occurred. Her score of 53 at the six month follow-up suggested that Laura's perception of herself as a worrier remained stable over time, and she remained in the clinical range on this measure. This would appear consistent with the PSWQ functioning as a measurement of trait anxiety, with an emphasis on establishing the degree to which the respondent perceives themselves to be a "worrier" by nature.

The foregoing is further illustrated by an examination of Laura's scores on the PSWQ-PW, which reframes the PSWQ questions such that the respondents provides answers which refer specifically to how they have been over the preceding week. Laura's pre-therapy score on the PSWQ-PW was 77. Her score on the same measure by the mid-point of therapy was 46, and by the end-point of therapy, her score was 42, both of those scores showed reliable change, and indicated improvement, as did Laura's score of 47 at the six month follow-up assessment. It is interesting to note how Laura's scores on the PSWQ (a trait

measure) remained reasonably constant while her scores on the PSWQ-PW (a state measure) revealed considerable variation over time; a factor to be considered when utilising the PSWQ as an outcome measure.

On the CORE-OM, Laura's pre-therapy score of 2.50 placed her in the *clinical* range of distress. Her score at the mid-point of therapy was 1.29, exactly on the cut-off point between *clinical* and *non-clinical*, and upon the completion of therapy, her score was 1.02 which established that she was in the non-clinical range. Given the foregoing, and the fact that Laura's score improved by a number greater than 0.48, thereby satisfying the criteria for RCI, it can be said that Laura had *recovered* according to this measure. Laura's subsequent score on the CORE-OM of 1.58 at the six month follow-up interview, however, suggested that her mood had dipped again. In her six-month follow-up Client Change interview she attributed this to the recent break-up of her relationship.

Laura's pre-treatment score of 31 on the BDI-II placed her in the *severe* range of depression on the measure. Her mid-point assessment score of 26 indicated that she was in the *moderate* range of depression, and her post-treatment assessment score of 14 indicated that she was now in the *mild* range of depression for this instrument. While Laura's pre-post-differential on this measure was sufficiently large as to satisfy the criteria for RCI, suggesting that the change due to therapy was reliable, the fact that she remained in the clinical range meant that she could only be described as *improved*, rather than *recovered*. Laura's score of 15 at her six-month follow-up assessment suggested that her level of depression remained stable in the six months following the conclusion of therapy.

3.3.3.2 Analysis of Process measures

Target Complaints (TC)

Prior to each therapy session, Laura completed a Target Complaints (TC) form. The information provided by this measure is presented in Table 3.3.2

Table 3.3.2 Data from Laura's Target Complaints (TC) Forms

Complaint	Pre-therapy	Mid-therapy	Post-therapy	Pre-post difference
Issues at work	9	5	2	7
Financial difficulties due to boyfriend out of work sick	7	6	1	6
Moving to a new apartment	5	0	0	5

It is interesting that Laura's complaints on the Target Complaints form, in many respects, illustrate the high level of avoidance, which played such a prominent role in her therapy. While they are undoubtedly valid issues, it is apparent from her first entry on the Helpful Aspect of Therapy form that work at a deeper level is required. The distinction between her Target Complaints, which are quite superficial and 'problem focused' and her Helpful Aspect of Therapy form entries, which all value increased self-awareness and being understood at a level of considerable relational depth, is noticeable. This suggests that the former were likely symptomatic expressions of the latter and therefore perhaps easier, or safer, to admit to, or acknowledge, at a pre-therapy stage.

Helpful Aspect of therapy Form (HAT)

An examination of the data contained in Laura's HAT forms is illuminating as, beyond Session 1; their content bears little relation to the issues set out in the Target Complaints form as being central to her distress (see Table 3.3.3). In Session 1 Laura commented that the session had helped to "*get my head around issues at work*"; she had some

success in working out why certain issues in work have been problematic. However by Session 2 there was a shift in emphasis towards a more EFT-centric position with the introduction of the critical self as Laura commented: "*Seeing that my 'critical self' is very unrelenting is helpful in the way that I'll know what it is when I'm putting myself down so I might be able to challenge it.*" Here Laura acknowledged that awareness of this process of self-criticism was a step towards resolving it, and introduced the notion of challenge in relation to the critical self. The process of increasing self-awareness progressed in Session 3, as Laura acknowledged the way in which she limits herself "*Finding out that I want to be a lot more fun and enjoy life and that I'm the one putting boundaries up to stop myself*", and Session 4 where she indicated a newfound awareness that her shame preventd her from being authentic "*Learning that I'm shutting down my anger reflex due to being afraid of looking stupid.*"

Table 3.3.3 Data from Laura's Helpful Aspects of Therapy forms.

Session	How Helpful?	Helpful Event	What made it helpful?	When in the session?	How long did it last?
1	7.5	Being able to get my head around issues at work.	Working out why it was stressing me out.	No data	No data
2	7.5	Seeing that my 'critical self' is very unrelenting is helpful in the way that I'll know what it is when I'm putting myself down so I might be able to challenge it.	As Above	Throughout	Throughout
3	8	Finding out that I want to be a lot more fun and enjoy life and that I'm the one putting boundaries up	I have a sense now that I can compromise to let myself go every now and then without it being a bad thing.	Towards the ¾ of the session	?

		to stop myself.			
4	7.5	Learning that I'm shutting down my anger reflex due to being afraid of looking stupid.	I have found that I have a strong and firm part of me that I can go to.	Towards the end.	About ten minutes.
5	6	The event that I found quite helpful was when we went through asking for help and support from my mam and how that made me feel.	I think realising that my feelings of vulnerability are uncomfortable was important in helping me get over it.	Middle to end	?
6	7.5	The chair work at the end of the session was very helpful.	It helped me to recognise that I invalidate some compliments or positive things that happen to me and that I can see it when it's happening and try to stop it so that I can feel good about myself.	Towards the end.	About 15 minutes.
7	7.5	Talking out how my anger is necessary. Allowing myself to tell my 'mam' that I was angry at her for making me feel isolated and alone when I was younger.	I was able to feel the anger without it getting out of hand (or what I thought would be out of hand).	Mid-way.	10 minutes approximately.
8	8	I found out that the negative things said by my friends when I was	I found it very helpful that I know now that I would not tolerate it, so I must take it	Middle.	10 minutes approx.

		younger are actually how I judge myself as an adult.	into consideration when judging myself.		
9	8	Getting underneath the frustration and anger I felt to see that it's derived from loneliness and isolation.	That I know that it's why I was getting angry. That I understand that I need to feel heard and let in some feelings when they are there.	Throughout	Throughout
10	8.5	I feel that realising that that me taking offence to what my mam said was in reality because I felt exposed as that is how I judge myself is very important.	It was good to know that I have to be much nicer to myself and how I judge myself so that I don't feel rejected and help make changes to myself.	Halfway through.	About 20-25 minutes.
11	7.5	The part of the session where we discussed being there for each other as family as we need each other.	Just thinking that my mam is very like me and we could join together to support one another without feeling embarrassed and building strength from being backed up.	Middle approx.	5-10 minutes.
12	8.5	Being able to open up, talk and express my fear about work and sister.	I was able to calm down after getting it out in the open.	Start.	Throughout the session.
13	8.5	Going over what happened last year before	I found it important as it led onto dealing with	Start.	I don't know.

		my first panic attack, and trying to make sense of why it happened.	my negative thoughts and challenging them.		
14	No data	No data	No data	No data	No data
15	9	Doing the chair work to find out how to deal with my anxiety.	Seeing that I have the strength within me to help me overcome my anxiety or to tell that 'inner voices' to stop when it gets too much.	Middle –end.	About 15 minutes approximately.
16	9	When I said I felt selfish for wanting a lot because I felt I didn't deserve it without earning it.	It put into the picture that I actually do a lot but it's the fear of being selfish that does not allow me to rest and get things.	Throughout.	?
17	9	Seeing that I'm catching myself in a negative cycle. It is the negative side of me that makes me worry unnecessarily and puts pressure onto me.	I found that I can be rebellious against this negative side and have a positive effect. I don't have to be constantly on 'duty' and that's ok.	Midway.	From midway through to end.
18	8	Talking about the fact that I am feeling much better and more able to take on the stress of my work etc.	I'm able to see that I'm my own worst enemy at times and can cause my own stress cycle but to know that If it gets bad again that I can get	Throughout	Throughout

			myself out of it.		
19	8.5	Going through all we had done over the sessions.	I could see how much help I have gotten from the therapy and can see the effects lasting.	Throughout	Throughout

Laura's comment on Session 5 referred to chair-work, a dialogue with her imagined mother, which she described as "*quite helpful*"; here again, she referred to the value of increased self-awareness, and acknowledged that she was uncomfortable with her feelings of vulnerability. Chair-work was mentioned explicitly as being helpful in Session 6, and in Session 7 Laura referred again to an unfinished business dialogue with her mother in which she experienced the anger she felt towards her, and was even able to express it "*I was able to feel the anger…Allowing myself to tell my 'mam' that I was angry at her for making me feel isolated and alone when I was younger*".

Comments on Session 8 illustrated Laura's realisation that her self-treatment had been determined by interactions from the past "*I found out that the negative things said by my friends when I was younger are actually how I judge myself as an adult.*", and her recognition that she could no longer tolerate this level of judgement. Her comments regarding Session 9 revealed an awareness of how being stuck in secondary emotion has obstructed her ability to access her core pain, *"Getting underneath the frustration and anger I felt, to see that it's derived from loneliness and isolation."*, and evinceed an appreciation of the value of acknowledging emotional experience "*That I understand that I need to feel heard and let in some feelings when they are there*". Sessions 10 and 11 both involved work around

unfinished business with mother and developing the capacity for opening up emotionally, while Session 13 incorporated work around an episodic memory of her first panic attack and showed signs of *meaning making* and an attempt to make sense of past disturbance in light of new awareness.

Chair-work was again employed in Session 15 as Laura accessed assertive anger to combat the worry agent "*Seeing that I have the strength within me to help me overcome my anxiety or to tell that 'inner voices' to stop when it gets too much*", while Session 16 focussed on Laura's debilitating fear of appearing selfish (shame), which inhibited her ability to move forward in life "*...that I actually do a lot but it's the fear of being selfish that does not allow me to rest and get things*". Sessions 17 and 18 both focused on affirming Laura's new found sense of agency, and her awareness that she could access new, alternative, emotional responses to old patterns; that she could be "rebellious" in relation to her Worry Agent and need not be at the mercy of negative thinking. The concluding Session 19 formed a consolidation of emotional learning acquired to date *"I could see how much help I have gotten from the therapy and can see the effects lasting"*.

Retrospective Recall of Helpful and Unhelpful Aspects, and Client Reported Changes (Client Change Interview).

Unfortunately there was no data for Laura's end of therapy interview, due to a technical issue which resulted in the recording being accidentally erased, so in order to best capture the flavour of her experience of therapy the following summaries of her mid-point of therapy, and her six-month follow-up interview are presented.

Mid-point of therapy interview

In her mid-point of therapy interview, Laura commented that so far she found therapy helpful, observing that she now felt more positive in general *"Really good. I find it really*

good; I find it kind of.... Coming out, coming out a lot more positive, a lot more kind of..." She noted however, that this positivity tended to fade after a number of days *"But it lasts a few days. I'm trying to make it last longer into the week... I kind of leave here in real strong mode... Not going to let people at work annoy me, going to be able stand up for myself and this kind of stuff. But by Monday it all kind of ..."* She reported finding therapy soothing *"...I suppose calming. Yeah it's... It's not distressing, it's not... I don't feel worried about coming into therapy or anything like that."* but acknowledged that initially she found talking to another person somewhat anxiety provoking.

Regarding changes she had noticed since attending therapy, Laura described feeling less at the mercy of negative emotions, and less inclined to worry than before *"Em, especially when it comes to work now as well. I'm able to kind of not worry as much about it."* She noted a newfound awareness of her self-critical process and referred to an emerging ability to challenge it *"I'm able to back down and say "okay, if anybody else was criticizing me like this what would you feel like? " And then I can ration...rationalize with myself and say "right, maybe you're in the wrong. I'm going to feel this way instead."* Laura reported not being able to think of anything that had changed for the worse since commencing therapy, but observed that she would have hoped to have felt less anxious and worried about things by now; she felt she was making gains, but found it hard to hold onto them between sessions. Laura stated that she was not particularly surprised by these changes, and acknowledged that it would have been highly unlikely for them to have occurred had she not been in therapy. In support of this, when asked to mention any aspect, inside or outside of therapy, which might have brought about these changes she immediately referred to chair-work *"I suppose inside therapy would be the chair work. Even I notice in the chair work... That's getting me to be both characters kind of thing... I can see, especially when I'm doing self-criticism, I'm very hard on myself and I notice so that so when I'm outside I can remember the chair work and*

go, "Hang on yeah, that's not right. That's not nice or that's not necessary"". She reported that chair-work had also deepened her understanding of interpersonal processes *"Em, that. I've just found it extremely helpful. It very kind of em... I can see how others... I guess others treat me".*

When asked about personal strengths which may have contributed to her ability to engage in therapy, Laura clung to the idea that it was her detached, logical side which supported her, *"Em, I think the logical side of me, if I can think anything. I think the logical side ah... I can look at things sometimes from a perspective that doesn't necessarily have to be emotionally attached to it."* At this point she still displayed a distrust of some of her emotional processes, and diminished the significance of her emotional life. As she later reported *"... I find it difficult to engage with like an emotion like some of my emotions as in like crying and stuff like that. I find that difficult. Once I get to that stage where I think, "oh I'm going to start welling up soon" I cut that out.* , which was consistent with her internalized negative attitude towards the expression of emotion. Laura observed that it was her environment, which she felt was most hostile to the possibility of her changing *"Em, I think some of my family and my friends and my job actually. All of them are not willing to let me change... That's the hard part, 'cause I'm willing to change but they're not willing to let me change"* and this made it difficult for therapeutic change to take hold.

When specifically questioned regarding helpful aspects of therapy, Laura once more cited chair-work as being most helpful, followed by meaning-making around issues raised in chair-work. She was unable to pinpoint anything which could be described as unhelpful, hindering or negative in her therapy. Interestingly when asked to identify an aspect of therapy that was difficult at the time but possible helpful in the long run, Laura described talking about her mother as being somewhat problematic, *"Yeah. Em... I... Oh, initially when we were kind of talking about my mom I kind of felt that was difficult. Yeah... I didn't know to*

feel about her. I felt like I was betraying her even though I wasn't. But I felt like I was kind of... I was guilty. I felt guilty about talking about her." She then made a generalization, and observed that talking about her childhood in any form was emotionally draining. Nevertheless she recognized the importance of, and the rationale for, such exploration *"Then later on I kind of go "Oh no, I understand the reason that I've had to talk about it. I understand the reason... That led into this."*

Laura reported that she did not find being part of the research project particularly problematic *"It doesn't bother me whatsoever. It's fine em.... I understand there's a need for it so...."* And went on to describe how, on occasion, it could be helpful as she could see that her scores were improving on certain measures. Laura was unable (or unwilling) to point out any aspect of being involved in the research which was in any way unhelpful, hindering or difficult.

Six month follow up

At the time of Laura's six-month follow-up interview, she reported that she had experienced a number of crises in her personal life, including the break-up of her relationship, as a result of which, she had to move back to the family home. When asked if she had noticed any changes in herself as a result of having engaged in therapy, she responded, with reference to her recent ordeals *"I don't think...If I hadn't have done therapy I don't think I would have gotten through it as well as I did..."* She noted that since having been in therapy she has become slightly more self-compassionate *"I'm not treating myself as harshly as I would have, had I not done the therapy"*; although she was pragmatic about he gains she had made, *"I'm still harsh, but not as harsh"*. She observed that these changes had also been noticed by others, *"Everybody says I'm less stressed...and I can even feel that myself; I'm less stressed out"* and Laura concurred, *"I'm definitely much more relaxed than I was"*. In an elaboration

on the positive changes that she described, Laura reported, *"I did want to kind of become a more positive person, which I think I've kind have done"* and observed that *"I am doing things whereas before my anxiety would have stopped me"*.

Laura described how therapy gave her an increased awareness of her own personal processes and an improved sense of agency in relation to them " *If I hadn't gone to therapy I wouldn't have learned to deal with things in certain ways...when I finished it I could step back and see when things were going wrong, and not go over it too much in my head."* She described the degree to which she internalised the process of chair-work and made use of it in daily life, noting how she conducted *"...the chair work in my head...I have conversations in my head"*.

In response to the question concerning personal strengths which may have helped her to engage with therapy, Laura pointed out an aspect of herself, of which she had been previously unaware, *"...I think I'm not a quitter, I'll keep trying...and persevere with something..."* In therapy she became aware of a kind of doggedness and willingness to persevere, which she had not previously known in herself, *"I'm tougher than I thought!"* She described how this translated to a greater sense of agency outside of the consulting room, *"From therapy I'm a lot stronger in work, whereas until recently, I wasn't."* She was unable, however, to point out any aspect of life, external to therapy, which might have assisted her in any way. She observed that, in fact, *"being at home [living back with her parents] may have made things harder"*, but consistent with her newfound sense of determination asserted, *"I didn't crumble...I kept going"*.

Laura is unequivocal about the role that therapy played in her life, "*It was the only thing that kept me strong...kept my mind focused on what was positive rather than what was negative...It's changed my outlook...I don't automatically think of the negative"*, and when pressed, was unable to point out anything in her experience of therapy which might be

construed as unhelpful or negative. She noted that initially she had some awkwardness with chair-work, from a technical perspective *"I found the chair work initially...I...by the end I loved the chair-work, but initially I found it hard, I found it hard to put myself into someone else's position in terms of what they might say to me."*, but reported that overall there was nothing that she could think of, whether in connection with the therapy or the research process, that she would change; *"the way it went on was perfect!"*

3.4 Case Study 002, "Tony"

3.4.1 Introduction

Participant 001, who, for the purposes of this study has been assigned the pseudonym "Tony", is a 26 year old single male. Tony was referred into the service by his G.P. to be treated for high anxiety and low mood. Two months prior to attending the service, he was referred to a community psychiatrist who prescribed Prozac and Mirtizipine, (both primarily antidepressants), to help with his anxiety and mood disorders. He was also prescribed Stilnoct to help him cope with extreme and debilitating insomnia.

Tony is father to an 8 year old daughter, Molly, but is estranged from her mother. Tony had a brief relationship with Molly's mother while they were in college, which ended when she was unfaithful to him. He describes how, years later, he met her again, and discovered that she had given birth to a child; a paternity test showed Molly was Tony's daughter and he now sees her more frequently. He reported that he has an excellent relationship with his daughter, however due to the poor relationship with her mother he is constantly fearful that he will be refused permission to see his daughter, which has happened in the past. Tony is the eldest in his family, with one younger brother and one younger sister, both of whom live in the family home with their mother. Tony's father died suddenly, five years ago, which was devastating for all the family. Although he is in full time employment, he is currently suspended from work, and currently spends much of his time alone. Tony engaged in 20 sessions of therapy with a recently graduated counselling psychologist who had training in EFT, and was supervised by an experienced EFT therapist.

Prior to beginning therapy, Tony completed a Structured Clinical Interview for DSM-IV-TR Axis I Disorders; Non-Patient Edition: Research Version (SCID-I/NP-R). His results indicated that he met the DSM-IV diagnostic criteria for Current GAD. He also met the criteria for Current Major Depressive Disorder and Panic Disorder without Agoraphobia in

partial remission. Tony's score on the Global Assessment of Functioning scale was 55, which suggests moderate symptoms, (e.g. flat affect and circumstantial speech, occasional panic attacks), or moderate difficulty in social, occupational, or school functioning (e.g. few friends, conflicts with peers or co-workers) (SCID-I/P; First, Spitzer, Gibbon & Williams, 2002). Tony also completed the SCID-II for assessing DSM-IV-TR Axis II Personality Disorders which indicated that he met the diagnostic criteria for Obsessive-compulsive Disorder.

3.4.2 Therapist's Interpretation of Therapy, Case Formulation and Emotion Transformation

Therapist Perspective

The therapist believes that therapy went well in this particular case. It was difficult in the early stages as Tony was in such a state of agitation and heightened anxiety that he found it difficult to sit still or maintain eye-contact in therapy; he felt physically sick and on two occasions had severe panic attacks in session. In addition to his anxiety, Tony experienced a profound sense of hopelessness and helplessness which found expression in a defeatist, resigned attitude in the face of the many losses and challenges which he faced. He described himself as beaten and broken – and, he felt, deservedly so.

Initially, Tony found it very difficult to access his core pain without becoming either angry, or collapsing into secondary hopelessness. Over time however he became increasingly able to explore the impact of recent losses on him, and to examine the high levels of shame he was experiencing from a sense of having let his father down due to his current, complicated life situation. Tony became aware of and learned to use protective anger to stand up to a harsh critic which shamed him over his life choices, he learned to tolerate uncertainty and ultimately withstand the terror regarding the possibility of future losses which

had had such a debilitating effect on him of late. Tony also had the opportunity to grieve the loss of his father, and through chair work, to receive a level of acceptance from him. In worry dialogues, he developed a capacity for resourcing himself with assertive anger and became increasingly able to stand up to his Worry Agent. By the time therapy had ended, Tony had been able to resolve many of the external issues which had dogged him (i.e. work, access to his daughter), and reported significant improvements in all his interpersonal relationships.

Case Conceptualisation

The analysis of Tony's case formulation is based on the reflections of the therapist and is also informed by a study to which the author of the dissertation contributed (O'Brien, et al., 2012), which provides a qualitative analysis of the narrative and emotion events in the first half of Tony's therapy, and incorporates a number of quantitative scales (*CEPS-R/ CEAS-III/ CAMS*; see O'Brien et al., 2012). O'Brien and colleagues (2012) observe that Tony's anxiety was mainly informed by his fear that something bad would happen to a member of his family or that he was in some way a failure, or perceived to be a failure, in the eyes of others, in particular his deceased father. He found it difficult to tolerate uncertainty "*The worst is not knowing what it's going to be*", and described living in *"constant fear"*, referring to "*weeks that I didn't sleep... losing days by simply staring into space while me mind was running riot*". O'Brien et al (2012) draw attention to the intensity of the somatic symptoms Tony described, which included palpitations and nausea; he described in session *"feeling claustrophobic in yourself, you just kind of feel boxed in... you're struggling for air"*. Indeed Tony's physical presentation in therapy was characterised by uneasiness, constant fidgeting, and continuous shaking of one or other leg, which varied in intensity with his emotional state. His description of his current lifestyle painted a picture of hopelessness and helplessness as he chronicled his gradual withdrawal from society, which he perceived to be unjust and unfair.

In keeping with the EFT model of case formulation for GAD, O'Brien and colleagues (2012) attended to the various stressors/triggers, both past and present, which may have brought Tony into therapy at this time. Perhaps most devastating of all was the sudden and unexpected loss of his father, whom he idealised, from sudden adult death syndrome. Shortly after, Tony's grandmother and uncle passed away and his grief was complicated by his mother's inability to cope with this amount of loss. Massively anxious in case further tragedy might befall the family, Tony felt the need to protect his mother and siblings, yet struggled with his own sense of loss and uncertainty regarding the future. To complicate matters further he had only recently begun seeing his daughter, of whose existence he had been unaware for four years, due to a breakdown of relations with her mother. Furthermore, difficulties at work (which are not described here due to issues concerning confidentiality) led to his suspension, and he now faced considerable uncertainty as to whether or not he would be reinstated.

In identifying Tony's core emotional pain, O'Brien et al (2013) focused on his experience of loss, trauma, loneliness, shame and sadness. His sense of loss *'you left me'* and trauma '*I am abandoned'* was evident in his recent bereavements, but could also be scented in failed relationships and the betrayals associated with them. The pain, sadness and loss attached to the death of Tony's father was curiously mirrored in the sadness and loss attached to his own experience of fatherhood; in so far as he was unaware he had a daughter for four years *'... it hurts me so much that I never got to hold you as a baby'*. All of these experiences have fuelled Tony's sense of loneliness and isolation *'I lost my best friend, I have no one*', while his inability to live up to the standards set by his idealised father and his acute awareness of the mistakes he has made, have intensified his sense of shame *'I am a failure'*; resulting in a terrible sadness '*I'm hurting so much inside*'.

Tony's needs were related to unmet emotional requirements from childhood, such as unconditional love, safety and reassurance. He struggled with a sense of not being good

enough, linked historically to his mother's emotional unavailability and his father's frequent criticism and high standards. The loss of his father, the most significant attachment relationship in his life, has left him feeling abandoned and uncertain, with a heightened need for a sense of security and safety in a cruel and unpredictable world.

In order to cope with his core emotional pain, Tony evolved a GAD dynamic that frustrated the successful processing of his core emotional pain, which was centred on shame, loneliness, sadness and loss. Tony engaged in a number of avoidance strategies both emotional (shutting down, withdrawal, moving into secondary anger) and behavioural (taking sleeping tablets, distraction). He worried incessantly as a means of sidestepping his core emotional issues, while (secondary reactive) anger was employed in order to protect himself from any (anticipated) perceived rejection. Similar to other participants in the research (i.e. Ann) Tony's concern for the wellbeing of others (i.e. family) on the one hand, distracted him from some of his own issues, but on the other, left him vulnerable to feelings of shame if, for example, he felt that he might have failed in his responsibilities. Tony has internalised the belief that he must suffer alone, fearing that if he shared his worries with others, they would become burdened. This has reinforced his sense of loneliness and has further complicated the possibility of symbolising and expressing his core pain to others, such that it might be resolved. He found himself stuck with the belief that he deserved all of the painful experiences in his life.

Emotional Transformation

The analysis of emotional transformation for this client is based on the therapist's reflection and is informed by the Emotional Processing model (Pascual-Leone & Greenberg, 2007) which was employed throughout therapy as a supervisory tool. In the case of Tony, it was apparent from the beginning of therapy, how his GAD dynamic prevented him from

accessing his core pain. Tony's worry and his somatic symptoms in conjunction with other forms of emotional and behavioural avoidance effectively distanced him from his own emotional experience, and as maladaptive coping strategies, 'protected' him from his core pain. As described in the preceding section (Section 3.4.2.2) on case formulation, the pain which Tony was so anxious to avoid comprised loss, trauma, loneliness, shame and sadness.

Initially in therapy, Tony's emotional processing style made it difficult for him to engage at a deeper emotional level, and while he was obviously affected by both recent and historic issues, his narrative focussed on events and symptoms with an underlying sense of hopelessness "*There's nothing I can do, because I know no matter what happens it's always going to be the same reaction. I won't be surprised, I won't be in shock. I'm already feeling like this now because I know what's going to happen*". He presented as either vulnerable and needy or aggressive and rejecting; in particular, he could be dismissive of therapy and the therapist, which appeared inconsistent with comments on his HAT forms where he reported valuing the relationship. In the early sessions Tony was distant and evasive, speaking of events in the past tense, with himself as a character in the narrative; there was a degree of bravado in the way he downplayed the impact of emotionally significant events on him *"I don't care what other people think of me"*. He adopted a victim stance and an externalising defensive position "*You just realise that life isn't fair*".

As therapy progresses, however, and especially with the introduction of chair-work, Tony began to connect with his core pain. His initial response to encountering this level of emotional experiencing was still either to collapse into global distress (hopeless/helplessness), to move to secondary rejecting anger (particularly in relation to core experiences of shame), or to become over whelmed by anxiety/panic. As the therapeutic alliance developed and the level of chair work increases Tony found that he became increasingly able to tolerate and unpack his core pain. In a series of poignant dialogues with

his father across sessions 4 to 7 Tony experienced first the pain associated with the loss of the primary male figure in his life, whom he idealised and considered his "best friend" and then the shame attached to having failed to live up to his father's values. *"I go in to the house and I see his picture on the wall and I just feel his eyes burning in to me. I can't bear it"*. In the dialogues Tony spoke from his imagined father's position and was able to offer himself conditional support *"you're right in what you're saying that you don't deserve praise or recognition... you have to get it done right. I'll be proud of you at the end of the day when you get everything sorted"*. In this dialogue, however, he realised the extent to which his life has centred upon gaining his father's approval *"I was always frightened about what you would think or you would say... terrified that you were gonna just disapprove, and then that was always the worst thing in the world"*. From this point on, he began to tentatively assert himself in so far as he could accept his father's support as valuable but acknowledged that he needed *"to stand on [my] own two feet"*.

Other dialogues around this time focus on the pain, loss and uncertainty attached to Tony's relationship with his young daughter. Here, in dialogues with his (imaginary) daughter, he expressed his love for her and the pain he felt at not being aware of her existence until she was four years old *"I have a recurring dream where I'm holding a baby but I can't see the face... it hurts me so much that I never got to hold you as a baby"*. In the dialogues, his daughter responded with compassion and soothed him; she told him how she understood the complicated situation he was in at the time and validated him as a father now, which afforded Tony great relief. In worry dialogues (the first of which precipitated a panic attack) Tony gradually became able to stand up to his worry agent, and as his fear of not being able to cope diminished a nascent sense of agency gradually emerged.

As Tony progressed through therapy, his self-rejection and self-criticism, receded and he became increasingly able to access self-compassion and understanding in their place. His

capacity for adaptive, assertive anger developed and he became less likely to slip back in to the rejecting, self-pitying anger that informed so much of his early narrative. The closing sessions of therapy focused on meaning-making as Tony integrated his new-found capacity for accessing the emotional information that was previously inaccessible to him.

3.4.3 Measures

3.4.3.1 Analysis of Quantitative pre-post-Outcome Measures.

Tony's scores are presented for pre-, mid-, post-therapy and at his 6 month follow-up assessment in Table 3.4.1.

Table 3.4.1 Tony's Pre-Post-Outcome Scores

Scale	Caseness	RCI	Pre-Treatment	Mid-Treatment	Post-Treatment	6 Month Follow Up
GAD-7	10	5	17	10	0	0
GADSS	7	n/a	18	11	5	0
BDI-II	10	9	49	34	0	0
CORE-OM	1.29	0.48	2.23	1.70	0.09	0
PSWQ	45	9	80	74	35	22
PSWQ-PW	n/a	28	61	52	2	8

Note: Caseness = the cut-off for determining whether client is clinically distressed. RCI=Reliable Change Index; GAD-7 = Generalised Anxiety Disorder-7; GADSS = Generalised Anxiety Disorder Severity Scale; BDI-II = Beck Depression Inventory; CORE-OM = Clinical Outcomes in Routine Evaluation – Outcome Measure; PSWQ = Penn-State Worry Questionnaire; PSWQ-PW = Penn-State Worry Questionnaire (Past Week).

At the beginning of therapy, Tony's score on the GAD-7 was 17, which indicated that he was in the *severe* clinical range for GAD. By the mid-point of therapy, Tony's score had reduced to 10, which placed him in the *moderate* clinical range for GAD, and by the end of therapy, his score had reduced to 0, which suggested the absence of GAD symptomatology. Tony's post treatment assessment revealed that his pre-post differential of 17 met the criteria for reliable change. This, in conjunction with his post-treatment score of 0, which is in the

non-clinical range, suggested that Tony had *recovered* on this measure. Six months after the conclusion of therapy, Tony's score of 0 indicated he remained symptom free.

Tony's scores on the GADSS also appeared to follow this trajectory. His pre-therapy total score of 18 placed him in the *severe distress/impairment* range. By the mid-point of therapy Tony's total score had dropped to 11, which placed him in the *moderate distress/impairment* range, and by the end of therapy his total score had dropped to 5, which placed him in the *mild distress/impairment* range, and suggested remission from GAD symptomatology in that he had reached the cut-off point for non-clinical (caseness being set at 7). Tony's six month follow-up total score of 0 suggested that he remained free from GAD.

Tony's score on the PSWQ at the beginning of therapy assessment was 80 which placed him clearly in the clinical range. By the mid-point of therapy his score was 74, which suggested that he still considered himself to be a worrier; to a clinical degree. By the end of therapy, however, Tony's score had dropped to 35, which placed him in the non-clinical range and suggested a significant shift in self-perception with regard to identifying himself as a 'worrier'. Tony's pre-post-change of 45 was larger than RCI and the fact that he was now in the non-clinical range suggested that he had *recovered* according to this measure. Tony's score at six month follow up of 22 suggested that he remained stable in relation to worry on this measure and was still *recovered*. His score on the PSWQ-PW at the pre-therapy assessment was 61, which placed him in the clinical range, as did his mid-point assessment score of 51. However, by the conclusion of therapy, Tony's score on this measure had fallen to two which suggested a significant and reliable level of relief from worry. This improvement was still evident at the six month follow-up, when Tony scored eight on this measure.

On the CORE-OM, Tony's pre-therapy score was 2.29 which placed him clearly in the clinical range of distress (1.19 being the cut-off point for males) and this level of ongoing

distress was reflected in his mid-point of therapy score of 1.70, which while showing some signs of improvement, indicated that he was still in the clinical range. By the end of therapy, however, Tony's score had dropped to 0.09, which suggested that he was now in the non-clinical range. That Tony's pre-post-change on this measure was larger than RCI, and the fact that he was in the non-clinical range, suggested that he was *recovered* according to this measure. At his six month follow-up assessment Tony scored 0 which indicated that he was still recovered.

Tony's pre-treatment score on the BDI-II of 49 placed him in the *severe* depression range. His score at the mid-point of therapy of 34 indicated a small degree of improvement; however he remained in the *severe* depression range on the measure. By the end of therapy, however, Tony's score had reduced to 0, which suggested the total absence of depressive symptomatology. Tony's pre-post-change on this measure was larger than RCI and he was now in the non-clinical range, which suggested that he was *recovered* according to this measure. At the time of his six-month follow-up assessment, Tony's score remained at 0 on this measure which indicated that he was still recovered.

3.4.3.2 Analysis of Process Measures

Target Complaints (TC)

Prior to each therapy session, Tony completed a Target Complaints form. The information provided by this measure is presented in Table 3.4.2

Table 3.4.2 Tony's Target Complaints Data

Complaint	Pre-therapy	Mid-therapy	Post-therapy	Pre-post difference
Thoughts of my family and loving them	13	12	2	11

Having no access to my daughter growing up	13	10	1	12
A life of not being able to think of my father without getting upset	13	11	1	12
Worries about the future	13	11	1	12

Tony's TC forms contained a number of issues, including worrying about his family, worry about acquiring access to his daughter, worry about the future and the worry that he will never be able to think about his father without becoming upset. These are broadly consistent with the themes addressed later in his HAT forms. Tony rated these issues in a manner which suggested that they were causing him the maximum possible distress. While the issues were still seemingly quite problematic at the mid-point of therapy, by the time therapy concluded, Tony's scores suggested that all issues had been addressed to the extent that they appeared resolved.

Helpful Aspects of Therapy (HAT)

From Session 1 onward Tony acknowledged the value of being able to share his fears and concerns with a receptive other (see Table 3.4.3). In reference to Session 2, he commented on his awareness of the extent to which he suffered when comparing himself to his idealised father "*getting a grasp of how much I feel I compare myself to him and how much I let him down*". Tony reports that this helped in terms of "*Just understanding how I feel about him and having someone else hear how I feel about him*". He acknowledged the value of feeling heard by another person in session 3, "*I think the continuing discussion about my family and my dad with a (...) listener is really benefitting me*", which reflected the extent to which he had been unable to share his experience with others in the past. Tony's first chair

work, in session 4, afforded him the opportunity to explore his relationship with his father "*Explored different sides of the coin with myself and what I perceive as my father speaking through me*" and this was developed further through chair work in session 5, when Tony was able to experience his father's understanding of his current situation "*It's just the feeling that I can express what I feel his words would be to me*". In session 7 Tony reflected on the nature of his anger and reported an awareness of its somewhat ambivalent impact on his life "*Exploring my anger and history of how it seems to be a good driving force with bad results*".

Table 3.4.3 Tony's Helpful Aspect of Therapy Form Data

Session	How helpful?	Helpful Event	What made it helpful?	When in the session?	How long did it last?
Session 1	7	I feel that the fact that I embraced the fact with someone else that all my mistakes seem to have been after I had given up on a relationship needlessly has an improved aspect on my mind frame.	No data	Towards the conclusion	About 15 to 20 minutes
Session 2	7	Speaking consistently about my father and getting a grasp of how much I feel I compare myself to him and how much I let him down.	Just understanding how I feel about him and having someone else hear how I feel about him.	Towards the end of the session	For the remainder of the session
Session 3	6	I think the continuing discussion about my family and my dad with a (…) listener is really benefitting me.	As above	Almost from start to finish	As above
Session 4	8	The changing of roles between chairs and explaining of love between my father and me and others.	Explored different sides of the coin with myself and what I perceive as my father speaking through me.	Midway	For the remainder of the session.
Session 5	7	The switching roles.	Hearing out loud my father's opinion and taking in what he said.	About 20 minutes in.	Almost the remaining time
Session 6	7	The role switching between father and me.	It's just the feeling that I can express what I feel his	Midpoint	Almost to the conclusion.

			words would be to me.		
Session 7	7	Anger acknowledging	Exploring my anger and history of how it seems to be a good driving force with bad results.	Midway	For remainder of the session.
Session 8	7	Expressing how I think that my work colleagues will react to me.	It just gave me a perspective from what I think they will see and my reaction to them.	Midpoint	For a good bit.
Session 9	8	The contact between me and my daughter.	The switching roles between me and my daughter just so I could know she knew how I felt.	Almost from the start	Most of the session.
Session 10	7	Switching roles to illustrate the positive and negative of keeping the job and not just ignoring the negative.	As above	midpoint	Through till the end.
Session 11	8	Backtracking and telling of what has gone on.	Just talking out loud about what has gone on in the last few weeks. It's just great to hear out loud.	No data	From start to finish almost.
Session 12	7	Discussing my friends and how things have improved.	Just in the way that my roommate and I have reprised our friendship.	Halfway	Until the end of the session.
Session 13	8	Talking about the feelings over the last few weeks.	Elaborating on the undermined feeling that I have been given almost menial tasks to do (at work).	Almost the whole session for this theme.	No data
Session 14	6	Catching up over the weeks goings on, talking about work and a bit of family.	As above	Start to finish	No data
Session 15	No data	Discussing the issue with the bank job and my dad.	As above	Combined together lasted from start to finish.	As above
Session	No data	The discussion of what	As above	The	No data

16		happened in the investigation and how I felt and how it impacted me.		discussion lasted from start to finish.	
Session 17	No data	Just everything to be honest, a recap of what's happened over the last while.	As above	All the way throughout the session.	All session
Session 18	8	As always, talking and recapping on the problems and frustrations on-going in the last week.	As above	Throughout the entire session	As above
Session 19	9	The chatting and venting of frustration of what is happening both in work and at home. It's wonderfully reassuring to know that I'm acknowledged here.	As above	Throughout the session	No data
Session 20	No data	The explaining of elation at hearing everything was ok with my job and just enjoying the feeling over again.	As above	All session	As above.

In session 8, Tony used chairs to work through an attributional split, thereby exploring how he felt he might be perceived by colleagues upon his return to work "*It just gave me a perspective from what I think they will see and my reaction to them*". Here Tony struggled with his shame, and how he feared others may judge him as harshly as he judges himself, a theme that is developed in Session 10. In Session 9, Tony focussed on his relationship with his daughter and through chair work was able to express his feelings for her and to experience how they may be received, which offered some relief. He described as helpful "*the switching roles between me and my daughter just so I could know she knew how I felt*".

Tony reported that in Session 11, the most helpful aspect of therapy was the opportunity to discuss the work which had taken place over the previous months and again, he acknowledged his satisfaction at the newfound experience of sharing his experience with another "*Just talking out loud about what has gone on in the last few weeks. It's just great to hear out loud*". In Sessions 12 to 14, Tony elaborated further on this theme, integrating aspects which had been happening in his life with therapy. Tony further explored issues related to shame in Sessions 15 and 16 when he used chair work to explore his difficult situation at work, and also with his father, and then reflected on the impact of the problems at work on him. Sessions 17 to 20 involved meaning-making and integrating emotional learning so that current events could be coped with in a more adaptive fashion. Again, Tony prized being heard "*It's wonderfully reassuring to know that I'm acknowledged here*" which indicated that he valued the relational aspect of therapy. Therapy concluded in Session 20, by which time Tony had resolved the issues at work and felt that he could proceed with his life again.

Retrospective Recall of Helpful and Unhelpful Aspects, and Client Reported Changes (Client Change Interview).

In his Client Change Interview Schedule assessment, upon completion of therapy, Tony observed that things had improved greatly for him since commencing therapy "*Oh from when I started in here, they're a thousand times better. It's ridiculous*". He pointed out how dramatically his ability to relate to other people had shifted "*...compared to when I came in here, when I was afraid to kind of sit up straight and be slouched in the chairs and I wouldn't be able to make eye contact for long*", and referred to how badly he felt the need to withdraw, prior to therapy "*You know I was just in that mode where I just wanted to be left alone but I felt that I had to come here... Like you'd had seen me about eight months ago I would probably be hiding under the collar of me coat*". Tony referred to how, in the past he tended

to bottle everything up and was incapable of sharing his inner world with others "*...I was really a closed off person. I never really shared anything with anyone and I didn't realize how much I kept everything in...until I came here*".

Tony observed how in therapy "*...when I started opening up the floodgates kind of opened a little bit and things that I didn't really think bothered me started... I had to kind of come out and say them because I didn't realize that they bothered me at all*" and described how prior to this he had always felt "*...kind of a bit closed off*". He noted that his new found openness improved relations with family, especially with his mother, and that in general he was less dismissive of others. When questioned about how he experienced therapy, Tony commented that the idea of talking to a stranger was odd, but after a while things became easier "*progressively through everything it became very easy to talk to him. There were days I could turn around and say it as if I knew him for twenty odd years*". He referred to this new openness throughout the interview.

When asked to identify what had changed in his thoughts feelings or attitudes since attending therapy Tony observed that "*...just like from coming here and realizing what has... what was bothering me and then... I think it was more I always kept everything held up. I always was very... always very defensive for meself... I always just took offence to most things*". He noted that while previously he would try to get away from people, he could now tolerate his emotions sufficiently as to be able to stay with them, until a connection was built. Interestingly, Tony noted that he has become more emotional, even to the point of tearing up at a poignant moment in a movie *"..... Because eh, I was getting all watery in the face. Me Ma just goes "Ah now you're one of us, properly now, because you're crying at this film""*, which appears to have led to greater acceptance from family. As with his openness, Tony referred to his improved interpersonal relationships throughout the interview. When asked if

he thought these changes would have been possible without therapy, Tony commented "*I don't think it would've and that's the God's honest truth*".

In terms of identifying his progression in therapy, Tony described how the process of identifying his core emotional experience, symbolizing it in language and expressing it to another "*started to relieve everything...Instead of kind of hiding back in the hurt*". He reported how his confidence grew with each session and how this allowed him to be increasingly open in therapy. When asked what might have brought about these changes he again mentioned the possibility of talking to another person about his feelings, adding "*I was always one who just boxed feelings in because I... kind of sign a of weakness kind of a way and you just, you have to hold onto the pain to keep you a certain way... coming here then was kind of letting loose. I realized that you don't have to hold onto the pain all the time*". In conclusion, Tony also noted that his willingness to stay in therapy and persevere stood to him in the early stages when he felt uncertain about the safety of disclosing vulnerability. This was particularly so in relation to his father, and Tony reports that was one of the main issues for him, that was difficult at the time, but helpful later *"Well there's the difficult topic of me dad...It had to be done. Like it was helpful because I... I was hearing out loud what was really bothering me that I thought my dad was disappointed"*. At the end of the interview, Tony commented on where he felt he was at, now that therapy has concluded "*Worries about the future, I think everyone always has worries about the future... And the ways things will be but as far it goes now, it's eh a lot more clearer for me. It's a lot more easier for me to think about the future now*".

3.5 Case Study 5, "Jackie"

3.5.1 Introduction

Participant 005, who for the purposes of this study has been assigned the pseudonym "Jackie", is a 50 year old Caucasian female, who was referred to the primary care service by her G.P. who felt that she was suffering from anxiety as a result of historical and current stressors. Initial intake at the service suggested that she was indeed suffering from considerable anxiety. Jackie scored 15 on the GAD-7 at the service intake assessment, placing her in the *severe* range, and consequently she was asked if she would be interested in participating in the study.

Jackie is the mother of two boys, Cormac aged 28 years and Dillon aged 14. She lives at home with her two sons and her partner Greg, who is not the boys' biological father. Jackie separated from the boy's father ten tears before, as he was emotionally and physically abusive. Prior to commencing therapy, Jackie's G.P. had prescribed Effexor (Venlafaxine: an anti-depressant of the serotonin-norepinephrine reuptake inhibitor (SNRI) class). Jackie engaged with the author for 23 sessions of therapy.

Prior to commencing therapy, Jackie completed a Structured Clinical Interview for DSM-IV-TR Axis I Disorders; Non-Patient Edition: Research version. SCID-I/NP-R. Her results indicated that she met the DSM-IV-TR diagnostic criteria for Current GAD and Current Major Depressive Disorder. Her score on the Global Assessment of Functioning scale was 55, which suggested moderate symptoms, (e.g. flat affect and circumstantial speech, occasional panic attacks), or moderate difficulty in social, occupational, or school functioning (e.g. few friends, conflicts with peers or co-workers) (SCID-I/P; First, Spitzer, Gibbon & Williams, 2002). Jackie also completed the SCID-II for assessing DSM-IV-TR

Axis II personality disorders which indicated that she met the diagnostic criteria for Avoidant Personality Disorder.

3.5.2 Therapist's Interpretation of Therapy, Case Formulation and Emotion Transformation

Therapist Perspective

Overall, the therapist felt that therapy with Jackie went well. At the beginning of therapy Jackie was resistant to the idea that her personal history had any bearing on her current distress and consequently, she was confused and terrified by the way she felt; she constantly referred to the fact that she must be crazy. As therapy progressed, however, she became increasingly able to recognise the impact of past interpersonal relationships on her although her acknowledgement of the pain this caused her was complicated by a dismissive attitude towards her own emotional experience and a desire not to be seen as weak.

In addition to an extremely difficult history Jackie experienced a number of crises during the course of therapy, which, while they might have threatened to derail the therapy may, in fact have provided valuable openings for therapeutic work. During the course of therapy, Jackie's mother passed away, as did her older brother. In addition to this, her son received a lengthy prison term and her abusive former husband moved onto her street. In dealing with these issues Jackie increased her ability to access and tolerate painful emotions in a manner which would have been virtually impossible prior to therapy. Jackie reported that she felt safe in the therapeutic relationship, and the therapist felt that this made a considerable contribution to her ability to engage in the therapeutic work. By the end of therapy Jackie reported feeling much more stable and calm than she had felt for years

Case Conceptualisation

The analysis of Jackie's case formulation is based on the reflections of the therapist and is also informed by a study to which the author of the dissertation contributed (O'Brien, et al., 2012), which provides a qualitative analysis of the narrative and emotion events in the first half of Jackie's therapy, and incorporates a number of quantitative scales (*CEPS-R/ CEAS-III/ CAMS*; see O'Brien et al., 2012). From early on in therapy, through her narrative and presentation, it became apparent that Jackie had somewhat under under-reported the level of distress which she was experiencing. She reported that she had suffered from anxiety since childhood, and that a number of traumatic family events, occurring over the preceding decade, had amplified her condition. Jackie reported almost constant worry about the wellbeing of others. She described an exhaustive list of GAD somatic symptoms, including tension, sleeplessness, headaches, trembling, nausea, dizziness, grinding teeth at night, jaw spasm, and high blood pressure. Consistent with her scores on outcome measures, Jackie was highly avoidant and suppressed her emotional experience by either dismissing, or diminishing it, or by focussing on the needs of others.

Jackie's personal narrative was complicated and referenced numerous traumatic events. O'Brien et al (2012) differentiate between past, recent and current stressors in her history. Examples of past and recent stressors would include growing up in poverty with an alcoholic father who was physically and emotionally abusive, the loss of a sister who was raped and murdered when Jackie was in her early twenties and of her older brother who was murdered in a gangland killing. Both parents suffered irrevocable psychological damage after the murder of Jackie's sister; her father's drinking led to a psychiatric admission and her mother became depressed, developed cancer and more recently, dementia. Jackie also married a violent and emotionally abusive partner, from whom she is currently separated, with whom she shared an extremely difficult and traumatic twenty tears. Current stressors

include her son's recent incarceration for criminal offences (he received a lengthy sentence after therapy had commenced), the health of her disabled brother (who died during the course of therapy), and gradual deterioration of her mother's health (she also passed away during the course of therapy)

Jackie's core pain consisted of trauma, shame, loneliness and pain/sadness; it reached back to her earliest memories. Jackie's earliest experiences were informed by shame "*We always had fleas, there was always a smell off us and we had nothing... A lot of stigma at the time about the 'poor beggars' they used to call us on the road. We were filthy going around*". Jackie's relationship with her siblings was complicated by the fact that she was her father's favourite, which led to their resentment of her and to her becoming isolated from them, experiencing profound loneliness. In such an environment, Jackie learned early on that she should keep all of her problems to herself, and internalised the family's coping mechanisms regarding emotional experience.

In addition to the obvious trauma associated with the violent murder of her sister, Jackie experienced a complex mixture of guilt and shame in so far as she was meant to have been with her sister on the night of her murder, and expressed survivor's guilt in her wish that she had died rather than her sister. Jackie experienced tremendous pain and sadness as her parents collapsed following her sister's death, and in attempting to hold the family together, as the eldest daughter, she felt a profound sense of helplessness and hopelessness as she became ever more immersed in her role and things around her gradually fell apart *"I was the eldest girl then [...] I had to make it as normal as possible [...] I kind of lost a lot of my identity"*.

O'Brien and colleagues (2012) draw attention to the devastating impact of Jackie's twenty year marriage to an emotionally and physically abusive man *"He used to bully me and*

terrorise me. He was crazy, kind of psychotic [...] very manipulative like [...] he was a bully and a dictator [...] very violent, very violent, very violent". In addition to the fear and hopelessness she experienced in this relationship, Jackie blamed herself for way her eldest son turned out, feeling that she over-indulged him in childhood and adolescence, which caused her intense guilt and sadness. She also felt responsible for the manner of her mother's passing in so far as she recognised her own experiences of loneliness and neglect in her mother's relative isolation in a nursing home, abandoned by her family.

As a child, Jackie's needs were seldom met, and when they were, it was quite inconsistent. The ambivalence she felt regarding her father's positive attention, given his treatment of her siblings, caused her strong feelings of guilt, and led to rejection from other family members. Meeting her emotionally distant mother's emotional needs meant that Jackie forfeited the opportunity to have her own needs for unconditional love, safety and emotional support met.

The specific impact of the foregoing on Jackie's GAD dynamic was manifest in her dismissal of all emotional displays (with the exception of anger) by herself and others. Emotion was perceived as either a sign of weakness, of intolerable vulnerability, or as a disingenuous means of manipulating others for some personal gain. Hence, in therapy Jackie constantly questioned herself when becoming upset "*Am I looking for sympathy? Or feeling sorry for myself?"* Jackie expressed a deep rooted fear that if she were to experience her emotions, she might become overwhelmed, collapse entirely and have some form of mental breakdown *"I've a fear I'll break... that I'll have a nervous breakdown. That's my fear".* She feared that others might judge her negatively, and be dismissive of her, if she were to express herself emotionally; an element of this involved an attributional split, as Jackie feared this was how her self-treatment may unfold.

In keeping with a classic GAD profile Jackie engaged in avoidance, both emotional and behavioural in order to avoid confronting her core pain; she worried constantly and focused on meeting the needs of others. She described feeling as though she were on "autopilot", disconnected from the events which had occurred in her life; a maladaptive coping strategy which denied her the opportunity for emotional processing of her lived experience. O'Brien and colleagues (2012) note that Jackie evinced a harsh inner critic, which chastised her at every opportunity, "*You're like a clown you're performing, performing, performing... thick, stupid, clown*", and induced shame and loneliness. Even in her constant attending to the needs of others, she was rebuked by the critic for being used by them, remaining essentially unloved and unlovable; lonely to the core. As a consequence of this, Jackie's core emotional pain, comprising shame, loneliness, sadness and trauma, was unavailable to her, and without access to this, she remained unable to begin the necessary work of emotional processing which resolution requires.

Emotion Transformation

Jackie's process of emotion transformation was complicated by the fact that in the early stages of therapy she was either disconnected from, or overwhelmed by, her emotional experience. Initially, she narrated highly poignant stories, but without any clear emotional response to them, although by the end of the first session she acknowledged that she could feel a swell of emotion arising, in connection with her narrative. By the time she reached the mid-point of therapy, Jackie was able to differentiate, access and experience core emotions in session, however her ability to tolerate them was not great, and she remained highly avoidant, utilising strategies such as laughter and changing the subject.

As therapy progressed, the therapeutic alliance deepened as client and therapist worked through a number of difficult issues in Jackie's current life (involving loss and

bereavement). This allowed Jackie to feel safe enough to access elements of her core pain (shame, loss, abandonment and fear) and she was now able to mourn past losses, in a manner which was previously impossible. By the end of therapy, Jackie had stood up to her Worry Agent on a number of occasions (*"I won't let you terrorise me anymore"*), had accessed adaptive sadness in relation to past and recent losses and now expressed a newfound sense of pride in how she survived an extremely difficult past.

3.5.3 Measures

3.5.3.1 Analysis of Quantitative pre-post-Outcome Measures.

Jackie's scores are presented for pre-, mid-, post-therapy, and at 6 month follow-up assessment in Table 3.5.1.

Table 3.5.1 Jackie's Pre-post Outcome Scores

Scale	Caseness	RCI	Pre-Treatment	Mid-Treatment	Post-Treatment	6 Month Follow-up
GAD-7	10	5	10	10	8	4
GADSS	7	n/a	10	8	4	7
BDI-II	10	9	12	13	5	8
CORE-OM	1.29	0.48	1.50	1.35	0.41	0.70
PSWQ	46	9	55	49	48	54
PSWQ-PW	n/a	28	57	44	No data	42

Note: Caseness = the cut-off for determining whether client is clinically distressed. RCI=Reliable Change Index; GAD-7 = Generalised Anxiety Disorder–7; GADSS = Generalised Anxiety Disorder Severity Scale; BDI-II = Beck Depression Inventory; CORE-OM = Clinical Outcomes in Routine Evaluation – Outcome Measure; PSWQ = Penn-State Worry Questionnaire; PSWQ-PW = Penn-State Worry Questionnaire (Past Week).

At the beginning of therapy, Jackie's score on the GAD-7 was 10, which indicated that she was in the *moderate*, clinical range for GAD. By the mid-point of therapy, her score had reduced to 9, which placed her in the *mild*, non-clinical range for GAD, and upon the

conclusion of therapy, her score was 8, which suggested that she was still non-clinical (but did not meet the criteria for RCI), but in the *mild* range of GAD symptomatology. Six month follow-up data reveal that Jackie's score on this measure remained at 8, which indicated that she remained stable, in the *mild* range of GAD symptomatology.

Jackie's pre-therapy assessment score of 10 on the GADSS placed her in the *moderate distress/impairment* range. By the mid-point of therapy, her total score had dropped to 8, also in the *moderate distress/impairment* range. By the end of therapy however, her total score had dropped to 4, which placed her in the *mild distress/impairment* range of GAD symptomatology for this measure which, in terms of caseness, indicated that she was now non-clinical. At her six month follow up assessment, Jackie's total score was 7, which suggested that she was once again in the *mild distress/impairment* range for the measure.

On the PSWQ, Jackie's pre-therapy assessment score of 55 placed her in the clinical range on the measure. By the mid-point of therapy this had reduced to 49, which remained clinical. By the end of therapy assessment, Jackie's score of 48 suggested that she remained in the clinical range on this measure and her pre-post differential indicated that she did not meet the criteria for RCI. At her six-month follow-up assessment, Jackie scored 54 which indicated that she remained in the remained clinical range on this measure. Jackie scored 57 on the PSWQ-PW in her pre-therapy assessment. As therapy progressed, Jackie's scores improved to 44 at the mid-point assessment, and although there is no data for the end of therapy assessment, her score of 42 at the six-month follow-up assessment suggests that she remained stable on this measure, although her pre-post differential suggested that she did not meet the criteria for RCI.

Jackie's score of 1.50 on the CORE-OM placed her in the clinical range of distress on this measure. By the mid-point of therapy, this score had fallen to 1.35, which remained in

the clinical range. By the end of therapy, however, Jackie's score had reduced to 0.41 which placed her in the non-clinical range and, given that her pre-post differential met the criteria for RCI, indicated *recovery* from GAD symptomatology on this measure. At her six-month follow-up assessment Jackie scored 0.70 on the measure which suggested that she remained non-clinical on this measure.

On the BDI-II, Jackie's pre-treatment score of 12 placed her in the *minimal* clinical range of distress. By the mid-point of therapy, her score had slightly increased to 13, remaining in the *minimal* clinical range; however, by the end of therapy, in her post-treatment assessment, this had fallen to 5 which placed her in the minimal non-clinical range for depression on the measure. Although Jackie met the requirements for non-clinical in terms of caseness, her pre-post differential suggested that she did not meet the criteria for RCI. At her six month follow-up assessment, Jackie scored 8, which suggested that she remained in the *minimal*, non-clinical range of depression.

3.5.3.2 Analysis of Process Measures

Target Complaints (TC)

Prior to each therapy session, Jackie completed a Target Complaints form. The information provided by this measure is presented in Table 3.5.2

Table 3.5.2 Jackie's Target Complaints Data

Complaint	Pre-therapy	Mid-therapy	Post-therapy	Pre-post difference
My son's wellbeing	6	5	3	3
My relationship	6	5	3	3
My mother and family	5	5	3	2

My home life	5	5	3	2

It appears as though Jackie has consistently under-reported the level of distress that she was experiencing. While she evinced progress across the course of therapy, according to outcome measures, this trajectory is captured less on this idiosyncratic measure than on the generic, standardised quantitative measures. It is as if Jackie, although able to identify areas of distress, is reluctant to fully acknowledge the impact of these events on her and the amount of suffering that she experiences in relation to them.

Helpful Aspects of Therapy Form (HAT)

At the end of each session Jackie was asked to fill out a Helpful Aspect of Therapy form, the data from which is presented in Table 3.5.3. It is evident from comments made regarding Session 1 that Jackie valued the opportunity to discuss her difficulties in a safe environment; she referred to *"Talking about things that happen in my life. Not being afraid... Opening up. Letting my feelings out"* as being helpful. In Session 2, Jackie accessed her core pain for the first time and found it quite overwhelming. Although she commented that this was beneficial *"Letting go of some of the hurt and pain that's inside of me"*, she acknowledged that it produced an element of panic and she needed to learn to breathe into her emotional experience to achieve a degree of emotional regulation. Comments on Session 3 further illustrate how Jackie valued being heard, and she observed that the realisation that her life has, indeed, been difficult and that her response to this is not abnormal offered her comfort *"That I don't feel I'm going crazy that my life is stressful"*.

Table 3.5.3 Jackie's Helpful Aspects of Therapy form Data

Session	How helpful?	Helpful Event?	What made it helpful?	When in the session?	How long did it last?
1	8	Talking about things that happen in my life. Not being afraid.	Opening up. Letting my feelings out.	No data	One hour
2	8	Letting go of some of the hurt and pain that's inside of me.	Learning how to breathe, try to take some timeout for me – most days.	No data	No data
3	9	Somebody to listen to me.	That I don't feel I'm going crazy that my life is stressful.	No data	No data
4	8	Trying to heal old wounds.	Getting rid of some of my baggage. Learning to deal with pain and hurt.	No data	No data
5	9	Speaking about my mother.	Letting someone know how I feel the truth.	No data	No data
6	4	To let me see both sides of me, the clown and the sad person.	To know people are draining me.	No data	No data
7	7	Being able to let my feelings go. Not being afraid to cry.	Speaking about my mam.	No data	No data
8	9	Being able to speak about my feelings and to know that my pain is real. Also to feel that I am not going	Being able to express my true feelings	Talking about my inner feelings	

		crazy.			
9	8	Being able to cry and not feel guilty. Stop pretending it will go away. I have to talk.	To explain my true feelings, not be afraid to open up and let my true feelings out.	No data	No data
10	8	Being able to let my feelings out and cry. Not afraid to be human that I can show my feelings.	Not pretending to be strong all the time. Letting my true self be seen.	Half way through.	10 minutes
11	8	Opening up old wounds.	Let the past go.	In the middle.	No data
12	8	Being able to explain how people twist things making me feel I'm wrong or mad.	Explaining about people putting demands on me.	Halfway through.	No data
13	8	Letting my inner being out. Realizing I may be hard on myself.	By saying how I felt when it happened.	Halfway.	No data
14	8	Realizing that going back to the past helps move to the future.	Going back and letting out some of my pain.	No data	No data
15	8	Being able to cope with my own feelings. Letting out my own pain and hurt.	Halfway through hearing that my own feelings are real. Have to learn to deal with them.	No data	No data
16	8	No data	Being able to let some of my feelings out and get rid of some of my pain.	10 minutes into it	No data

17	8	Being able to talk through my fear.	Right from the beginning.	No data	No data
19	8	By talking about myself and family. Not blaming myself too much.	No data	Quarter way through.	No data
20	No data	No data	No data	No data	No data
21	9	Right from the start I felt a lot more in touch with my own feelings.	Honestly letting my feelings out.	No data	No data
22	9	Realizing that I am not crazy. There is a lot going on. When I cry it helps.	No data	Right at the beginning.	No data
23	9	Learning to be honest with myself.	Right at the start.	Start	No data

Jackie's comments on Session 4 referred to something which will become a recurring theme in her appraisal of helpful aspects of therapy; the relief obtained by directly engaging with her core pain *"Getting rid of some of my baggage. Learning to deal with pain and hurt."* In the first of her unfinished dialogues with her mother, in Session 5, Jackie reported being happy with the opportunity to let another person know how she *"feels the truth"*, while a two chair dialogue with a critical other in Session 5 revealed her self-treatment as miserable and foolish "*To let me see both sides of me, the clown and the sad person*". A second dialogue with her imaginary mother, in Session 7, allowed Jackie to access her core pain and cry without self-reproach *"Being able to let my feelings go. Not*

being afraid to cry"; this was reiterated in Session 8, *"Being able to speak about my feelings and to know that my pain is real. Also to feel that I am not going crazy"*.

In Sessions 9 and 10 Jackie again expressed how helpful she found being able to cry without feeling guilty *"Not afraid to be human that I can show my feelings"* and expressed relief at not feeling the need to pretend to be strong all the time. She referred to a new found confidence in relation to engaging with her emotional experience *"To explain my true feelings, not be afraid to open up and let my true feelings out"*. Further exploration of past injuries took place in Sessions 11 and 12, while in Session 13, as a result of a two chair dialogue with her critical self, Jackie became aware of the degree to which she can be harsh and unforgiving of herself *"Letting my inner being out. Realizing I may be hard on myself"*. In Session 14 she acknowledged her recognition of the rationale underlying much of her work in therapy to date *"Realizing that going back to the past helps move to the future"*, and in the following session, described an increasing ability to tolerate and work with her core pain *"Being able to cope with my own feelings. Letting out my own pain and hurt [...] my own feelings are real. Have to learn to deal with them"*.

In the remaining five sessions of therapy, Jackie cited a number of aspects as being helpful, including *"Being able to talk through my fear"*, feeling "*a lot more in touch with my own feelings*", *"Realizing that I am not crazy. There is a lot going on. When I cry it helps"* and *"Learning to be honest with myself"*. In a broader sense, these descriptions of aspects of therapy which Jackie found beneficial, illustrated her process of overcoming the avoidance which had been such a prominent feature of her emotional and behavioural coping since childhood. They also illustrated her recognition that she could access her emotional experience without becoming completely overwhelmed and that by acknowledging the emotional impact of her past experience on her, she could learn from her emotional experience without fear.

Retrospective Recall of Helpful and Unhelpful Aspects, and Client Reported Changes (Client Change Interview).

Unfortunately there is no data for Jackie's end of therapy Client Change Interview Schedule. She was, however interviewed at the six-month follow up assessment and the following observations are taken from there.

When asked to comment on what she felt to be the major areas of change which she recognised since completing therapy, she reported that she was *"much, much more relaxed and taking each day as it comes...not panicking and sleeping more"*. When asked how she actually experienced being in therapy, Jackie observed that *"The truth...I really didn't realise how many emotional problems I had...how hurt I was...how affected I was...I really thought I was mad sometimes"*. She described how initially she found therapy to be quite challenging, she was "shocked" by what actually came up, *"a lot of history...a lot of baggage...it all came flooding up...some days I found it very overwhelming...I didn't realise how much I went through"*. She reported that since therapy finished, she has felt *"a lot more confident with meself"* and described not being so harsh on herself with the metaphor *"I used to have a stick and like beat meself with it"*; she has stopped blaming herself for all of the difficulties she has experienced in life. She reported that she no longer feels *"cursed"*. Jackie stated that therapy gave her the sense that she now has a *"certain road"*, a sense of direction, whereas previously, she used to feel that she was *"stuck on a roundabout"*. She also described how she is now much more able to be honest with herself and others. She reported that she was on the same anti-depressant that she had been on for the last four or five years but that as she felt herself "opening up" in therapy she asked the G.P. to wean her off them and she was now taking less than half the dose that she had been taking at the onset of therapy.

When asked if anything had got worse for her since attending therapy, Jackie reported that she could not think of any examples of this. When the interviewer inquired as to how much she expected to change at the beginning of therapy, Jackie responded, *"I hadn't got much confidence in it, no...I only came to therapy to please the doctors"*. She reported that this was the reason she was so shocked at the changes which occurred for her as a result of therapy, referring specifically to an increased sense of self-worth and a newfound sense that she *"deserves to be happy"*. When asked if she felt the changes would have been possible without therapy Jackie stated that without the treatment she would *"probably be sedated in a locked ward in [name of psychiatric hospital]...I probably would be dead by now...I probably would have took a breakdown...I wasn't able to cope"*. When asked how important she felt the changes have been for her, she is unequivocal *"It was life or death...simple as that"*. She made the point that in addition to her troubled past, a number of events occurred while she was in therapy (the death of her mother and brother, her son's imprisonment) that she feels she would have been unable to cope with had she not been in treatment.

In response to a question concerning what she might attribute change to, Jackie claimed that the most important thing for her was *"realising that I wasn't mad...that the things that did happen happened, and they were horrific things...and I can justify my behaviour"*. She further noted that *"I was hurting bad, and I didn't realise how bad it was...inside I was dying...I was terrorising myself night and day"*. She reported thatat that point in time, although she would not kill herself, she did not want to live *"it would be easier if I didn't wake up."* Jackie also described how she used to relate her history *"as though it was a story that had happened to somebody else"*; this is no longer the case. She acknowledged that she received a good deal of support from friends, with whom she became increasingly able to share her experience as therapy progressed.

Jackie observed that the most important personal quality the she brought to therapy, was that *"for the first time in a long time, I was honest. I conned the last therapist and told him what he wanted to hear, but this time I was completely honest"*, noting that *"I could lie so easy that I'd convince meself"*. She also mentioned that she was able to cry in the therapy, which shocked her, *"I could feel the pain flowing out of me"*. When asked what was difficult in therapy for her Jackie immediately pointed to her fear that engaging with her emotional experience might *"open the doors"* and lead to a breakdown that she might not be able to come back from.

When asked what she found helpful in therapy, Jackie answered *"I can breathe"*, referring to how, in the past, living on her nerves, she felt in a constant state of panic, whereas now she can relax and enjoys her own company. She reported that therapy has improved her ability to cope with the various difficulties that life presents for her, that she has learned to live *"day by day"*, no longer dreading the future. Jackie described how she used to worry about things all the time *"I used to terrorise meself before they even happened"* imagining, for example, her son stretched out dead on a morticians slab. She has since learned not to worry about the things that are beyond her control, and no longer feels the need to terrify herself in order to feel she will be able to cope. Jackie reported that she now feels more able to live in the present.

Jackie admitted that she found the chair-work in therapy difficult, as she found it hard to imagine things from another person's point of view. She also occasionally struggled with going back to some of the more traumatic incidents in her past, although she was aware of the necessity of doing so. Ultimately however, she believes that it was this process which helped her to reach the position of acceptance towards herself and her situation which has characterised her post-therapy experience.

3.6 Case Study 6, "Mark"

3.6.1 Introduction

Participant 006, who for the purposes of this study has been assigned the pseudonym "Mark", is a 35 year old Caucasian male who was referred to the service by his G.P. with a diagnosis of low mood and anxiety with occasional panic attacks. Marks initial intake assessment at the service confirmed this diagnosis, noting that he described himself as having been a "worrier" since childhood and that he recorded a score of 18 on the GAD-7. Accordingly, Mark was invited to participate in the research.

Mark reported that while his current emotional distress has been particularly difficult for the last four years, it recently spiked when he was diagnosed with a chronic medical condition which he became increasingly anxious about managing. Mark's G.P. prescribed Prothiaden (a tricyclicic anti-depressant) to treat his low mood and, in the short term, Alprazolam (Xanax; a short-acting anxiolytic of the benzodiazepine class) to assist with panic attacks. By the time of his induction to the research program, Mark's panic attacks were in remission. He engaged in 19 sessions of therapy with an experienced EFT therapist.

Prior to commencing therapy, Mark completed a Structured Clinical Interview for DSM-IV-TR Axis I Disorders; Non-Patient Edition: Research version. SCID-I/NP-R. His results indicated that he met the DSM-IV-TR diagnostic criteria for Current GAD, Social Phobia with Agoraphobia and Dysthymic Disorder. His score on the Global Assessment of Functioning scale was 61 which suggests some mild symptoms with difficulty in work or social functioning, but generally functioning reasonable well, with some meaningful interpersonal relationships (SCID-I/P; First, Spitzer, Gibbon & Williams, 2002). Mark also completed the SCID-II for assessing DSM-IV-TR Axis II personality disorders which

indicated that he met the diagnostic criteria for Avoidant, Dependant, Passive-aggressive, Depressive and Paranoid Personality Disorder.

3.6.2 Therapist's Interpretation of Therapy, Case Formulation and Emotion Transformation

Therapist Perspective

The therapist reported that work with Mark was quite difficult as he was extremely interpersonally and emotionally avoidant. He initially had difficulty looking at the therapist and did not disclose much beyond saying that he was grand, okay, not okay, etc. Each session took some time before he would begin to speak. When therapist and client started to use more active EFT interventions such as chair tasks, Mark had difficulty in engaging in them and mainly looked at the therapist rather than at the empty chair. He typically also held a hand in front of his face out of shyness. Nevertheless, as therapy progressed he reported that he found it helpful, which encouraged the therapist to persevere with focusing on the experienced emotions and evocative tasks.

Mark was also avoidant with regard to the content of his disclosures. He did not reveal much about his personal history and thus it was difficult for the therapist to keep a clear focus in therapy. Mark only engaged in one dialogue with his mother, which he found anxiety provoking due to her anxiety over the course which his life was taking and her difficulty in seeing him too weak to cope with things. Mark had one dialogue with his father, who left the family when he was very young. Although he reported missing his father very much as a child, he acknowledged that he currently enjoyed a pleasant relationship with him (despite some sadness due to not being able to see him as often as he would like). The person Mark felt closest to was his brother, despite the fact that they had fought a great deal in childhood. The worst things he reported in his personal history were memories of being

bullied as a child due to being overweight. He also recalled feeling very lonely throughout primary and secondary school (he had had to change school because of his parents' divorce) and overeating to compensate. Mark engaged in sport on a competitive basis, which gave a boost to his fragile self-esteem (however this could be anxiety provoking as he worried that he would not perform well). He reported feeling very isolated and dreamed of having a romantic partner, but his anxiety was so debilitating that he mainly stayed home (he described being frequently unable to leave the house for fear of panic attacks). Mark reported that when he went out socially, he tended to feel extremely shy, unless he were to drink excessively, in which case he felt he became more entertaining; however he reports having no no close friends (and has little hope that this will change). Although he described nurturing career aspirations in the area of professional sport (as a coach), he conceded that he felt too shy to pursue them. Mark worries constantly and feared for his health (he has a serious and chronic condition), he worries about interpersonal rejection and humiliation, he longs for connection but is fearful of rejection.

Case Formulation

The main triggers for Mark's distress were interpersonal rejection in all forms, bodily reactions showing signs of the worsening of his chronic condition (resembling anxiety symptoms, which he experienced throughout the whole day), and any signs of anxiety or panic which were interpreted traumatically. Other triggers included thoughts about his future which he was not optimistic about. These triggers led to profound emotional avoidance (mainly featuring strong and pervasive worry) and behavioural avoidance (demonstrated in session by not looking at the therapist or by holding a hand in front of his face). Mark had difficulty in engaging in imaginary dialogues as he found them to frightening, and too exposing.

Outside of therapy, Mark's behavioural avoidance mainly took the form of staying home and not going anywhere or, if going somewhere, walking close to the walls so he could lean on them if he felt panicky. He also avoided going anywhere where he might encounter large crowds of people which was quite difficult given his involvement in professional sport. His self-treatment (apart from worrying the self) was extremely critical. Mark considered himself to be weak, a failure, unable to live like a 'normal' person, not able to trust himself that he would be able to bear interpersonal rejection or the bodily symptoms of his chronic illness and anxiety. He spent most of his time in global distress, characterised by a great deal of anxiety, hopelessness, helplessness, and irritability with the self. He was very anxious in relation to the triggers highlighted above and thus engaged in emotional and behavioural avoidance rather than allowing his core underlying painful feelings to come to the fore. His core painful feelings were only unfolded in therapy through the use of experiential (chair) interventions. Deep down he was profoundly lonely and longed for connection (with a romantic partner, with his father, with friends), he experienced a huge amount of shame (I am a failure, weak) and was terrified of being in the world on his own with all his somatic symptoms (of his chronic illness and anxiety). The unmet, unarticulated needs were to be loved and to feel connected, to be validated and accepted and to be strong and/or protected.

Emotional Transformation

The therapist reports that work with Mark was quite complex; it was very difficult to facilitate him in engaging with therapy. Despite this, the therapist believed that as much progress as possible was made. Mark managed to access his core pain through imaginary dialogues. He accessed his loneliness (in so far as he felt he had not had any friends as a child) in dialogues with his imagined peers, potential romantic partner or in relation to his dad (with whom he currently had a good relationship, but had not had a close connection with in childhood). He also accessed his shame through the dialogues which focussed on his

experience of being bullied in childhood, attributional judgements of others' negative assessment of him, doubt instilled by his mother's fears, or through self-criticism. Similarly, Mark and the therapist were able to access his fundamental dread when, in the imaginary dialogues, he enacted panic attacks, or his illness, taking over. In all of these dialogues they were able to gradually articulate his fundamental needs to be loved and connected with, to be self-acceptant and accepted by others and to be strong enough (protected) to face the physical adversity of his illness and anxiety. As therapy progressed he became increasingly self-compassionate (either as himself, or as his imagined father, brother or a friend). He was increasingly able to access protective anger and confront the bullies, doubting/critcising others or self. With time Mark was able to fight against the enacted panic attacks and illness as well as his debilitating worry. In terms of his worry process, Mark became increasingly able to experience its debilitating impact and stand up to it, but at the same time he experienced considerable ambivalence as he became more aware of the protective function of worry that made sure that he was prepared for anything bad that might happen to him. He became aware that the worry process tired him out, keeping him anxious and hyper-vigilant, but he was reluctant to soften it or fight it fully as he valued its protective function. This (in addition to overpresent emotional/behavioural avoidance throughout the whole therapy) perhaps reflected his moderate change in anxiety symptoms. Nevertheless, towards the end of therapy Mark reported that he was able to go out and socialise, without drinking. He also signed up for a coaching course, which was extremely scary for him, required that he participate in numerous social situations and involved travelling; nevertheless he was able to successfully enagge in it. He has taken the first steps towards starting a career that he could only dream of in the beginning of therapy.

3.6.3 Measures

3.6.3.1 Analysis of Quantitative Pre-Post-Outcome Measures.

Mark's scores are presented for pre-, mid-, post-therapy, and at six month follow-up in Table 3.6.1.

Table 3.6.1 Mark's Pre-Post-Outcome Scores

Scale	Caseness	RCI	Pre-Treatment	Mid-Treatment	Post-Treatment	6 Month Follow up
GAD-7	10	5	19	12	9	15
GADSS	7	n/a	18	12	14	12
BDI-II	10	9	36	31	10	24
CORE-OM	1.29	0.48	2.05	1.55	0.88	0.91
PSWQ	45	9	67	66	58	57
PSWQ-PW	n/a	28	61	72	38	47

Note: Caseness = the cut-off for determining whether client is clinically distressed. RCI=Reliable Change Index; GAD-7 = Generalised Anxiety Disorder–7; GADSS = Generalised Anxiety Disorder Severity Scale; BDI-II = Beck Depression Inventory; CORE-OM = Clinical Outcomes in Routine Evaluation – Outcome Measure; PSWQ = Penn-State Worry Questionnaire; PSWQ-PW = Penn-State Worry Questionnaire (Past Week).

At the beginning of therapy, Mark's score on the GAD-7 was 19, indicating that he was in the *severe* range for GAD. By the mid-point of therapy, his score had reduced to 12, which placed him in the *moderate* range for GAD, and by the end of therapy, his score had reduced to 9, which placed him in the mild, non-clinical range for GAD. Mark's post-treatment assessment reveals that his pre-post differential of 10 meets the criteria for reliable change, which, in conjunction with his post treatment score of 9, indicates that he has *recovered* on this measure. Mark's six-month follow-up assessment indicated that his score on this measure had slipped back to 15, which would place him once more in the *severe* range for GAD on this measure.

Mark's pre-therapy, total score on the GADSS of 18 placed him in the *severe distress/impairment* range of GAD. By the time the mid-point of therapy was reached, his total score had reduced to 12, placing him in the *moderate distress/impairment* range on this measure. By the end of therapy, however, his total score had increased slightly to 14, placing him back in the *severe distress/impairment* range of distress, suggesting that he remained clinical on this measure. At his six-month follow-up assessment Mark's total score had dropped once more to 12, indicating that he was once more back in the *moderate distress/impairment* range.

On the PSWQ, Mark's pre-therapy assessment score of 67 placed him in the clinical range on the measure. His mid-point assessment score of 66 suggested little change had occurred, while his post-treatment score of 58 suggests some improvement, although he remained in the clinical range on the measure. Mark's pre-post differential met the criteria for RCI, suggesting reliable change had occurred, indicating that he had *improved* according to this measure. At his six-month follow-up assessment, Mark scored 57 on the PSWQ, suggesting that he remained relatively stable on this measure. His pre-therapy score of 61 on the PSWQ-PW, by the mid-point of therapy, this score had increased to 72. By the end of therapy, at his post-treatment assessment, Mark's score on the measure had fallen dramatically to 38. His pre-post differential satisfies the criteria for RCI suggesting that reliable change between mid-treatment and post-treament has occurred. At his six-month follow-up assessment, Mark's score of 42 suggested that he remained relatively stable in terms of state-worry.

During his pre-treatment assessment, Mark scored 2.05 on the CORE-OM, which indicated that he was in the clinical range of distress on this measure. By the mid-point of therapy, this score had reduced to 1.55 which, despite suggesting improvement, remained in the clinical range. By the post-treatment assessment at the end of therapy, however, Mark's

score had fallen to 0.88 which placed him in the non-clinical range. His pre-post differential also met the criteria for RCI, suggesting that reliable change had occurred and that Mark had *recovered* according to this measure. At his six-month follow-up assessment, Mark's score of 0.91, which confirmed him in the non-clinical range, suggested a degree of post-treatment stability, as measured by the CORE-OM.

Mark's score of 36 on the BDI-II at the beginning of therapy indicated that he was experiencing *severe* clinical depression according to this measure. By the mid-point-of therapy, this score had reduced to 31 which while indicating some alleviation of symptoms, remained in the *severe* clinical range of depression. By the end of therapy, however, at his post-treatment assessment, Mark's score on the BDI-II had fallen to 10 which placed him in the *minimal* clinical range of depression. Although Mark remained clinical on the measure, his pre-post differential suggests that reliable change has occurred and that Mark has therefore *improved* on this measure. His score of 24 at the six-month follow-up assessment suggests the return of some of his depressive symptomatology as he is now in the *moderate* clinical range of depression.

3.6.3.2 Analysis of Process Measures

Target Complaints (TC)

Prior to each therapy session, Mark completed a Target Complaints form. The information provided by this measure is presented in Table 3.6.2

Table 3.6.2 Mark's Target Complaints Data

Complaint	**Pre-therapy**	**Mid-therapy**	**Post-therapy**	**Pre-post difference**
Anxiety	12	7	5	7
Feeling Alone	10	10	4	6

Worry about my future	10	10	6	4

As can be seen from Table 3.6.2, two of Mark's Target complaints, *"Anxiety"* and *"Worry about my future"* are directly connected to his diagnosis of Current GAD, whilst the third "Feeling alone" references anxiety but also hints at the low mood from which he reports suffering. At the beginning of therapy, all of Mark's self-reported scores on the Target Complaints are high, with anxiety being one point from the maximum possible score. By the mid-point of therapy, the Score for Anxiety has almost halved, while the scores for the remaining two complaints remains constant. By the end of therapy, however all of the Target Complaints listed by Mark show considerable improvement, with pre-post-differences of 7, 6 and 4 for *"Anxiety"*, *"Feeling Alone"*, and *"Worry about my future"* respectively.

Helpful Aspects of Therapy (HAT)

In common with other participants, Mark's comment regarding the most helpful aspect of his first therapy session refers the value he attaches to being heard by an attentive and empathic other (see Table 3.6.3), *"Found it all quite helpful just to talk about my anxiety and loneliness and get it out there"*. He observes that this experience affords him some relief and that he feels more comfortable with himself as a result of being able to share his experience *"Made me feel like a bit of a weight has been lifted off my shoulders and made me feel more at ease with myself"*. In Session 2 he comments on how exploring his sensitivity to perceived negative responses or attitudes towards him can be problematic, and frequently causes emotional distress, while Session 3, wherein he engages in a two-chair dialogue for a critical split, heightens his awareness of the extent to which his self-treatment is harsh and punitive, *"Made me realise I can be far too harsh on myself and it's holding me back. My criticism needs to be more constructive"*. A second two-chair dialogue in Session 4 deepens

Mark's understanding of this self-critical process as he becomes aware of the impact of constantly failing to meet impossible standards, *"Made me realise I'm punishing myself out of disappointment I have about myself"*.

Table 3.6.3 Mark's Helpful Aspects of Therapy form Data

Session	How helpful?	Helpful Event	What made it helpful	When in session?	How long did it last?
1	7	Found it all quite helpful just to talk about my anxiety and loneliness and get it out there.	Made me feel like a bit of a weight has been lifted off my shoulders and made me feel more at ease with myself.	No data	No data
2	7	Talking about my sensitivity to negative comments and reactions to me.	Made me realise not to be as sensitive.	Middle	5 – 10 minutes
3	7	The part when I had a conversation between myself and a negative side	Made me realise I can be far too harsh on myself and it's holding me back My criticism needs to be more constructive.	Middle	20 minutes
4	7	The role-play between myself and my feelings.	Made me realise I'm punishing myself out of disappointment I have about myself.	Middle third	20 minutes
5	7	The session in	No data	Start to finish	60 minutes

		total was good, just talking and realising why I feel the way I do at some times.			
6	No data	Not data	No data	No data	No data
7	7	The role-play with myself.	Makes me realise why I feel certain ways and gives me the belief to overcome the negatives I feel about myself.	Throughout	20 to 3-minutes
8	7	The role-play scenarios.	I realise why I feel certain ways about myself	Middle third	20-25 minutes
9	8	Role-play talking about/to my mam and dad about traits they have, I wish I had or wish I didn't have.	Made me realize what kind of person I crave to be in life.	Two thirds of session	30-40 minutes
10	No data	No data	No data	No data	No data
11	7	The role-play between myself bringing a scenario that made me feel uncomfortable as a child.	Made me realise things that happened then that made me feel the way I do now.	Mid-session	20-30minutes
12	8	Role-play during the session.	Makes me realise why I do or think certain things.	Last 30 minutes or so	30 minutes
13	7	The role-play dialogue between myself and a person whom	Made me realise what emotions I feel and why.	Two thirds of session.	30 or 40 minutes.

		I interact with.			
14	9	Dialogue between myself making realise why I feel certain things about myself.	Made me realise why I've felt such feelings, good and bad about myself.	No data	No data
15	No data	No data	No data	No data	No data
16	No data	No data	No data	No data	No data
17	8	Role play in the chairs.	Makes me realise why I feel certain feelings and emotions.	No data	30 minutes
18	No data	No data	No data	No data	No data
19	No data	No data	No data	No data	No data

In Session 5 Mark reiterates the positive aspect of being able to talk to someone about his issues and describes the increased awareness regarding his emotional experience as helpful. There is no data for Session 6, however in Session 7, Mark engages once more in a two-chair dialogue for a critical split which, he reports, facilitates him in improving awareness and instils confidence that he might be able to transform the way he feels about himself *"Makes me realise why I feel certain ways and gives me the belief to overcome the negatives I feel about myself"*. This is further elaborated on in Session 8.

Session 9 gives Mark the opportunity to engage in an unfinished business dialogue with his parents, exploring the way he experiences them alongside the way he experiences himself. In his estimation, the most helpful aspect of the session was that it *"Made me realize what kind of person I crave to be in life"*. Once again, there is missing data for Session 10, however in Session 11 Mark reports how further chair work, relating to a difficult episode from his past, has impressed upon him the manner in which historical episodes can influence current emotional processing *"Made me realise things that happened then that made me feel*

the way I do now". Sessions 12 to 14 repeat the value Mark places on the ever increasing awareness regarding his emotional processing and self-treatment gleaned from a succession of two-chair dialogues, in which Mark reports exploring the ambivalent feelings he holds towards himself *"Made me realise why I've felt such feelings, good and bad about myself"*.

Mark's HAT forms are not filled out for Sessions 15, 16. In his report on Session 17 he refers again to increased awareness of his emotional experience, while sessions 18 and 19, his final sessions have no data.

Retrospective Recall of Helpful and Unhelpful Aspects, and Client Reported Changes (Client Change Interview).

In his post-therapy Client Change Interview, Mark reports that while he still experiences good and bad days, on the whole he feels *"A lot better... well I do get anxiety but it doesn't faze me as much as what it probably used to"*. He describes how he has found the therapy experience helpful overall, especially in so far as coming from a small family who are not particularly close, he valued the opportunity to talk to someone; *"to let things out"*. In the past, although family asked him how he was feeling, he never felt that they really understood him, which was frustrating and upsetting; therapy was different *"...at least when I come here I can feel understood"*.

Mark recognises that the therapeutic relationship is different to his other interpersonal relationships, in that when he expresses his feelings of anxiety to his family (especially his mother) they try to tell him to "relax and breathe" which only serves to heighten his distress. He describes how in therapy, while he may feel that things are "going nowhere" at the beginning of the session, invariably, *"what he's [the therapist] saying just triggers something in my head"* and he begins to open up. Mark notes that he is unable to open up to his friends in this way, *"It's kind of because, as I say, I don't talk to people during the week, not that I*

don't talk to people, like I talk to my mates about football stuff like that, so it takes a while to trigger something to, not open up... but to think".

When invited to report on changes that he may have experienced as a result of coming to therapy, Mark describes himself as feeling more confident and willing to try out new experiences, *"I'm sick of staying in my comfort zone and I do, but you know but my comfort zone still had a little anxiety piece... so I try to push, maybe at the start I wouldn't go look for things to do, but now there's a chance I might do something a bit different".* He reports how in the past, if he had a bad day, the anxiety could *"cripple"* him for days afterwards, whereas now he *"feels a bit braver"* and is inclined to get on with things as soon as possible. He emphasises that he is no longer as self-critical as in the past and has developed a capacity for encouraging himself *"Yeah...One thing we did here, I was really critical of myself, now I'm more reassuring rather than critical, you know... ".*

Mark elaborates on the notion of his self-critical nature, commenting that *"... I used to criticise myself so much and I was very critical about myself, that I used to think everybody felt that way about me, so, as I was saying to (the therapist) when I was out, when I was getting anxiety, I just felt everyone was looking at me going "Jesus, he's a weirdo, there's something wrong with him" you know. I just felt everyone was going like that... so I just assumed everyone saw me as someone who was flawed, who failed. Now that's not as bad you know".* Tellingly, this extract reveals the attributional nature of Mark's negative self-treatment, in so far as he expects that others will feel towards him, the same way he feels about himself. He describes himself as judgemental and expects that others will be so.

Although neither family nor friends have explicitly commented on any of his reported changes, Mark describes feeling much more comfortable around others *"I feel it myself when I'm around people, I'm happier, now no-one's actually said that to me, but sometimes when*

I'm around people, I can be a bit more...you know... ". He describes how this newfound confidence would also extend to making conversation with strangers, although he acknowledges that it is still early days. Mark acknowledges that while treatment for his anxiety was his primary motivation for attending therapy, he was always aware of his issues with self-confidence, and is pleased with the gains he has made in this area. He cannot really think of anything that he wanted to change in therapy that has not changed.

Mark reports that he is somewhat surprised by the change in his anxiety levels occasioned by therapy. He remarks on his natural pessimism, his expectation that he will fail in everything he attempts, and observes that although he was interested in the idea of therapy his self-doubt led to him having low expectations in terms of therapeutic outcome. He is adamant, however, that no change would have taken place were it not for therapeutic intervention and he is inclined to view the change as very important to him personally. *"I went away to England for a few days and I bump into people who'd be into football I'd just chat to them, and I opened up to a bloke there as I was saying, and he goes I suffered with anxiety years back as well. I think that helped me, it's forced me to talk to people"*. His new confidence and reduced anxiety have opened up the possibility of engaging in contact with others at a level which would previously have been inconceivable.

Mark observes, in a poignant passage, how he never spoke about himself in the past, because he felt he was not worth talking about *"Because I probably just felt my life was crap, I'd just try and stay away from a conversation, and just go "Aw, did you see the rugby?", I don't want to talk about personal stuff because I don't feel what I do is important enough to talk about, or feel like I felt like, that's the critical nature in me, I don't want to talk about me or my life because it wasn't worth talking about...*". He feels that this is no longer the case; that as a result of therapy he has been able to make significant changes to his life *"...back probably a while ago I probably wasn't happy, whereas now the anxiety... I've changed job, I*

have a new job, and I've got more involved in other things, and I enjoy them things, I talk about them then, compared to the way I was a while ago...".

Mark attributes his changes, in part, to his therapist's perseverance, noting that he frequently became anxious and frustrated by the therapeutic process, but guided by his therapist, eventually "the penny would drop" and he would experience the episodes of increased self-awareness that he refers to so frequently in his HAT forms. He notes that one of the major inhibiting factors which impeded his progress was his lack of self-belief in the early stages of therapy. This became particularly evident to him in the chair-work when, out of deference, he would go through the motions; compliant, but lacking in conviction. *"maybe at the start if I'd believed in myself more... because like I'd, he'd make me do that kind of role play thing where I'd talk to myself... but I'd be saying things but I wouldn't believe it, I felt at first I was saying stuff just to say it, to keep him happy, and at first I wouldn't quite believe it... because I didn't have the confidence in myself to believe what I was saying".* Mark observes how, as therapy progressed and his confidence grew, he began to increasingly believe in what he was saying, *"...probably towards the end of it, the latter stages I did start believing it... I got a little more confident and believed it, when I said something, I believed it a little bit more..."*

When questioned about external factors which may have contributed to his therapy outcome, Mark stated that he could not think of anything in his life situation which made a significant contribution. Rather he felt that his own dogged approach, which would not let him give up until his confidence grew, was the major contributor to therapeutic outcome. At the same time, he did not feel that any aspect of his life situation made things particularly difficult for him.

As might be expected from viewing his HAT forms, Mark maintains that one of the most helpful aspects of therapy for him, was understanding where the anxiety came from, which is consistent with EFT's policy of making explicit the mechanisms underlying the various processes contained in therapy. This awareness helped him to confront his avoidance, *"At first if I'd see a scenario I'd just cross the road or go into a shop, whereas now if something happens, it happens, and not to run away from it, you know. Because then if I run away from it, that's my safety thing, I'm never going to come out if I keep running away. It mightn't be enjoyable at the time, it might knock you sideways, but the more hopefully I do it then hopefully the easier it gets..."* Mark was unable to identify any aspect of the therapy that was unhelpful or hindering.

Mark was, however, able to identify a particular aspect of therapy that was difficult at first, but was probably helpful in the long run. *"Sort of the first time I felt a little bit probed, because that's something I didn't like, I didn't like talking about myself, so at first I just felt very I'd come out feeling a bit drained because it was so much pushing and pushing and pushing. It wasn't that I didn't want to talk, but I wasn't used to it."*. This acknowledgement of the manner in which therapy directly challenged his avoidance is elaborated upon as Mark describes how the simplistic, yet socially acceptable, answers which served him in the past when people enquired as to his well-being, no longer served, *"I find it hard to put words on things because I wasn't used to it you know, asking me "How do you feel?", I've been used to saying the last 20/30 years "grand" and I don't know how I actually do feel, because I'd just say "fine""*. He reports that the entire process of becoming aware of his felt experience, symbolising it with language, and expressing it to another was a massive learning curve, which encouraged him to confront the avoidant manner in which he had been living up to the point of engaging in therapy.

With regard to his actual experience of participating in the research, Mark claimed to have no difficulty with the technical aspects such as screening, recording, completing questionnaires etc. *"no it's fine, it's just part of the process, so absolutely no problem doing anything like that..."* When pressed further, however, he ceased to distinguish between the research and the therapy in his answer, and proceeded to reiterate points made earlier regarding the helpful aspects of therapy.

3.7 Case Study 7, "Susan"

3.7.1 Introduction

Participant 007, who for the purposes of this study has been assigned the pseudonym "Susan", is a 35 year old Caucasian female, who was referred to the primary care service by her General Practitioner (GP). For a long time prior to engaging in therapy, Susan had been suffering from depression and anxiety. She had recently become disturbed by the level of anger which she was experiencing and which had erupted in a number of outbursts directed towards family members. She lives with her husband, who she describes as supportive. Susan engaged in 24 sessions of psychological therapy with an experienced EFT therapist.

Prior to commencing therapy, Susan completed a Structured Clinical Interview for DSM-IV-TR Axis I Disorders; Non-Patient Edition: Research version. SCID-I/NP-R. Her results indicated that she met the DSM-IV-TR diagnostic criteria for Current GAD and Major Depressive Disorder. Her score on the Global Assessment of Functioning scale was 60, which suggests moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social occupational or school functioning (e.g. few friends, conflicts with peers or co-workers) *(SCID-I/P; First, Spitzer, Gibbon & Williams, 2002)*. Susan also completed the SCID-II for assessing DSM-IV-TR Axis II personality disorders which indicated that she met the diagnostic criteria for Avoidant, Obsessive-compulsive, Passive-aggressive and Paranoid personality disorder and met sub-threshold criteria for Paranoid and Borderline personality disorder.

3.7.2 Therapist's Interpretation of Therapy, Case Formulation and Emotion Transformation

Therapist Perspective

The therapist reports that work with Susan was quite complex. Initially she reported feeling quite drained after the sessions, particularly if work involved experiential (chair) work. The therapist noted that later on, even when he had a sense that the alliance and the relationship had settled down and that they had a good working collaboration, her mood could be dramatically affected by events that had happened during the week. (In some instances these were really major events – e.g., serious health concerns). Susan was also quite distressed and easily fell into hopelessness and just anger (albeit, unproductive), particularly towards an undermining mother (but also some friends). Hopelessness and anger were so pervasive that occasionally it was difficult to process other aspects of experiencing.

Despite this, the therapist had a sense that the therapy progressed well, although he was aware that she could easily become upset during the week, between sessions. Also, as therapy was about to finish, she had a serious health scare and expressed a wish that therapy might be extended (which in the therapist's clinical judgment was a good thing) however, the number of the sessions was limited by the project and the service itself (the service normally offers 8 sessions and, in exceptional circumstances, 16). The work with Susan concluded as soon as she was somewhat improved and had a sense that she could be on her own. Optimally the therapist would have preferred to have worked in a long-term capacity. They met for one booster session after six months, and Susan reported that in general she felt quite well, although she was currently distressed about an incident with her mother (which was the reason for the session). She reported that she still missed the therapy and would have liked it

to continue. She was referred to alternative possible services, which might be beneficial for her.

Case Formulation

Susan presented with a lot of fear and pervasive worry. She was scared of being personally harmed, and feared that her loved ones (parents, children, husband, siblings, etc.) might also be harmed. She worried about how she would cope at work, home, etc., fearing triggering, or potentially triggering, situations where, for example, she might be criticized (at work, or by her mother), or when her loved ones might be criticized (e.g., her husband) or when she or her loved ones were threatened by potential health issues. Susan engaged in a great deal of worry and worked hard to ensure that nothing bad (primarily criticism) could happen. She then became exhausted and blamed herself for not being on top of things, or criticized herself for not achieving what she could have achieved. Underlying painful feelings centered on the sense of not being good enough (particularly for her mother) and thus not feeling fully lovable, or indeed, loved. She also feared some ultimate disaster, a feeling that she perhaps introjected from her mother who was a big worrier and always expected the worse from people and situations. Although she felt quite angry for being undermined and criticized by her mother, Susan was ambivalent about the anger as she felt bad about being angry at her mother and also she felt that perhaps she was doing something wrong in order to deserve her mother's questioning/doubting of her. She had unarticulated needs, connected to core painful emotions of not being loved, accepted, protected or self-sufficient.

Emotion Transformation

The work on emotion transformation was somewhat impacted by the level of the Susan's initial distress (unprocessed hopelessness and anger and then feeling bad about the anger and hopelessness). Despite in-session progress, she could easily relapse if something

difficult occurred during the week (particularly in relation to her mother, unsupportive friends or health issues that she had while in therapy). It was difficult to tease out her underlying pain as she had difficulty staying with feelings of not being loved as she would have wished, falling easily into hopelessness and helplessness (global distress). She also had great difficulty accessing self-compassion, which mirrored the reality of her relationship with her mother. Nevertheless, as therapy progressed, Susan showed signs of becoming more self-compassionate. She also was able to turn her (easily triggered) reactive anger into a more protective and self-assertive, subtle, anger, although it was always a very thin line, and any perceived injury brought more of the reactive, rejecting anger. Nevertheless, she quite often reported (in sessions in the second half of therapy) that she felt more relieved, hopeful and confident inside. She also spontaneously communicated that she felt heard by the therapist and frequently expressed the wish that therapy could continue (this also reflected her anxiety of being without the support of therapy [and the Therapist]).

With regard to her worry, Susan could see how it protected her from ending up facing rejection or other disaster. She could also see how worry was tied up with self-criticism, in so far as, if she ended in a *'disaster'* (e.g., rejected or criticised by somebody), she would blame herself, believing that it was her fault. In some of her worry dialogues she was able to see that although she might want to give up the worry and was able to stand up for the self against the worry agent, this was quite tentative. She was aware that if something bad happened during the week, she would quickly recommence worrying; almost by default (the worry was very ingrained). She also worried almost out of self-punishment (because it was tiring her), so if something went wrong, she worried, but also ruminated over what could be wrong and what she could have done differently.

3.7.3 Measures

3.7.3.1 Analysis of Quantitative Pre-Post-Outcome Measures.

Susan's scores are presented for pre-, mid-, post-therapy, and at six month follow-up in Table 3.7.1.

Table 3.7.1 Susan's Pre-Post Outcome Scores

Scale	Caseness	RCI	Pre-Treatment	Mid-Treatment	Post-Treatment	6 Month Follow-up
GAD-7	10	5	18	15	14	14
GADSS	7	n/a	17	10	14	13
BDI-II	10	9	19	14	9	18
CORE-OM	1.29	0.48	2.05	1.79	0.94	0.94
PSWQ	46	9	57	No Data	59	60
PSWQ-PW	n/a	28	69	75	68	52

Note: Caseness = the cut-off for determining whether client is clinically distressed. RCI=Reliable Change Index; GAD-7 = Generalised Anxiety Disorder–7; GADSS = Generalised Anxiety Disorder Severity Scale; BDI-II = Beck Depression Inventory; CORE-OM = Clinical Outcomes in Routine Evaluation – Outcome Measure; PSWQ = Penn-State Worry Questionnaire; PSWQ-PW = Penn-State Worry Questionnaire (Past Week).

At the beginning of therapy, Susan's score of 18 on the GAD-7 indicated that she was in the *severe* clinical range of distress. By the mid-point of therapy, her score had reduced to 15, indicating that she was still in the *severe* clinical range, and by the end of therapy, her score of 14 indicated that she was now in the *moderate* clinical range of distress on this measure. Susan's pre-post differential of 4 does not meet the criteria for RCI, which suggested that reliable change had not occurred, while reference to the cut-off point indicated that the client was still in the *clinical* range of distress. Susan's six-month follow-up assessment score of 14 suggested that she had neither improved nor deteriorated on this measure.

Susan's pre-treatment, total score of 17 on the GADSS placed her in the *moderate distress/impairment* range. At her mid-point of therapy assessment, her total score of 10

placed her in the *mild distress/impairment* range of distress; however, by the time of her post-treatment assessment, her total score had increased to 14, which placed her in the *moderate distress/impairment* range on this measure. Susan's score of 14 suggests that she meets the criteria for casement on this measure. At the time of her six-month follow-up assessment, Susan's total score of 13 confirmed that she was still in the *moderate distress/impairment* range of distress.

On the PSWQ, Susan's pre-treatment assessment score of 57 placed her in the *clinical* range. There is no data for her mid-point assessment score on this measure; however, by her post-treatment assessment Susan's score had increased marginally, to 59, suggesting that she remained clinical. Her six-month follow-up score of 60 indicated no change. On the PSWQ-PW, Susan's pre-treatment score was 69; by the mid-point of therapy, her score had dis-improved to 75, and by the post-treatment assessment, her score of 69 suggested that no reliable change had taken place. Susan scored 52 on the PSWQ-PW at her six-month follow-up assessment.

Susan scored 2.05 on the CORE-OM at her pre-therapy assessment, which placed her in the *clinical* range. Her mid-point assessment score of 1.79 indicated that she was still in the *clinical* range at this point in treatment; however, her post-therapy assessment score of 0.94 placed her in the *non-clinical* range and her pre-post differential suggested that reliable change had occurred, indicating that she had *recovered* according to this measure. At her six-month follow-up assessment, Susan's score of 0.94 suggested that she remained stable on the CORE-OM.

At her pre-treatment assessment, Susan scored 19 on the BDI-II which placed her in the *mild*, clinical range on the measure. By the mid-point of therapy this had reduced to 14, which remained in the *mild* clinical range of depression, however by the time of her post-

therapy assessment this had fallen further to 9, which indicated that she was now in the non-clinical, *minimal* range on this measure, and below the cut-off for casement. Susan's pre-post differential on this measure satisfied criteria for RCI which suggested that reliable change had occurred. Data suggested that Susan had *recovered* on this measure. By the time of Susan's six-month follow-up interview however, her score had risen to 18, which placed her in the clinical *mild* range on the measure.

3.7.3.2 Analysis of Process Measures

Target Complaints (TC)

Prior to each therapy session, Susan completed a Target Complaints form. The information provided by this measure is presented in Table 3.7.2

Table 3.7.2 Susan's Target Complaints Data

Complaint	Pre-therapy	Mid-therapy	Post-therapy	Pre-post difference
Worrying about how my anxiety and worry affects who I am.	10	12	10	0
Worrying about family issues.	10	13	6	4
Worry about my future.	10	12	11	-1

As can be seen from Table 3.7.2, all of Susan's target complaints are related to her GAD diagnosis. In addition to worrying about family issues and her future, she also reported worrying about how her anxiety and worry affected her identity which references the Type Two worry (meta-worry) described by Wells (1995) as representative of GAD. At the

beginning of therapy, Susan scored all of her Target Complaints equally (10), however by the mid-point of therapy they had deteriorated. By the end of therapy her score on "*Worrying about how my anxiety and worry affects who I am*" had returned to the pre-therapy level of 10, while her scores on worry about family issuers and the future had settled at 6 and 11 respectively.

Helpful Aspects of Therapy Form (HAT)

Unfortunately, there is a relative paucity of data in Susan's HAT forms (see Table 3.7.3), which may reflect the occasional difficulty she had in engaging with the "research" aspect of the study. While the early forms provide a fairly consistent amount of information, second half of therapy evinces a distinct fall-off in the quantity of material volunteered. By Sessions 12 and 13, Susan stopped filling in forms altogether, and while she resumed completing them by Session 14, she had stopped again by Session 18.

Table 3.7.3 Susan's Helpful Aspects of Therapy form Data

Session	How helpful?	Helpful Event	What made it helpful?	When in the session?	How long did it last?
1	8	The Therapist acknowledging my feelings.	It made me feel comfortable and understood.	Throughout.	
2	9	Acknowledging that I take huge responsibility to make others happy.	The realisation that I do this and that I need to put myself first from time to time and that it's ok to do so.	Near the end.	Few minutes
3	8	Role-play. Therapist acknowledging that he thought I was kind/caring.	I got to hear what I was feeling inside. Appreciated and understood.	No data	Most of the session.

4	9	My therapist really listening and understanding what I'm saying.	I felt comfortable to express myself. It gave me trust in my therapist.	Halfway	Most of the session
5	8(but I feel wrecked)	The chair dialogue.	It made me realise how critical I am of myself.	Most of the session.	
6	9	The therapist got me to separate and detach various issues I was dealing with and set them aside. A visualisation/meditation technique.	The meditation made me feel relaxed. Relieved the tension pain in my chest.	Whole session.	First three quarters.
7	8	Role-play.	Being able to separate myself from my thoughts.	No data	Throughout
8	8	Role-play	Help me to express/release.	Halfway	Half hour
9	No Data	No Data	No Data	No Data	No Data
10	8	Role-play	Awareness of my feelings about a particular situation.	Halfway	Rest of session.
11	8	Role-play task	Hearing myself speak out about anxieties. Therapist understanding and appreciating who I am.	Halfway	Rest of session.
12	No data	No data	No data	No data	No data
13	No data	No data	No data	No data	No data
14	8	Chair-work/role-play	Figuring out why I feel certain things. Being able to put a word to describe it.	Throughout	Most of session.
15	9	Role-play	Acknowledging the critic in me.	Halfway	Rest of session.

16	No data	No data	No data	No data	No data
17	9	Role-play (Child with tied wings)	Realising I criticise myself so much.	Throughout	No data
18	No data	No data	No data	No data	No data
19	No data	No data	No data	No data	No data
20 - 24	No data	No data	No data	No data	No data

In Session 1, as appears to be the case with most participants, Susan refers to the supportive and validating experience of being heard by an empathic listener, *"the therapist acknowledging my feelings"* which she observes, made her feel *"comfortable and understood"*. In Session 2 Susan describes a moment of insight as she becomes aware of the burden of responsibility she feels in relation to ensuring the wellbeing of others *"acknowledging that I take huge responsibility to make others happy"*, which is coupled with the realisation that occasionally prioritising her own needs is both necessary and acceptable *"...that I need to put myself first from time to time and that it's ok to do so"*. When Susan engages in her first experience of chair-work in Session 3, a task which gives her the opportunity to *"hear what [she] was feeling inside"*, the helpful aspect of the session which she identifies concerns the therapist's validation of her as a *"kind/caring"* person; noting that she feels *"appreciated and understood"*.

Session 4 extends and deepens the theme of a developing therapeutic alliance, and it is particularly significant, given Susan's interpersonal issues around trust, that she readily expresses the degree to which she trusts her therapist *"My therapist really listening and understanding what I'm saying... I felt comfortable to express myself. It gave me trust in my therapist."* In Session 5, Susan once again refers to chair-work, noting that while it has allowed her to realise how critical of herself she can be, she is exhausted after the process. In Session 6, Susan describes engaging in a *Clearing a Space* task, which she refer to as a

"visualisation/meditation technique". She reports how, in this task she is able to bring the various issues that she is dealing with to awareness and set them to one side in a way that provided her with relief from the psychological and physiological symptoms which had been troubling her *"The meditation made me feel relaxed. Relieved the tension pain in my chest."*

From sessions 7 to 11, the aspect of therapy which Susan reports finding most helpful is the chair-work, which she refers to as *"role-play"*. She refers to processes such as *"being able to separate myself from my thoughts", "Awareness of my feelings about a particular situation"* and *"Help me to express/release"* as helpful. These are all consistent with EFT's focus on bringing to awareness, symbolising in language, and then expressing to an empathic other, hitherto inaccessible emotional material. Once more, she notes the positive aspect of being heard and understood, *"Hearing myself speak out about anxieties. Therapist understanding and appreciating who I am"*.

There is no data for Sessions 12 and 13. Susan's commentary on Sessions 14 to 17 refers to the ongoing use of chair-work to explore her emotions and, in particular, focuses on work with her critic *"Acknowledging the critic in me", "Realising I criticise myself so much"*. There are no data for Sessions 18 to 24; 18 and 19 were returned blank, and no H AT forms were issued thereafter.

Retrospective Recall of Helpful and Unhelpful Aspects, and Client Reported Changes (Client Change Interview).

As part of her post-treatment assessment, Susan participated in a Client Change Interview. When asked what, if anything, had changed for her as a result of being in therapy, she responded by describing how, in general, she felt she had been rescued from low mood and anxiety, *"I definitely haven't gone back to a very dark place where I felt I can't do anything. I can live with the fact that I have worries and I have irritations, whereas before I*

used to get so into it that I would get very depressed." She remarks on how she valued therapy as a weekly occurrence, which helped her to manage her symptoms on a day by day basis *"I miss therapy because it kept me on top of it [the anxiety/worry]; I'm still able to not let it get that far"* and notes how, overall, the experience of being in therapy promoted self-awareness *"It's helped me to observe or realise what I've been feeling for years"*.

In terms of aspects which Susan would have liked to see change as a result of therapy, but which have not, she describes initially having had the expectation that therapy might be able to solve everything, *"I feel like I thought that doing all of this work that it would eventually all go away, but I feel like I've come to the stage where I'm just going to have to live with some of this, that's nothing's going to change"*; Susan recognises the necessity of accepting that which she currently feels she cannot change. When asked, she is unable to identify any aspect of therapy which might have been unhelpful.

Again, when invited to comment on any of the major changes attributable to therapy, Susan responds in rather general terms, for example, *"I definitely got rid of...it definitely lifted a huge weight off my chest. I definitely feel more free."* When encouraged to elaborate on this, she is unable to provide information on specific changes which have occurred. She points out, however, that the general sense of change which she feels has taken place would not have occurred had she not been in therapy. She notes that some personal qualities have contributed to her ability to engage effectively in therapy *"I suppose I'm honest, and open to it"*, but also highlights other aspects of her personality which, she feels, may have made things more difficult for her *"The fact that I'm very self-critical or that I suffer from guilt that I think that. Sometimes maybe when we vocalise things I'd be fine for a while and then later I'd feel quite crap [for having said it]"*. Susan remarks that the greatest external source of support throughout the whole experience has been her husband.

In response to a question asking her to identify specific helpful or hindering aspects of therapy, Susan reports that, for her, the outstanding helpful aspect was the bond she felt developed with her therapist, rather than any one particular task or technique, *"Having [the therapist] listen and understand, and they are the real things I remember...the relationship with him, more than the role playing thing we did."* She does, however refer to the session when she did the Clearing a Space task (also mentioned in HAT form; Session 6), which she found helpful *"There was one session where he was asking me to take all my worries and put them in places, I definitely remember that bit. So I've been trying to do a bit of that...that works sometimes."* Although she also found the Unfinished Business dialogues with her mother to be quite helpful, she maintains, overall, that the most nourishing and supportive aspect of her therapy experience was essentially relational *"I more remember having that kind ear, the person who was kind and listening and understanding and helped me to observe things more clearly".*

In the final portion of the interview, Susan is asked if there was anything missing or absent from her therapy and, perhaps unsurprisingly given the amount support she derived from the relationship, she comments on the brevity of the treatment *"Nothing missing, but I would have liked more."* She reiterates that *"It was all very helpful"*, and makes reference again to the immediate impact of each session on her mood *"I always felt like...every time after I left I felt so relieved...I felt like...lighter,"* adding the caveat *"For me it was quite immediate...I needed it the next week, like"* suggesting that she may have benefitted from a more long term intervention in order to meet her more complex needs. Susan claims that she didn't mind participating in the research program, but this statement is at variance with her behaviour at certain points in the course of treatment. She also noted some ongoing discomfort at the thought of being recorded.

3.8 Case Study 8, "Fiona"

3.8.1 Introduction

Participant 008, who for the purposes of this study has been assigned the pseudonym "Fiona", is a 28 year old Caucasian female, who was referred into the service due to a history of low mood and chronic anxiety. Initial intake at the service confirmed that Fiona worried almost continuously about a broad range of issues such as health, interpersonal relationships and work. At the time of treatment Fiona was living in the family home, which was a source of considerable stress for her due to a complicated relationship with her father. Fiona engaged in 27 sessions of therapy with an experienced EFT therapist.

Prior to commencing therapy, Fiona completed a Structured Clinical Interview for DSM-IV-TR Axis I Disorders; Non-Patient Edition: Research version. SCID-I/NP-R. Her results indicated that she met the DSM-IV-TR diagnostic criteria for Current GAD and Major Depressive Disorder. Her score on the Global Assessment of Functioning scale was 61 which suggests some mild symptoms with difficulty in work or social functioning, but generally functioning reasonable well, with some meaningful interpersonal relationships (SCID-I/P; First, Spitzer, Gibbon & Williams, 2002).. Fiona also completed the SCID-II for assessing DSM-IV-TR Axis II personality disorders which indicated that she met the diagnostic criteria for Avoidant, Obsessive-compulsive, Depressive, Paranoid and Borderline personality disorder.

3.8.2 Therapist's Interpretation of Therapy, Case Formulation and Emotion Transformation

Therapist Perspective

The therapist reports that work with this client was extremely difficult. From the beginning of therapy, Fiona was quite fragile and distressed. She was prone to being easily upset, by any number of triggers during the week, which would leave her feeling very low. The therapist believed she would have benefited greatly from a long-term therapy, perhaps combined with medication. He observed that she was initially quite avoidant in the sessions, trying not to show how distressed she really was inside. Fiona experienced a profound crisis when she had to leave her job due to becoming overwhelmed by it (she effectively walked out because she was too upset to stay) and this became the focal point of therapy. She was terrified to go home, because she anticipated that her father would not accept either the fact that she had left work, or her reasons for doing so. At this point she contacted the research assistant (on a Saturday morning), communicated to him that she could not go home, and reported that she felt actively suicidal. The therapist then contacted her by telephone. She appeared confused and in acute distress on the phone (she still appeared to be acutely suicidal), which led him to decide to meet with her immediately. The therapist then spent two hours with her in a crisis intervention. They agreed a practical plan for the weekend and set up routine check-ins so he would know she was safe. By the time they parted, she appeared to the therapist to be much calmer.

Nevertheless, her father then contacted the therapist by telephone, stating that he feared that she was actively suicidal. Accordingly, an arrangement was made for her to be seen her being seen in A&E by a psychiatrist. From that day on, Fiona commenced attending a day hospital (three days a week). The therapist also met with her on the first day after she

was in A&E to provide support. For a while, therapy changed into the provision of supportive sessions, which were not recorded. Recording recommenced after session 20. Ultimately, the therapist was required to end their work together because of the external limit on the number of sessions (imposed by both the project and service). Fiona still was seen for considerably more sessions than would have normally have been provided by the service. Towards the end of their work together, the therapist felt that she stabilised somewhat (although she was still quite fragile).

Eventually, Fiona finished attending the day hospital and reported starting a new job. The therapist also provided her with several options in case she wished to continue with counselling somewhere else. The therapist reports having had one email contact with Fiona since the conclusion of therapy and was given to understand that she was engaged in counselling elsewhere. He is aware (from the 6 months follow-up) that she has had quite a good six months, however, at the time of follow-up she was becoming quite upset again, as her job was finishing, and she was worried about the future.

Case Formulation

Although Fiona presented with a great deal of GAD symptomatology, the therapist believes that her underlying dynamic was more consistent with borderline features. Fiona reported feeling quite fragile inside from early on in her personal history. She felt profoundly undermined by her father, who was himself, quite unhappy. She also witnessed her mother's suffering due to chronic mental health difficulties that impaired her life. Naturally, this led to a great deal of insecurity (and also internally felt shame) quite early on in Fiona's childhood; which was further complicated by her being bullied at school, leaving her insecure, alone, unsupported, and full of doubt, She constantly struggled with feelings of worthlessness and

low esteem. Occasionally she rebelled against being invalidated, but this led to her being in foster care for a while which did not help her sense of security in any way.

Fiona also struggled academically (possibly because she could not concentrate due to high levels of distress in her life and her lack of self-confidence). For the first time in her life, she was trying to be more independent, however this was complicated by the fact that she still lived in her parents' house, and felt persecuted and undermined by her father. She was also very aware of her mother's distress and worried about her constantly (her mother is home constantly due to chronic mental ill-health). Although she was trying to start her independent work career, (which is quite difficult because of her stress) she felt quite negative about her career prospects, which filled her with hopelessness.

From the perspective of GAD symptomatology, Fiona's core pain is triggered by invalidation and attacks (primarily judgment/rejection – currently from her father, at work, people in social circles (friends, acquaintances); historically it was her father, bullies at school, and fragility about witnessing her mother's distress. Fiona's underlying pain is based around insecurity/fear (of unstable, unpredictable experiences), shame (sense of worthlessness (she feels undermined by people around her, and over-identification with the difficulties of people around her), and a profound sense of isolation and loneliness. She ends up in global distress, characterised by hopelessness and anxiety. Fiona judges herself quite harshly, blaming herself (in a very similar manner to the way her father blames her) for her own suffering and weakness. Her worries are centered on the above mentioned triggers and her awareness of the unbearable nature of the experiences they might bring. Her unarticulated, unmet needs are to be loved and accepted, connected and secure.

Emotional Transformation

Emotion transformation was only the focus of therapy, in a very limited way, as after her crisis (the situation at work and subsequently fear of going home), most of Fiona's therapy focused on the provision of support and assistance with coping. Eventually, the therapist reported that they were able to do some more transformative emotion-focused work, but it was always done carefully and only to a certain extent, as she remained quite fragile until the end of therapy. Eventually, however, Fiona became slightly more able to stay with her felt core pain (although this could only be managed in small doses). She was able to articulate some of her needs. Fiona had a few experiences when she was very self-compassionate (her faith in God was quite pivotal and she reported feeling God's love and support). She was also able to stand up for herself in dialogue with her (imaginal) father and in the worry dialogue, where she was able to stand up to the Worry Agent, suggesting an ability to access protective anger. Fiona was very compassionate towards herself as a little girl who was bullied, and had very moving dialogues with that younger self. As she remained quite fragile, the end of the therapy focused more on practicalities, such as how she might resource herself in the future, when dealing with difficulties (e.g., The therapist provided her some options for affordable counselling), They also discussed the practicalities of her starting in new jobs (e.g., how to access support in the workplace). Fiona also joined a self-help group.

3.8.3 Measures

3.8.3.1 Analysis of Quantitative Pre-Post-Outcome Measures.

Fiona's scores are presented for pre-, mid-, post-therapy, and at six month follow-up in Table 3.8.1.

Table 3.8.1 Fiona's Outcome Scores

Scale	Casement	RCI	Pre-Treatment	Mid-Treatment	Post-Treatment	6 Month Follow up
GAD-7	10	5	19	12	11	13
GADSS	6	n/a	16	14	12	13
BDI-II	10	9	36	11	11	14
CORE-OM	1.29	0.48	2.14	1.17	0.64	1.20
PSWQ	45	9	76	76	50	60
PSWQ-PW	69	28	73	34	34	56

Note: Caseness = the cut-off for determining whether client is clinically distressed. RCI=Reliable Change Index; GAD-7 = Generalised Anxiety Disorder–7; GADSS = Generalised Anxiety Disorder Severity Scale; BDI-II = Beck Depression Inventory; CORE-OM = Clinical Outcomes in Routine Evaluation – Outcome Measure; PSWQ = Penn-State Worry Questionnaire; PSWQ-PW = Penn-State Worry Questionnaire (Past Week).

At the time of her pre-treatment assessment, Fiona scored 19 on the GAD-7, which indicated that she was in the *severe* clinical range of distress. By the mid-point of therapy her score had fallen to 12, which placed her in the *moderate* clinical range for GAD symptomatology and in her post-treatment assessment, her score had further fallen to 11, which while remaining in the *moderate* clinical range, satisfies the criteria for RCI. This indicates that reliable change has occurred, suggesting that Fiona has *improved* on this measure. At the time of her six-month follow-up assessment her score was 13 which suggests that while still in the clinical range, the level of Fiona's GAD symptomatology remains *moderate*.

Fiona's pre-treatment, total score of 16 on the GADSS placed her in the *severe distress/impairment* range. At the time of her mid-point of therapy assessment, Fiona's total score of 14 confirmed that she was still in the *severe distress/impairment* range; while her end of therapy assessment yielded a total score of 12, which placed her in the *moderate distress/impairment* range. Six months later, in her follow-up assessment, Fiona's total score of 13 which confirmed that she was back in the *severe distress/impairment* range of clinical distress on this measure.

On the PSWQ, Fiona's pre-treatment score of 76 places her in the *clinical* range of distress on the measure. By the mid-point of therapy her score remained at 76, however by the end of therapy, in her post-treatment assessment, Fiona's score on the PSWQ had fallen to 50 which suggested that although *reliable change had occurred*, she remained in the *clinical* range. At the time of her six-month follow up assessment, Fiona scored 60, which confirmed that she was still in the *clinical* range on this measure, but maintained *reliable* improvement. Fiona's score on the PSWQ-PW at the time of her pre-treatment assessment was 73, however by the midpoint of therapy this had fallen to 34. In her end of therapy assessment, Fiona's score on the PSWQ-PW remained constant at 34 indicating that *reliable change had occurred*. However, by the time of her six-month follow up, her score had increased to 56.

Fiona's score of 2.14 on the CORE-OM at her pre-treatment assessment placed her in the *clinical* range of distress. Her mid-point assessment score of 1.17 moved her in to the *non-clinical* range, and her score of 0.64 in the post-treatment assessment confirmed that she was now in the *non-clinical* range and indicated that *reliable change had occurred*, which suggests that she had *recovered* according to this measure. Fiona's score of 1.20 at her six-month follow-up assessment confirms that she is still in the *non-clinical range* on the measure.

At her pre-treatment assessment, Fiona scored 36 on the BDI-II, which placed her in the *severe* clinical range on the measure. By the mid-point of therapy, this had reduced to 11, situating her in the *mild* clinical range of depression. In her post-treatment assessment, Fiona's score of 11 indicated that despite remaining in the mild clinical range, she exhibited *reliable change*, suggesting that she had had *improved* on the measure. Her score of 14 at the six-month follow-up assessment suggests that while still in the *mild* clinical range on the measure, the level of Fiona's depressive symptomatology has remained relatively stable.

3.8.3.2 Analysis of Process Measures

Target Complaints (TC)

Prior to each therapy session, Fiona completed a Target Complaints form. The information provided by this measure is presented in Table 3.8.2

Table 3.8.2 Fiona's Target Complaints Data

Complaint	Pre-therapy	Mid-therapy	Post-therapy	Pre-post difference
Work	12	11	11	1
Health	13	8	9	4
Family	10	7	10	0
Relationships	8	4	9	-1

Fiona's main concerns in therapy as expressed in her Target Complaints, focus on four domains, work, health, family and relationships; which she scores 12, 13, 10 and 8 respectively. By the completion of therapy, Fiona's rating on work has fallen to 11, yielding a pre-post-difference of 1; her rating on health has dropped to 9, yielding a pre-post-difference of 4; her rating on family remains at10 yielding no pre-post-difference; and her rating on relationships has increased to 9 yielding a pre-post-difference of -1.

Helpful Aspects of Therapy Form (HAT)

In Fiona's HAT form below there are a number of instances in which data are missing; when forms have been returned blank it is recorded as "No data", however when no form had been returned, it is recorded as No form. In Fiona's commentary on the helpful aspects of Session 1 (see Table 3.8.3), she focusses on her emotional experience, becoming aware of the degree to which her anxiety impacts her, *"dealing with what is happening emotionally and focussing on those feelings"* and *"I learned that I have a lot of stress and*

worry in my life. Especially starting a new job so my anxiety levels will rise" This awareness coincides with a realisation that she could be more self-accepting and less concerned with the opinions of others. In Session 2, Fiona engages in her first piece of chair-work, an unfinished business dialogue with her father, with whom she has a very difficult relationship. The helpful aspect of the session for her lies in the realisation that her emotions are a valuable source of information which can be of service to her in disputes with him *"I have learned to look inside to what I'm feeling when I have a confrontation with him".*

Table 3.8.3 Fiona's Helpful Aspects of Therapy form Data

Session	How helpful?	Helpful Event	What made it helpful?	When in the session?	How long did it last?
1	5	Dealing with what is happening emotionally and focussing on those feelings. I have learned that I need to focus on accepting myself instead of worrying on what other people think.	I learned that I have a lot of stress and worry in my life. Especially starting a new job so my anxiety levels will rise.	Halfway through	5 minutes
2	7	Using exercise with the chair to pretend I was speaking to my dad. I have learned to look inside to what I'm feeling when I have a confrontation with him.	I learned that I have to get in touch with what I'm feeling when I speak to him.	Start of the session.	30 minutes
3	No data	No data	No data	No data	No data
4	No data	No data	No data	No data	No data
5	No data	No data	No data	No data	No data

6	No data	No data	No data	No data	No data
7	No data	No data	No data	No data	No data
8-13	No form	No form	No form	No form	No form
14	7	I feel that the exercise with the chairs where I tried to stand up to the critical voice in my head helpful.	I feel that I need the critical voice in my head to be more encouraging and supportive. I feel the negative things it says have no real evidence and that I need more compassion and love from it. No data	Start of the session.	Throughout the session.
15-16	No form	No form	No form	No form	No form
17	8	I have learned that even though during the crisis I experienced two weeks ago before Christmas when I felt so depressed that the feeling does not last forever, that it quickly passes.	What made this event helpful is that I now understand that during a crisis I may feel suicidal, hopeless etc. but things that help are meeting with friends etc and that after doing this my mood quickly shifts. Basically I now know that in a month's/week's time my mood does change. When I feel good I tend to feel more positive about the future and more motivated to take action to improve how I feel.	Beginning	Throughout
18	8	To stand up to the critic in	Using the exercise with	Beginning	Throughout

		my head regarding my future and not having a job.	the chairs and realising that a lot of the critical thoughts are not helpful and will make things worse.		
19	7	Using my dad in the exercise using the chairs and realizing that I need him to give me freedom.	What made it helpful is articulating my feelings that and thoughts I have towards him.	Middle	10-15 minutes
20	7	I found that I'm clever and talented is just that I spend too much time worrying and thinking of the worst case scenario.	We looked at my former boss with dialogue and saw that the way treated me was not fair and that I didn't deserve to be treated badly.	Midway	10 minutes
21	8	My therapist said that I protect myself by worrying. I think that I think of the worst case scenario to prepare myself. Also when I don't stand up for my needs and say no to people, it can put a lot of pressure on me.	My therapist also said that one area of life that is particularly distressing for me is being unemployed. What I got out of this is that I worry about work to prepare myself if for example, if I have to emigrate.	Middle	10 minutes
22	8	I feel that I worry and feel scared about different things such as work because I need to	What made this event helpful is my therapist says that visiting times of pain when using the chairs	Start	Throughout

		protect myself from pain and prepare myself for the worst case scenarios. My therapist said that taking risks and standing up for myself will help me grow in confidence.	can help heal it and also will help me to stand up to the critical voice in my head.		
23	7	I brought emotions to the session that I don't normally bring. Even though I felt embarrassed and shy it made things clearer in my mind.	What made this event important is outlining what my needs are and that I deserve the best when it comes to being in a romantic relationship with someone.	Middle	Throughout
24	7	This week romantic relationship was bothering me the most. I felt pressurised by someone who didn't want a relationship which I did.	What made the event helpful was that I learned how to say "no" and recognise my own needs. It was a hurtful experience but will make me stronger in order to deal with other situations.	Beginning	Throughout
25	7	Trying to challenge the negative feelings and thoughts by ignoring them. I can't stop them but I can acknowledge them and then let them go. My therapist said that when	I will try and not let these negative thoughts take over my mind all of the time. Also by taking more risks it will make me stronger and braver to approach different	Middle	10 minutes

		I attend support groups that I shouldn't feel guilty about being positive and that if others are being negative I should not let it impact me.	situations.		
26	7	That when I'm not feeling too good and distressed that I don't hold back and that I confide in others so that I don't isolate. When I analyse negative thoughts in my head it is distressing, when I discuss it with someone it is easier.	I have learned that when I take a risk, e.g. Meeting new people that the next day that I keep myself distracted so that I'm not overanalysing thoughts.	Middle	Throughout
27	No form	No form	No form	No form	No form

For sessions 3 to 6 there is no data available, however when Fiona resumes filling in the HAT forms in Session 14, it is in reference once again to chair-work. This time the helpful aspect takes the form of a two-chair dialogue for a critical split, in which Fiona finds *"[trying] to stand up to the critical voice in my head helpful"* and observes that she needs the inner critic to soften and be more supportive, commenting that she needs more "compassion and love from it". In Session 17, Fiona refers to the first of a number of difficult episodes that she will experience during the course of her treatment. She describes as helpful, the understanding that even though she may feel depressed, the feeling will pass. Fiona also

mentions that there are things outside of therapy which she can use to resource herself in times of crisis *"I now understand that during a crisis I may feel suicidal, hopeless etc. but things that help are meeting with friends etc and that after doing this my mood quickly shifts"*.

In Session 18, Fiona once again refers to chair-work as helpful as she engages in another dialogue with her harsh inner critic, bringing home to her the impact on her psychological well-being of this hitherto unchallenged process, *"realising that a lot of the critical thoughts are not helpful and will make things worse"*. In an unfinished business dialogue with her father in Session 19, Fiona reports articulating the need that she be given more freedom by him as being helpful. In Session 20 she explores the impact of her worrying and in a dialogue with her former employer begins to understand that she deserves to be treated fairly *"the way treated me was not fair and that I didn't deserve to be treated badly."* Fiona explores the nature and function of her worry in Session 12 and also comes to the realisation that her inability to set boundaries leads to problems for her in the long run; she also tackles her fear of being unemployed. These themes are further explored in Session 13.

Fiona reports bringing different emotions into Session 23 as she discussed romantic relationships, which was difficult for her, but beneficial in the long run, *"Even though I felt embarrassed and shy it made things clearer in my mind"*. She found it helpful to assert her needs in this session, and to validate herself *"outlining what my needs are and that I deserve the best when it comes to being in a romantic relationship"*. In the following session she acknowledges having had to make a hard decision in terms of a romantic relationship, and reports that although it was painful, recognising her own needs in the situation was a validating experience. Fiona reports that the last two sessions deal with both her ongoing struggle with negative feelings and thoughts and also with her tendency to isolate herself from others when things are not going well. She describes the positive benefit of *"taking a*

risk" in terms of meeting new people, but recognises that she is prone to "overanalysing" the next day and needs to be mindful of this; recognising that talking with friends may be beneficial, rather than ruminating on her own. Session 26 produces the last completed HAT form and Fiona's comments suggest that while she is still increasing awareness of herself and her processes, she is still prone to moments of anxiety and low mood. *"When I'm not feeling too good and distressed that I don't hold back and that I confide in others so that I don't isolate. When I analyse negative thoughts in my head it is distressing, when I discuss it with someone it is easier"*.

Retrospective Recall of Helpful and Unhelpful Aspects, and Client Reported Changes (Client Change Interview).

Unfortunately Fiona's data could not be presented in the current study. Due to her distress she was unable to participate in mid-point and six-month follow-up interviews, and the data from her brief post- therapy assessment was accidentally erased. While the author can recall aspects of her interview, it was felt that they should not be included in the cross-case analysis. In her post-treatment interview, Fiona reported feeling stronger inside than she had ever felt before, She reported greater understanding and awareness regarding her internal emotional processes but felt that she was still at the mercy of powerful mood swings from time to time. She reported greatly valuing her relationship with her therapist, who she felt understood and supported. For her, this was the most helpful aspect of therapy. Fiona acknowledged that she found chair-work difficult and that she had problems with appearing distressed in front others. She believed that the therapy had made it possible for her to get on with her life but was frightened that things might not work out for her.

3.9 Cross-case Analysis

3.9.1 Cross-case Quantitative Analysis of Pre-post Outcome Data

Cross-case, pre-post outcome data for all participants are presented in Table 3.9.1

Table 3.9.1 Cross-case Quantitative Analysis of Pre-post Outcome data

Scale	Pre-Treatment		Post-Treatment		Effect Size (Cohen's d)
	Mean	***SD***	***Mean***	***SD***	
GAD-7	16.50	3.16	*6.62	5.12	2.32
GADSS	16.00	2.82	*7.88	4.73	2.08
BDI-II	27.62	12.94	*7.12	4.61	2.11
CORE-OM	1.87	0.47	*0.67	0.38	2.80
PSWQ	66.87	10.13	*50.62	7.54	1.82
PSWQ-PW[a]	66.33	7.86	*37.66	21.18	1.79

[a]The analysis carried out with respect to this measure had a smaller sample size (n = 6) due to the late introduction of the measure to the research.
GAD-7 = Generalised Anxiety Disorder–7; GADSS = Generalised Anxiety Disorder Severity Scale;
BDI-II = Beck Depression Inventory; CORE-OM = Clinical Outcomes in Routine Evaluation – Outcome Measure;
PSWQ = Penn-State Worry Questionnaire; PSWQ-PW = Penn-State Worry Questionnaire (Past Week).
* The pre-post difference on all measures was found to be statistically significant

In order to test the efficacy of treatment on the GAD-7, a Paired *t* test was conducted. This test was found to be statistically significant, $t\ (7) = 5.35$, $p < .05$, two tailed; $d = 2.32$. The effect size for this analysis ($d = 2.32$) was found to exceed Cohen's (1988) convention for a large effect ($d = .80$). These results indicate that participants reported fewer symptoms on this measure in the post-treatment assessment ($M = 6.62$, $SD = 5.12$) then in the pre-treatment assessment ($M = 16.50$, $SD = 3.15$).

In order to test the efficacy of treatment on the GADSS, a Paired *t* test was conducted. This test was found to be statistically significant, $t\ (7) = 5.19$, $p < .05$, two tailed; $d = 2.08$. The effect size for this analysis ($d = 2.08$) was found to exceed Cohen's (1988) convention for a large effect ($d = .80$). These results indicate that participants reported fewer symptoms

on this measure in the post-treatment assessment ($M = 7.88$, $SD = 4.73$) then in the pre-treatment assessment ($M = 16.00$, $SD = 2.82$).

In order to test the efficacy of treatment on the BDI-II, a Paired t test was conducted. This test was found to be statistically significant, $t\ (7) = 4.21$, $p < .05$, two tailed; $d = 2.11$. The effect size for this analysis ($d = 2.11$) was found to exceed Cohen's (1988) convention for a large effect ($d = .80$). These results indicate that participants reported fewer symptoms on this measure in the post-treatment assessment ($M = 7.12$, $SD = 4.61$) then in the pre-treatment assessment ($M = 27.62$, $SD = 12.94$).

In order to test the efficacy of treatment on the CORE-OM, a Paired t test was conducted. This test was found to be statistically significant, $t\ (7) = 6.15$, $p < .05$, two tailed; $d = 2.80$. The effect size for this analysis ($d = 2.80$) was found to exceed Cohen's (1988) convention for a large effect ($d = .80$). These results indicate that participants reported fewer symptoms on this measure in the post-treatment assessment ($M = 0.67$, $SD = 0.38$) then in the pre-treatment assessment ($M = 1.87$, $SD = 0.47$).

In order to test the efficacy of treatment on the PSWQ, a Paired t test was conducted. This test was found to be statistically significant, $t\ (7) = 2.94$, $p < .05$, two tailed; $d = 1.82$. The effect size for this analysis ($d = 1.82$) was found to exceed Cohen's (1988) convention for a large effect ($d = .80$). These results indicate that participants reported fewer symptoms on this measure in the post-treatment assessment ($M = 50.62$, $SD = 7.54$) then in the pre-treatment assessment ($M = 66.87$, $SD = 10.13$).

In order to test the efficacy of treatment on the PSWQ-PW, a Paired t test was conducted. This test was found to be statistically significant, $t\ (5) = 3.46$, $p < .05$, two tailed; $d = 1.79$. The effect size for this analysis ($d = 1.79$) was found to exceed Cohen's (1988) convention for a large effect ($d = .80$). These results indicate that participants reported fewer

symptoms on this measure in the post-treatment assessment ($M = 37.66$, $SD = 21.18$) then in the pre-treatment assessment ($M = 66.33$, $SD = 7.86$).

3.9.2 Cross-case Analysis of Qualitative Data

3.9.2.1 Cross-case Analysis of Data from Client Change Interviews

The following section analyses data from the first seven clients' post-treatment assessment interviews (Client Change Interview).

Client Experience of Change

Participants' comments on their "Experience of Change" are presented in in Table 3.9.2.

Table 3.9.2 Client Experience of Change

Experience of Change	Number of respondents
Improved emotional regulation	7/7
Reduction of anxiety symptoms	6/7
Improved coping/sense of agency	6/7
Increased self-acceptance/worth	5/7
Increased confidence	5/7
Reduction in somatic complaints	3/7
Increased awareness/insight	3/7
Improved interpersonal relationships	2/7

In total, seven categories of experience of change were reported by participants in their post-treatment assessment interviews. All participants commented on a sense of improved emotional regulation as a result of therapy. Examples of improved emotional regulation would be *"Em, I've noticed that I'm not flying off the handle. Em, I'm handling situations better"* (Tina), or *"I'm much, much more relaxed and taking each day as it*

comes...not panicking and sleeping more" (Jackie). Six out of the seven participants referred explicitly to a reduction in anxiety symptoms; *"It's sort of unknotted all the tensions in me"* (Tina), *"I'm not as highly strung. And I'm not as em, agitated. All the time"* (Ann), *"Everybody says I'm less stressed...and I can even feel that myself; I'm less stressed out" I'm definitely much more relaxed than I was"* (Laura).

Six of the participants referred to an improved coping/sense of agency. Examples of improved coping/sense of agency include, *"Yeah absolutely. I'm more able now to deal with things [...] I can cope with situations now and I don't feel that I'm worthless. I feel that I'm worth something now"* (Tina), *"I'm not letting really anything bother me at all. Just basically just going back to what I used to be"* (Tony), *"I try to push now, maybe at the start I wouldn't go looking for things to do, but now there's a chance I might do something a bit different"* (Mark). Increased self-acceptance/worth is commented on by five of the participants, and examples of this would include, *"Em... from being able to em, realize the... I'm allowed feel the way I am, the way I was feeling. But...I can ah... I'm allowed to be me"* (Tina), *"The truth...I really didn't realise how many emotional problems I had...how hurt I was...how affected I was...I really thought I was mad sometimes"* (Jackie). Increased confidence is also referred to by five of the participants and examples of this would be *"Yeah, I'm going back to where... how confident I used to be for one"* (Tony), *"From therapy I'm a lot stronger in work, whereas until recently, I wasn't."* (Laura) and *"Yeah I'm feeling more confident now. I feel that I don't have to be... beat yourself up about things that..."* (Tina).

Three out of the seven participants remark on a reduction in somatic symptoms, *"No Headaches"* (Tina), "*I definitely got rid of...it definitely lifted a huge weight off my chest. I definitely feel more free"* (Susan). Three of the participants commented on the benefits of increased, an example of which would be, *"I understand where the anxiety's come from, so*

that's been helpful, you know" (Jackie). Other categories of change identified by participants include an improvement in interpersonal relationships, *"But ever since this started, I became eh, a lot more open with other people with even thinking and things like that. So in that way that was a great thing as well because it helped improve the relationship I had with me mother which was getting a bit strained"* (Tony).

Helpful Aspects of Therapy

Participants' comments on the aspects of therapy they considered helpful are presented in Table 3.9.3.

Table 3.9.3 Helpful Aspects of Therapy

Helpful Aspects of Therapy	Number of respondents
Therapist support/empathic listener	5/7
Facilitated emotional expression	4/7
Experiential Techniques (i.e. Chair-work)	3/7

In their post-treatment assessment interviews, participants identified three categories of helpful aspects of therapy. Five of the respondents commented on the value of having the therapist as supportive/empathic listener, "*"Having [the therapist] listen and understand, and they are the real things I remember...the relationship with him, more than the role playing thing we did."*(Susan). Four participants regarded the facilitation of their emotional expression as being particularly helpful, *"...And you might be in bits and you're crying and everything else but you've really touched the spot"* (Tina), *"Every time you kind of said something that you thought was bothering you or was bothering you, you came out and said it. It was just em... very relieving"* (Tony). Three out of seven respondents referred to experiential techniques as being helpful, *"Everyth... The thing that really stood out for me all*

the time was when I kept going swapping over the role-play. Really did it for me because..." (Tina).

Unhelpful Aspects of Therapy

None of the participants reported finding any aspect of the therapy as being unhelpful in any way.

Aspects of therapy which were difficult at the time but beneficial in the long run

Only a small number of participants responded to this question, and their comments concerned either talking about painful issues from their pasts or discussing complicated and painful relationships with developmentally significant others, for example, *"Eh.... Yeah really, talking about my mother who di... She's died now. And eh the relationship with me mother. Now I found that hard and... but I realized it had a lot of meaning like we had to talk about all that, you know"* (Tina). The only other issue raised, related to chair work, and referenced concerns around mastering the technical or conceptual aspects of the task, as Laura comments, *"I found the chair work initially...I...by the end I loved the chair-work, but initially I found it hard, I found it hard to put myself into someone else's position in terms of what they might say to me"* (Laura).

3.9.2.2 Cross-case Analysis of Helpful Events and Impacts from HAT forms

An analysis of HAT forms was performed to extract the events and impacts which were deemed to be helpful on the basis of client post-session reports. In total, five categories of helpful events and seven categories of helpful impacts were identified (See Table 3.9.4).

Table 3.9.4 Cross-case Analysis of Helpful Events and Impacts from HAT forms

Helpful Events	**No.**	**Helpful Impacts**	**No.**
EFT Tasks	8/8	Awareness and Insight	8/8
Emotional expression	6/8	Relief	7/8
Accessing core Pain	6/8	Self-acceptance	6/8
Therapist Validation	5/8	Achievement/ self-efficacy/ empowerment	6/8
Exploration of Current Issues	3/8	Feeling Supported	5/8
		Feeling Understood	5/8

Helpful Events

Eight clients identified participating in tasks, specific to EFT, as being helpful during the course of their therapy. Examples from this category include: *"The changing of roles between chairs and explaining of love between my father and me and others"* (Tony; referring to unfinished business dialogues); *"The part when I had a conversation between myself and a negative side"* (Mark; referring to a two chair dialogue for critical split); *"The therapist got me to separate and detach various issues I was dealing with and set them aside. A visualisation/meditation technique"* (Susan; referring to clearing a space).

Six clients refer to the opportunity afforded for emotional expression as being helpful in therapy. Examples of this include: *"I felt comfortable to express myself. It gave me trust in my therapist"* (Susan); *"It's just the feeling that I can express what I feel his words would be to me"* (Tony), and *"Being able to express my true feelings"* (Jackie). Six clients referred to accessing core pain as being a helpful event in therapy, and examples of this include: *"Speaking consistently about my father and getting a grasp of how much I feel I compare myself to him and how much I let him down"* (Tony); *"The event that I found quite helpful was when we went through asking for help and support from my mam and how that made me*

feel" (Laura), and *"Going back to my early childhood. Bringing the bad memories out"* (Tina).

Five clients referred to therapist validation as a helpful event in therapy. Examples of this include: *"Therapist telling me to tell myself I am not worthless"* (Tina) and *"The therapist acknowledging my feelings"* (Susan). Three of the clients found the opportunity to explore current issues particularly useful in therapy, for example: *"Being able to get my head around issues at work"* (Laura) and *"Expressing how I think that my work colleagues will react to me"* (Tony).

Helpful Impacts

Eight clients referred to insight and awareness as a helpful impact of therapy. Examples from this category include: *"To let me see both sides of me, the clown and the sad person"* (Jackie); *"Made me realise I can be far too harsh on myself and it's holding me back My criticism needs to be more constructive"* (Mark), and *"Learning that I'm shutting down my anger reflex due to being afraid of looking stupid"* (Laura). Seven of the clients reported that a sense of relief was a helpful impact, due to therapy, for example: *"Made me feel like a bit of a weight has been lifted off my shoulders and made me feel more at ease with myself"* (Mark); *"I was able to calm down after getting it out in the open"* (Laura), and *"Feelings of letting upsetting things go"* (Tina).

Six clients commented on self-acceptance as a helpful impact of therapy. Examples of this category include: *"The realisation that I do this, and that I need to put myself first from time to time and that it's ok to do so"* (Susan) and *"I have a sense now that I can compromise to let myself go every now and then without it being a bad thing"* (Laura). Six clients referred to Achievement/ self-efficacy/ empowerment as a helpful impact of therapy, for example: and *"To be able to know that I am capable of getting on top of it and being told that"* (Ann).

Five clients commented on feeling supported as a helpful impact of therapy, for example: *"We looked at my former boss with dialogue and saw that the way treated me was not fair and that I didn't deserve to be treated badly"* (Fiona); *"Just understanding how I feel about him and having someone else hear how I feel about him"* (Tony) and *"Somebody to listen to me"* (Jackie). Five clients reported feeling understood as a helpful impact of therapy, for example; "*"It's wonderfully reassuring to know that I'm acknowledged here"* (Tony); *"It made me feel comfortable and understood"* (Susan).

3.9.3 Cross-case Case Conceptualization

This analysis of all eight cases in terms of case conceptualisation is based on the retrospective recall of the therapists involved in the particular cases (see Chapters 3.1. – 3.8., sections on case conceptualisation). A similar cross case analysis of the first five cases was also conducted by O'Brien, Timulak and McElvaney (the author of the current study) (2012), however, this analysis of the first five cases was based on the actual session transcripts from the first half of the therapy of those clients. O'Brien et al.'s analysis served as a triangulation for the current analysis.

The cross-case conceptualisation reveals certain patterns. In half of the cases, *trauma* and *loss* form the poignant backdrop to the clients' narrative; for example, Ann, Tina, Tony and Jackie all experienced traumatic loss (in the form of bereavement) of a parent, and in some cases, tragically, siblings. These clients commonly report feeling *abandoned* as a result of their loss and express this in therapy as a form of profound *loneliness*.

Another common factor is that of *abusive* or *neglectful* treatment at the hands of a parent, which may be historic, as in the cases of Ann, Tina and Jackie or current as in the case of Fiona. This is also connected to a core experience of *shame*, which affects all cases to some degree, where, even if parents are not explicitly abusive or neglectful, they may

communicate a level of judgement to their offspring which suggests that they will never be able to live up to the standards expected of them (e.g., Tony's idealised father). This finds expression in the clients' perception that there is somehow, something intrinsically flawed in them. Constant exposure to a caregiver who is critical and invalidating establishes and reinforces this core shame. To varying degrees, all clients report the *core sadness/pain* of being on their own, *sense of being a failure* and *the terror of sudden trauma* that they experienced. These experiences characterised primary underlying emotional experiences that the clients dreaded and wanted to avoid (for instance through the worrying about the triggers that could set them off). The clients, in general, also developmentally attributed the responsibility for those painful experiences to themselves, perhaps out of an effort to have some control over the unpredictable circumstances. Thus, they engage in self-blame, self-doubt, self-criticism (for instance, the negative self-treatment shows in self-addressed messages like: (*If was different my mom would have loved me, It is my responsibility to be sure that my kids won't get hurt, I am weak, etc.*).

Current triggers serve to activate core pain, and in some cases, serve to add new dimensions to older injuries (e.g., Tony and Laura's current difficulties at work amplify their feelings of not having lived up to one or other of their parents' standards). Core pain is activated by a variety of current triggers, including, criticism at work or home (all clients), fear of hurt or danger to loved ones, incorporating a perceived inability to protect them (Ann, Tina, Tony, Jackie, Susan), current loss and trauma (Jackie). All of those dreaded core painful experiences are linked with the historic pain described in the previous paragraph. A feature of the core pain is that all clients find it so unbearable that they seek to evade it by means of a variety of emotional and behavioural strategies; for example constant worrying to distract from core pain (emotional) or avoiding situations in which triggers may be encountered (behavioural).

All participants thus rather than being involved in processing of the primary underlying painful emotions (shame, loneliness, fear/terror) are fearing them and are trying to avoid them, but eventually collapse to secondary emotional experience, with features that correspond to their GAD diagnosis; i.e., overwhelmed, panic, hyper-vigilance, fearful, etc., and others which reference a more depressive position; i.e., hopelessness, helplessness etc. All participants, to varying degrees, report a range of somatic symptoms including insomnia, exhaustion, chest pains, breathlessness, headaches, shaking and feeling suffocated. All report spending a great deal of time in states of undifferentiated global distress, and manifest profound emotional avoidance by constant worrying about potential triggers which might bring about the feared core emotional pain. The core emotional pain is particularly difficult for participants to tolerate as it makes clear to them that their needs in the *trigger situations* are not being met. For example, the needs attached to the shame-based emotions experienced by all the participants in the current study are the needs to feel appreciated, validated, prized, seen, the needs attached to loneliness/sadness are the needs for being loved and connected and the needs attached to primary fear/terror are to be safe and protected, etc., and it is the fact that this need remains unmet which causes unbearable pain.

3.9.4 Cross-Case Emotion Transformation

A cross-case analysis of emotional transformation is based on the therapists' retrospective recall and it is further supported by triangulation with data taken from the clients HAT forms. In case of the first two clients it is also informed by two studies with which the author was involved (Keogh et al, 2013; Crowley et al, 2013). In these two studies the analysis is not solely based on the therapist's recall, but on an actual analysis of the transcripts of the all the sessions including the use of observer-based scales (CAMS, CEAS, & Emotional Productivity Scale). In all cases the therapist perspective on transformation is

theoretically embedded in the developing EFT model of emotion transformation (Pascual-Leone & Greenberg, 2007; Pascual-Leone, 2009; Timulak & Pascual-Leone, 2014).

Following the therapists' recall we can recognise discernable patterns across specific stages of the therapeutic encounter. As has been described above, (Section 3.9.3) early on in therapy, all clients seek to avoid their core emotional pain through a variety of emotional and behavioural strategies, and this pattern is pervasive throughout therapy. It appears that the clients with better outcomes demonstrated greater progress in overcoming avoidance. Nevertheless, avoidance was extremely noticeable, and was exhibited to varying degrees, in all clients (six of whom met DSM-IV diagnostic criteria for Avoidant Personality Disorder). This often had the effect of leaving clients stuck in the states of distress described in the previous section on case conceptualisation.

In the early stages of therapy, the therapist worked hard to facilitate the clients in increasing their awareness of triggers and negative self-treatment. Though common to all clients, the degree to which it could be achieved was often contingent upon the clients' level of avoidance. For example, in the early stages, whenever Tony accessed his core pain he either had a panic attack or moved swiftly to secondary anger. The therapist endeavoured, through the provision of an empathic and caring relationship, to assist the clients in overcoming avoidance, with a view to connecting with their underlying core painful emotions; achieved mainly by the use of empty-chair and two-chair techniques. All of the clients were impacted by historic (i.e., abusive, neglectful or unresponsive parents) and current (rejecting partner or parent, loss) triggers which drove them into states of secondary emotion, global distress and rejecting anger. For example, all clients apart from Mark struggled with experiences related to developmentally significant others; in the cases of Laura, Fiona, and Susan, these troublesome relationships also existed in the present. In their desperate attempts to avoid such painful experience, they engaged in emotional (i.e.,

worrying, dismissal of own emotional experience) and behavioural (i.e., people pleasing, avoiding contact with others) avoidance. Tony, for example engages in constant worrying about the safety and welfare of others, alternately withdraws and expresses secondary anger in relation to others and relies heavily on sleeping tablets. Such strategies result in distancing clients from their core pain, ensuring that it remains unprocessed and that their issues remain unresolved.

The therapists facilitated the clients in accessing their core pain (i.e., shame, sadness, loneliness etc.) in the hope that, having access to this emotional information would enable them to identify, experience and express the need attached to that pain. Clients had varying degrees of success in accessing their core pain; for example, Mark and Laura exhibited a highly avoidant emotional processing style with limited arousal, while Jackie and Ann, who took time to build trust, eventually opened up and were able to access their core pain in session (Susan and Fiona opened as well but they were overwhelmed by pain). Once the core pain was accessed the therapists tried to help clients articulate unmet needs embedded in the core painful emotional experiences. Once these needs were expressed, the therapists sought to facilitates the clients in generating emotional responses to them. The therapists did so either by responding compassionately themselves, or by guiding the client in providing compassion towards themselves in the imaginary chair dialogues. Clients like Susan, for example, consistently had difficulty in expressing their vulnerability (viewing it as contemptible or an indicator of weakness), and struggled to express compassion towards a vulnerable part of self for which, historically, she had little regard. On the other hand, all clients were ultimately able to express self-compassion, (although Susan and Fiona were too fragile and kept falling back into global distress), often from the point of view of the other who was previously held to be neglectful or abusive, and frequently after having had to overcome negative appraisals of personal vulnerability.

In tandem with the development of this new self-compassionate response, observation of the cases reveals the therapists-facilitated emergence of a protective anger. This new, alternative, emotional experience, increases clients' sense of agency, empowering them, in so far as they might now assert that they did, indeed, deserve to be loved, appreciated and respected. There are many examples of this across cases, especially when clients stand up to their inner critics or developmentally significant others in two-chair and empty-chair dialogues, for example Anne saying to her critic, *"I have my power, Shut up!"* (all clients accessed protective anger but Mark was still fearful, while Susan stayed mainly in rejecting anger and Fiona could stand up for herself but collapsed quite easily) This is also noticeable in worry dialogues, when, for example, Ann, Tina, Laura and Jackie harness the agency inherent in protective anger, in order to stand up to the worry agent. The worry process in some clients [Tina, Laura] also appeared to become resolved by a more compassionate stance on the part of the Worry Agent who did not want to burden the self; however in most of the clients the Worry Agent, although protective, did not want to relent [Mark] or stayed intrusive [Susan, Fiona]). This assertiveness goes beyond mere cognitive awareness that such needs deserved to have been met, but is an experiential emotional process that contributes to the building of emotional resilience and a more agentic, empowered, self..

Generation of self-compassion and protective anger was generally followed by a grieving process wherein, that need which is (or was) unmet could be acknowledged and let go; however this was not completely achieved by all clients. Susan and Fiona, for example endured such fragile processes throughout the course of therapy that it was difficult enough for them to stay with the core pain long enough to express unmet needs, let alone move to a position of letting go. In cases where this stage was more readily attained (for example, Ann, Tina, Tony, Jackie, Laura) clients experienced an increased sense of agency in relation to their emotional experience. With this new found resilience in the face of emotional adversity,

they are now able to stay in contact with, and explore, their emotional experience, utilising the adaptive information contained therein, in a way that would have been difficult pre-treatment.

4.0 Discussion

The aim of the current study was to contribute to the development of EFT as an effective treatment of GAD. By examining the impact of treatment across eight case studies in terms of quantitative (from a battery of outcome measures; GAD-7, GADSS, PSWQ, BDI-II, CORE-OM, PSWQ-PW) and qualitative data on the outcomes of therapy as well as helpful and unhelpful aspects of the therapy process, it was hoped to establish a preliminary assessment of the potential efficacy of EFT for GAD and the processes that may or may not contribute to it. Gathering the therapists' perspectives (which was, to a certain extent, supported by the findings of related studies, which examined portions of the same data set), case conceptualisation and case transformation (i.e. therapeutic change), we aimed to explore both the similarities and differences between an EFT understanding of GAD and its treatment, and empirically well-established approaches to GAD (essentially comprising a variety of CBT approaches).

4.1 Discussion of Cross-case Quantitative Analysis of Pre-post Outcome Data

The data presented in Section 3.9.1, suggests that the pre-post difference in mean scores for the treatment group was statistically significant, with large effect sizes, across all measures. On the GAD-7, the mean score shifted from 16.50 pre-therapy, to 6.62 post-therapy, with an effect size of d=2.32; suggesting that clients had moved from the clinical into the non-clinical range. On the GADSS, the mean score shifted from 16.00 pre-therapy, to 7.88 post-therapy, with an effect size of d=2.08; suggesting that clients had remained in the clinical range, but improved significantly. On the BDI-II, the mean score shifted from 27.62 pre-therapy, to 7.12 post-therapy, with an effect size of d=2.11; suggesting that clients had moved from the clinical into the non-clinical range. On the CORE-OM, the mean score shifted from 1.87 pre-therapy, to 0.67 post-therapy, with an effect size of d=2.80; suggesting

that clients had moved from the clinical into the non-clinical range. On the PSWQ, the mean score shifted from 66.87 pre-therapy, to 50.62 post-therapy, with an effect size of d=1.82; suggesting that clients remained in the clinical range, but improved significantly. Finally, on the PSWQ-PW, the mean score shifted from 66.33 pre-therapy, to 37.66 post-therapy, with an effect size of 1.79. The effect sizes in the current study are large (i.e. they exceed Cohen's (1988) convention for a large effect (d = .80)), and are generally better than, or equal to, effect sizes which are normally found in empirical studies of GAD. For example, Stewart and Chambless's (2009) meta-analysis, which reports on 11 studies assessing pre-post outcomes of CBT treatments for GAD in routine practice, indicates pre-post effect size (Cohen's d) of 0.92 (CI: 0.77-1.07) for GAD symptoms (without stating which specific measures where included to measure the GAD symptoms) and 0.89 (CI: 0.70-1.07) for symptoms of depression (again without specifying the measure). Although they calculated pre post effect sizes using pooled SD (while the current study uses pre-treatment SD), this ought to have little impact on the actual effect sizes, and strongly suggests that findings in the current study are substantially better than those which would be expected in routine CBT practice.

In terms of overall performance on the various measures, six out of eight clients moved from the clinical to the non-clinical range on the GAD-7. Similarly, six out of eight clients moved from the clinical to the non-clinical range on the GADSS, while five out of eight moved from the clinical to the non-clinical range on the BDI-II. All clients moved from the clinical to the non-clinical range on the CORE-OM. One client moved from the clinical to the non-clinical range on the PSWQ. As there is no established clinical cut-off point for the PSWQ-PW, data cannot be presented regarding this measure, however three out of six clients for which this measure was used exhibited reliable change on this measure, using a very conservative version of RCI (e.g., at $p < .05$; while Elliott (2002) recommends $p < .2$ for the assessment of improvement in his HSCED studies, (cf. Macleod and Elliott, 2012)).

In the following discussion, which compares the results of the current study to those of other studies focussing on GAD (with the occasional inclusion of depression), it is important to stress that given the size of our sample (n=8) statistically meaningful comparisons would be difficult to make. In light of this, for the purposes of comparison, mean outcomes and pre post effect sizes will be reviewed. The current study will be tentatively benchmarked against some representative studies using the same measures (some of these measures were used in a number of studies, some in only a few; accordingly, when benchmarking the results of the current study on different measures the number of studies referenced will vary).

With regard to results on the **GAD-7**, when compared to the Improved Access to Psychological Therapies (IAPT) evaluation by Clarke and colleagues (2009) of two UK 'demonstration sites' offering CBT related therapy to people with anxiety and depression (not only GAD) the current study exhibited an average pre-post difference of 9.88 (scale range 0-21) points on the GAD-7 (pre mean 16.50, post mean 6.62; Cohen's d=2.32); while Clarke and colleagues' data for one site indicate a pre-post difference of 7.1 (N=1647; pre mean 13.9, post mean 6.8; Cohen's d=1.36), and for the other site indicate a pre-post difference of 6.9 (N=221; pre mean 13.7, post mean 6.8; Cohen's d=1.35). Although Clarke's data also include other types of anxiety problems and depression and are therefore not solely confined to GAD, a tentative benchmarking shows that the results in the current study are potentially better than, those found in routine CBT practice on the GAD-7 (in order to claim this, the difference of 0.3 between our effect size and that of Clarke et al.'s is taken into consideration and will used as a proxy measure for all of the studies reviewed below– 0.3 is a small effect size according to Cohen (1988) – however, the reader has to be cautious as this is not an actual statistical comparisons, but only a tentative rough comparison). Titov and colleagues' (2011) RCT studying transdiagnostic internet treatment for anxiety and depression reported

data on the GAD-7 for the treatment (anxiety) group indicated a pre-post difference of 4.05 (N=19; pre mean 11.68, post mean 7.63; Cohen's d=0.76), suggesting that in comparison, a tentative benchmarking shows that the results in the current study are potentially better than those found in this internet based treatment.

When compared to Craske and colleagues' (2011) study of Disorder-Specific Impact of Coordinated Anxiety Learning and Management Treatment for Anxiety Disorders in Primary Care, the current study reported data which indicated a pre-post difference on the **GADSS** of 8.12 (pre mean 16.00, post mean 7.88; Cohen's *d* =2.08), while Craske and colleagues report data which indicated a base-line to 6-month difference, in the intervention group, of 4.51 (base-line 13.36, 6-month 8.85; Cohen's *d*=0.44), which suggests that, subject to tentative benchmarking, the results in the current study are potentially better than the results presented in Craske et al. (2011). Craske and colleagues regarded time as a categorical variable (with base-line and follow-up every six-months). Accordingly a 6-month period has been selected here, for the purposes of comparison, as it is closest to the period of time required for clients to complete treatment in the current study. In Stanley and colleagues (2009), data indicated a pre-post difference on the GADSS for the CBT group of 2.8 (N=115; pre mean 11.4, post mean 8.9; Cohen's *d*=0.77), and for the EUC give full wording group, of 1.4 ((N=115; pre mean 11.3, post mean 9.9; Cohen's *d*=0.41), which suggests that, subject to tentative benchmarking, the results of the current study are potentially better than both experimental and control conditions in Stanley et al (2009).

With regard to results on the **PSWQ**, when compared to Borkovec and Costello's (1993) investigation (n=55) of the efficacy of applied relaxation (AR) and cognitive-behavioural therapy (CBT) (comprising applied relaxation, self-control desensitisation and brief cognitive therapy) as a treatment of GAD compared to a non-directive (ND) (supportive listening) control condition), the current study indicated an average pre-post difference of

16.25 (pre mean 66.87, post mean 50.62; Cohen's *d*=1.82), while Borkovec and Costello's data for the CBT group indicated a pre-post difference of 19.5 (pre mean 65.5, post mean 46.0; Cohen's *d*=1.85); data for the AR group indicated a pre-post difference of 19 (pre mean 68.7, post mean 49.7; Cohen's d=2.75); and data for the ND group indicated a pre-post difference of 6.8 (pre mean 65.5, post mean 58.7; Cohen's d=0.82). A tentative benchmarking suggests that the results of the current study on the PSWQ are potentially comparable to the CBT group better than the ND group but not as good as the AR group, as presented in Borkovec and Costello (1993). Borkovec and colleagues' (2002) analysis of CBT for GAD and the role of interpersonal problems, which investigated the efficacy of (a) applied relaxation (AR) and self-control desensitisation (SCD), (b) cognitive therapy (CT) or, (c) a combination of these (CBT), as a treatment of GAD found that data for the CT group indicated a pre-post difference of 18.35 (pre mean 69.09, post mean 50.74; Cohen's *d*=2.05); data for the SCD group indicated a pre-post difference of 19.26 (pre mean 67.43, post mean 48.17; Cohen's *d*=2.58); and data for the CBT group indicated a pre-post differential of 19.46 (pre mean 67.11, post mean 47.65; Cohen's *d*=1.64). Tentative benchmarking suggests that the results of the current study on the PSWQ are comparable to the CBT and CT conditions, but not as good as the SCD group, as presented in Borkovec et al (2002). It is perhaps worth noting that the mean BDI score across the three groups in Borkovec et al (2002) is 17.85 (compared to a mean of 27.62 in the current study) suggesting that the clients in the current study were enduring significantly higher levels of comorbid depression, than those in Borkovec's research studies, suggesting that the sample in the current study was much more chronic and complex.

Dugas and colleagues' (2003) study assessing the efficacy of group cognitive-behavioural therapy for GAD, focusing on targeting *intolerance of uncertainty* in 48 clients who received 14 sessions of small group (4-6 people) CBT found that data on the PSWQ

indicated a pre-post difference of 12.89 on the (pre mean 62.08, post mean 49.19; Cohen's *d*=1.35), suggesting that tentative benchmarking indicates the findings of the current study on the PSWQ to be potentially better than the findings reported by Dugas et al (2003). Evans and colleagues' (2008) evaluation of mindfulness-based CBT for GAD found that data indicated a pre-post difference of 12 on the PSWQ (*N*=11; pre mean 60.82, post mean 48.82; Cohen's *d*=1.09) which suggests that the results of the current study on the PSWQ are potentially better than, those found in Evans et al. (2003). Dugas and colleagues' (2010) RCT of CBT and AR for adults with GAD produced data which indicated a pre-post difference in the CBT group of 10.52 on the PSWQ (N=65; pre mean 61.65, post mean, 51.13; Cohen's *d*=1.27); and data which indicated a pre-post difference in the AR group of 5.85 (*N*=65; pre mean 58.01. post mean 52.16; Cohen's *d*=1.06). A tentative benchmarking suggests that the results in the current study on the PSWQ are potentially better than the results presented by Dugas et al. (2010).

Van der Heiden and colleagues' (2012) Randomised controlled trial (RCT) on the effectiveness of MCT and IUT for GAD produced data on the PSWQ which indicated a pre-post difference for the MCT group of 20.37 (*N*=43; pre mean 68.67, post mean 48.30; Cohen's d=2.95), and produced data on the PSWQ which indicated a pre-post difference for the IUT group of 10.52 (N=42; pre mean 66.62, post mean 56.10; Cohen's d=1.16), which suggests, subject to tentative benchmarking, that the results in the current study on the PSWQ are potentially better than the IUT results presented in Van der Heiden et al. (2012) and perhaps worse than those found in the MCT condition. These results would suggest potential superiority of the MCT model over other models, including models from within the CBT paradigm.

Newman and colleagues' (2011) RCT of CBT for GAD with integrated techniques from Emotion-focused and interpersonal (IEP) therapies, reported data on the PSWQ which

indicated a pre-post difference in the CBT (augmented by supportive listening) group of 18.49 (pre mean 67.55, post mean 49.06; Cohen's d=2.28), and indicated a pre-post difference in the CBT/IEP group of 16.14 (pre mean 67.14, post mean 51.00; Cohen's d=1.97), which suggests, subject to tentative benchmarking, that the results in the current study on the PSWQ comparable to CBT/IEP group, but not as good as the CBT (augmented by supportive listening) group as presented in Newman et al., (2011). Titov and colleagues' (2011) RCT studying transdiagnostic internet treatment for anxiety and depression reported data on the PSWQ for the treatment (anxiety) group which indicated a pre-post difference of 5.68 (N=19; pre mean 63.21, post mean 57.53; Cohen's d=0.58) suggesting that tentatively benchmarked results in the current study on the PSWQ are potentially superior to the results in the internet treatment examined by Titov et al. (2011). In Stanley and colleagues (2009) RCT studying CBT (vs. enhanced usual care (EUC) as a control) for GAD among older adults in primary care, data indicated a pre-post difference on the PSWQ for the CBT group, of 7.7 (N=115; pre mean 53.3, post mean 45.6; Cohen's d=0.72), and data for the EUC group indicated a pre-post difference of 3.2 (N=115; pre mean 57.6, post mean 54.4; Cohen's d=0.29), which suggests that the results of the current study, subject to a tentative benchmarking, are better than those presented in Stanley et al. (2009). It is noteworthy that in the Stanley et al. (2009) study, clients evinced a lower baseline level of distress, pre-treatment (i.e. GADSS=11.4, PSWQ=53.3 and BDI-II=16.3) than in the current study (i.e. GADSS=16.0, PSWQ=66.87 and BDI-II=27.62) suggesting that clients in the current study experienced a higher level of chronic symptomatology.

With regard to results on the **CORE-OM**, the current study exhibited an average pre-post difference of 1.20 (pre mean 1.87, post mean 0.67; Cohen's d=2.80), while Clarke and colleagues' data for one IAPT site indicated a pre-post difference of 0.70 (N=1647; pre mean 1.88, post mean 1.18; Cohen's d=1.18), and for the other IAPT site indicated a pre-post

difference of 0.76 (N=221; pre mean 1.83, post mean 1.07; Cohen's d=1.24); a tentative benchmarking indicates that the results of the current study are possibly better than those found in routine practice on the CORE-OM. In Stiles and colleagues' (2005) evaluation of the effectiveness of Cognitive-Behavioural (CBT), Person-Centred (PCT), and Psychodynamic (PDT) Therapies as Practiced in National Health Service Settings (i.e. not solely treating GAD), data for the CBT group indicate a pre-post difference of 0.88 (N=298; pre mean 1.69, post mean 0.8; Cohen's d=1.25); data for the PCT group indicate a pre-post difference of 0.87 (N=332; pre mean 1.76, post mean 0.89; Cohen's d=1.31); and data for the PDT group indicate a pre-post difference of 0.77 (N=122; pre mean1.76, post mean 0.99; Cohen's d=1.22). A tentative benchmarking suggests that the results in the current study are possibly better than those presented in Stiles et al. (2005).

With regard to results on the **BDI-II**, when compared to Borkovec and Costello (1993), the current study indicated a pre-post differential of 20.5 (pre mean 27.62, post mean 7.12; Cohen's d=2.11), while Borkovec and Costello's data for the CBT group indicated a pre-post difference of 8.2 (pre mean 12.8, post mean 4.6; Cohen's d=1.10); data for the AR group indicated pre-post mean of 8.5 (pre mean 15.3, post mean 6.8; Cohen's d=1.18); and data for the ND group indicated a pre-post difference of 4.9 (pre mean 13.7, post mean 8.8; Cohen's d=0.59), which tentatively suggests that the results of the current study on the BDI are potentially better than those presented in Borkovec and Costello (1993). The average BDI score across groups in Borkovec and Costello's research is 13.9 (compared to 27.62) which indicates that the sample in the current study was considerably more distressed than the sample in Borkovec and Costello (1993). When compared to Borkovec and colleagues (2002) study, which reported that data for the CT group indicated a pre-post differential of 11.43 (pre mean 20.00, post mean 8.57; Cohen's d=1.23); data for the SCD group indicated a pre-post difference of 9.69 (pre mean 16.73, post mean 7.04; Cohen's d=1.76); and data for the

CBT group indicated a pre-post difference of 10.35 (pre mean 16.83, post mean 6.48; Cohen's d=1.41), this tentatively suggests that on the BDI, the results of the current research are possibly better, than the results reported in Borkovec et al. (2002). The average BDI score across groups in Borkovec and Costello's research is 17.85 (compared to 27.62) which indicates that the sample in the current study was more distressed than the sample in Borkovec et al. (2002)

When compared to Dugas and colleagues' (2003) study which reported that data indicated a pre-post difference of 7.59 (pre mean 15.92, post mean, 8.33; Cohen's d=0.95), tentative benchmarking suggest that the findings of the current study on the BDI-II are potentially better than the findings reported in Dugas et al, (2003). Evans and colleagues' (2008) evaluation of mindfulness-based CBT for GAD found that data indicated a pre-post difference of 4.98 (N=11; pre mean 13.80, post mean 8.82; Cohen's d=0.63) which suggests that, tentatively benchmarked, the results of the current study on the BDI are better than, those found in Evans et al, (2003). When compared with the results presented in Dugas et al., (2010), which reported that data on the BDI-II indicated a pre-post difference in the CBT group of 6.53 (N=65; pre mean 15.36, post mean 8.83; Cohen's d=0.79); and indicated a pre-post difference on the AR group of 6.38 (N=65; pre mean 16.65, post mean 10.27; Cohen's d=0.68), which suggests, subject to tentative benchmarking that the results in the current study on the BDI are better than the results presented by Dugas et al. (2010). In Stanley and colleagues' (2009), data indicates that the pre post difference on the BDI-II for the CBT group was 6.1 (N=115; pre mean 16.3, post mean 10.2; Cohen's d=0.76), and data indicated that the pre-post difference for the EUC group was 3.6 (N=115; pre mean 16.4, post mean 12.8; Cohen's d=0.37), suggesting that, the results of the current study on the BDI, subject to tentative benchmarking are superior to the results presented in Stanley et al. (2009).

Van der Heiden and colleagues' (2012) RCT on the effectiveness of MCT and IUT for GAD produced data on the BDI-II which indicated a pre-post difference for the MCT group of 16.35 (N=43; pre mean 24.19, post mean 7.84; Cohen's d=1.56), and indicated a pre-post difference for the IUT group of 12.26 (N=42; pre mean 21.29, post mean 9.03; Cohen's d=0.98), which suggests, subject to tentative benchmarking that the results in the current study on the BDI are potentially better than the results presented in Van der Heiden et al., (2012). Again, it is noteworthy that all samples, across these studies give significantly lower scores on depression measures than the current sample, which suggests that participants in the current research struggled with higher, chronic levels of distress compared to those in other studies, which may have implications for the amount of change reported on the PSWQ. The clients in the current study were recruited from an area with complex needs, where high levels of psychological distress and comorbidity were very common. Although clients in the current study presented at a primary care service, they had frequent interactions with secondary services.

The findings in the current study suggest that in general, the pre-post outcomes achieved by the eight clients are potentially equal to, and frequently better than, outcomes reported in studies using the same measures and studying other (predominantly CBT) interventions for GAD or related anxiety disorders. The only exception to this are the results on the PSWQ where the picture is more mixed, with some studies suggesting worse, some equal and some better outcomes. Again, as has been suggested above this might be explained by the sample characteristics (i.e. the sample in the current study appears to be more complex, according to elevated scores on the BDI-II.). On the other hand, it is possible that EFT intervention in this study did not focused primarily on the worry process as is the case in CBT treatments, but rather on the underlying core pain.

4.2 Discussion of Qualitative Outcomes

In terms of qualitative outcomes, our findings are broadly consistent with the literature on the qualitative aspects of humanistic and experiential therapies to date (Timulak & Creaner, 2010). In their post-treatment assessment interviews, offering a retrospective perspective on an entire course of treatment, clients identified seven areas of change, in which they felt that therapy had had a positive impact on them. These areas are all recognisable, in one form or another, in comparison to Timulak and Creaner's (2010) qualitative meta-analysis of outcomes from nine studies examining qualitative outcomes in humanistic-experiential therapies. For instance, all of the clients reported a sense *of improved emotional regulation*. This was expressed as an improved awareness of emotion along with an increased ability to tolerate and express it to others. Clients described feeling calmer and less emotionally labile; moreover they expressed increased hopefulness and a confidence in this new way of functioning. Timulak and Creaner (2010), in their meta-analysis draw attention to a number of studies featuring this category, or at least, something which closely resembled it. Such outcomes are reported in Klein and Elliott (2006) who, under the domain of *changes within the self*, offer three sub-categories of client-reported change (*emotional wellbeing*, *psychological health and stability* and *hopefulness*) under the category of *affective change*. A study investigating the counselling experiences of adults who were abused as children, found that one of four main benefits attributed to counselling was *ability to express and contain feelings* (Dale, Allen & Measor, 1998). Similarly, in a study examining the attitudes of clients in relation to Client-centred therapy, Lipkin (1954) reported that a number of clients reported improvement in mood in their *final focused interview*, in which respondents reflected on the whole of therapy. The category is expressed as *feeling more grounded* in Elliot's single case study of EFT for Social Anxiety and apparent in other writings by Elliott (2002), Elliott et al., (1990) and MacLeod et al. (2012). The category is

also found in two other studies (McElvaney & Timulak, 2013; Rodgers, 2002), however these studies are not reporting exclusively on Humanistic therapies.

Another change which was reported by clients in their end of therapy interviews described a *reduction in (anxiety) symptoms* (Elliott et al., 2009; Lipkin, 1954) which is also reported in Carey and colleagues (2007) qualitative investigation of psychological change as part of the theme; *the relief of talking*. Clients also reported an *improved sense of agency* (coping) that can be found in Timulak and Creaner's meta-analysis (2010). Clients also reported *increased confidence* (which was also reported in Timulak & Creaner's meta-analysis, specifically in studies by Rodgers, 2002; Klein & Elliott, 2006; Lipkin, 1954) and a *reduction in somatic complaints*, which is reported as symptom improvement in Timulak Creaner (2010). The final two categories reported by clients were *increased awareness/insight* (which is also reported in Timulak & Creaner's meta-analysis, specifically in studies by Elliott, et al., 1990; Gallegos, 2005) and *improved interpersonal relationships* (which is also reported in Timulak & Creaner's meta-analysis, specifically in a study by Klein & Elliott, 2006). It is noteworthy that all of the clients referred to improved emotional regulation as a positive change, attributable to therapy, given the emphasis in EFT on promoting same, in order to access and utilise the adaptive information contained in, and the transformative power of, emotion.

Interestingly, comparison with McElvaney and Timulak's (2013) study reporting on client retrospective, post-treatment accounts of CBT and solution-focused informed counselling in primary care reveals that the categories are matched across the two studies. Both groups prize improved emotional regulation/functioning most highly, however where the second most highly endorsed category in the primary care group is improved interpersonal relationships, perhaps not surprisingly the second most highly endorsed category in the GAD group is reduction of anxiety symptoms. Otherwise, similar categories

populate the retrospective recall of clients in both studies; only the GAD group's mentioning of relief from somatic symptoms is markedly different. It is well established in the literature that GAD sufferers also exhibit high levels of somatic complaints (see section 1.1.7; Non-Psychiatric Medical Comorbidity: Allgulander, 2012; Hazlett-Stevens, Pruitt & Collins, 2009)

In the only study focusing exclusively on CBT processes, Clarke and colleagues (2004) analysis of clients' retrospective assessment of a brief course of cognitive therapy produced three clusters comprising 10 categories of client response, organised into three clusters. The first cluster (*"The listening therapist"*) and the second cluster (Big idea) relate more closely to the retrospectively recalled *Helpful aspects of therapy* category in the current study, and will be discussed below. The third cluster (*"Feeling more comfortable with self"*), contained themes directly related to the qualitative outcomes of therapy and reports on positive change from clients' post-treatment client change interviews. The three categories of client response include, (a) **Confident and comfortable**, which contains references to improved confidence/assertiveness, improved self-acceptance/authenticity, improved self-compassion, and being more relaxed and more reflective. This fits with the categories of *improved emotional regulation*, *improved coping/sense of agency*, *increased self-acceptance/worth* in the current study, (b) **Responsibility**, which refers (amongst other things) to clients being able to worry less about areas which are out of their control (i.e. *reduction of anxiety symptoms* in the current study) and, (c) **Positive feedback** which concerns positive appraisals of change made by significant others, family members and friends. As can be seen, there is some overlap between this study of cognitive therapy and the current study, however, there are also some notable differences.

The principal differences between Clarke's research and the current study centre on features which may be particular to anxiety (i.e., reduction in anxiety symptoms, reduction in

somatic complaints). The current study also refers specifically to improved emotional regulation. Both *emotion regulation* and *facilitated emotional expression* are referred to as unique aspects of therapy in the current study, which is consistent with the central role of emotion in EFT. The clients in the current study also refer specifically to *improved interpersonal relationships* which resonates both with EFT's focus on relational and interpersonal (i.e., UBDs) work and also the prominence of interpersonal difficulties as a feature of GAD.

Helpful aspects of therapy – retrospective recall

When clients were asked to volunteer helpful aspects of therapy during their post-therapy assessment interviews they generated three categories. The first category, which referred to the positive impact of *therapist support,* was reported by five of the seven clients and is consistent with the literature (cf. Paulson and Everall, 2003; Nillson, Svennsson, Sandell and Clinton, 2007; Gershefski, Arnkoff, Glass and Elkin, 1996; Paulson, Truscott and Stuart, 1999). Levitt, Butler and Hill, (2006), although not exclusively reporting on humanistic therapies found that, similar to the current study, their most extensive cluster was the one relating to the therapeutic relationship (similar findings were reported in McElvaney & Timulak, 2013 in primary care clients).

In McElvaney and Timulak (2013), both good and poor outcome clients endorsed the aspect of *beneficial support* as helpful. Interestingly the poor outcome clients in that study reported that heightened awareness of problematic functioning and mastery of problematic experience were helpful in-session impacts of their treatment. This contrasts with the current study where *facilitated emotional expression* and *experiential techniques* were endorsed by four and three clients respectively; however it perhaps reflects the theoretically driven emphasis which distinguishes the two therapies, in so far as the current study evinces a

humanistic/experiential approach to therapy, whereas the therapy offered in McElvaney and Timulak (2013) was cognitive-behavioural in nature.

Paulson and Everall's (2003) analysis of helpful aspects of therapy as reported retrospectively by suicidal adolescents contains five clusters which produce categories that resonate with the current research. Their first category, creative expression does not relate explicitly to the current study, however the second category, enhanced self-understanding although strongly related to suicide in the context of their research, is immediately recognisable, with its references to enhanced personal insight and improved self-awareness (which is noted in the Qualitative outcomes section of the current research). The third category proposed by Paulson and Everall is Communication, however its items (i.e. *"letting me know that it's ok to be me"*), viewed from the perspective of the current research appears to suggest impacts such as *improved self-acceptance* and *feeling understood* rather than simply communication. Category four, Therapeutic Relationship is also immediately recognisable and touches on the category of *Therapist support/empathic listener.*

As was noted above, the first cluster in Clarke and colleagues' (2004) analysis (*"The listening therapist"*) relates to retrospectively recalled *Helpful aspects of therapy* in the current study and contains the categories: (a) **resistance and fear**, which corresponds with some of the clients in the current study's observations regarding aspects of treatment which were difficult at the beginning but beneficial in the long run (i.e. chair-work, unfinished business dialogues); (b) **excited and absorbed**, which resonates with the category of *facilitated emotional expression* in the current study (i.e. clients express excitement at this novel form of experiencing and relating); and (c) **safety** which references the category *therapist support/empathic listener* in the current study (i.e. positive references to the therapeutic relationship, implying support, safety and containment).

The second cluster in Clarke and colleagues' (2004) analysis (*"The big idea"*) contains four categories of client response, (a) **the model**, which resonates with the current study's utilisation of EFT techniques, (i.e. tasks presented within a clearly outlined theoretical context/rationale), (b) **dealing with thoughts**, this form of cognitive work was not explicitly engaged in during the current study, (c) **Understanding /patterns/core beliefs** resonates with the *increased awareness/insight* category wherein clients in the current study report greater self-understanding and experiential awareness, and (d) **testing things out**, which is not explicitly mentioned in end of therapy interviews in the current study. However, perusal of the therapist reports of therapy, and HAT forms reveals references to clients attempting to initiate new behaviours, either socially or at work or home. Again, in the current study, clients' perspectives appear to be referring to the process of therapy rather than the outcome. What is apparent is that while there is some compatibility with the CBT model, these categories were not fully observed in the current study. This, of course, may be also a function of the researchers' perspective, which in the current study is informed by the EFT model, as opposed to Clarke et al.'s (2004) study which is influenced by the CBT model.

A number of papers have examined client reported hindering or problematic aspects of therapy (Henkelman and Paulson, 2006;Paulson, Everall and Stuart, 2001; Levy, Glass, Arnkoff and Gershefski, 1996), using a variety of data collection and analysis methodologies, however, clients in the current research were unable to identify any unhelpful aspects of therapy (although some reported that they wished therapy had lasted longer). When asked to report on aspects which were difficult at the time but beneficial in the long run, their responses were mostly limited to difficulties early on in therapy in areas such as tackling past interpersonal injuries or problems in mastering the technical aspects of some EFT interventions (i.e., chair-work). Interestingly, in Gershefski and colleagues (1996)

examination of clients' perceptions of helpful events in treatment of depression, their inclusion of a Research client response category (which incorporates the idea that participating in the research may not have been helpful) fits with some of the participants in the current study's observation that they occasionally found the outcome measures confusing, and difficult to complete. Moreover, while clients often declined to comment on this area as being problematic, their occasional non-compliance regarding the completion of HAT forms further suggests a possible area of difficulty.

Helpful aspects of therapy – session reports

Data collected from the clients' HAT forms provides a picture of the client identified, in-session, helpful events and helpful impacts. Timulak (2010) notes that the types of helpful events that are established on the basis of helpful impacts of the events are not surprising, in so far as they broadly correlate with the impacts espoused by various theoretical approaches, and this is certainly so in the case of this study. All reported items in the current study are consistent with Elliott's taxonomies of helpful events, and of helpful events and their impacts (Elliott, 1985, Elliott & Shapiro, 1988). All clients referred to in-session engagement in EFT specific tasks (i.e., chair-work, clearing a space) as helpful, with a majority of clients (six out of eight) reporting that the opportunity to *freely express emotion* and to *access their core pain*, in session, were also extremely valuable. Instances of *therapist validation* as a helpful event, which echoes the notion of *therapist as audience* (Grafanaki & McLeod, 1999), led to the impacts of *feeling supported* and *feeling understood*. In-session opportunities to *explore current life difficulties* were also reported as helpful events. In terms of helpful events, as with reported changes due to therapy in the Client Change interviews, the categories produced a significant degree of overlap with the literature.

The client post-session reports of helpful impacts are consistent with Elliott and colleagues' (1985) Therapeutic Impact Content Analysis system, developed on the basis of significant events research, in relation to both *task* and *interpersonal impacts*. All clients reported that heightened *awareness and insight* were helpful impacts of therapy, a finding which has been reported in a number of studies see the Timulak's (2007) meta-analytic review. Finally, categories such as *feeling supported* and *feeling understood* by the therapist, although differentiated in the current study are occasionally subsumed under the more general heading of therapeutic relationship/alliance in other studies (see Timulak, 2007).

Cummings and colleagues (1994) qualitative analysis of the change process in 10 female clients attending brief therapy utilising the Important Events Questionnaire (administered at the end of each session), produced three distinct categories of change; consistent, interrupted and minimal change patterns are delineated. While the underlying themes which comprise these patterns (i.e. "learning to express feelings", "learning to tolerate painful self-feelings") are recognisable in the reported helpful impacts in the HAT data produced by the current study (i.e. Awareness and insight, self-acceptance, relief) it is interesting to observe how the three reported patterns capture some of the aspects (difficult and otherwise) of the emotional transformation process outlined in the current study (i.e. rather than following a linear pattern, therapy frequently requires patiently working with resistance and avoidance to achieve collaboratively agreed aims).

Richards and Timulak's (2012) examination of helpful and hindering events in on-line CBT treatment of depression used a similar method of analysis as was used in the current study (distinguishing between events and impacts of the events). Although these analyses compared two very different treatments, there is some overlap in terms of reported helpful events and impacts. For instance, the on-line CBT intervention reports events containing CBT interventions such as provision of new information, restructuring, monitoring/recording and

scheduling/planning as being the most highly endorsed categories of helpful events, whereas the current study emphasises engaging in experiential (EFT) tasks, emotional expression, accessing core pain and moments of therapist validation as being the most salient helpful events. In terms of helpful impacts, both studies endorse awareness and insight and achievement/self-efficacy empowerment to a considerable degree; however while clients in Richards and Timulak's study report learning coping skills and behavioural change as helpful impacts, the clients in the current study endorse relief and self-acceptance; once again, possibly reflecting the theoretical differences in emphasis of treatment.

4.3 Discussion of Case Conceptualisation

The analysis of case conceptualisation in the current study was based on the retrospective recall of the therapists regarding their particular cases, and in five cases also O'Brien and colleagues' (2012) findings were used. The therapists' conceptualisation as well as O'Brien et al.'s work was guided by the traditional EFT model of case conceptualisation and further informed by case conceptualisation thinking summarised in Timulak and Pascual Leone (2014). The analysis reveals certain patterns of the GAD dynamic from an EFT perspective.

Clients initially present in therapy in states of emotional dysregulation, experiencing undifferentiated painful (secondary) emotions such as fearfulness, hopelessness and helplessness (global distress) or irritability (rejecting anger). Typically clients with a GAD presentation report feeling overwhelmed, panicky, hyper-vigilant, and fearful; moreover, they struggle with numerous somatic issues, such as headaches, breathlessness, feeling suffocated, grinding of teeth and trembling. These aversive emotional states occur in response to current or past triggers activating emotion schemes which produce core pain and indicate that the clients' basic needs are not fulfilled. Due to the fact that the core pain is so intolerable, clients

either collapse to secondary hopelessness/helplessness or, fearing exposure to further triggers, engage in emotional and behavioural avoidance strategies. The impact of these avoidance strategies is mainly that they prevent GAD sufferers from accessing and processing core painful experience. The emotional avoidance strategy most commonly associated with GAD is worry.

O'Brien and colleagues' (2012) and the current study's position on the role of worry in GAD differs somewhat from some contemporary theories, which are expressed mainly in the literature from the cognitive behavioural paradigm. As has been discussed in Section 1.2.1., over time, excessive worry has become identified as the central, defining feature of GAD (Roemer, Orsillo & Barlow, 2002), to the extent that Andrews and colleagues (2010) proposed that the name of the disorder should be changed to Generalized Worry Disorder, Major Worry Disorder, or Pathological Worry Disorder, to better reflect this. The impetus behind the move to delineate, operationalize and measure the worry construct has come mainly from research programs from within the cognitive behavioral paradigm, and this has reinforced the position of worry as the central, essential and defining feature of GAD.

The current research supplements the traditional assumptions regarding the role of worry in GAD. For instance, the Avoidance Model of Worry (AMV; Borkovec, 1994; Borkovec, Alcaine & Behar, 2004) conceptualises worry as a verbal linguistic, cognitive activity (Borkovec, 1994; Behar, Zuellig & Borkovec, 2005; Borkovec & Inz, 1990), which is intended to enable the worrier to avoid painful imaginal experience, and thereby avoid the emotional or somatic pain associated with it. Worry is believed to be negatively reinforced (by the reduction in aversive imagery) and it is maintained that clients hold positive beliefs regarding worry (i.e., that it helps with problem-solving). While the current study supports the idea that worry operates as a form of emotional avoidance, it suggests that in the case of GAD sufferers, worry is being deployed to facilitate the avoidance of the sufferer's

idiosyncratic core emotional pain which has formed due to personal history and not just any emotional experience. Rather than simply being an immediate response to an anxiety provoking trigger, the GAD sufferer experiences a continuous, relentless drive to escape from such core painful experience (essentially unresolved maladaptive primary emotion) which may be amplified and exacerbated by current or historic triggers and is compounded by the fear of encountering such triggers. In this sense worry is but one of a number of strategies employed by the GAD sufferer to facilitate the avoidance of core painful emotional experience.

Borkovec and colleagues assert that worry is predominately associated with *surface level concerns*, captured in the notion that GAD sufferers and non-pathological worriers worry about the same things, the difference lies in the matter of how, and the degree to which, they worry. It is apparent from the cases in this study that the worries of GAD sufferers, from the point of view of an EFT conceptualization, operate at multiple, complex levels. The main distinction lies in the recognition that from an EFT perspective, worrying is inextricable linked to avoidance of an idiosyncratic core pain, and as the study reveals, core pain is commonly informed by experiences such as trauma, loss, abandonment, neglect and abuse. Accordingly the difference may be that whilst two people may worry about the same thing, the function and impact of worry varies greatly due to the individual's core pain. For example, in the cases of Laura and Tony it may be argued that their worry regarding situations at work in some way reflects surface level concerns, however, the fact that these worries are linked to long-standing, emotional, core pain feelings of inadequacy, worthlessness, failure to live up to parents standards and perceived inability to cope, suggests that the degree of pain from which they are trying to escape goes deeper than this.

The Intolerance of Uncertainty Model (IUM, Dugas & Robichaud, 2007) proposes that GAD sufferers have difficulty tolerating ambiguous situations with uncertain outcomes

and experience intense and chronic worry as a result. Central to the IUM are the propositions that GAD sufferers hold positive beliefs regarding the value of worry as a coping strategy, experience negative problem orientation and manifest cognitive avoidance (Dugas & Robichaud, 2007; Dugas et al., 1995; Dugas, Buhr & Ladouceur, 2004; Dugas, Gagnon, Ladouceur, Freeston, 1998; Freeston et al., 1994). The main point of divergence between the IUM and the findings of this study hinges on the assumption of causality, in so far as, while there is no dispute over the claim that intolerance of uncertainty may be an issue for GAD sufferers, it seems unlikely that it operates as the principal causal agent in driving the worry process. As described above (in relation to the Avoidance Model), GAD sufferers, from the perspective of EFT case conceptualization, fear exposure to their specific and idiosyncratic core pain and the intense and disturbing emotional experiences that this might entail. Repeated exposure to this type of painful experience in the past, i.e., the repeated failure to have core needs met, or repeated activation of core pain feelings of shame, loneliness or sadness may indeed, over time, produce feelings of trepidation and uncertainty in the face of ambiguous situations, which might prove hurtful. However, it would appear as though intolerance of uncertainty is byproduct of these processes rather than the initiator of them (cf. Fisher and Wells, 2009).

With regard to clients holding positive beliefs in the value of worrying, there is some evidence in the current study which would support this. For example, clients commonly reported the important role that worry played in their daily lives, either as a means of preparing for future negative events or as a galvanizing, or driving, force which helps mobilize them and enables them to stay in control of difficult situations. In therapy, the cost of holding such a belief would often become clear in worry dialogues, when the Worry Agent would be contemptuous towards, and dismissive of, the experiencer, insisting that he/she would not be able to cope without the Worry Agent's help. When made explicit in this

manner, (i.e., enacted in a two chair dialogue) it becomes clear how the positive belief in worry is closely linked to a core feeling of inability to cope, which highlights the cost to the client of this particular coping strategy.

An EFT case conceptualization of GAD, as presented in the current study does not find specific support for the notion of negative problem orientation (cf. Dugas & Robichaud, 2007). Rather it suggests that while the clients' negative self-evaluation (e.g., I am flawed, useless, worthless etc.), viewed as a component of core-pain, may impact on their attitude towards problems, it is best viewed as the product of internal processes linked to their GAD dynamic, and may find expression in beliefs like *"I have to do everything otherwise it won't be done properly"*. It is possible, however, that there is a degree of negative problem orientation in the hopelessness and helplessness experienced as a result of repeated failures to have core needs met. Finally with regard to the IUM model, while the current study accepts the role of cognitive avoidance in GAD it views it as part of a broader process of avoiding core pain.

The Metacognitive model (Wells, 1995, 1999) distinguishes between *Type 1 worry* which refers to worry about external events and internal non-cognitive issues and *Type 2 worry* or *meta-worry*, which comprises troubling and negative thoughts regarding worry as uncontrollable and harmful. Interpretation of Type 1 worry as dangerous leads to the activation of Type 2 worry (worry about worry). The model also proposes that further distress is caused to clients by the difficulty in integrating simultaneously held positive and negative beliefs regarding worry. The current study found no evidence to support the claim that Type 2 worries were responsible for driving the GAD dynamic. Although clients became aware, in therapy, of the negative impact of constant and debilitating worry in terms of exhaustion, sleep disruption, etc., they more commonly held the belief that worry was a useful coping strategy, expressing greater concern (through negative self-treatment) over the fact that they

were in distress in the first place, which they linked to core painful experiences of vulnerability, loneliness, feeling oneself to be defective and so on. With regard to the claim that clients have difficulty integrating positive and negative beliefs about worrying, this was not a major concern for the clients in the current study. Rather, clients' generally positive beliefs concerning worry were unpacked in two chair dialogues and addressed accordingly.

The Emotion Dysregulation Model of GAD (Mennin, Heimberg, Turk & Fresco, 2002; Mennin, Turk, Heimberg, & Carmin, 2004) proposes that GAD sufferers experience positive and negative emotional arousal to a greater degree than their non-clinical counterparts, have a limited understanding of their emotional experience, view emotion in a negative light and consequently overuse cognitive coping strategies to assist with affect regulation. While there are a number of areas in which the current study concurs with the propositions of the EDM, there are differences in how these findings are interpreted. Although both theories recognize the centrality of emotional processes in the production and maintenance of the GAD dynamic, EFT focusses less on the intensity of the felt emotion, but rather, distinguishes between primary and secondary emotions, which has implications for how client distress is interpreted. An EFT case-conceptualization, as presented in the current study, would hold that although the client may be experiencing intense secondary emotions (undifferentiated Global Distress) the real difficulty lies in the clients' inability to access and tolerate the primary emotions associated with their core pain. For example, Tony's experience of intense rejecting anger towards his ex-partner is a result of his inability to access the vulnerability implicit in his core feelings of loneliness, rejection, abandonment and keen sense of personal failure. Following from this, his difficulty is compounded, not by a poor understanding of emotion in a cognitive sense, but by an experiential inability to access, organize and integrate primary emotional experience in a meaningful way. Tony's fear of his core pain leads him to avoid it by any means possible (anger, panic etc.), so that while his

experience of secondary anger is, doubtless, intense, it is the unprocessed core feelings of abandonment, rejection and loneliness which are fuelling his GAD dynamic. While he may view his secondary emotional experience in a negative light, it is his inability to access his painful core emotions (the actual source of his distress), which is problematic. For Tony, and indeed all of the clients in the current study, cognitive coping strategies are only one component of a variety of strategies mobilized in order to facilitate avoidance of the core pain.

Roemer and Orsillo's Acceptance Based Model of Generalized Anxiety Disorder (2002, 2005) proposes that individuals experience difficulty with internal experience due to negative responses to internal experience and a fusion with internal experience. In common with the other theoretical approaches discussed, while there appears to be superficial convergence between the ABM and EFT regarding case conceptualization, there exists a difference in emphasis regarding the understanding of the processes involved. The ABM proposes that GAD sufferers have negative reactions to internal experience which makes it difficult to identify, tolerate and understand emotional experience and to a degree this is supported by findings in the current study. The second proposition is somewhat problematic, however, in so far as it asserts that the individual fuses with the temporary negative belief, mistakenly believing that it is permanent. As in other CBT oriented models, this appears to suggest that clients experience negative, reactive responses to stimuli, which, through faulty thinking or poor understanding of emotional processes, they construe as permanent, identity defining problems. The findings in the current study, however, suggest that the clients' experience of emotion is contained in emotion schemes, where self- organization as a result of developmental factors features profound and enduring idiosyncratic core pain. As a result of an inability to tolerate and process this very specific personalized core pain, further maintained by complex and varied mechanisms of avoidance, clients remain in a state of

unresolved emotional distress, which, to all intents and purposes, is experienced as permanent and self-defining.

4.4 Discussion of Emotion transformation

As in the previous section, it is evident that O'Brien and colleagues (2012) and the current study's position on the role of emotion transformation, differs somewhat from other, current (and mainly cognitive-behavioural) accounts of treatment for GAD. The first factor which stands out is how CBT models tend to focus on symptom reduction and the containment of worry as primary outcomes of treatment. This contrasts with EFT's position which focusses more on the idea of healing core emotional pain which is being currently avoided by means of the worry process (see below).

The various means of treatment for CBT models are set out in section 1.2.1, however to briefly summarise; all of the models adopt a combination of CBT principles such as self-monitoring, relaxation techniques, cognitive restructuring and challenging beliefs around worry. Some model specific variations occur. For example, the AMW incorporates aspects of worry outcome monitoring, present-moment focus and expectancy-free living in its treatment plans, while the IUM focuses on psycho-education regarding intolerance of uncertainty, evaluation of worry beliefs, improving problem orientation and processing central fears (Robichaud and Dugas, 2006). In shift of emphasis, the MCM additionally targets 'Type 2' worries and utilizes shared case formulation to explore the worry fully, socialization, discussions regarding the perceived uncontrollability of worry, and exploration of concepts such as worry as dangerous and positive beliefs in worry (Wells, 2006). The EDM in addition to the CBT interventions, makes an attempt to address the emotion component of GAD by focusing on emotion regulation techniques such as increasing emotional awareness and exposure, and also focusses on emotion related areas, which are consistent with its case

conceptualization such as emotions' belief reframing, psychoeducation around emotion, emotional skills training and experiential work around emotion (Mennin, 2004; 2006; Fresco, Mennin, Heimberg & Ritter, 2013). However, these appear to be rather mechanistic, containment strategies for managing emotion rather than attempts to transform emotion with emotion as proposed by EFT.

Clearly the treatments described above are consistent with the case-conceptualizations of their respective models, which have already been discussed, and are subject to the same observations regarding their limitations. For example processes which rely on cognitive restructuring, see worry as being based on dysfunctional beliefs, and assume that challenging the content of worry leads to resolution reveal a different emphasis in focus of treatment between these models and EFT. A principal distinction between emotion transformation in EFT and the above approaches is EFT's focusing on experiential processes in session targeting the core 'unresolved' emotional injuries and vulnerabilities, rather than cognitive features of the worry process (with the exception of the EDM and some exposure work that also focus on emotion, albeit, in a more mechanistic, skills training based manner) and psychoeducation around them.

EFT proposes that clients are suffering from an inability to access and transform their specific idiosyncratic core pain (usually centred around the feelings of loneliness/sadness, shame, and fear/terror – (cf. Timulak & Pascual-Leone, 2014)). This core pain needs to be accessed and transformed through the experiences of compassion and protective anger (see Timulak & Pascual-Leone, 2014). Once this underlying pain is transformed, i.e., made more bearable and supplemented with self-organizations containing self-compassion and protective anger, the client has less reason to be afraid of this core pain and fewer reasons to engage in emotional and behavioral avoidance strategies, one of the most significant of which, is worry. In fact, it was initially expected that the worry element might not need to be addressed at all

in the treatment, and the principal investigator of the overall GAD project (Timulak, personal communication) assumed that as the clients became stronger internally, with regard to their primary emotional injuries and vulnerabilities, there would not be a need to address the worry directly as it's reason for existence (the protection against the core pain) would no longer exist. However, the experiences with clients showed that the worry process is very entrenched and almost has a life of its own.

Thus, it was learnt by the researchers and the therapists in the project that it is important for clients to engage with their Worry Agent in two-chair dialogue tasks. This proved to be an important aspect of treatment as it allowed the client to recognize both the protective function of worry (Worry Agent states: *"If I didn't worry you, you wouldn't be able to cope with anything"*), but also facilitates recognition of the cost of worry for the sufferer in terms of hopelessness, helplessness and loss of agency (Experiencer concludes: *"I cannot cope with anything"*). Clients also became aware of how physically and emotionally exhausting this process was over time. In addressing the worry process, it appears that resolution requires two important aspects to occur. While it is hoped that the client can be facilitated in accessing self-compassion, reflected in the softening of the worry agent in relation to the experiencer (i.e., *"I'm sorry, I didn't mean to put you under so much pressure"*); emotion transformation also requires that the experiencer is able to access and express protective/assertive anger in order to establish appropriate boundaries with the Worry Agent (i.e., *"I won't allow you to terrorize me like this any longer"*).

However, to reiterate, the key element of EFT theory is the recognition that resolution of worry is not considered to be the end product of therapy; it merely represents helping the client to overcome avoidance. The ultimate aim of EFT in terms of emotion transformation, is to facilitate the client in accessing their idiosyncratic core pain and then transforming it in a manner which could be described as consistent with EFT transformation processes found

elsewhere in the literature (cf: *Depression*; Greenberg & Watson (2005); *Complex Trauma*: Paivio & Pascual-Leone, (2010)). The perspective on emotion transformation described here is theoretically embedded in the developing EFT model of emotion transformation (Pascual-Leone & Greenberg, 2007; Pascual-Leone, 2009; Timulak & Pascual-Leone, 2014). One of the main features distinguishing GAD from other disorders treated within the classic EFT perspective is the pervasiveness of worry. Thus in treating GAD from an EFT perspective it is essential to focus on and work with, this particularly complex and relentless form of avoidance and the (secondary) apprehensive anxiety that drives it (Timulak & Pascual-Leone, 2014). However, in terms of EFT's overall theoretical position regarding emotion transformation, it is assumed that when core pain is accessed, and transformed, then the need for such a form of avoidance will be less pronounced.

4.5 Implications for Theory

Overall, from a review of the first eight cases in a wider study of thirteen cases, the results of the current study appear promising, suggesting that both EFT theory of GAD, and EFT theory of treatment of GAD warrant further examination. An examination of qualitative and quantitative results indicates that therapy appears to have been effective, to varying degrees across all cases. However in some cases, both therapist and client felt that therapy would have been more beneficial, had it been allowed to continue for longer. Unfortunately the treatment was limited to 20 sessions, which was consistent with our research goal of developing a therapy that could be offered in a way which matched the timeframe typically offered by existing empirically based treatments for GAD. In three of the cases (Ann, Susan, Fiona), therapy exceeded the 20 session limit, however it is worth noting that, (a) this is not representative of the wider study (wherein, only these three clients out of 12 exceeded the limit), (b) the clients in question all experienced particularly traumatic issues prior to completing therapy (i.e., serious medical complications, and legal issues) and their

subsequent fragility made it clinically necessary to prolong treatment, and (c) it may be part of the GAD presentation that attachment issues around the separation implicit in finishing treatment are activated and make it difficult for clients to let go of a supportive and healing relationship. In these three cases the therapist attempted to finish the therapy as close to 20 sessions limit as was clinically possible, however, in at least two of those three cases, the therapist and the client agreed that it would be beneficial to have a more long term therapy. Research also suggests that clients evince a variety of recovery patterns and indicates that in the case of more chronic clients, with complex presentations, that assessment ought to be conducted in terms of improvement rather than full recovery (Lutz, Stulz, Martinovich, Leon, & Saunders, S. M., 2009). Notably all clients, either in post-treatment interviews or HAT forms, commented on finding the therapy to be a helpful and valuable resource.

While the current study supports the notion that worry is the avoidance strategy most commonly associated with GAD, it disputes the role and character assigned to worry by other contemporary (mainly CBT) theories. On the other hand, despite initially theorising that worry was quite superficial (when compared to idiosyncratic core pain), the current study now supports the idea that due to the chronic, ingrained and identity-defining nature of worry, it is in fact, central to case conceptualisation. While acknowledging that worry has a protective function (protecting the client from core pain) it is also a debilitating and terrifying process which directly undermines the client's sense of agency. Rather than seeing worry as the cause of distress (cf. Wells, 1995, 1999) the current study notes that clients often have an almost exaggerated belief in the positive aspects of worry (for example in response to item 5 on the GADSS, many clients respond by claiming that their worry makes them extra efficient in work). The current study, therefore, supports the idea that to effectively treat GAD from an EFT perspective it is necessary to facilitate the client to the position in which they are both resilient in the face of their Worry Agent, and also to the position in which the Worry Agent

softens and is less reactive when exposed to potential triggers (of the core pain). This is only one stage in the work however, as the main work of EFT in relation to resolving GAD, lies in helping clients to access and process idiosyncratic, core painful experience, mainly by transforming it through accessing both self-compassion and protective anger in response to the unmet needs attached to core painful emotions; worry is essentially an obstacle to achieving that goal. Resolving worry is not the end goal of EFT treatment of GAD. Perhaps most significantly, while alternative conceptualizations of worry (mainly from within the CBT paradigm) perpetuate the idea that GAD sufferers are tormented by their worrying, and will worry about almost anything (hence the *generalized* nature of their condition), EFT proposes that they are in fact worrying in order to manage, or cope, with a very specific, idiosyncratic core pain, which is, in fact, the real source of their distress.

4.6 Implications for Clinical Practice

It follows logically from EFT's case conceptualization of GAD that, although accessing and transforming the clients' idiosyncratic core pain is the ultimate goal of treatment, it is important that the clients' worry process be addressed early in therapy, for a number of reasons. As described above (section 4.5) worry is the principal means of emotional avoidance employed by GAD sufferers to protect them from their core pain. As long as this form of avoidance is in place and unchallenged, the client is cut off from vital adaptive information regarding their emotional experience, and will be unable to access, and as a result unable to process, their core pain. This is further complicated by the fact that clients' worry agents are generally firmly embedded in the clients' identities and have most effectively asserted their integral importance to the client (i.e. *"you couldn't cope without me"*). As a result the negative impact of the worry agent may frequently go unacknowledged, and when attention is drawn to it, there may be ambivalence on the part of the client who is, perhaps naturally, reluctant to give up something which has, over the years, positioned itself

as a valuable strategy for coping with (i.e. avoiding) emotional experience. Hence the emphasis in EFT treatment of GAD, on both softening the Worry Agent's treatment of the experiencer through activating self-compassion (i.e. *"I didn't mean to frighten you so badly...it wasn't my intention"*) and at the same time, strengthening the experiencer in relation to the Worry Agent by mobilizing protective anger (i.e. *"I will not let you terrorise me like that anymore... I've had enough"*), so that appropriate boundaries can be set.

It is important for clinical practice that EFT therapists focus on facilitating clients in accessing and transforming their specific idiosyncratic core pain; by accessing experiences of self-compassion and protective anger (see Timulak & Pascual-Leone, 2014). When the client is able to tolerate their core pain and use the adaptive emotional information contained therein, to identify their unmet needs, they are then in a position to symbolize those needs in language and express them to a listening other. Through the use of two-chair techniques, they can then address the previously unmet need, by enacting self-compassion (towards the experiencer in chair-work: i.e. *"I always loved you. I never wanted you to feel so alone"*) and protective anger (expressed by the experiencer in chair-work: i.e. *"I deserve to be appreciated, and I will not let you dismiss me anymore"*). Ultimately, when the core pain has been transformed and clients become increasingly resilient in the face of adverse emotional experience it is expected that this will further reduce the need to engage in behavioral and emotional avoidance.

4.7 Implications for Future Research

As stated in Section 4.1, the aim of this study was to contribute to the development of EFT as an effective treatment of GAD. Through analysis of eight case studies from both a quantitative and a qualitative perspective the current study hoped to establish a preliminary assessment of the potential efficacy of EFT for GAD and the processes that may or may not

contribute to it. It would appear from our findings that the treatment can be considered to be at least comparably effective, when tentatively benchmarked against larger outcome studies of a variety of therapies for GAD. The wider project is still ongoing, and while 11 clients have completed therapy, another 3 are in currently in therapy. Data suggests that the results appear to be consistent with the findings in the current study. From the outset of this research it was felt that should pre-post difference in GAD symptoms prove comparable to, or better than, those of other psychotherapeutic treatments for GAD, it would warrant conducting a randomised controlled trial comparing EFT to treatment-as-usual (e.g. some form of CBT). The quantitative results of the current study, when compared to other therapies for GAD (Section 4.1) suggest that it would now be appropriate to conduct such an investigation.

This may be particularly pertinent, given the tendency of therapies from within the cognitive behavioural paradigm, working from within a DSM diagnostic framework, to somewhat overemphasise the role of worry in both cause and maintenance of GAD, to such a degree that, according to CBT and DSM conceptualisations of GAD, reduction in worry as the defining feature of GAD is considered virtually equivalent to resolution of GAD. The current research, in terms of both case conceptualisation and emotional transformation proposes that the resolution of GAD requires more than simply addressing its principal mechanism of avoidance (i.e., worry). Significantly, the core pain which EFT targets as a priority, is accessed and processed in clinical practice, in a manner which is already considered to be consistent with APA Division 12, Empirically Supported Treatments (cf. Depression: Greenberg and Watson, 2006). That this method of treatment informs the core of EFT treatment of GAD, strongly suggests that an RCT would be timely, in order to establish the efficacy of EFT for GAD in the context of the broader evidence base.

4.8 Limitations of the Research

Perhaps the most obvious limitation of the current study is the small sample size, which necessitates that findings are held to be tentative. While the research question is satisfactorily addressed, in so far as results appear to warrant further investigation of EFT for GAD, one possible limitation is that as all of the clients in the current study evinced good outcomes at least on some, and in majority of cases, most of the measures (i.e. either improved or recovered), a potentially valuable source of data (i.e. from poor outcome cases), which might have enriched our understanding of this particular form of treatment, is not available. On the other hand, it appears that the clients who benefited least from the therapy had more chronic and complex issues and it was generally agreed between them and their therapist that they would benefit from longer term therapy.

It is worth noting that the clients who participated in this research endured particularly chronic debilitating forms of GAD, with high levels of comorbid depression and Axis II personality disorders. This is reflected in the fact that some clients commented that they would have preferred their therapy to have continued beyond the allotted 20 sessions. This was confirmed by their therapist who also felt that certain clients would have benefited from a longer treatment (it is worth noting that in three cases the therapy exceeded allotted 20 sessions for clinical reasons – however, it was finished at the first possible opportunity when the client could be discharged). A number of clients expressed difficulty in completing the outcome measures due to ambiguously phrased questions, reversed questions and possibly, in some cases to undiagnosed literacy issues.

While as much as possible has been done to safeguard objectivity in conducting this research, the author is aware of Luborsky and colleagues' (2006) findings in relation to the manner in which researchers' theoretical allegiance may predict the results of outcome

studies. It is worth noting that this consideration frequently refers to RCTs wherein the researcher's theoretical allegiance leads to the model or theory espoused by the researcher achieving better outcomes than the control (or alternative condition) group. In the case of the current research, it is safe to assume that the following assumptions may hold. Given that if a researcher/therapist is conducting therapy in a manner which is consistent with his/her chosen theoretical modality then it is likely that this will positively affect therapy outcome. Relatedly, the client may be afforded additional optimism by the therapist's clear belief in their chosen way of conducting therapy and their expertise in same. It has been observed that when the researcher has a strong allegiance to a particular therapeutic modality, that this can be transmitted to therapists participating in the research and may affect outcome (Luborsky et al., 2006). Arguably, as the treatment is being recorded and used in clinical research, therapists may be inspired to work harder than usual at aspects of therapy such as adherence to protocol and therapeutic alliance.

It is hoped that the degree of triangulation provided by the various data sources (i.e. *client report*: HAT, client change interview, outcome measures; *therapist report*: case conceptualisation, emotional transformation; *observer report*: CEPS-R, CEAS-III, CAMS) goes some way to ensure a degree of scientific objectivity. While the fact that the *case conceptualisation* and *emotional transformation* sections are dependent on the therapist's perspective, rather than that of observers, they are, fortunately, augmented by (observer-based) O'Brien and colleagues' (2012) analysis in the first five cases, and by Keogh and colleagues' (2013) and Crowley and colleagues' (2013) single case studies of the first two clients respectively, and by Murphy and colleagues' (2013) and Hughes and colleagues' (2013) analysis of specific aspects of the therapeutic process, which offers a further degree of objectivity.

Another possible aspect which may have affected the findings of the study concerns the possible impact upon the clients of being involved in the research process itself. Unlike in treatment as usual in the service, it is possible that clients' expectations of good outcome are raised by participation in a structured, assessment-focussed treatment, which, on a regular basis, solicits their opinion as to how therapy is progressing. Moreover the warm and supportive attitude of the research team may have offered an extra-therapeutic resource to clients (i.e. confirming sessions by text) which is not ordinarily offered to clients. Those who chose to participate in the research also received between 16-20 sessions of therapy which exceeds the number of session usually offered by the primary care centre. To some degree, this may have helped to off-set the potentially anxiety-provoking aspect of being filmed and video-recorded during treatment.

4.9 Author's Reflexive Statement

It hardly needs to be said that embarking on a PhD is a daunting undertaking, and the current research proved to be no exception. Due to the complex nature of the research I faced a number of challenges, some of which, in retrospect, were predictable and, indeed unavoidable, whilst others proved to be somewhat more unexpected.

A decision was taken early on, for both theoretical and pragmatic reasons, to conduct the research in association with a local primary care centre, who would act as host. This was consistent with research findings which indicate that GAD is particularly prevalent in primary care settings, thereby lending greater ecological validity to our findings by providing a more representative sample. It was also born of necessity, in so far as the university does not have an in-house psychotherapy clinic for research purposes. While no doubt adding to the authenticity of the study, this arrangement produced a number of logistical and organisational difficulties.

Utilising an off-site host institution necessitated weekly assembling and dismantling of all recording equipment, which had to be transported to and from the premises on a weekly basis. This may have contributed to occasions when, due to technical mishaps (i.e. faulty connections, camera positions shifting), data were not recorded. All data (audio and audio-visual, self-report measures etc.) were then transported to the University for storage. In the case of paper documentation this simply required being placed in a file in a locked cabinet, however for all digital data, it was necessary to upload the material to an encrypted hard drive which (given the somewhat limited nature of our equipment) proved time consuming. As project manager, this meant that I spent a great deal of time transferring data from one repository to another; time which might have been more productively spent on other tasks.

The situation was further complicated mid-way through the research process when the building in which we were conducting the research was demolished and the host service was fragmented and distributed across three new centres. The implications of this move quickly became apparent in that I felt a diminished sense of control over the proceedings. To illustrate, in the early part of the research, which was focussed in one centre, I was managing one therapist, seeing one to two clients, and was in a positon to collect and store all data. After the demolition of the host building and the subsequent decentralisation of services, I was managing two therapists across three settings, and was now largely dependent on a number of research assistants (counselling psychologists in training) to collect data and conduct assessments.

Parallel to my own research, as has been described earlier, I was involved in a number of other studies which conducted analyses based on the data produced by the current study. This required attending two to three sessions (generally of two hours duration) of data analysis on a weekly basis. These meetings generally took place in the evenings. It was necessary at this point to enlist the assistance of a number of transcribers in order to provide

transcripts of therapy sessions, required to facilitate analysis. Given the strict ethical guidelines governing data protection (i.e. no use of email), this required regular face to face meetings with the transcribers in order to hand over recordings for transcription. Given the respective availability of the five transcribers to meet on any given day, combined with my own commitments, this quickly proved to be something of a logistical nightmare. I found this aspect of the research, coordinating multiple persons across multiple domains, to be highly challenging.

In addition to project management duties, I was the therapist for two of the clients contained in the current study; this brought its own unique set of challenges. One of my duties in the first year of setting up the research was to organise a training in EFT (levels 1, 2 & 3) to facilitate the development of a pool of therapists (including myself) who might be considered to be of a sufficiently high standard as to be able to participate in the research. This was hugely beneficial and doubtless contributed to the quality of adherence overall in the project. Nevertheless I found the whole experience of performing as therapist in the study to be quite nerve-wracking. Having qualified as a counselling psychologist in 2009, I felt reasonably secure with regard to my abilities as a therapist, however the thought of being recorded and scrutinised, delivering a theoretically and technically complex treatment was quite intimidating. I suspect that for most of the therapy I delivered, I was more acutely aware of, and impacted by, the presence of the camera than the clients. The awareness that the work was being assessed by Professor Greenberg for adherence was quite daunting. I also found the weekly supervision sessions, in which the entire course of the session was analysed on video, to be draining. Professor Greenberg suggests that EFT clinicians need to have two full cases of EFT psychotherapy fully supervised before they can feel competent to practice. Unfortunately my first two cases occurred simultaneously and both were recorded for the current study which caused elevated levels of anxiety on my part. In conversation, Clara Hill

once referred to a recently qualified therapist as being at a 'narcissistically immature stage of development' and there were many times during the course of supervision when I struggled to maintain the levels of confidence required to deliver therapy which was consistent with strict EFT practice. Moreover, at the time, (and even now), I did not consider myself to be a purely EFT therapist, and therefore felt something of a struggle to compartmentalise and bracket competing theoretical positions and practical interventions from other orientations. I noted that as the EFT protocol became more clearly embedded in my mind it became more fully expressed in my work and that my clients appeared to respond well, however I believe that therapy is an essentially relational activity and took solace at the time from the fact that I had extremely good working alliances with both of my clients.

In terms of the analysis, as has been described earlier, the current study presents eight cases in open trial format. It is somewhat ambitious in its scope in so far as it aims to present these cases with as much detail as possible. The reason for this is twofold. Firstly, it is hoped that by providing a rich account of the client's journey through therapy, utilising data from multiple sources, including the clients own description and therapists process observations; the reader may have greater access to the client's inner world and their journey through therapy. Secondly, although it was not possible to perform full HSCED analyses of each case, it is hoped that the foregoing data sources, triangulated with quantitative outcome measures allow the reader to make meaningful inferences regarding the outcome and potential contributors to outcome (be it positive or negative). I was comfortable with the fact that although we did not utilise the quasi-judicial protocol described by Elliott (2002), in which a dialectic between the 'sceptic brief' and the 'plausibility criteria for good outcome' prevents premature completion of the hermeneutic cycle, I felt that data were presented in a sufficiently transparent way as to allow the informed reader to draw their own conclusions.

In sum, I found that the overall experience was both highly rewarding and highly challenging, which is perhaps what one would expect. I feel that I had the opportunity to develop as a clinician in addition to acquiring skills as a researcher. Importantly, thanks to the support of my supervisor (who also doubled as a clinical supervisor) I also had the opportunity to present my preliminary research findings at international scientific conferences which allowed me to contextualise my own research within a broader research paradigm. The sense that I was contributing to treatment development within a broader movement dedicated towards the evolution and development of effective and efficient psychological treatments of mental health issues was both validating and hugely motivating.

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Appendices

Appendix A: Ethics consent

Appendix B: Client Forms

Appendix A



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

North Dublin Psychology Services
The Nurses Home
Rathdown Road
Dublin 7

Telephone: (01) 8360137
Fax Number: (01) 8825130

The Research Ethics Committee
School of Psychology
Trinity College
Dublin

Re: Research Proposal; "Emotion-focussed therapy (EFT) for mood and anxiety disorders" submitted by Dr. Ladislav Timulak, and James McElvaney M.Sc.

To Whom It Concerns,

This letter is to confirm that the research described by the above proposal, submitted by Dr. Timulak and Mr. McElvaney will be hosted by the Primary Care Psychology Service of the North Inner City. Research will be conducted in accordance with the Guidelines set out by the School of Psychology at Trinity College Dublin and will conform to the ethical guidelines pertaining to HSE Psychology Departments.

Yours faithfully

Elaine Martin
Senior Psychologist
Partnerships in Primary Care – North Inner City

COLÁISTE NA TRÍONÓIDE, BAILE ÁTHA CLIATH | TRINITY COLLEGE DUBLIN
Ollscoil Átha Cliath | The University of Dublin

21st July 2010

F.A.O. James McElvaney and Ladislav Timulak

School of Psychology Research Ethics Committee

I am pleased to inform you that your application entitled "Emotion-focussed therapy (EFT) for mood and anxiety disorders" has been approved by the School of Psychology Research Ethics Committee.

Yours sincerely,

Dr. Tim Trimble
Chair
School of Psychology Research Ethics Committee

SCHOOL OF PSYCHOLOGY
Aras an Phairsaigh
Trinity College
Dublin 2

Scoil na Síceolaíochta,
Dámh na nEolaíochtaí Sóisialta agus Daonna,
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Appendix B

PARTICIPANT CONSENT FORM

Principal Investigators: Dr. Ladislav Timulak, Course Director, Doctorate & MSc in Counseling Psychology, James McElvaney, Counselling Psychologist.

Declaration of Participant

The nature and purpose of this study have been explained to me both verbally and through the information sheet supplied.

I, _____ understand that I am consenting to participate in research which looks at emotion-focused therapy for generalised anxiety disorder at the North Inner City Primary Care, with a view to improving the service for future attendees. I have been given an opportunity to ask questions about the nature of the study and am satisfied with the answers.

I understand that in signing this consent form I am agreeing to allow information from questionnaires, pre and post outcome measures, process measures and therapy sessions to be used by the researchers in this study.

I am aware that this consent includes granting permission for my interview and therapy sessions to be (video and/or audio-recorded), the data transcribed, analysed and used in the research.

I understand that my participation in any part of this research is entirely voluntary. I may withdraw my consent and terminate my participation at any time without affecting any future treatment at the North Inner City Primary Care.

I am aware that the data in this research may be published in professional outlets and used in workshops and seminars. I understand that my personal details will not be revealed in the published research or in any subsequent published material, which uses the information contributed to the study.

I have been provided with the contact details of the researchers should I have any questions or concerns regarding this study.

Name:_____

Signed: _____ Date: _____
(Participant)

Declaration of Researcher

I have explained the nature of the study to the above named participant. I have answered any questions and addressed any questions and addressed any concerns with him/her. I am confident that the participant understands the nature of the study and that s/he is freely giving consent.

Name:_____

Signed: _____ Date: _____
(Researcher)

PARTICIPANT INFORMATION SHEET

Dear participant,

Purpose of study

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this

Who will conduct the research?

Dr. Ladislav Timulak, Course Director of Doctoral & MSc in Counselling Psychology and James McElvaney, a counselling psychologist and a PhD. Candidate at Trinity College Dublin are principal investigators in this project. Other psychologists and doctoral trainee psychologists may collaborate on the project. We are conducting an investigation into how persons suffering from Generalised Anxiety Disorder experience their condition. We are also investigating how Emotion Focussed Therapy, a scientifically validated form of psychological therapy for depression can be adapted for the treatment of Generalised Anxiety Disorder.

Title of the Research

Investigation of the application of Emotion-Focussed therapy as a treatment for Generalised Anxiety disorder

What is the aim of the research?

Currently persons suffering from Generalised anxiety disorder have a limited range of options available to them when it comes to scientifically validated psychological therapies according to current stringent criteria. Cognitive-Behavioural therapies are routinely considered by clinicians to be the first line therapeutic response when confronted with anxiety, and are frequently administered in combination with medication. Research has shown however that not all people respond to these methods.

There are three aims to this research. (i) This project aims to place anxiety sufferers at the centre of the research by investigating how they actually experience the condition. It is our hope that improved understanding of how anxiety is experienced will contribute to the development of an EFT program for anxiety. (ii) Our aim is to adapt Emotion Focussed Therapy, (a psychological therapy which has already been scientifically proven to assist in the treatment of depression), to the treatment of anxiety. (iii) Our goal is to increase the range of choices available to anxiety sufferers by demonstrating that there are viable alternatives to those currently on offer.

Why have I been chosen?

Your initial intake at the primary care centre indicates that you may be experiencing some difficulty with anxiety. Accordingly you have been offered the opportunity to participate in this research which aims investigate emotion-focused therapy as a treatment for anxiety

What would I be asked to do if I took part?

Prior to beginning therapy you will be asked to fill out a number of questionnaires. The same will be repeated at the end of therapy and at follow-ups (see below). Therapy itself will then commence as normal. Throughout the course of therapy your situation will be carefully monitored. You will also be asked to contribute to the evaluation of your therapy by means of self-report questionnaires filled out after therapy sessions.

What are the benefits of your participation?

You will be offered therapy that will be closely supervised by experts in this therapy. The length of therapy that is available to you is approximately twice as long as is normally available in the service. It is hoped that therapy would be more beneficial than routine care provided.

What are potential hindering aspects of your participation?

As in any psychologically therapy, the effects may not be achieved. Small number of people gets worse while in therapy. The research procedure may be time consuming. The therapy or research procedure may stir difficult emotions. All of those hindering aspects are responded to by availability

of qualified professionals and by respecting your preferences for treatment and/or research participation.

The Nature of the Research

It is necessary when exploring a participant's experience of anxiety and in evaluating their response to a course of therapy, to look for information of a sensitive nature. It is in the nature of therapy that information of a sensitive nature be disclosed. Such disclosures are an integral part of therapy and will be treated with the utmost respect by therapists and researchers alike. Moreover, you will have an opportunity to address any such issues raised in therapy.

What happens to the data collected?

Data collected from outcome and process measures will be gathered and analysed by the researchers. Transcripts of therapy sessions will be analysed by the researchers and other trained raters (trainee counselling psychologists). Interviews will be transcribed and analysed by the researchers.

How is confidentiality maintained?

Each participant will be assigned a code number upon signing the consent form and accordingly data can be stored anonymously using only the code as reference. Consent forms will be stored separately and securely in a locked cabinet. See http://www.tcd.ie.foi/ for details. Data will be stored for ten (10) years in keeping with School of Psychology Guidelines. Research abides by the Data Protection acts (1988, 2003) (The Data protection commissioner: Data Protection Guidelines on research in the Health Sector)

What happens if I do not want to take part or if I change my mind?

Participation in this research is entirely voluntary - It is up to you to decide whether or not to take part. Refusal to agree to participate will involve no penalty, prejudice or loss of benefits to which you might otherwise be entitled. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to

withdraw at any time without giving a reason and without detriment to yourself. You may then engage in the standard form of therapy provided by the primary care centre.

Will I be paid for participating in the research?

No-one will be paid for their participation in this research

What is the duration of the research?

You will be asked to complete a battery of tests prior to commencing therapy, at the end of therapy and at follow-up. This will take approximately 30 to 45 minutes. You will be offered up to 20 sessions of therapy, lasting approximately fifty minutes each, and may be asked to complete a brief self-report measure after each therapy session. You will be contacted 6 months, 12 months, 18 months, and 24 months after the end of therapy to fill out a battery of tests monitoring your well-being at those times.

Where will the research be conducted?

Initial assessment will be carried out at the North Inner City Partnership in Primary Care. The research will be conducted at the North Inner City Primary Care centre.

Will the outcomes of the research be published?

It is anticipated that the research findings will be published in professional outlets and will be presented at conferences.

Contact for further information

Ladislav Timulak, Ph.D.

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PARTICIPANTS DEBRIEFING FORM

Principal Investigators: Dr. Ladislav Timulak & James McElvaney

Dear Participant,

I would like to thank you for your valuable contribution to this research study. Your participation is greatly appreciated, and will directly contribute to our greater understanding of anxiety and the suitability of Emotion-focussed therapy as a treatment for it. Your participation remains entirely voluntary. You are free to withdraw your consent to participate in the study at any point without any prejudice or consequence.

If, for any reason, the experience of taking part in this research has caused you any distress please feel free to contact either of the principal investigators. If you feel you need further counselling support please contact the North Inner City Primary Care Team at 01-8380137.

Ladislav Timulak, Ph.D.
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Course Director, Doctorate in Counselling Psychology
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Thank you again for your generous participation.
Yours sincerely,

_____

Client Change Interview Schedule (v5; 02/2008)

After each phase of counselling, clients are asked to come in for an hour-long semi-structured interview. The major topics of this interview are any changes you have noticed since therapy began, what you believe may have brought about these changes, and helpful and unhelpful aspects of the therapy. The main purpose of this interview is to allow you to tell us about the therapy and the research in your own words. This information will help us to understand better how the therapy works; it will also help us to improve the therapy. Your therapist will not be shown this information until you have finished counselling with them, and only then if you give us permission to do so. This interview is recorded for later transcription. Please provide as much detail as possible.

1. General Questions: [about 5 min]

1a. How are you doing now in general?

1b. What has therapy been like for you so far? How has it felt to be in therapy?

1c. What medications are you currently on? *(interviewer: record on form, including dose, how long, last adjustment, herbal remedies)*

2. Changes: [about 10 min]

2a. What changes, if any, have you noticed in yourself since therapy started? *(Interviewer: Reflect back change to client and write down brief versions of the changes for later. If it is helpful, you can use some of these follow-up questions: For example, Are you doing, feeling, or thinking differently from the way you did before? What specific ideas, if any, have you gotten from therapy so far, including ideas about yourself or other people? Have any changes been brought to your attention by other people?)*

2b. Has anything changed for the worse for you since therapy started?

2c. Is there anything that you wanted to change that hasn't since therapy started?

3. Change Ratings: [about 10 min] *(Go through each change and rate it on the following three scales:)*

3a. For each change, please rate how much you expected it vs. were surprised by it? (Use this rating scale:)

(1) Very much expected it

(2) Somewhat expected it

(3) Neither expected nor surprised by the change

(4) Somewhat surprised by it

(5) Very much surprised by it

3b. For each change, please rate how likely you think it would have been if you hadn't been in therapy? (Use this rating scale:)

(1) Very unlikely without therapy (clearly would not have happened)

(2) Somewhat unlikely without therapy (probably would not have happened)

(3) Neither likely nor unlikely (no way of telling)

(4) Somewhat likely without therapy (probably would have happened)

(5) Very likely without therapy (clearly would have happened anyway)

3c. How important or significant to you personally do you consider this change to be? (Use this rating scale:)

(1) Not at all important

(2) Slightly important

(3) Moderately important

(4) Very important

(5) Extremely important

4. Attributions: [about 5 min] **In general, what do you think has caused the various changes you described? In other words, what do you think might have brought them about?** (Including things both outside of therapy and in therapy)

5. Resources: [about 5 min]

5a. What personal strengths do you think have helped you make use of therapy to deal with your problems? (what you're good at, personal qualities)

5b. What things in your current life situation have helped you make use of therapy to deal with your problems? (family, job, relationships, living arrangements)

6. Limitations: [about 5 min]

6a. What things about you do you think have made it harder for you to use therapy to deal with your problems? (things about you as a person)

6b. What things in your life situation have made it harder for you to use therapy to deal with your problems? (family, job, relationships, living arrangements)

7. Helpful Aspects: [about 10 min] **Can you sum up what has been helpful about your therapy so far? Please give examples.** (For example, general aspects, specific events)

8. Problematic Aspects: [about 5 min]

8a. What kinds of things about the therapy have been hindering, unhelpful, negative or disappointing for you? (For example, general aspects. specific events)

8b. Were there things in the therapy which were difficult or painful but still OK or perhaps helpful? What were they?

8c. Has anything been missing from your treatment? (What would make/have made your therapy more effective or helpful?)

9. The Research:. [about 10 min]

9a. What has it been like to be involved in this research? (Initial screening, research interviews, completing questionnaires etc)

9b. Can you sum up what has been helpful about the research so far? Please give examples.

9c. What kinds of things about the research have been hindering, unhelpful, negative or have got in the way of therapy? Please give examples.

10. Suggestions: [about 5 min] **Do you have any suggestions for us, regarding the research or the therapy? Do you have anything else that you want to tell me?**