New Developments for Case Conceptualization in Emotion-Focused Therapy

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Emotion-focused therapy (EFT) has increasingly made use of case conceptualization. The current paper presents a development in the case conceptualization approach of EFT. It takes inspiration from recent research on emotion transformation in EFT. The case conceptualization presented here can guide the therapist in listening to the client's narrative and in observing the client's emotional presentation in sessions. Through observing regularities, the therapist can tentatively determine core emotion schemes' organizations, triggers that bring about the emotional pain, the client's self-treatment that contributes to the pain, the fear of emotional pain that drives avoidance and emotional interruption strategies. The framework recognizes global distress, into which the client falls, as a result of his or her inability to process the underlying pain, the underlying core pain and the unmet needs embedded in it. This conceptual framework then informs therapists as to which self-organizations (compassion and protective anger based) have to be facilitated to respond to the pain and unmet needs, so that they might transform it. The conceptual framework can guide the therapist's thinking/perceptions and actions in the session. Copyright © 2014 John Wiley & Sons, Ltd.

Key Practitioner Message:
- Therapists can better facilitate emotional transformation when they understand the dynamics involved in the client's distress.
- Emotion transformation is facilitated by first helping the client to access the core underlying painful feelings and unmet needs embedded in them and then by helping the client to generate adaptive emotional responses to those unmet needs.

Keywords: Emotion-Focused Therapy, Case Conceptualization, Emotion Transformation, Emotional Processing

INTRODUCTION

Case conceptualization is a defining feature of psychotherapy. Each therapist attempts to understand his or her client's presenting issues, so he or she might apply a therapeutic strategy in order to address them. Traditionally, humanistic and experiential approaches to therapy have downplayed this therapist activity, as they rather preferred and valued the authenticity of the relational encounter in therapy (e.g., Rogers, 1951). Thus, traditional methods focused on the immediacy of the therapeutic encounter and the client's ever-changing experiencing as a form of case conceptualization. Current experiential approaches such as emotion-focused therapy (EFT), a research-informed approach that focuses on transformation of problematic emotions by generation of healthy ones (Greenberg, 2011), continued in this tradition. Therapeutic work in EFT traditionally focused on the provision of a validating empathic

relationship and the empathic exploration of a client's emotional experience. This effort in the relationship was further supplemented by a focus on the processing of unresolved emotional problems as they emerged moment by moment during the client's in-session process. To this end, EFT therapists focused on a process (marker-guided) diagnosis in which a specific client presentation in the therapy session (e.g., unfinished business with significant other) led therapist to apply a particular task (an empty-chair dialogue) that typically followed a research-informed model of work (Greenberg, Rice, & Elliott, 1993).

The EFT approach has also been based on an ongoing emotion assessment (Greenberg *et al.*, 1993) that traditionally distinguishes between primary emotions (very first emotional reactions to triggers), secondary emotions (reactions to primary emotions or accompanying thoughts) and instrumental emotions (acted emotions fulfilling some need). EFT also distinguishes between adaptive and maladaptive emotions depending on how they are experienced and what actions they inform (cf. Greenberg, 2011). EFT therapists focus on the primary emotions: when primary maladaptive emotions are accessed, therapists seek to help

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clients transform them by way of more primary adaptive emotions (Greenberg, 2011).

However, although the relationship, empathic exploration and emotion assessment as well as the use of experiential tasks remain central, EFT increasingly views case conceptualization as important for treatment (Greenberg & Goldman, 2007; Greenberg & Watson, 2006; Watson, 2010). This conceptualization emerges co-constructively between the therapist and the client during the process of therapy and is an important part of the empathic exploration (Greenberg & Goldman, 2007). As described in the literature so far, it contains eight steps that are followed fluidly and are attended to across therapy sessions (from Greenberg & Goldman, 2007; Greenberg & Watson, 2006). These are as follows: (1) identification of the presenting problem; (2) exploration of the client's narrative about the presenting problem; (3) gathering of information about past and current identity and attachment-related experiences; (4) identification of the 'core pain' (i.e., the most painful and poignant experiences); (5) observation and attention to the client's style of processing emotions (i.e., whether the client is over-regulating or under-regulating his or her emotions); (6) identification of thematic interpersonal and intrapersonal processes; (7) identification of markers informing the choice of therapeutic tasks (EFT uses a variety of experiential techniques that are used at particular 'markers'— the clients' in-session presentations—Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg *et al.*, 1993); and finally, (8) attention is paid to moment-to-moment process within the session and tasks.

The existing EFT case conceptualization (Greenberg & Watson, 2006; Greenberg & Goldman, 2007) represents an elaborated experiential approach to case conceptualization that is firmly embedded in the empathic and validating relationship. However, the existing model is primarily descriptive of what happens in therapy and apart from guiding the therapist's action in tasks (such as unfinished business dialogues), the model is not particularly informative for an overall treatment strategy (e.g., in promoting the client's self-compassion). The current theoretical paper presents an original development in emotion-focused case conceptualization. Our contribution to EFT case conceptualization is built on recent research on sequential steps of emotion transformation in EFT. As we also will argue, the approach we present herein can be somewhat more direct in informing a therapist's overall treatment strategy, although still embedded in an empathic approach respecting the client's pace and moment-to-moment experiencing. The approach we present here is somewhat more direct as it guides the therapist to go beyond moment-to-moment marker focused responding. This approach helps therapists focus on the distinct underlying painful emotions and unmet needs that their clients have and facilitation of specific healing adaptive emotions. Thus, our approach provides a detailed description of emotional processing phases (cf.,

for instance, Greenberg & Watson, 2006). Before we start with the presentation of the case conceptualization model, we briefly look at the empirically based model of emotional transformation that was the starting point of our thinking about case conceptualization.

EMOTION TRANSFORMATION IN EMOTION-FOCUSED THERAPY

Pascual-Leone and Greenberg (2007; Pascual-Leone, 2009) presented a model of productive emotional processing of painful emotions in experiential therapy for depression and long-standing interpersonal difficulties (Figure 1). They showed that in good 'in-session' outcome events that started with an experience of a high emotional arousal and undifferentiated pain, the emotional processing followed a particular path. This path consisted of several stages: *global distress* stage (characterized by undifferentiated emotional pain, hopelessness, helplessness, confusion, despair etc.) was followed by a second stage of *fear/shame* (characterized by enduring pain and experiences of inadequacy, fear, guilt etc.). Fear/shame stage was further followed by a third stage characterized by *negative self-evaluation* (e.g., self-critic, i.e., '*I am inadequate*') and the expression of *need* (e.g., '*I need to be loved*'). This was then followed by a fourth stage that entailed the expression of *assertive anger* ('*I deserve to be appreciated*') and/or *self-soothing* (*self-compassion*) ('*I feel appreciated*') and *grief/hurt* ('*It was painful not to get the appreciation*'—an experience that was without blame or resignation) and finally a sense of *acceptance and agency* ensued. Pascual-Leone and Greenberg also showed an alternate pattern (see left side of Figure 1) in which global distress was followed by second stage of *rejecting anger* (i.e., rage, hate, frustration and angry tears, directed towards a hurtful other or noxious circumstances— characteristic by low differentiation of meaning). Some clients then directly proceeded to the later stage of *assertive anger* and eventually *grieving*.

Pascual-Leone (2009) further showed that clients in good in-session outcome events progress alongside the outlined stages in a sawtooth pattern (wedge-shape variance with a rising-slope), in a two-steps-forward-one-step-back manner. This means that clients in good in-session outcome events experienced a wider range of emotional states, with increasingly higher order stages. However, advancements (i.e., moving down Figure 1) were often interrupted by regressions (i.e., emotional collapses) back to the preceding stages of shallower levels of processing. Pascual-Leone concluded that clients in successful events increase their emotional range, *emotional flexibility*, with more adaptive and healthy emotional processing appearing with greater ease.
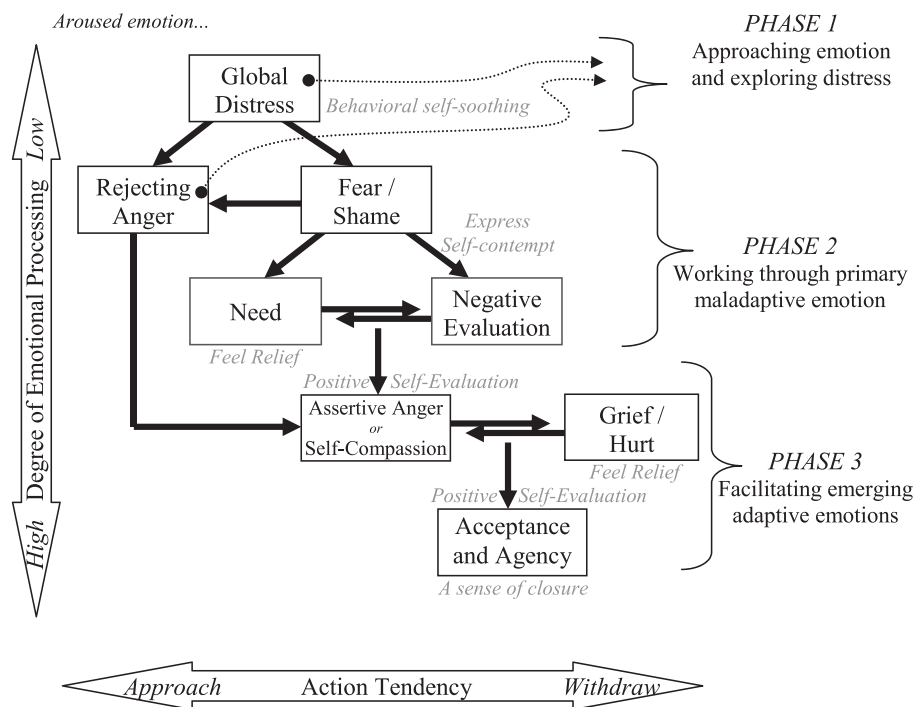
Figure 1. A sequential model of emotional processing (modified from Pascual-Leone & Greenberg [2007] and Pascual-Leone [2005])

Work by Pascual-Leone (2005, 2009; Pascual-Leone & Greenberg, 2007) and collaborators (e.g., Kramer, Pascual-Leone, Despland, & de Roten, 2013; Paivio & Pascual-Leone, 2010) led the [Ladislav Timulak] (led by first author) to a series of case studies that used the model developed by Pascual-Leone and Greenberg (2007) as a basis for observing emotional processing across all sessions of psychotherapy in particular cases (primarily of clients with depression, anxiety disorders and co-morbid personality disorders and clients with chronic illness) and further complemented observations described in Pascual-Leone's studies (e.g., Crowley, Timulak, & McElvaney, 2013; Keogh, Timulak, & McElvaney, 2013; Keogh, O'Brien, Timulak, & McElvaney, 2011; McNally, Timulak, & Greenberg, 2014; O'Brien, Timulak, McElvaney, & Greenberg, 2012; Timulak, Dillon, McNally, & Greenberg, 2012).

Across those studies, we noticed that the emotion transformation model's framework helped us understand clients and their progress. We then started to use this understanding in our thinking about the clients, strategies for therapy and in teaching EFT. Thus, a case conceptualization model was developed, which we present in the following pages. We present the model within an EFT conceptualization of therapy, but in the paper's conclusions, we also discuss it in the context of cognitive–behavioural and psychodynamic conceptualizations.

EMOTION-FOCUSED CASE CONCEPTUALIZATION

Our thinking about the case conceptualization evolved into a conceptual framework. Through observing re-occurring patterns, the therapist (supervisor, researcher) can tentatively determine core emotional organizations. In EFT, these organizations are called emotion schemes, i.e., *'emotion memory structures that synthesize affective, motivational, cognitive, and behavioral elements into internal organizations that are activated rapidly, out of awareness, by relevant cues'* (Greenberg, 2011, p. 38).

Although the original model in Figure 1 already lends itself to case formulation, it remains for the model to be functionally elaborated for the purpose of case formulation, using the cues, behaviours and processing difficulties that are most salient to emotion-focused therapists and supervisors. Thus, the developments presented in Figure 2 offer a conceptual framework that has several layers, which interact together. The case conceptualization framework assumes that the client's general distress, which shows in the form of undifferentiated painful emotions characterized by hopelessness and helplessness (global distress) or by irritability (rejecting anger), is the response to current and past triggers. These triggers represent situations, in which the client's needs were violated or not responded to, which left the client with core painful

NEGATIVE
SELF-TREATMENT
I do not deserve love/
Something is wrong with
me/ I should not be
distressed / Worry/
something will happen and
I am responsible

Start...
TRIGGERS
Historical: abusive, non-
responsive mother and her
loss; trauma of sudden death
Current: children suffering
as she did, potential loss or
trauma to loved ones

BEHAVIOURAL
AVOIDANCE
I have to make sure
that nobody would get
upset – I could be
rightly judged and
rejected

PHASE 1
Approaching
emotions and
exploring
distress

SECONDARY EMOTION:
GLOBAL DISTRESS &
REJECTING ANGER
Hopelessness, helplessness, upset,
overwhelmed, anxious, tense, rage, irritated,
frustrated

EMOTIONAL
AVOIDANCE
Worry; Something bad
will happen. My
feelings & needs are
not important.
Feelings will never
end & will be
unbearable

ANXIETY/ APPREHENSION
Triggers/core pain will be unbearable

CORE PAIN – primary and painful emotion
Loneliness – I do not feel loved
Shame – I am fundamentally flawed, I do not deserve love
Fear/Terror – Something terrible will happen that will find me
unprotected (I will be respponsible)

PHASE 2
Working
through
primary
maladaptive
emotions

NEED
To be loved (connected)
To be accepted
To be safe

COMPASSION
Enacted compassion
from self, imagined
father, mother,
husband

PROTECTIVE
ANGER
Standing up for self
against dismissive
imagined mother and
other abusive figures

GRIEVING
/LETTING GO
It should not have happen,
it is remembered, it pains,
but it is in the past

PHASE 3
Facilitating
emerging
adaptive
emotions

RELIEF
I feel calm & light

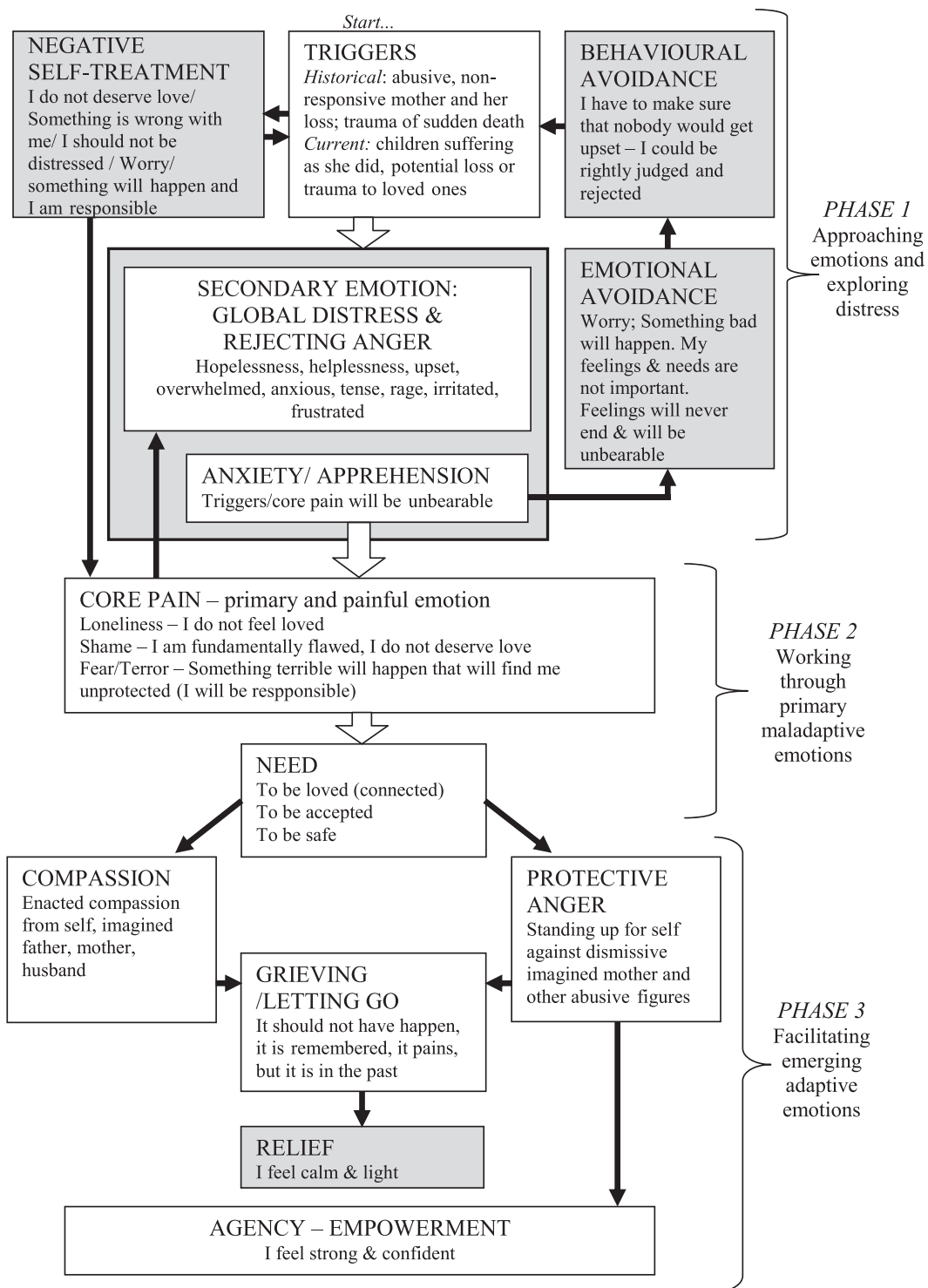AGENCY – EMPOWERMENT
I feel strong & confident

Figure 2.   The model of emotion transformation in therapy (applied to the case of Ann)

emotions (studies on primarily depressed and anxious clients suggest that they are shame-based, loneliness/sadness-based and/or terror/fear-based—this is somewhat akin to the psychodynamic formulation developed by Blatt [2008] that distinguishes self-definitional from relatedness aspects of personality and psychopathology). Since these core painful emotions are difficult to bear and there is a sense that the needs contained in them cannot be fulfilled, the client collapses to a more general hopelessness and helplessness.

Furthermore, the client is afraid of potential triggers that might bring the pain as well as of his or her own painful experiences and thus engages in various emotional avoidance strategies (e.g., distracting himself or herself when emotions arise) and behavioural avoidance strategies (e.g., avoiding situations in which the client could be criticized as is common with social anxiety). An interesting part of the dynamic is also the client's self-treatment, by means of which the client enhances his or her own control over the triggering situation. This conceptual framework then informs which self-organizations (compassion and protective self-assertive anger) have to be facilitated to respond to the pain and unmet needs, so that they might transform the experienced emotional pain. Individual aspects of the case conceptualization framework contain a number of features that we will describe in the sub-sections that follow.

Triggers

These are typically current, interpersonal situations that trigger underlying painful, unbearable emotions (such as feeling rejected, abandoned, overlooked and not responded to). The triggers are actions or perceived actions of significant others such as rejection (i.e., exclusion, invalidation, humiliation, blaming, omission and neglect). Often, the perceived triggers are current (e.g., a hurtful behaviour of spouse) but resemble the developmental injuries from the time when the client was still developing and did not have resources to process the pain. Because the client's emotional schematic processing does not lead to experiences and actions in which the client would be able to look after his or her own needs, the client resigns himself or herself to hopelessness and/or helplessness.

Secondary Emotions—Global Distress

This is an aroused emotional state (see also Table 1) in which the client expresses a global form of emotional pain. (Note: the word secondary in the heading refers to a more superficial, undifferentiated levels of distress.) The client's pain embedded in the presenting issues often comes to the surface very early in therapy. The attempt on the therapist's part is to arouse emotional experience in order to be able to

follow a '*pain compass*' (experiences that are most painful; Greenberg & Goldman, 2007; Greenberg & Watson, 2006) that might lead him or her to the underlying painful emotions (core pain). In the secondary emotion stage, those underlying emotions are often unclear. Rather, what is present is a global sense of hurt: undifferentiated sadness, pain, despair, hopelessness, helplessness etc. ('*I am tired, unhappy, I cannot cope anymore…*').

Sometimes, reactive anger may be present ('*How could he do that? I hate him for it!*') or a mixture of anger and sadness ('*Why did you hurt me?*'). This type of rejecting anger is often more general and less articulate than assertiveness *per se* (see also Table 1; Pascual-Leone, Gillis, Singh, & Andreescu, 2013). It is often a defence against the underlying hurt and in that sense may be somewhat easier to tolerate than to confront the deeper experience of core pain. Rejecting anger is characterized by a high reactivity to the other's behaviour and the sense that one is not in the control of the emergent feelings of anger. In this way, rejecting anger also sometimes has a similar quality as the global nature of distress. Although the process model of Pascual-Leone and Greenberg (2007; Figure 1) distinguishes between global distress and rejecting anger as secondary emotions, that distinction may be less important from the perspective of most therapist's case formulations. The exception to this will be for client's suffering from anger problems, for whom a detailed assessment of the qualities of rejecting anger may help a therapist in helping the client to overcome entrenched aspects of the anger expressions (Pascual-Leone & Paivio, 2013; Pascual-Leone *et al.*, 2013).

Negative Self-Treatment

Interestingly, in common with many before us (Greenberg *et al.*, 1993), we noticed that the interpersonal triggers interact with the client's self-treatment, the client's own way of relating to self. In developing case formulations, it is useful for therapists to notice that problematic self-treatment comes usually in two forms: one form is trying to avoid painful feelings (see the discussion on Emotional Avoidance, below) and another is somehow negative about the self. The usual presentation observed in depressed (Greenberg & Watson, 2006) and anxious clients is one of self-criticism, negative self-judgement, self-contempt etc. It often appears in a more superficial way, e.g., the client is critical of self because of being depressed ('*You should not be depressed*'). This critical response to one's own problems is typically an expression of a more core negative self-judgement, e.g., '*something is wrong with me, I am flawed.*' The concept of self-criticism is similar to core dysfunctional self-beliefs in cognitive therapy (Beck, Rush, Shaw, & Emery, 1979), although in EFT we emphasize the process (experiential) aspects of the negative self-treatment, not only the content of the belief.

Table 1.   Key emotion presentations and the therapist's treatment of them

Emotion	Verbal expression	Nonverbal expression	Function of emotion	Therapist's work with emotion
Global distress	E.g., *'I am overwhelmed', 'I am tired, unhappy, I can't cope', 'I feel hopeless, helpless', 'I am anxious, irritated hurt'* …	Pain, hurt, crying, signs of despair, hopelessness and helplessness, general unhappiness and global sadness such as resignation, low energy and expressions of being down; also mixtures of feelings, particularly anger and hurt, irritability, signs of anxiety (tensions, bodily aches), physical tensions, physical tiredness etc. Emotional arousal may be very high.	Secondary emotions that are typically a response to the underlying primary emotions such as shame, fear and sadness/loneliness. Since the primary emotions are truncated or do not lead to adaptive action, the client 'resigns' to secondary emotions.	The therapist acknowledges global distress, expresses empathy about it but tries to differentiate it by focusing on the more underlying and primary emotions.
Rejecting anger	E.g., *'I hate you!', 'How could you do that?', 'You are disgusting!'*	Physical signs of rage, (e.g., loud voice, clenched fists, jaws, teeth, angry look and threatening behaviour). Sometimes, rejecting anger is mixed with hurt/sadness. The client is very reactive to the aspects of the other's behaviour and does not have a sense of being in control of own anger. Emotional arousal is very high.	Functionally equivalent to global distress. This is undifferentiated and/or secondary anger that may also serve as a defence against the underlying hurt and vulnerability.	The therapist acknowledges the anger and either focuses on underlying hurt or tries to form it into a more assertive anger, one that is not as reactive and other-oriented. For clients who have difficulty in accessing any anger, accessing this can actually be productive. Doing so gives clients permission to be angry as they are learning to access and express anger. The longer term goal is to express anger in a more adaptive and symbolized form without attacking the other.
Anticipatory anxiety (fear)	E.g., *'I am anxious', 'I feel panicky, tense.'*	Physical symptoms of panic and anxiety such as restlessness, tension, stomach upset and irritability. Worries, scanning the environment for threat. Emotional expression is obstructed.	Functionally different from primary fear (see below). Apprehension that leads to emotional avoidance (e.g., worrying, self-medicating and self-distracting) and behavioural avoidance (e.g, avoiding feared situations).	The therapist acknowledges anxiety, may work with symptoms to offer some (superficial) soothing, if anxiety otherwise interferes with therapeutic work. Ultimately, the therapist aims to help a client overcome avoidance and thereby see the obstructions anxiety causes. Therapists

				facilitate working through this debilitating and obstructing anxiety. The therapist helps the client stay with the shame, rather than avoid it. This is carried out by helping a client to articulate aspects of it, particularly any unmet needs to be seen, valued, recognized, respected etc.
Shame (in core pain)	E.g., 'I am flawed, worthless, defective, small', 'I deserve to be mistreated'.	The action tendency of this shame is to hide, shrink and disappear, which produces a client's presentation that may be slow, broken and often interrupted. Gaze may be directed down (to avoid being seen). The client may have a sense of shrinking or feel physically sick. The feeling may be occasionally subtle, but very uncomfortable and all consuming as if it is never going to go away. Emotional arousal may vary, and this emotion often presents with other emotions such as sadness and fear.	This is a primary experience of being rejected, judged and an outcast. The need to be recognized, acknowledged, seen and respected is violated.	
Sadness/loneliness (in core pain)	E.g., 'I feel empty, on my own, lonely', 'I am alone, missing him/her' etc.	Crying and feeling a void that something is missing. Longing for comfort. Low and tender voice, looking down and other typical signs of sadness. The client may also show signs of hopelessness and resignation, such as bowing ones head or having ones shoulders down. Emotional arousal may be high. Emotion often goes with other core emotions such as shame and fear.	This is a primary experience of being disconnected, abandoned or missing the other. The unmet need that is being signalled here is a need for love, comfort, care, looked after, for connection, closeness etc.	The therapist helps the client not to deflect or avoid the feeling but rather to articulate different aspects of loneliness and sadness. The aim is to help a client to recognize that the feeling embodies important needs for closeness and connection or support and care, which the therapist also helps the client to articulate.
Primary fear (in core pain)	E.g., 'I am scared, terrified', 'I am falling apart, loosing myself'.	Acute fear, dissociations, derealization, depersonalization, acute uncomfortable physiological upset and physical symptoms of losing control over one's own body. Emotional arousal may be high. Emotion often goes with	This a primary experience of being intruded, invaded or falling apart. In contrast to anticipatory anxiety, this is not a fear of what will come, but rather it is an experience of sheer terror and upset. The action tendency is to immediately	The therapist is trying to help the client to be able to stay with this fear and have a sense that the client is more than fear and that the fear can pass. The therapist is also trying to facilitate the client's articulation of the needs in the fear experience, the

(Continues)

Table 1. (Continued)

Emotion	Verbal expression	Nonverbal expression	Function of emotion	Therapist's work with emotion
		other core emotions such as shame and sadness.	escape (not just to avoid) danger or distress.	need for safety, security, protection etc.
(Self-)compassion	E.g., *'I am here for you'*, *'I love you'*, *'I care about you'* (towards the self).	Warm feeling, typically directed to the self in the imaginary dialogues. Feeling filled with love, caring, a sense of warmth, being moved, sometimes with a touch of sadness and pain. Possibly sensing relief and ease.	This feeling is generated as an adaptive response to the unmet needs embedded in core pain. It has a soothing, calming and healing quality.	The therapist facilitates this feeling by helping the client access and generate compassion, feel it and symbolize/express it fully. The therapist also helps the client to receive this compassion, experience and enjoy its impact (often leading to relief).
Protective (assertive) anger	E.g., *'I deserved your care'*, *'I feel strong, powerful'*, *'I am setting the boundary'*.	Supporting oneself and feeling a sense of confidence, strength. The body posture may be upright, and the voice calm, but resolute. In comparison with rejecting anger, the arousal is typically lower. The client is also not that reactant to hurtful others/situation.	The function of protective (assertive) anger is to mobilize response to the unmet needs in core pain and to provide support for oneself. It is a source of personal power and self-confidence that undoes the hurt.	The therapist facilitates the generation and expression of protective anger as a response to underlying hurt and unmet needs entailed in it. The aim is to help a client to generate and sustain an assertive stance.
Grief	E.g., *'It is sad that I had to go through all of this, but it is not distressing me that much anymore.'*	The feeling of sadness is difficult but also brings a sense of calmness and relief. The emotion has an accepting and understanding quality. This must be distinguished from sadness/loneliness in core pain, which is much more upsetting. The client may cry, but these are the tears of sadness and understanding rather than hopeless protest or pain.	This represents the later stage adaptive grief. It has a letting-go quality; the client is no longer tortured by the loss but on the contrary is accepting of it. The client may still recount hurts, which, although still difficult, do not have that torturing and upsetting quality.	The therapist welcomes adaptive grief as a sign that the client is progressing in therapy and that core pain has been transformed. The therapist provides empathic following and perhaps shares his or her own experience of witnessing the client's hurt and transformation.

Emotion description is informed by the original measurement criteria of Pascual-Leone & Greenberg (2005).

Negative self-judgement is often an introjected criticism from significant others (Kannan & Levitt, 2013). However, it can also be a conclusion drawn by the client in childhood, which provides some explanation as to why a significant other was hurtful ('*I deserve rejection, humiliation, exclusion, judgment—something in me is unlovable, etc.*'). We hypothesize that this type of conclusion was developmentally useful as it attributed the responsibility for the adverse treatment to the client and thus allowed him or her to have some sense of control over the otherwise unpredictable and hurtful behaviour of the other. Therapists can often observe this, when they gather experientially vivid personal history from clients, based on poignant memories.

The interplay between painful interpersonal triggers and a client's self-treatment is complex. The client tries somehow to make the hurtful triggers controllable. However, he or she does it in a punitive way that paradoxically contributes to one's distress (Pascual-Leone *et al.*, 2013). For many clients, however, this type of harsh self-treatment is not only negative but also contributes towards behaviour that brings them '*positive*' reactions and appreciation from others (Kannan & Levitt, 2013). It may therefore also have an important self-protective (albeit maladaptive) function. Examples of such self-treatment can be visible through messages such as '*Be nicer towards others so they will like you*', '*Work hard so you will achieve and be appreciated*' and '*Prepare yourself for potential danger*'.

Emotional and Behavioural Avoidance

Another form of self-treatment in which the client engages is self-interruption (Greenberg *et al.*, 1993) or emotional avoidance of painful underlying feelings and behavioural avoidance of situations that would trigger painful underlying feelings. Emotional avoidance can take many forms. For instance, it is well described in cognitive–behavioural literature. It may be present in the numbing of feelings, the tightening of the muscles, intellectualizing and not paying attention inwards, dissociation etc. (cf. Barlow, Allen, & Choate, 2004). In cases of clients with generalized anxiety disorder (GAD) and similar anxiety problems, this may take the form of worry (Borkovec & Roemer, 1995). The client may worry about what bad events may occur so that he or she might prepare for the impact of events that would be unbearable. The worry is typically also intertwined with behavioural avoidance, which means engaging in activities that reduce the likelihood of the feared situation (that would be unbearable; see, for instance, formulations from a CBT perspective Foa, Hembree, & Rothbaum, 2007).

Despite the motivation to avoid the pain, the pain is not resolved, nor is it alleviated in the long run. The avoidance prevents the client from processing the underlying painful emotions (see, e.g., Salters-Pedneault, Tull, & Roemer, 2004) and thus from developing flexible emotion schemes that would support greater maturity and resilience. Avoidance thus contributes to and becomes concomitant with global distress, contributing to hopelessness/helplessness and an undifferentiated sense of distress and pain.

Anxiety and Apprehension

The anticipatory fear of situations that might evoke painful emotions as well as fear of actual painful feelings drives the client's emotional and behavioural avoidance. This fear has to be distinguished from a more primary fear (see core pain, below), which may be experienced in trauma and has more of a '*terror*' quality (see also Table 1). Anticipatory fear is a main presenting feature of anxiety disorders. For instance, in social anxiety, the fear of a social situation is self-evident, but this is not the core painful primary emotion. Rather, the core underlying emotion is centred on the shame of humiliation (cf. Shahar, 2013). The anticipation of shame (of being ridiculed, negatively evaluated and humiliated) is played out on the surface in the form of anxiety. This anxiety then leads, for instance, to behavioural avoidance of social situations. This distinction is crucial for case formulation because EFT, does not focus on this anticipatory anxiety but primarily on the core painful emotion, which in this case is shame. Although the anticipatory fear has a protective function and prevents a client from feeling the underlying pain, it also prevents successful and healthily flexible emotional processing.

Core Emotional Pain

Core pain is the underlying primary painful emotional response to the triggering situations or perceptions. This core emotional pain is present in the form of discreet primary painful emotions (Greenberg & Safran, 1989; Greenberg, 2011) that are fundamental responses to the client's unmet needs in the triggering situations. We use the term '*core*' in this paper to highlight that these painful emotions are the ones that the therapist focuses on. They are in the centre of problematic emotional self-organizations (schemes) and need to be either worked through or transformed in therapy.

The core emotional pain consists of unbearable emotions that are personally devastating to the client and often affectively overwhelming. This is why clients often collapse into global distress, in which discreet emotions are buried by more secondary feelings of hopelessness and helplessness of not having the needs in the core painful emotions met. The studies investigating core emotional pain in depression (Greenberg & Watson, 2006), complex

trauma (Paivio & Pascual-Leone, 2010) and anxiety (O'Brien *et al.*, 2012; Shahar, 2013) suggest that core emotional pain centres around shame-based, loneliness-based and fear-based experiences. Still, it may be helpful to recognize that authors differ somewhat in their formulation of this (e.g., Greenberg and Watson [2006] and Paivio and Pascual-Leone [2010] emphasize the maladaptive nature of shame-based and fear-based emotional experiences as being the more fundamental experience when it comes to unhealthy experiences of loneliness/sadness; see also the original work of Pascual-Leone and Greenberg [2007] that linked loneliness to other maladaptive emotion; namely the shame of being alien or the fear of being abandoned, i.e., attachment insecurity).

Shame-based emotions are emotional experiences that incorporate an action tendency to hide, shrink, disappear and narrative messages such as '*I am flawed, worthless*' and '*I deserve to be mistreated*' (see also Table 1). They are responses to internal or external situations of rejection, judgement, humiliation etc. They can also be a response to negative self-treatment (e.g., '*I deserved to be bullied, because I was weak*'). This is particularly apparent in self-hate or self-loathing (Pascual-Leone *et al.*, 2013). Even so, the embedded need in those experiences is to be '*valued, appreciated, recognized, accepted, etc.*'

Loneliness-based emotions are emotional experiences of a profound isolation and loss of connection (e.g., loss of loved one; see also Table 1). However, there remains some debate as to whether loneliness as a form of core pain is ultimately most problematic on account of it being associated with concomitant feelings of shame or fear (Greenberg & Watson, 2006; Paivio & Pascual-Leone, 2010; Pascual-Leone & Greenberg, 2007). For the purposes of case formulation, the defining unresolved emotional difficulty that is important here is sadness and a chronic sense of missing connection, missing the caring presence of the other, or missing the presence of a vulnerable other that the client cared for. In narrative, loneliness shows in expressions such as '*I feel empty, on my own, alone, lonely*'. Loneliness and sadness are typically responses to situations of exclusion, loss of loved one, the situations in which the person is overlooked, neglected (as a child), not supported or not cared for etc. The embedded unmet needs in those experiences are the needs '*for closeness, support, love, connection, etc.*'

Fear-based emotions (Table 1) include experiences of terror, acute fear, dissociations from horrifying or overwhelming affective experiences etc. They include experiences of physiological and psychological upset, in which the client does not have control over the situation. The action tendency is to escape from danger or distress. In psychotherapy, these emotions appear in the form of the activation of a traumatic experience. Needs in these types of experience that remain unmet or unresponded to include a need for '*safety, protection, stability, etc.*'

Ultimately, core emotional pain usually consists of a mixture of shame-based, loneliness/sadness-based and terror/fear-based emotions. For each person, the core emotional pain will consist of several idiosyncratic variations of these emotions. The core emotional pain is an underlying vulnerability that builds on the injuries and painful experiences, often occurring at early developmental stages in the client's life. The lived experience of this vulnerability is that the client had insufficient strength to process or adequately cope with life circumstances. This is due to the natural vulnerability of childhood and the relative lack of support from caregivers and may likely be related to a client's genetic vulnerability to psychopathology (cf. Way & Taylor, 2011). The core emotional pain is activated, when the client experiences situations similar to the original emotional injuries. Core emotional pain can be similarly activated through identifying with the pain of others (whether this be '*real and accurate*' or projected or both). This is especially so, if the painful emotions are observed in dependant others such as one's own children.

The core emotional pain is the focus of treatment. The core experience in the scheme needs to be processed and transformed, allowing the client to be not entirely consumed by shame, loneliness or fear. The client becomes more resilient by moving more easily to experiences of self-assertion (i.e., strength and affirmation), self-compassion, and also of adaptive grief, when confronted by situations that previously triggered the core pain. The first step in therapy is to go beyond the global distress and avoidance to ensure that core painful emotions are accessed. Second, these core emotions must be regulated and made bearable enough to allow therapists and clients to collaboratively articulate the needs embedded in painful client experience.

Needs

Studies of EFT for depression, trauma and anxiety suggest certain types of needs to be associated with certain clusters of primary and painful emotions. The needs entailed in shame-based emotions include, for instance, the need to be *appreciated, respected, accepted, acknowledged, recognized, seen, validated* etc. The needs embedded in loneliness-related emotions include, for instance, the need to be *reached out to, connected to, loved, cared for, included* and also the need *to love, to reach out to, connect, to care for, to include* etc. The needs embedded in terror/fear-related emotions include, for instance, the need *for safety, for control, for mastery, for personal strength* etc.

These needs are primary existential (basic) needs of the person (Pascual-Leone & Greenberg, 2007). The appraisal of the person's environment in relation to their needs is expressed in one's emotional experience (Greenberg, 2011). This emotional pain informs us that we appraise

our fundamental needs (i.e., for survival, love and mastery) as not being sufficiently responded to or fulfilled. The fact that this lived experience of interaction with the environment does not provide an adequate fulfilment of the need, brings pain, which in turn leads to resignation in clinical cases: global distress (e.g., in the form of hopelessness and helplessness), fearful apprehension or avoidance of triggers that may remind one of not having one's needs met.

Facilitating Emerging Adaptive Emotions

Initially (see phase 1 in Figure 2), the therapist uses the outlined case conceptualization as a framework to inform his or her understanding of the dynamics related to a client's distress. This framework helps to orient the therapist in the client's experiencing and informs the therapist's actions that focus on highlighting the triggers and self-treatment, overcoming avoidance and focusing on the underlying core painful emotions. These are then further differentiated and unmet needs in them are articulated (see phase 2 in Figure 2). All of it is happening in the context of an empathic, caring and soothing relationship.

Once core pain is fully accessed and unmet needs are fully articulated, the therapist can facilitate the client's compassionate response to these needs (see phase 3 in Figure 2 and also Table 1). In EFT, this is sometimes achieved by a therapist's compassionate response to the client and through the validation of the need ('*I can sense your pain and so much want you to feel cared for*'). However, self-compassion is also achieved through experiential techniques that may allow the client to generate his or her own compassionate responses. For instance, using an imaginary empty-chair dialogue, the client could enact some remembered caring other or enact his or her current (adult) self and respond to the heart-breaking pain and unmet needs expressed by the (usually younger) self, who was hurt, ashamed, lonely or scared.

Similarly, assertive and protective anger is generated in well proceeding EFT cases (see the phase 3 in Figure 2 and also Table 1). Anger can again be expressed by the therapist on behalf of the client ('*You deserved your parents love*'), but in EFT, it is seen as particularly important that the client himself or herself feels the anger in the moment. This is typically achieved through the enactment, in an imaginary dialogue, of a situation in which the client expresses anger towards a harmful other (e.g., abusive parent or peer bully).

Several studies (e.g., Pascual-Leone & Greenberg, 2007; McNally, Timulak, & Greenberg, 2014) observed that once self-compassion and protective anger are generated and expressed without reservation, a grieving process begins (see phase 3 in Figure 2 and also Table 1). This is a grieving

of what was (historically or currently) not met and what contributed to the development of the core painful emotional self-organization. It is as if the client were saying '*it is sad that I had to go through all of this, but it is not distressing me that much anymore*'.

The enactment of compassionate and protective (self-assertive) anger response to the unmet needs in core pain and its impact leads not only to grieving but also to a sense of emotional resilience, self-acceptance and empowerment (see phase 3 in Figure 2). Clients at this stage feel confident. They may have a sense of personal maturity, they are sensitive to their own hurt (and thus also to the hurt of people around them), but do not feel scared of painful emotions (i.e., '*I am alright, I can manage, I am looking forward to things in life*'). The studies examining the model presented in Figure 2 (e.g., Crowley, Timulak, & McElvaney, 2013; Keogh, Timulak, & McElvaney, 2013; McNally *et al.*, 2014) found, as was also in Pascual-Leone's (2009) original work, that the progression across the phases was non-linear and recursive with successful cases eventually progressing more easily towards more adaptive self-organization, despite occasional setbacks.

CASE ILLUSTRATION: ANN

We now illustrate the presented case conceptualization framework using a case of brief (24 sessions) EFT. The client, Ann (pseudonym), was a woman in her early thirties, diagnosed with GAD. She consented to participate in a research project examining the efficacy as well as processes (including sessions analyses) involved in EFT (the client's characteristics and concerns are altered to protect confidentiality). Ann was referred by her physician because she was highly distressed, and she generally rejected medication. Her presenting symptoms were that she worried constantly, did not sleep well and frequently became so agitated that she was literally unable to sit with her anxiety, moving around the house. Her worries concerned the well-being of her children and her husband. She was sometimes overprotective of them, over-involved in their lives and often trying to control anything bad that could happen to them. For example, she anxiously phoned them with great frequency and was constantly checking her phone in session. She also worried about her own physical health (her brother had died of an unexpected illness at her age). She was also very critical towards herself, harshly blaming herself for her own difficulties.

Her initial score on the main measures of anxiety puts her clearly in the clinical range (on the GAD-7 scale; Spitzer, Kroenke, Williams, & Löwe, 2006; Generalized Anxiety Severity Scale; Shear *et al.*, 2006—Table 2). On the measure of depressions (Beck Depression Inventory-II; Beck, Steer, & Brown, 1996), her score was 12, which seemed under-reported given that in addition to meeting

Table 2. Pre–post outcomes of the illustrative case

Scale	Caseness	RCI	Pre-treatment	Post-treatment	6-month follow-up
GAD-7	10	4	19	8	8
GADSS	7	n/a[†]	19	6	5
BDI-II	10	9	12	4	2
PSWQ	46	9	78	51	42
CORE-OM	1.29	0.48	1.32	1.12	0.94

Note: We used caseness and RCIs as reported in the literature or we calculated it from the available data (Beck *et al.*, 1996; Behar, Alcaine, Zuellig, & Borkovec, 2003; Craske *et al.*, 2011; Evans *et al.*, 2002; Gyani, Shafran, Layard, & Clark, 2013; Seggar, Lambert, & Hansen, 2002; Spitzer *et al.*, 2006).
Caseness = the cut-off for determining whether client is clinically distressed. RCI = reliable change index. GAD-7 = Generalized Anxiety Disorder–7. GADSS = Generalized Anxiety Disorder Severity Scale. BDI-II = Beck Depression Inventory. PSWQ = Penn State Worry Questionnaire. CORE-OM = Clinical Outcomes in Routine Evaluation—Outcome Measure.
[†]The RCI was not reported in the literature nor the data that would allow its calculation.

criteria for GAD, she also met criteria for major depressive disorder as assessed by the Structured Clinical Interview Diagnosis-I/P (First, Spitzer, Gibbon, & Williams, 2002). She also completed the Structured Clinical Interview Diagnosis-II (First, Gibbon, Spitzer, Williams, & Benjamin, 1997) assessing personality disorders (DSM-IV-TR Axis II), which indicated that she met the diagnostic criteria for avoidant, obsessive–compulsive and depressive personality disorders. Overall, she made a good progress in therapy as indicated by the principal outcome measures (Table 2).

Ann's therapist was one of the authors of this paper. Although the original process model by Pascual-Leone and Greenberg (2007; Figure 1) shaped the therapist's thinking about this case, we now present a case conceptualization of Ann using Figure 2, the approach that was being formed at the time when Ann was in treatment. In session, the therapist focused on the differentiation of core pain, how that pain was triggered or sustained, and unmet needs. The therapist also focused on facilitating adaptive emotions that would undo the core painful emotions. This thinking supplemented the traditional focus of EFT on in-session markers as well as the emphasis on the elaboration of identity as well as attachment-related experiences (Greenberg & Goldman, 2007). This modified approach to case conceptualization is illustrated in the sub-sections that follow. In this approach, clinicians can fill in the figure's boxes with details from session notes, and Figure 2 shows notes specifically related to the case of Ann.

Triggers

The most current triggers that brought upset and unbearable anxiety for Ann were situations in which she could not protect herself, or loved ones, from a potential danger. Dangerous situations were mainly health concerning situations (e.g., asthma of her daughter or her own health). The therapist explored the client's narrative and the

poignant memories that contributed to her emotional pain. She had felt very much on her own as a child, since she was neglected and often attacked by her own mother. For instance, she had to hide in fear, when her mother drank too much and became angry and verbally abusive. Finally, she was traumatized when her mother died suddenly when she was just 9 years old. Around that time, Ann was afraid that she would lose more people from her family and that she would become even more lonely and abandoned than she already felt.

Self-Treatment

Ann was quite self-reproaching and self-contemptuous. She blamed herself for her difficulties and accused herself of '*moaning too much*'. In the initial imaginary chair dialogues, Ann clearly indicated that she did not deserve any compassion and, indeed, had a great difficulty in expressing anything resembling self-compassion (note: structured imaginary dialogues with significant others or parts of self are typical EFT interventions; Elliott *et al.*, 2004). On the contrary, she hated her own vulnerability and despised the need for a more compassionate and supportive treatment. She also took on any responsibility for the suffering of those close to her. Indeed, it was '*her job*' to prevent any harm to her loved ones. She was able to instil tremendous guilt in herself, if anything went wrong.

Secondary Emotions—Global Distress

The client presented with a pervasive sense of global distress. She would cry very easily and has high emotional arousal. When highly emotional, she made little eye contact and had difficulty engaging in dialogue. As a result, the therapeutic alliance was initially quite strained on account of the client feeling so hopeless and distressed that she could not see how anything could help.

Ann was particularly upset when those close to her found themselves in situations where they could be

harmed, mistreated, neglected etc. Similarly, she became easily upset at the thought of losing anybody close. With regard to the developmentally decisive triggers, she was upset by thoughts of her mother. In the initial imaginary (empty-chair) dialogues with her mother, the client would be either in a state of undifferentiated upset or react angrily and then feel bad and hopeless about the fact that her mother had not been there for her as a child.

Emotional and Behavioural Avoidance

The main feature of the client's emotional avoidance was her worry process. She worried that something bad would happen to her children and that they would suffer physical pain and feel desperate and isolated while dealing with difficult situations. The worry process was intensified by controlling behaviour (a form of behavioural avoidance) that attempted to minimize potential difficulties that her loved ones might encounter. She felt responsible for anything that might lead to another (traumatic) loss for her. Another form of avoidance was her agitation that escalated whenever she was confronted with a difficult life situation. The agitation kept her engaged in problem solving and prevented her from staying with the imagined consequences of the situation.

Anxiety/Apprehension

Anxiety was the most defining feature of Ann's presentation encompassing anticipatory fear attached to many situations, in which her loved ones would be exposed to suffering, isolation, pain, upset and also the fear of her responsibility for this. This anxiety fuelled her emotional and behavioural avoidance. The anticipatory fear was also present with regard to triggers of an older origin, when she was scared to engage with the memories of her mother as she found them too upsetting. She also felt that there was a great deal of anger towards her mother, anger in which she felt bad about herself for feeling it. In turn, this anxiety about her own emotions also influenced her self-treatment (e.g., self-interruption of anger; see top of Figure 2).

Core Emotional Pain

The client's underlying core painful feelings centred on a profound sense of loneliness, shame and traumatic terror/fear. Ann felt very alone, particularly with regard to developmentally significant points in life. The loneliness pertained to her feelings of not having had a mother present when she needed her ('*I had nobody to turn to*') as well as to the fact that the mother's premature death prevented her from improving that relationship, leading to a long-lasting loss and the absence of motherly support

in her life; e.g., '*I had nobody to help me when my own kids were small.*' Indeed, being unsupported and afraid was a salient theme of her personal history. Ann felt unsupported and overwhelmed by the responsibility of looking after own children and trying to keep them out of harm's way and shelter them from the suffering she had endured as a child.

Ann's sense of shame was particularly connected to the '*embarrassment*' of her mother who was '*a drinker*'. She particularly remembered how her mother '*ruined her birthday*', because she got so drunk:

> all this, all these relatives… and we came out of the restaurant… and the smell of drink on her… she fell twice…. So, that's my earliest memory… Other kids' mothers aren't like that.

She also expressed how she wished for her mother to be different: '*Every day there was hope that she wouldn't be drinking.*' Ann even asked her mother to stop but was attacked and invalidated: '*I asked you to stop and then you made it out that it was all my fault*' (the first person indicates that this statement was expressed in an imaginary chair dialogue). Indeed, the invalidation led Ann to believe that something was wrong with her, given that mom kept blaming her, and because deep down Ann feared she was like her mother: '*I'm afraid I'll end up like her.*' This corresponded with her negative self-treatment, in which she made clear that she did not deserve a good treatment and that all her problems were her own fault.

The terror/fear aspects of Ann's core pain probably had their origins in the intrusive and invalidating attacks from her mother as well as her mother's subsequent, sudden death. These traumatic aspects of her personal narrative were linked with the sense of abandonment and shame. Attacks that powerfully show the client's adverse experiences are visible in her memories of being,

> worried when I was a kid going home, and seeing what mood my Mom was in. If she's going to be ranting and raving, or what. You just didn't know what was going to happen when you walked in through the hall door… nine times out of ten it would be anger.

The sense of an impending, unpredictable and terrifying event was further worsened by the sudden death of her mother. She knew what catastrophe felt like and how it might deepen her loneliness even further.

Needs

The needs embedded in core emotional pain crystallized as the therapy progressed. The client had great difficulty expressing and owning that which her vulnerable experiences

suggested she needed. This was connected to her negative self-treatment, in which she harshly and contemptuously judged any need as selfish, implying that she was flawed, needy and mean. However, in the context of a compassionate and supportive alliance and in heart-breaking poignant dialogues with her imagined mother, children and husband, the client was eventually able to clearly articulate and express: her need for connection and support ('*I needed and deserved to have a mom that cared for me*'); her need for acknowledgement and validation ('*I needed to hear that there is nothing wrong with me and I deserved to be supported*'); her need for safety ('*I needed to be spared from attacks and traumas*'); and her need for protection as well as her determination to face the adversity (e.g., the most feared situations: '*I do not want to be hiding. I want to live freely*').

Strategy for Therapy Informed by Case Conceptualization

Different parts of this case conceptualization interplayed with each other (Figure 2). The therapist's understanding was further formed through the client's emerging narrative, particularly to the extent that this was anchored in observations during the experiential enactments in imaginary chair dialogues. Triggers in everyday life brought core pain, which was, however, not possible for Ann to process and she continually collapsed into global distress. While in a state of global distress, she further blamed herself for the distress and vulnerability and for her '*defective*' core-self. Ann was trying to avoid distress and pain, by managing and controlling triggers and subsequent experiences of the core pain. This happened in her everyday life, and it was also clearly visible in the treatment sessions. The departure point of therapeutic work was to enact triggers, typically through vivid imaginary dialogues with the relevant people from Ann's life (mother, children, husband etc.) and the critical and interrupting parts of herself.

The emerging case conceptualization informed therapy in several ways. The therapist's first task, after building an alliance and trying to help Ann regulate the strong emotional arousal she had in session, was to help differentiate her underlying pain. This was pursued by empathically evoking and exploring painful situations, initially, the current situations and then later on those based on memories of events that formed the core pain. Although traditional EFT tasks (Elliott *et al.*, 2004) were used as well, they were re-conceptualized as tools allowing evocation (and the eventual transformation) of core pain.

Access to core pain was difficult mainly because Ann often collapsed into global distress, whenever her core pain was touched on (a dynamic process in the model described by Pascual-Leone [2009]). When she collapsed, the therapist responded with compassionate empathic interventions, and also through interventions intended to

calm the client such as clearing a space (an EFT intervention similar to mindfulness; Elliott *et al.*, 2004), which helps clients to put their upsetting and overwhelming issues aside for the moment.

Experiential engagement with Ann's core pain was also obstructed by emotional avoidance. Avoidance processes were mainly visible through the constant worry that both flooded and was exhausting for the client. This process was eventually counteracted by the client's need for rest, her awareness of the impact of her worry (i.e., feeling tired), the need to be free and playful and finally through the protective (self-assertive) anger (see the lower part of Figure 2) that opposed the worry process ('*I have had enough of you*'). Again, traditional experiential tasks such as self-interruption (Elliott *et al.*, 2004) were typically used for that purpose. However, these tasks were re-conceptualized as work on avoidance with the added understanding that apprehensive anxiety and vulnerability of core pain were central motivators driving the avoidance. In short, avoidance was conceptualized as a broader phenomenon of which self-interruption was only one example.

Once core pain was accessed, it was important to put it into language through empathic responding as well as through a sustained effort to help the client to stay with it

(e.g., Therapist: '*Breath. Just see how loneliness feels. Try not to run away from it. You are more than that empty sense inside. It is just a powerful feeling. If you were to put it into words how does it feel? Speak to your mom [imagined in the other chair] from that loneliness. What do you say to her?*')

. The next step was to help Ann to articulate her unmet needs, embedded in core painful emotions. When the core painful feeling was fully unfolded, the therapist asked Ann: '*What is it that you needed? What is it that you need when you feel so profoundly lonely?*' She would then gradually articulate her needs (e.g., '*Every girl now-and-then needs her mom. I needed a mom*'). The work on Ann's capacity to stay with underlying and consuming loneliness, shame and trauma-related fear showed gradual progression over the course of therapy. The client became capable of staying longer and longer with those experiences before collapsing into global distress as predicted by the emotion transformation model and its recursive nature (Pascual-Leone, 2009). Ann also became gradually more capable of putting the experience into a detailed narrative and quicker in identifying her needs. This gradual progression in being able to feel and stay with the pain was understood through the lens presented here in the model.

When the unmet needs were fully expressed, the therapist tried to see whether Ann was capable of enacting a compassionate response to those needs (see 'Compassion', lower part of Figure 2). This would sometimes be carried out by asking Ann to enact a responsive other she remembered (i.e., her husband and dad). At other times, the therapist probed for whether Ann would be able to be compassionate as an adult towards the more vulnerable aspects of her own painful childhood experiences, which she enacted in session during imaginary dialogues. Alternatively, the therapist would explore whether Ann, when enacting her mother in an imaginary dialogue, could imagine her mother actually being responsive to the heart-breaking hurt that Ann had felt as a child. All of these intervention strategies proved to be difficult, as any of Ann's vulnerability was met with her usual self-contempt and the dismissal of unmet needs. However, as therapy progressed, Ann was more and more capable of enacting and expressing compassion towards her own hurt. She was gradually able to let in and accept this expressed compassion, which initially had been very difficult for her. The work on promoting compassion was pursued systematically (across sessions) on account of the conceptualization described through the model, although traditional EFT tasks were still relied on as the means for facilitating enactments of compassion. However, these were used creatively and in a manner that prioritized the generation of good quality experiences of compassion over actual task completion *per se* (as was originally postulated by, e.g., Elliott *et al.*, 2004).

Accessing the anger (see '*Protective anger*', lower part of Figure 2) that Ann would use to support what she deserved in childhood was somewhat easier, although she could easily get caught in the reactive and rejecting anger for which she would blame herself ('*If I am angry at my mother, then I am an ungrateful daughter*'). This healthy and protective (self-assertive) anger had to focus on setting a boundary for her mother's unresponsiveness (in imaginary dialogues) such as '*I deserved to be cared for regardless what you say, it is just a fact.*' The client was able to achieve that stance as a response to her mother's unresponsiveness, even though this was often followed by the sadness of not being loved and another collapse into global distress. The work on boundary setting with regard to the mother's dismissal and unresponsiveness was paralleled in the work on setting a boundary for the tiring and intrusive worry process. Eventually, the client became firmer and clearer in what she needed and in defining her perspective. Again, the work on promoting protective anger was informed by the conceptual framework presented in this paper. The therapist carefully assessed the quality of anger and promoted assertion and boundary setting anger. Many EFT tasks were used creatively for that purpose with the ultimate aim of helping the client generate a target emotional experience.

This sequence of emotional states centred not only around the issues with her mother, her own self-contempt and her own avoidance but also around a variety of situations that she or her children were caught in. These situations were typically enacted in session using chair dialogues, in which Ann played out the common emotional responses of the characters in the events (Elliott *et al.*, 2004; Greenberg *et al.*, 1993). Through these imaginary dialogues, Ann was eventually capable of developing an increasingly self-compassionate and protective (self-assertive) anger stance more easily following the expression of her pain and the unmet needs embedded in it. She was also more capable of '*bouncing back*' and reorganizing quickly from the global distress and hopeless desperation into an empowering assertive anger. The process was far from linear and only slowly and painstakingly gradual, which fits with the empirical observations made by Pascual-Leone (2009) about the change process often moving two steps forward, one step back. The process model offered a useful reference point for the therapist's understanding and assessment of the therapy over its session-to-session progression.

She saw the therapy as successful, and her anxiety (as measured by GAD-7 and GADSS) eventually moved into a normal range. Towards the end of the therapy, Ann had a stronger sense of inner confidence that she would be able to face issues that impacted either her or her loved ones. She was less upset about the neglect and mistreatment she experienced in her relationship with her mom. She had grieved what was not and what should have been and did this with sadness that was not overwhelming (again as expected by the model). She was finally capable of allowing her children to be independent, without becoming enmeshed in what they were struggling with in their own lives. As her life became richer, she found herself a new hobby (a yoga course at a local community centre) and made time for herself without feeling selfish and bad about it.

CONCLUSION

The case conceptualization model we have presented here complements the traditional EFT case conceptualization (Greenberg & Goldman, 2007; Greenberg & Watson, 2006). Its main strength is that it is based on an empirically derived model of emotional transformation in EFT (Pascual-Leone & Greenberg, 2007; Pascual-Leone, 2009; Timulak *et al.*, 2012) and that it can lead the clinical strategy and actions of a therapist working with her or his client. The strategy consists of several aspects:

1. *Triggers.* The therapist can note specific triggers that bring the client to core emotional pain.
2. *Self-treatment.* The therapist can note how negative self-treatment contributes to that core pain.

3. *Secondary emotions—global distress.* The therapist can better understand that the client is not able to bear the pain and how he or she collapses to global distress.
4. *Emotional and behavioural avoidance.* The therapist can understand that a client wants to avoid the pain and the triggers that precipitate that pain.
5. *Core pain.* Thus, the therapist can try to help the client in the context of caring relationship to overcome avoidance and in being able to bear the emotional pain (i.e., shame, loneliness and/or fear) without collapsing into despair and global distress.
6. *Unmet needs.* The therapist can aim at articulating unmet needs that the pain signals.
7. a. *Self-compassion.* With the articulation of the unmet needs, the therapist can aim to facilitate the client to experiences of (self)compassion that can be elicited through witnessing the heart-breaking quality of one's own pain.
   b. *Protective anger.* The therapist can also facilitate the client's healthy assertive anger, usually through helping the client to highlight and enact the hurtful triggers that lead the client to fight back and stand up for the self.
8. a. *Grief and letting go.* The process is then followed by a grieving of what happened and how hurtful it was, and the client is finally able to 'let go' of unresolved pain.
   b. *Empowerment and agency.* At the same time, healthy anger at violation also brings the sense of empowerment and personal agency.

The model presented herein highlights aspects of the client's perceptions, self-processes and emotional experiences that can inform a therapist's understanding of client suffering and suggest actions to facilitate its transformation. The usefulness of this approach should be examined using empirically based case studies of transformation (e.g., McNally *et al.*, 2014; Kramer *et al.*, 2013). It would be also interesting to examine whether therapists using this model could increase their effectiveness in therapy. On a more cautious side, it remains to be seen whether other theoreticians will find the model presented here as useful in organizing their understanding of their clients and in guiding their strategy for the work with clients. As the model was developed on the basis of process research on clients, primarily with mood and anxiety disorders (although with co-morbid trauma, chronic life-threatening illness and co-morbid personality disorders), it remains to be seen whether it will be a useful organizing framework for other presentations.

The model we present shares some characteristics that can be found in other theoretical approaches to case conceptualization. For instance, with psychodynamic therapies, it shares its focus on underlying motives in behaviour (wishes in psychodynamic approach [Luborsky & Barrett, 2007] and unmet needs in our formulation). It also shares an understanding that unfulfilment (real or perceived) of wishes is visible in

a client's distress; this parallels our understanding of the interplay between the triggers and unmet needs. Furthermore, one can also see that, similar to psychodynamic approaches (e.g., Curtis & Silberschatz, 2007), we highlight the role of a client's original painful experiences in the formation of sensitivity to particular triggers and in the formation of a particular self-treatment (e.g., pathogenic beliefs in Curtis & Silberschatz's and Weiss's [1993] understanding).

We can also see similarities with cognitive–behavioural approaches in recognizing the importance of emotional avoidance (e.g., Barlow *et al.*, 2004; Foa *et al.*, 2007) that prevents the processing of upsetting experiences. Our description of self-treatment and negative thoughts about the self (core dysfunctional self-beliefs) are similar to those found in cognitive therapy (cf. Beck *et al.*, 1979). The emphasis that our model places on emotional processing may also be a common element between our model and some CBT approaches (see, for instance, Watson and Bedard [2006] for discussion on the role of experiencing in both EFT and CBT and Castonguay *et al.* [1996] examination of experiencing in CBT). Indeed, some CBT approaches understand emotional processing as not only purely in terms of exposure (e.g., Foa *et al.*, 2007) but also in terms of awareness and in identifying points of emotion avoidance. Furthermore, there is also a similarity between aspects of our approach and the importance given to self-compassion in compassion-focused CBT (Gilbert, 2009), although the model we use herein gives equal emphasis to healthy assertive anger.

However, there are also many important differences between our presentation and that of the other theoretical approaches. Some of these major differences are captured in the ultimate goal of conceptualization and therapeutic strategy. For instance, in some psychodynamic therapies, case formulation is primarily used to help the client achieve some insight into the painful feelings and their reworking in the relationship with the therapist (e.g., see Luborsky & Barrett, 2007). Similar to behavioural approaches, we rather put emphasis on the experience of self-generated adaptive emotions (such as self-compassion, protective anger and adaptive grieving) rather than attributing change to new conceptual-cognitive understandings. Even so, like psychodynamic schools, we believe that an empathic and validating relationship can play an important role in a client's experience of healthy emotions whether in the relationship with others or with the therapist.

In some cognitive–behavioural therapies, the case conceptualization is intended to provide a rationale for replacing dysfunctional beliefs about the self with more adaptive ones (e.g., Beck *et al.*, 1979) or to encourage the mastery of problematic symptoms or avoided situations (Barlow *et al.*, 2004). We believe that the model presented herein can offer a nuanced conceptualization of what sort of emotions may be linked with the problematic beliefs

and are the most painful and avoided, which needs are not being met and what emotional experiences are necessary in to order to transform the painful feelings. This perspective could perhaps be incorporated into other intervention approaches. However, the presented model also elaborates the observation that transformation of painful emotional experiences through the generation of an adaptive and healing emotional experiences is a complex process, one that entails several sequential steps and require a different therapeutic strategy depending on the step in that process.

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