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Rhonda N. Goldman

Illinois School of Professional Psychology, Argosy University, Schaumburg, IL, USA

ABSTRACT

Case formulation in EFT is a relatively new concept and useful tool that helps therapists to both conceptualize cases as well as follow markers across therapy in order to initiate tasks that promote change in emotional processing. The paper summarizes the emotion-focused approach to case formulation and illustrates it in application to a case. First, the guiding principles of case formulation are explicated. Next, the three stages, unfolding the narrative and observing emotional processing style, cocreating a focus and identifying the core emotion, and process formulation, are outlined. The 14 steps of case formulation are nested within the 3 stages. Each of the steps is specified in application to the case of Sophie.

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Fall- Formulierung in der Emotionsfokussierten Therapie

Fall-Formulierung in der EFT ist ein relativ neues Konzept und ein nützliches Werkzeug, das Therapeut-Personen hilft, sowohl Fälle zu konzeptualisieren als auch über die Therapie hinweg Markern zu folgen, um Aufgaben zu initiieren, die beim emotionalen Prozessieren Veränderung fördern. Dieser Artikel fasst den Emotionsfokussierten Ansatz zur Fall-Formulierung zusammen und illustriert ihn, indem er ihn auf einen Fall anwendet. Zuerst werden die Leitlinien für die Fall-Formulierung erklärt, dann die drei Phasen skizziert: Ausfalten des Narrativs und dabei Beobachten des emotionalen Prozessier-Stils, Mit-Kreieren eines Fokus' und dabei die Kern-Emotion identifizieren und schließlich die Fall-Formulierung. Die 14 Schritte der Fall-Formulierung sind in diesen drei Phasen eingebettet. Jeder dieser einzelnen Schritte wird anhand des Falls von Sophie spezifiziert.

Formulación de casos en la terapia centrada en las emociones

La formulación de casos en TCE es un concepto relativamente nuevo y una herramienta útil que ayuda a los terapeutas tanto a conceptualizar casos como a seguir marcadores a través de la terapia con el fin de iniciar las tareas que promueven el cambio en el procesamiento emocional. Este artículo resume el enfoque centrado en la emoción para la formulación de casos y lo ilustra en la aplicación a un caso. En primer lugar, se explican los principios rectores de la formulación de casos. A continuación, se describen

las tres etapas desplegando la narrativa y observando el estilo de procesamiento emocional, la co-creación de un enfoque y la identificación de la emoción básica y la formulación del proceso. Los 14 pasos de la formulación del caso están anidados dentro de las tres etapas. Cada uno de los pasos se especifica en la aplicación al caso de Sophie.

La formulation de cas dans la thérapie centrée sur les émotions

La formulation de cas dans la thérapie centrée sur les émotions (TCE) est un concept relativement nouveau. C'est aussi un outil utile pour aider les thérapeutes tant à conceptualiser les cas que de repérer des indices au long de la thérapie en vue de mettre en place des tâches qui favorisent le changement dans le processus émotionnel. Cet article résume l'approche centrée sur l'émotion en une formulation de cas et l'illustre en l'appliquant à un cas. En premier lieu, cette contribution explique les principes directeurs de la formulation de cas. Ensuite, les trois phases sont exposées, à savoir: le déploiement du récit et l'observation du style de processus du traitement émotionnel, la co-crédation d'une focalisation sur le vécu interne et l'identification des émotions centrales, et enfin la formulation du processus. Les 14 étapes de la formulation de cas sont imbriquées dans ces trois phases. Chacune de ces étapes est précisée en étant appliquée au cas de Sophie.

A formulação dos casos na Terapia Focada na Emoção

A formulação dos casos na Terapia Focada na Emoção é um conceito relativamente recente e uma ferramenta útil que ajuda os terapeutas a conceitualizar os casos, bem como a seguir marcadores no curso da terapia, de modo a iniciar as tarefas que promovem a mudança no processamento emocional. Este artigo resume a abordagem da Terapia Focada na Emoção à formulação dos casos e ilustra-a através da aplicação a um caso. Primeiro, são explicados os princípios condutores da formulação de casos. Em seguida, são descritos os três estádios da mesma formulação: o desenrolar a narrativa e a observação do estilo de processamento emocional; a criação de um foco em simultâneo com a identificação de uma emoção central; a formulação do processo. Os catorze passos da formulação de casos são englobados nestes três estádios. Cada um desses passos é especificado mediante a sua aplicação ao caso de Sophie.

Emotion-focused therapy (EFT), steeped as it is in humanistic-experiential thinking, has, until recently, provided therapists with overarching theoretical principles and a set of well-specified therapeutic tasks but lacked an explicit organizing framework. From within the empathic relational framework that is fundamental to EFT, emotion-focused therapists draw from a set of tasks many replete with accompanying in-depth models of change, specifically tailored to address and treat a variety of clinical problems. Tasks are initiated in response to in-session markers or indicators of emotional processing problems. However, therapists are sometimes uncertain about which task to initiate in

response to particular markers. Emotion-focused case formulation (Goldman & Greenberg, 2015) has thus emerged from the theory and techniques of EFT developed over the past 25 years. It provides a guiding structure and organizing framework to aid therapists in mapping out what to do next from moment to moment.

Guiding principles of emotion-focused case formulation

The purpose of case formulation in EFT is twofold. First, it provides a guiding framework that allows the therapist to be highly process-oriented in the moment. In that sense, it provides a map that informs the therapist's moment-by-moment decision-making. Second, a thematic picture emerges as result of case formulation that occurs over the course of therapy (rather than prior to the beginning of therapy). This picture emerges at the end of the second stage of case formulation and is described as the formulation narrative. The formulation narrative describes the core maladaptive emotion scheme that connects presenting problems with triggering events. Thus, for example, by the fourth session, a theme such as self-criticism might emerge as the core issue and the formulation narrative might be depression (presenting problem) with a core maladaptive emotion of shame at its source that is triggered by a spouse or boss being dismissive or critical.

Case formulation is guided by a few important principles, each worthy of further elaboration. First, it is fundamentally process-constructive and process-diagnostic. This means that diagnosis is a moment-by-moment, process of discovery that always takes place in consultation with the client. Second, case formulation is ultimately guided by the client's emotional pain. Third, case formulation is embedded in the context of an emotion-focused therapeutic relationship that highlights an empathic, collaborative alliance. Fourth, case formulation follows the two tracks of emotion and narrative/meaning-making, through an ever-evolving, dynamically interactive process throughout a course of therapy.

Process-constructive and process-diagnostic

A key feature of case formulation in EFT is that it is fundamentally process-oriented; a moment-by-moment process is constructed and redefined from session to session (Goldman & Greenberg, 1997; Greenberg & Goldman, 2007; Goldman & Greenberg, 2015). Case formulations are not based on *a priori* assessments but rather evolve and emerge, particularly through the early stages of therapeutic exploration. As therapy progresses, working hypotheses are developed about underlying mechanisms related to presenting problems. In EFT, *process is privileged over content, and process diagnosis* (Goldman & Greenberg, 2015) *is privileged over person diagnosis*. Process-oriented, case formulation takes into account both the moment and the in-session context as well as understanding the narrative of their lives. The present moment is given priority in the performance of case formulation.

An EFT approach to case formulation aims at the development of an ongoing focus and comprises process diagnosis, marker identification and theme development rather than person or syndrome diagnosis. The case formulation must be flexible with the evolving construction of the person across the therapy situation.

Rather than determining which content should be the focus of which session as is done in typical treatment planning, the EFT therapist assumes the role of a process diagnostic expert who does not presume to know more about the client's experience

than the client. EFT therapists see themselves as process experts who carefully attune to client's moment-by-moment experience, listening for that which is most poignant or ambiguous (Rice, 1974) and thus calling for further exploration.

Following the pain

EFT therapists focus on clients' painful emotional experiences and their immediate responses. EFT therapists hold a metaphorical 'pain compass' and are seemingly magnetically drawn toward client's painful experience that calls for deeper exploration. This is akin to an emotional tracking device for following the clients' painful experience (Greenberg & Watson, 2006). The client's expression of pain and emergent markers provide a guiding framework for intervention more than does a diagnosis or even an explicit case formulation. The therapist's focus is on following the client's process, identifying markers of current emotional concerns and core pain rather than developing a picture of the person's enduring personality, character dynamics or core relational pattern. Exploration aims at unfolding *experience in particular events* to their edges rather than identifying patterns of experience and behavior *across situations*. The *client's chronic enduring pain* is, in a sense, an entry point into client's core concerns.

Emotion-focused therapeutic relationship

It is only in the context of a safe, trusting therapeutic relationship (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, Rice, & Elliott, 1993; Horvath & Greenberg, 1989) that clients feel comfortable to disclose significant emotional information. These conditions allow the relationship to solidify and the client's story, or narrative, to unfold. Therapist empathic attunement, a strong therapeutic presence and genuineness, as well as unconditional positive regard, are fundamental to the formation of a successful therapeutic relationship. It is only from this place that therapists hear how clients process emotion and create meaning.

Given that emotion-focused therapists see the therapeutic process as a discovery-oriented one (Elliott et al., 2004; Greenberg et al., 1993), the taking of an expert stance by the therapist is seen as in direct contradiction to this principle. The primary message conveyed to clients is that the client and therapist are both in a process of discovering what is important in the client's experience. This is not only a philosophical principle in concert with the humanistic-experiential tradition but a necessary element of the therapeutic change process. Clients are considered experts in their own experience and provided with the right therapeutic environment; clients' experience will act as a compass that will help guide therapy to the core issues and provide a sense of direction (Elliott et al., 2004).

Emotion and narrative: two interactive tracks

EFT case formulation (Goldman & Greenberg, 2015) relies on two sources of information about the client: emotion and narrative (Angus & Greenberg, 2011), where the former is nested within the latter. The narrative provides a context for understanding life events (i.e. what happened) and the meaning of these events, while the emotional process indicates how it feels; this in turn informs the therapist of the significance of the

experience and the current accessibility of the client's internal state and processes. Overall, emotion and narrative synthesize to help provide a focus on the underlying determinants of the presenting relational and behavioral issues. Throughout the case formulation process, therapist and client are continuously deconstructing the narrative, mining through and exploring the emotions in relation to it, proposing and engaging in tasks designed to shift emotional processing, and ultimately understand how changed emotion fits back into the changing narrative structure.

Case formulation in EFT

In EFT case formulation, information is organized along a number of dimensions including (a) a style of emotional processing, (b) narrative themes related to attachment and identity issues and history, (c) painful emotion, (d) problematic or maladaptive emotion schemes and (e) the markers and accompanying tasks that might be undertaken to address those problematic schemes. Themes emerge and are borne out of the therapeutic process after diagnosis of the nature of the emotional processing style and difficulties. We attend to important markers of emotional problems throughout as these are seen as indicators of points of entry or potential foci of intervention.

Stages and steps of case formulation

The steps of case formulation are summarized in [Table 1](#). The process is divided into three stages. The weaving of emotion and narrative occurs throughout, as well as the move back and forth between the process/state level and conceptual understanding.

Table 1. Stages and steps of case formulation.

Stage 1. Unfold the narrative and observe the client's emotional processing style
The therapist listens to the client in order to deconstruct the client's presenting problems and accompanying narrative and to observe the client's emotional processing style
● Listen to the presenting problems (relational and behavioral difficulties) ● Listen for and identify poignancy and painful emotional experience ● Attend to and observe the client's emotional processing style ● Unfold the emotion-based narrative/life story (related to attachment and identity)
Stage 2. Cocreate a focus and identify the core emotion
The therapist guides the client by listening for markers, unpacking the different elements of core emotion schemes, identifying themes, and a coherent formulation narrative emerges. Work on MENSIT
● Identify markers (M) for task work ● Identify underlying core emotion (E) schemes, either adaptive or maladaptive ● Identify needs (N) ● Identify secondary emotions (S) ● Identify interruptions (I) or blocks to accessing core emotion schemes ● Identify themes (T) (a) Self–self relations (b) Self–other relations (c) Existential issues ● Co-construct the formulation narrative linking presenting relational and behavioral difficulties to triggering events and core emotion schemes
Stage 3. Attend to process markers and emergent new meaning
The therapist listens for emerging task markers and embedded micro-markers, and facilitates the construction of new meaning
● Identify emerging task markers ● Identify micro-markers ● Assess how new meaning influences the reconstruction of new narratives and connects back to presenting problems

The first stage of case formulation, *Unfolding the narrative and observing emotional processing style*, focuses on an initial framing of the presenting relational and behavioral problems and understanding them in terms of narrative themes. Therapists begin to hear the core pain and observe emotional processing style. At this beginning stage, EFT therapists gain an understanding of just how clients are making sense of current events in their lives and their accompanying emotional impacts (step one). Therapists are guided by what is painful and poignant (step 2). Through the exploratory process and discussion of the history of current problems, key aspects of the narrative or focal topics and issues emerge. Narratives tend to be heard, organized and understood around core themes of identity and attachment (step 4). Identity themes center upon issues of how people relate to or treat themselves. Attachment centers upon self in relation to other or attachment relationships. As the narrative unfolds, therapists simultaneously observe the nature of the clients' emotional style of processing (step 3), attending to the client's emotional engagement with material, the nature of vocal quality, facial expression, bodily expressions, levels of emotional arousal and other nonverbal aspects of communication. In addition, at this early point, therapists are understanding client's capacity for emotion regulation which is an assessment of whether clients are particularly over-regulated in their emotional style, indicating that they are having difficulty accessing emotion or symbolizing it in awareness, or under-regulated, indicating that they are having trouble controlling their emotional expression and are generally overwhelmed by emotion. Thus, stage one attends to the narrative track and observes emotional processing style.

The second stage, *Cocreate a focus and identify core emotion*, is guided by the chronic enduring pain, but focused on the identification of core emotion schemes seen as determining presenting problems, and co-constructing emerging, related themes. Exploration of emotionally poignant and painful material is seen as creating windows into emotion schemes that ultimately become the focus of therapy and objects for transformation. The acronym of MENSIT (marker, emotion, need, secondary emotion, interruption, theme) describes the steps 5 to 10 in this second stage. That is, in this stage, therapists are listening for markers (M) that indicate they can initiate tasks for particular types of emotion (E) processing problems, at the core of which is the maladaptive emotion. In so doing, the therapists listen for the need (N), embedded in the emotion. The secondary (S) emotion most often emerges, however, which is like a cover or defense on top of the primary maladaptive emotion, as well as interruptive (I) blocks that cover, either consciously or unconsciously, the core maladaptive emotions. Ultimately, the aim is to transform core emotion schemes through the therapy process. Themes (T) thus emerge toward the end of this stage of case formulation and they are seen as further organizing the formulation. As themes emerge through the process, they are symbolized, named and subsequently understood in terms of the larger narrative. This is a reflexive process that grows out of emotional processing (Pascual-Leone & Greenberg, 2007). The themes tend to organize and coalesce and form some of the basic fabric of the therapy as client and therapist find themselves continuously returning to them.

Themes tend to fall into three separate categories (self-self, self-other or existential). Examples of self-self might be self-criticism, self-silencing or self-annihilation. Self-other themes might center upon unmet needs for validation or security or wounds related to abuse or neglect from developmentally significant others. Existential themes may involve coming to terms with life changes or disappointments related to grown children or careers.

In the final step of this stage (step 11), therapists will help clients tie emotion schemes and narrative themes back to the presenting relational and behavioral difficulties as a way of providing further direction and goals for the ongoing therapeutic work. This is a formulation narrative that links the MENSIT or the core elements of the emotion schemes back to the presenting problems. Thus, clients come to explicitly understand what triggers the core emotion schemes, as well as the behavioral responses and consequences of their current emotional coping process. This further helps to deepen understanding and the alliance as client and therapist now feel more than ever that they have clear mutual goals and a direction that can lead to emotional change.

The third stage is referred to as process formulation. Formulation in this stage mainly happens through the ongoing process of therapy. Since stage two has occurred, client and therapist now have an explicit and clear idea of key thematic issues related to underlying emotion schemes, and as such, therapeutic sessions are organized around them. The focus of stage three turns to the continuous observation and formulation of ongoing emotional states, markers and micro-markers. These in-session markers signal therapists to make particular momentary decisions about how to best proceed to facilitate productive emotional processing. Throughout this stage, therapists attune to and listen for markers and micro-markers and suggest tasks or subtasks, designed to address the particular processing problems that present themselves in the course of therapy sessions. This continues throughout the process. In this stage, as pieces of the narrative puzzle are continually taken apart, emotionally explored, reorganized and put back together, tasks resolve, new emotions and meanings emerge, and new markers appear that suggest further tasks or subtasks.

In the final step of this stage, emergent new meaning is tied back into existing narrative themes and connected to the relational and behavioral difficulties that originally brought people to therapy. Case formulation in this last stage is thus a process of moment-by-moment process diagnostic formulation (steps 12 and 13) and continuous narrative reworking and meaning making (step 14).

Case formulation in application

In the following section, the steps and stages of EFT case formulation will be explained and illustrated through application to a case example. What follows is the case of Sophie, a woman who came to therapy because she felt depressed due to recent events with her teenage son. Sophie is a single mother and her son is an only child.

Stage one: unfolding the narrative and observing emotional processing style

Listening to presenting problems and following the pain (steps 1 and 2)

In the first session, Sophie explains how her recent depression has been triggered and connects it with a life-long struggle. She states that her mother dealt with depression as well. As the therapist listens to her presenting problems and unpacks Sophie's story of her and her son, she tracks and attends to her underlying feelings:

- S: And I haven't been getting along with him and um we've always been really close (T: mm hmmm). He's always been just a wonderful kid from the time he was little. He was a great kid and he's now sixteen and he hasn't been going to school and got himself involved in drugs (T: hmmm mmm) And uh, with the wrong crowd and uh I had a lotta trouble dealing with all of that. And I felt really guilty about how I'd failed him. (T: mmm, hm mmm) And it just kind of brought me back into that same spiral again.
- T: Uh, huh, a tailspin. And so the feeling was sort of 'I failed him' and that made you feel so awful.

The therapist is moved by Sophie's statements and the tears that form in her eyes. She empathically reflects the underlying feeling of failure. Guided by poignancy, the therapist hears and reflects what is painful for her:

- C: Yeah. I have invested all this time.
- T: So you're sadness is so big. Hmm mmm.
- C: (beginning to cry) I was doing fine until (weak laugh) I got here.
- T: Somehow that really touches something. This feeling of, I've failed or I done it right, or what did I do wrong again?
- C: yeah, right.

The therapist is beginning to formulate Sophie's pain. When tears begin to fall down Sophie's face, again, the therapist validates the pain, suggesting that this whole experience is important. Her voice softens but does not lose conviction. There is an interest conveyed behind the therapist's statements. The therapist is implicitly inviting Sophie to experience her pain and voicing what needs attention. The therapist also conveys that her sadness and tears hold important information about the source of her bad, depressed feelings.

Assessing emotional processing style (step 3)

At this first stage of case formulation, the therapist is implicitly assessing Sophie's emotional processing style. The therapist notes that even though Sophie is talking about an emotion, she talks in objective terms. In addition, at times she describes external events in a rhythmic tone, taking on a pre-rehearsed quality. This is considered an external voice (Rice & Kerr, 1986). At other times, however, she has a more focused voice. For example, when she says, 'And I never realized that people don't think that of me, who I am really'. In this moment, her voice has a focused searching, 'eyes turned inward' quality. Her tone is more ragged and broken. Voice contours are uneven. Her exploration has a fresh quality as if she is perhaps saying this for the first time out loud. This indicates that she is forming new meanings and has the capacity to use exploration productively. At other points, Sophie is clearly emotional, for example, when she is crying and saying that she does not like to be sad, tears and sadness are clearly breaking through her speech. Thus, thinking in terms of formulation, this client is able to move through a range of vocal qualities, which is prognostically positive for her capacity to explore internally across the course of therapy. Higher proportions of focused and emotional voice have been associated with outcome (Watson & Greenberg, 1996) and with empathically guided exploration, this client is able to attain these vocal

qualities. Someone who shows no focused voice will be much more difficult to reach emotionally and will require more process guidance to help them shift attention inward or evoke more felt experience.

The therapist is also attending to emotional arousal (Warwar & Greenberg, 1999). In this regard, she notices that Sophie begins to cry when she talks about feeling alone. Her voice gets lower, cracks a little and tears begin to fall. At this point, Sophie's emotional arousal is moderate. Emotion is being experienced in her face, body and posture but is not significantly interrupting her speech or posture as this would suggest severe dysregulation. In terms of formulation, this suggests a capacity for emotional involvement. It indicates that the material she is talking about is of concern to her and needs to be considered as pointing toward the focus.

Attending to emotional processing style also means attending to Sophie's levels of experiencing or depth of engagement in what she is talking about. The therapist notices that in general, when Sophie describes her experiencing, she is highly subjective, referring to her own experience and elaborating upon it in detail. She is concrete and specific in her descriptions of herself and her personal interactions. Her descriptions are vivid and evocative. This indicates levels 3 and 4 on the experiencing scale (Klein, Mathieu-Coughlin, Gendlin, & Kiesler, 1969) and is associated with a moderate capacity for involvement in content of speech. At times, she is conceptual, stating 'I am just an angry person', which is considered lower on the experiencing (level 3), while at times she focuses further inward, with experiential statements like 'I'd rather be angry (than sad) inside' (level 4).

From a formulation perspective, Sophie overall demonstrates a capacity to focus inward on experiencing. That is, guided by therapist empathic responding, she is able to 'turn eyes inward and explore'. In some cases, clients have more difficulty 'using' empathic statements to in turn guide inner exploration and need more specific work to aid in this activity. A client consistently low in experiencing, in spite of continuous accurate empathic explorations and conjectures on the part of the therapist, would require of the therapist to formulate that the person needs more focused work specifically to help access core emotions. If the person is low in experiencing, more psycho-education and process directiveness is needed; if high on experiencing, then more following and exploratory responses will help get to the core emotion schematic material.

The therapist is also assessing Sophie's capacity for productive emotional processing (Greenberg, Auszra & Hermann, 2007; Auszra & Greenberg, 2008). In part, this judgment not only is informed by assessments of levels of experiencing, arousal and vocal quality but also involves higher-level judgments about the nature of emotional expression. Emotional expression here is defined as observable, verbal and nonverbal behavior that communicates and/or symbolizes emotional experience that can occur with or without self-awareness. Here, the therapist first notices whether Sophie is contactfully aware of her emotions and assesses this affirmatively. Then, the therapist observes whether Sophie is able to symbolize, attend, be congruent with (i.e. feeling and express the emotion as she verbalizes it rather than for example smiling when expressing anger) regulate, differentiate, accept and feel agentic with (i.e. feel she is at the center of her own experience rather than blame or hold another responsible for) her emotions.

With respect to the evaluation of Sophie's capacity for emotional productivity, the therapist notices that Sophie struggles slightly to accept her emotions, saying for

example as she begins to cry, 'I was doing fine until I got here,' she also has some difficulty regulating her experience. She avoids her sad feelings stating, 'I would rather be angry than sad,' and 'When I am angry I can clean my house in 15 minutes; when I am sad, I don't want to get out of bed'. Furthermore, when she does access painful feelings, she feels overwhelmed and attempts to distract from them. On the other hand, Sophie is able to access and attend to her emotions, symbolize them with the help of the therapist's reflections and is congruent with respect to her emotions. She is agentic and does not blame others for her feelings, and she is able to differentiate her feelings (again with the empathic guidance of the therapist).

Thus in terms of the assessment of emotional processing, by the end of the first session, it seems that Sophie has shown a capacity for a focused and emotional voice, has reached at times a moderate depth of experiencing, has the capacity for moderate emotional arousal, does not become severely under or overregulated when talking about emotions and shows a strong capacity for productive emotional processing. These are all indications that client and therapist can continue to work toward identifying her core emotion schemes and related core themes, process emotions productively in relation to them and work toward emotional transformation.

Emotion-based narrative (step 4)

In EFT, therapists generally do not ask a prepared set of questions either in the first session or over the course of therapy. This is in part based on the assumption of an implicit growth tendency inherent in all people and the corollary that people are motivated toward change and growth. Thus, therapists assume that clients will disclose necessary information in the context of an empathic, nonjudgmental relationship as they will feel safe and trusting enough to reveal vulnerable and painful emotions that are generally the source of the problems they bring to therapy. Empathic responses are used to deepen emotion and find a focus.

Through the unfolding of the empathic relationship, the therapist learned in the first session of Sophie's story. She described how her mother, who lived in a city 5 h away and with whom she did not have a close relationship, had been very critical and invalidating while she was growing up. She was the only girl with four brothers, none that she felt close to with the exception of one. In the first session, she recalled longing for her mother's attention and support, and only remembering one specific occasion where her brother was soothing and caring toward her at a time of distress. Otherwise, she remembered feeling neglected by her parents, forgotten or abused by her other brothers and counting down the days to be able to move out when turned 18.

Stage two: cocreate a focus and identify the core emotion

The second stage of case formulation is concerned with identifying the core maladaptive emotion scheme that is driving the problems that clients bring to therapy. By now, therapists understand client's presenting problems and are beginning to get a sense of the pain that brings them to therapy and drives their angst. The therapist has a background sketch or narrative framework that is the 'story behind the story' or the story of their life. That is, they have a sense of what happened to them before they got here. In

addition, the therapist has also assessed the client's emotional processing style and thus knows whether further, specific work is needed to regulate or access deeper emotion or whether the therapy can proceed through the empathic relationship and the identification of markers and tasks.

The focus thus turns to identifying the core maladaptive emotion and the different components of the MENSIT. While these components are explored over the course of the second stage of case formulation, they do not necessarily emerge in this particular order. Markers (M) are useful guides, however, as they are indicators of emotional processing difficulties and opportunities to intervene, deepen and access the core maladaptive emotion. Most often, clients will at first present secondary (S) emotions such as hopelessness or blaming, secondary anger (Pascual-Leone & Greenberg, 2007). In this case, the therapist will notice this but work to understand the primary maladaptive emotion (E) that lies behind that secondary emotion. Once the maladaptive emotion is activated and felt, therapeutic exploration leads to the emergence and accessing of the core need (N). Interruptions (I) do emerge throughout the process and these are often customary styles that people have learned earlier in their life that on the one hand aided survival but on the other keep them stuck. The T in the MENSIT acronym is well-placed, however, at the end as it is only after the exploration of the other aspects of the MENSIT. It is through the exploration that themes emerge as therapist and client find themselves continuously returning to that which is thematic such as unresolved grief or loss and a painful sense of inadequacy. These are continuously worked on with various therapeutic tasks that help clients resolve emotional issues and transform maladaptive emotional processes. The theme is often reflected in the formulation narrative that ties together presenting problems with triggering events and the underlying core painful maladaptive emotions. Identification of the themes and the formulation narrative help make the implicit more explicit and thereby create a stronger focus for work and a stronger alliance to keep going.

In the following excerpt, we see the marker emerge and how it leads to her core primary maladaptive, painful emotion of shameful inadequacy. She is describing common interactions with her mother. We pick up with her describing the nature of their interactions:

- C: Our contact is, minimal. Very superficial. It is just so difficult to talk to her.
 T97: Yeah. So you're saying there are some unpleasant memories that really haven't gone away and they still come to you.
 C98: Yeah. (T: mm hmmm) And because my parents are still alive and still there it's like they don't ever go away. Unless I break that tie completely.
 T98: So as long as they're still alive you can't break the tie.
 C99: Well, the same old reminders are always there.
 T99: Oh I see so the things...
 C100: My mother's very critical (T: mm hmmm) Extremely critical. I've never done anything right in her eyes. And I still don't. Even though she lives miles and miles away. So it's a constant reminder if I try in my adult life to work on not being so critical of myself and not be so critical of Jeremy (son), every time I talk to her it just ... she's very critical. It's always in my face.

- T100: I see. Yeah.
- C101: So I can not to talk to her for months and do great and then in one phone call she could just...
- T101: Huh. So she could wipe you out in that time.
- C102: Yeah. ... well.
- T102 : No?
- C103: She doesn't wipe me out anymore because, I try not to put, I try to realize this is the source. She'll never change. (T: mm hmmm) So she doesn't crush me, but it brings back all my feelings of not being adequate and not being good enough and then those are like the ones that I keep down.

In this last excerpt, we see a marker emerge for unfinished business with her mother. While she is now an adult with her own career, and family, living 500 km away from her mother, a telephone conversation with her mother can still devastate here. Her mother was and still is very critical of her and this can trigger a core maladaptive emotion of shame. She has tried to emotionally distance with physical distance but the core emotion scheme remains and can be easily activated. In later sessions, the therapist will invite Sophie to have an imaginary dialogue with her mother in an empty chair (Goldman & Greenberg, 2015) in order to work through some of her broken-ness and express her hurt and anger. In other sessions, the therapist will invite her to have a self-critical dialogue in which she can become aware of she has internalized the voice of her mother and through self-criticism, can shame herself, leading to feelings of depression (Goldman & Greenberg, 2015). While the therapist notices these markers, at this point, she will not invite the client into such tasks as this is still a first session and a therapeutic relationship marked by safety and trust is still in formation. In the following excerpts, we see more elements of the MENSIT emerge.

In sessions that followed, Sophie's secondary feelings are of hopelessness, resignation and anger (S) continue to emerge in relation to her son being involved with drugs. Continuous exploration of such feelings leads to core painful, maladaptive feelings fear of failure, inadequacy (E). Here, she is talking about her one brother that she felt close to and the emotion and a time in which she was distressed and he provided soothing.

- C: And even though we were a large family, we didn't really grow up together. Most of us were either at boarding schools or summer camp; I don't think there was ever the five kids living in the same home at the same time. (T: mm hmmm).
- T: So you weren't close to any of your brothers?
- C: One. The second, I don't know how close I was but he's the only one I have good memories of where I can remember sitting on my bed crying and he actually came in to my room, to hold me and hug me. (T: mm hmmm)
- T: it's what you really needed
- C: (crying) I don't think I ever got that from my dad or from my mom. (T: mm hmmm)
- T: Yeah, it's what you so crave.

- C: (crying) I wasn't allowed to be angry. I wasn't allowed to cry. (T: mmm) I know I learned that feeling as a kid. It was do what you're told. This is how it is. You're supposed to be happy all the time. So they didn't talk about anybody's problems. (T: mmm) It was a big front.
- T: Yeah. It's almost as if you weren't seen. You weren't heard from (C: oh no) it was like you weren't really there.
- C: (crying) No. (T: mmmm) The only time I wasn't was when I was supposed to be (laugh).
- T: The companionship, the closeness and the affection.
- C: Just that one brother. And that's when I think I was a teenager by then. He was a bit older. Or I'd say I was 10/11. I remember my brother being really nice, saying 'don't cry, it's ok'.
- T: Just sort of soothing you.
- C: Yeah.
- T: And that makes you sad just remembering.
- C: Yeah, that should be a happy thought, right (crying).
- T: Well, I guess you got so little of that, it sounds like. You know, it's like those times were so few and far between.
- C: Cause he wasn't home much. He was in boarding school (crying). (T: Mmhmm) I wish he'd been home more.

Thus, a very important memory emerges here of one of her older brothers soothing her when she was distressed. The pain is brought about through the sharp contrast with the lack of love and affection she received from other family members. She paints a picture of a barren landscape wherein she received little attention and affection and would retreat to her room to cry by herself for comfort. Her brother was the small beacon of hope that represented all that she was missing but he was hardly available. As she continues to talk about him, she actually interrupts the emotion. Client and therapist continue the emotional exploration as we see the core painful emotion begin to emerge:

- T: Yeah, yeah. Cause he (brother) was somebody who could actually understand. You needed a whole lot more of that. And, um ... mm hmmm.
- C: See I stopped (laugh) (referring to crying)
- T: How did you ... you sorta cut off?
- C: I don't know how. I just kinda take a deep breath and cut it off. I just think it really scares me to go there. (T: yeah) (Crying)
- T: So you kinda cut it off, like I don't want to feel too bad. And yet you do go there. You do dip in. And access it.
- C: I just kinda scratch the surface.
- T: So you're saying it doesn't really speak to what I actually feel. I feel so much more, the wounds are so much deeper. And it scares me, yeah.

Here, the client briefly interrupts (I) her emotions but with the empathic guidance of the therapist, allows her experience, and explores and accesses the underlying core

painful emotion. We see the exploration of these core emotions and the emotion schematic memories of unresolved sadness and shame (E) to which they are tied:

- C: (crying) I remember not wanting to live as a teenager ... and it was really scary.
 T: So you felt like it would just be easier if you were dead.
 C: OH, I just remember wishing I'd get leukemia or something then. (Crying) if I was at a hospital dying somebody would probably ... like maybe my mom would give me the last month of my life or something. Then she would notice that I was there.
 T: It sounds like you were just craving to be seen. To be held. To be loved. Mm hmmm. sounds like
 C: And I've pushed it away ever since. (crying) (T: mm hmmm)
 T: I guess it's just like it wasn't there. You couldn't get it and uh, you needed it. Somehow though it doesn't exactly go away.
 C: (laugh) No. As we know. It doesn't go away. Although I wish it would.
 T: Yeah, yeah. And I guess you're saying it is also scary when you get into these feelings because sometimes those feelings are pretty strong and intense. And you've even felt like you'd like to just stop living.

Here, the client conveys the depth of her pain that began when she was a teenager feeling lost among four other male siblings, in a very restrictive, judgmental and unsupportive environment. The feeling is one of being primarily overlooked and ignored. When she was attended to, the feeling was one of doing something wrong. Her accompanying pain and distress as she tells the story reveals how formative and important these experiences were. For this formulation, two themes (T) are emerging: a strong sense of self-invalidation that had its genesis in her family of origin experiences, and problematic emotional self-regulation which seems to be her adopted, albeit untenable, strategy of attempting to disavow or strangle painful affect related to unmet needs that feels unbearable and never-ending. This leaves her feeling, however, lonely, cold, detached and depressed.

Sophie felt unrecognized and invalidated by her mother. Inherent here but not quite formed this early in therapy are potential markers of negative self-criticism and unfinished business, (M). Her core unmet need (N) was to feel adequate and valid. In addition, she interrupts (I) her feelings of shame and inadequacy with anger, shrugs of resignation, and blocks her pain and sadness for fear of becoming overwhelmed. The main theme is not only self-self in which she feels inadequate and worthless but also unfinished business (self-other) as the original wound occurred in the context of feeling criticized and invalidated by her mother. The formulation narrative that was formed by her and her therapist is one in which they understood that her presenting problems of social withdrawal, depression and despair is symptomatic of a maladaptive emotion scheme marked by shame and invalidation which is triggered by her perceived sense of failure with respect to her mothering and work life. The overall theme then is of self-criticism, shame and inadequacy.

Stage three: process formulation

The task markers in this therapy that emerged later (step 12) were related to unfinished business after the two-chair dialogue for negative self-evaluation had

been worked on. Initially, self-evaluative conflict splits had been triggered by issues with her son. At these markers, the therapist would ask her to put herself in the chair and make herself feel like she had failed. Through this process, she was able to own her self-contempt, become aware of how she was criticizing herself and making herself feel depressed. She was also able to access assertive anger and stand up to her negative self-critic. Next, she would come to therapy telling stories of conflict with her boss by whom she felt invalidated. The task would then involve putting her boss in the other chair and having her boss invalidate and criticize her. Note that this was not unfinished business as the boss was seen as the 'projected introject' who embodied her own self-criticism. After enacting her boss, she came to realize that she was indeed very sensitive to invalidation and that in response she would get depressed and go to bed for a few days.

Over the course of the next eight sessions, Sophie began to access assertive anger and stand up to her very harsh critic. She began then to access a sense of pride and self-confidence and that she was indeed worthwhile. She was still mildly depressed although was no longer withdrawing and retreating to bed for days. She was also doing much better and felt more accepting of her son. She felt more able to talk with him and share her concerns and put limits on him.

In the sessions that followed, what emerged next was unfinished business with her mother. In subsequent sessions, therapy centered upon empty chair dialogues for unfinished business with her mother. She would enact her mother being dismissive, come back to the other chair (self) and collapse into worthlessness and shame. After some time, she accessed unmet needs for validation, respect and love. She was able then to come to an understanding of her mother's inability to meet her needs due to her own pain, shortcomings and unmet needs. She was able to see her mother more clearly, understand her and feel more differentiated. Importantly, upon interacting with her mother, even though her mother was often still critical, Sophie did not become depressed and saw her mother as 'doing the best she could'. She also felt more compassion for her mother and herself. She was able to access compassion and soothing for herself in the therapy sessions.

Micro-markers that occurred (step 13) in the course of the work related to self-interruption as Sophie would sometimes stumble upon strong feelings of painful shame and becoming frightened, cut them off or block access to them. The therapist would then help her detour into a self-interruptive split where she would enact this sudden self-interruption and, in response, express the need for self-expression. She also engaged in self-soothing work that helped Sophie develop self-support and feel strong enough to be able to 'withstand' strong, painful emotions. When new meaning emerged through the process (step 14), such as 'I am worthwhile' and 'I can assert my needs with my boss', the therapist would facilitate its integration through empathic exploration, into the overall narrative so that Sophie came to develop a sense of 'I am enough. I am okay as I am,' as an alternate narrative to 'I am a failure' and a new script in the face of potential invalidation. Also, a result of a shift in her view of herself and her mother, she felt a greater sense of self-validation and support and that she could 'handle challenges that life handed her'. A summarized version of the case formulation of Sophie can be found in [Table 2](#).

Table 2. This is the case of Sophie, broken down and applied to the chart form.

Case formulation chart: depression
Stage 1: Unfold the narrative and observe emotional processing style Presenting problems: I am depressed. My son has gotten involved with drugs and I don't know what to do. I feel I have failed Pain and poignancy • I have suffered with depression most of my life • I am an angry person • I don't trust people • I shut down when people let me down Assessing emotional style • Vocal quality – mainly external, although responded with focused when empathic explorations offered • Emotional arousal – moderate to high when talking on emotional topics • Client experiencing – mostly external but capable of focusing internally when guided • Emotional productivity (a) Attending? Off and on (b) Symbolizing? Yes. Clearly has capacity. Responsive to therapist's focusing on internal experience (c) Congruence? Some mismatch, for example, some laughing when talking about vulnerable emotions (d) Acceptance? Difficulty, less with anger than with vulnerable emotions such as sadness and hopelessness (e) Differentiation? Yes, has capacity (f) Agency? Yes, she feels she is at center of her own experience (g) Regulation? Both under and over. Over-regulation, however, is seen more as strategy to control under-regulated emotions that get scary when expressed such as sadness and hopelessness Emotion-based narrative/life story: I live 5 hours away from my parents and I am glad there is distance between us. I only see my parents approximately every 5 years, and yet I still feel devastated when I leave them. My mom is extremely critical and always was. Now she is critical of my son. My father is generally not supportive. I grew up in with 5 brothers but none of them bothered with me, except for one but he was not around much as he was away at boarding school most of the time. My parents never understood me; they always had different double standards for girls. I couldn't wait to leave when I was 18. I felt isolated and alone and I still do. I am not married and never have been. My son was my light, my hope. He has always been such a good kid. Now he is involved with drugs and will not listen to me. I feel I have failed. In a way I have always failed. This is familiar Stage 2: Cocreate a focus and identify the core emotion Identify markers (M) for task work: (1) Negative self-evaluation 'You are not smart enough' Task: Two-chair dialogue for Self-criticism Identify underlying, core (E) emotion schemes, including both adaptive and maladaptive elements: The core emotion is maladaptive shame (I am a failure), that is mixed with fear, sadness, and loneliness that therapist and client work hard to access Her core need (N) is for self-validation, and self-pride The client often opens sessions with her secondary (S) anger, as she has typically felt this to her source of strength. It is, in fact, a 'straw man', protecting a vulnerable underbelly Identify blocks or interruptions (I) to accessing core emotion schemes: I cannot access core pain as I will become severely depressed and dysfunctional; I will never get out of bed Identify themes (T) (a) Self-self relations – I am not worthwhile. I am a failure (b) Self-other relations – Others are not trustworthy, they will always invalidate me. It is better not to let anyone too close Co-construct the formulation narrative that helps tie presenting relational and behavioral difficulties to triggering events and core emotion schemes. Once the various emotions and problems were deconstructed, the therapist helped clarify how they related to problems she presented, saying such things as, 'It is understandable that you feel depressed, given you fundamentally feel like a failure. Your pride in your son was one area of life where you felt good and now you feel that has soured. This triggers a core sense of failure and worthlessness that stems back to feeling criticized by your mother. With such negative experiences, you fear being invalidated and criticized, so you don't let people close to you. However, you feel lonely and unsupported in your life' Stage 3: Process formulation Identify emerging task markers. <i>Marker:</i> Through course of two-chair work for self-criticism, it becomes clear that the 'critical voice' mirrors her boss and then eventually her mother. 'She wipes me out every time I see her'. <i>Task:</i> Therapist and client undertake several rounds of empty chair work for unfinished business with her mother, related to feelings of neglect and invalidation. (2) In two-chair work, stubborn critic had trouble softening (emerging marker). Formulation decision to switch and attempt self-soothing task

(Continued)

Table 2. (Continued).

Case formulation chart: depression
Identify micro-markers within tasks. (2) <i>Micro-marker:</i> In empty-chair work, enacts mother sweeping and being dismissive; would then switch into self-chair, become hopeless and despondent. <i>Micro-formulation:</i> validate and empathize and then ask what she needs Assess how new emotion and meaning influences the reconstruction of a new narrative and connects back to presenting problems. In two-chair work, she was able to access a sense of assertive, self-pride and a stronger sense of self-worth. Her sense of self-worth carried over to the relationship with her son. At later points in therapy, while she still felt he was involved with 'the wrong crowd', she no longer felt it was her fault, or that she was responsible. She was more able to make demands of him and set limits. In the empty chair task, she got angry with mother and stated needs for support and validation. This led to her being more assertive with her boss at work with whom she had previously had difficulty standing up. She then felt better about going to work

She was a 42-year old, single mother, suffering here second depressive episode.

Conclusion

Case formulation in EFT provides a way of conceptualizing clients and a scaffold or framework of understanding that allows them to think through what to do next. The case formulation framework helps therapist specify from moment to moment, markers and emerging markers that form a complex map that ultimately guides therapy through the emotional change process. In this paper, the stages and steps of case formulation have been outlined and the method has been applied to the case of Sophie in order to illustrate how case formulation works across a case.

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Notes on contributor

Rhonda N. Goldman, PhD, is a professor at the Illinois School of Professional Psychology at Argosy University, Schaumburg and a therapist affiliate of the Family Institute at Northwestern University in Evanston, Illinois where she sees both couples and individuals. She has authored four texts on Emotion-Focused Therapy including her most recent book (2014) on case formulation. She practices, teaches and conducts research on emotional processes, empathy, vulnerability, depression and soothing. She is the 2011 recipient of the Carmi Harari Early Career Award from the Society of Humanistic Psychology, Division 32 of the American Psychological Association. She is past-president of the Society for the Exploration of Psychotherapy Integration (SEPI). Rhonda Goldman is a cofounding board member of the International Society for Emotion-Focused Therapy (ISEFT). Dr. Goldman travels internationally, conducting trainings and workshops in Emotion-Focused Therapy.

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