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Emotion focused therapy (EFT) was developed in the 1980s by Sue Johnson and Les Greenberg initially to help couples. They published the first EFT couple therapy manual (Greenburg & Johnson, 1988). EFT integrates person centred, gestalt and existential therapies with modern thinking in psychology and was developed alongside the theories of adult attachment. Our emotions help us understand our needs and behaviour and how we select goals and commit to achieving those goals. The modality is based on the premise that our emotions play a critical role in who we are and how we function (Greenberg, 2004). Emotions shape decisions and play an important role in conveying feelings and intentions. Neuroscience has demonstrated that emotion is the foundation for decision making (Bechara, et al. 1997). EFT recognises that emotions are central to identity and a lack emotional awareness and the avoidance of unpleasant emotions can be harmful. Human emotions include compassion, love, affection, caring joy, happiness, surprise, interest, curiosity, disgust, guilt, shame, sadness, anger and emotional pain.

This essay will examine the fundamental principles of EFT, investigate post-traumatic stress disorder (“PTSD”) and demonstrate that EFT is a valid and sophisticated modality for treating trauma and specifically PTSD. We will explore: the incidence of trauma and PTSD; the National Institute for Health and Care Excellence (NICE) (National Institute for Care and Excellence, 2018) and Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 2013) definitions of PTSD; briefly examine PTSD; explore the validity of the definitions; delve into literature and research into the treatment of PTSD and consider how cultural differences might affect the treatment of PTSD.

The next section will deal with the key theories of EFT: emotion schemes; the task focused therapeutic alliance; the three phases of treatment; primary adaptive, primary maladaptive, secondary reactive and instrumental emotions and markers, emotion regulation and transformation; microprocesses; emotion; and research into the efficacy of EFT. The final section focuses on the treatment of PTSD: symptoms; re-experiencing trauma; complex PTSD; phases of treatment; unfolding and retelling; clearing a space; two chair work; empty chair work and critics of EFT, followed by a conclusion. I will, with limited exceptions, focus on individuals and adults as opposed to children, couples and families.

It is conservatively estimated that between 60% and 80% of adults in the United States and Europe experience at least one traumatic event during their lives (Kessler, et al. 1995; de Vries & Olf, 2009). Therefore, it is likely that a very large proportion of clients in therapy have experienced trauma. Psychological trauma is caused by stressful events that a person experiences or witnesses which destroys their sense of security and may make a person feel helpless and vulnerable. Trauma can be caused by single event or by prolonged violence or abuse. If the person does not recover naturally and symptoms persist (see below) the ongoing illness is categorised as PTSD (Havens, 2020). MIND 2020 estimates that 4 in 100 people in England suffer with PTSD. There are approximately two million people affected by PTSD in the UK (Mental Health Research, 2020). PTSD is widespread: 6.8% of Americans will experience PTSD during their lives. Women (9.7%) are more than two and a half times as likely as men (3.6%) to develop PTSD in the United States. Approximately 3.6% of adults in the United States (5.2 million people) have PTSD in any given year (Hamblen, 2009).

The NICE criteria for PTSD are: serious accidents; abuse including childhood or domestic abuse; work-related exposure to trauma; including remote exposure; trauma related to serious health problems or childbirth experiences (for example, intensive care admission or neonatal death); war and conflict and torture. There has been much discussion in respect of what constitutes a traumatic experience and how a traumatic experience differs from other negative life events. Most people do not continue to experience symptoms after a traumatic event but some develop PTSD. The DSM included PTSD in a new category in DSM-5, Trauma- and Stressor-Related Disorders. PTSD is defined as a Criterion A defined trauma where an individual experiences, or witnesses actual or threatened death, serious injury or sexual violence. Further criteria including symptoms are set out in Criterion B to F. Although a number of individuals may be involved in the same trauma only some will go on to develop PTSD (Carmassi et al. 2014). Prolonged or repeated trauma can be far more complex; survivors develop personality changes, problems with relatedness and identity (Herman, 1992). Whilst a Criterion A event is necessary for a PTSD diagnosis it tells us very little about the complexity of the condition. The diagnostic criteria were derived mainly from combat, disaster and rape.

The DSM's and to some extent NICE's guidelines binary approach is a rather basic methodology for categorising trauma. Spence et al. 2013 propose that trauma should be seen as a continuum of threat, a spectrum of magnitude which should also recognise the significance of loss (for example bereavement), danger (for example the threat of ongoing violence) humiliation (rejection, devaluation and role failure) and entrapment (imprisonment in an extremely negative situation with little chance of escape). Negative experiences including trauma tend to cluster and their effects can have multiple and cumulative impacts.

Herbert, 2005 points out that PTSD is a serious illness that is often missed. PTSD is difficult to diagnose because the nature of the symptoms makes it difficult for the client to disclose and

the condition has multiple and diverse clinical features. Those suffering with PTSD often do not report their symptoms to clinicians as this in itself may activate symptoms. Clients can change from the extremes of numbness to hyperarousal which can be confusing and frightening. The client may try and hide the symptoms. Moreover, symptoms are often be misdiagnosed as another mental health problem in primary care as the patient's narrative may well describe depression, anger problems, panic disorder anxiety, social phobia or personality disorder. It is important to bear in mind that the clinician is asking the client to abandon the defence mechanisms that protect her or him from re-engaging with the horror of the experienced trauma. The three groups of symptoms which characterise PTSD are: intrusions and reliving, avoidance and numbing and hyperarousal. PTSD is a major health concern that is inconsistently diagnosed and treated. Indeed, the consequences of PTSD are costly both in respect of the individual's wellbeing but also literally in terms of expenditure and resources (Herbert, 2005).

There is large body of literature relating to trauma and the treatment of PTSD. Cognitive Behavioural Therapy is regularly proposed as an effective treatment (Cohen et al. 2011). Harvey et al. (2003) came to the conclusion that CBT was an effective and safe treatment for PTSD. They did note, however, that further more rigorous trials were needed. An Eye Movement Desensitization and Reprocessing (EMDR) study looked at 44 randomized controlled trials and concluded that treatment of PTSD with EMDR in early traumatic stress, and traumatized children was effective. Prolonged Exposure (PE), also a favoured treatment allows individuals to gradually approach trauma-related memories, feelings and situations and the increased exposure decreases symptoms (American Psychological Association, 2017). The research on the efficacy of treating PTSD with EFT is set out below.

Therapists and medical practitioners need to be respectful of and sensitive to the client's age, gender, sexual orientation, socioeconomic status and in particular the client's specific differences (including cultural, ethnic and religious background) and any disability. If a therapist is not sufficiently aware of a client's hinterland it is going to be difficult to build a positive therapeutic relationship or an effective working alliance. Exposure to repeated verbal racism only during childhood can itself cause PTSD. In a recent episode of *All in the Mind*, a discussion between the presenter Claudia Hammond, Rajan Datar, psychiatrist Kam Bui and Professor Craig Morgan, there was general agreement that exposure to regular verbal racism could lead to a child developing PTSD (British Broadcasting Corporation, 2020). It is arguable that even some eminent academics, for example Elliot & Greenberg (2015), do not accord sufficient importance to differing cultures' divergences and disparities. For the Roma for example, the concept of *lajav* ("shame") is important, whereas concept of *bezax* ("sin") does not have such significance (Grigore, 2001) which could lead to confusion. In the same vein eastern collectivist societies have a very different worldview to individualist western societies.

Elliot et al. 2004 p.3 explains that the key idea behind Process-Experiential (PE) therapy (an earlier nomenclature for EFT): emotions are adaptive but can be problematic because of past traumas or because individuals are taught to pay no attention to or even dismiss their emotions. Feelings tell us what is important in any given situation and therefore guide us in respect of what we need or want and the appropriate action to take. Furthermore, self-awareness and managing emotions give a person a sense of wholeness and consistency. EFT supports an individual's growth orientated voice which is in conflict with the negative voice. The therapist will notice the client's internal experience as it changes from moment to moment and the therapist actively works towards a goal with the client (Mahrer, 1983). The therapist is an experiential guide, following and guiding at the same time. Therapy is co-exploration, an active

collaboration. However, when conflict arises the therapist views the client as the expert in their experience.

From childhood onwards experience is organized into “emotion schemes” which include feelings and action tendencies and sometimes beliefs. The purpose of EFT is to change dysfunctional emotion schemes, the maladaptive ways clients experience and respond to the environment. Emotion schemes can be linguistic ideas, but can also include images and somatic experiences. We are not aware of the schemes but they can be known through the experiences that they produce for example a memory which can be reflected on or an emotional event that can be mulled over. EFT facilitates clients to access schemes in a safe environment enabling clients to restructure emotive schemes that are no longer adaptive (Greenberg, 2002).

The relationship is a task focused therapeutic alliance wherein the client feels safe enough to discuss and explore their distress and pain. Elliot et al. 2004 pp.5-11 set out the three key treatment principles: firstly, entering and tracking the client’s immediate and changing experience; secondly the therapeutic alliance – communication of empathy, caring and presence and thirdly facilitative involvement in goals and tasks. These three relationship principles are mirrored by three principles relating to the client’s therapeutic tasks. Firstly, helping the client to work in different ways at different times (honouring the humanistic adherence to pluralism and recognising that clients have different ways of productive working). Secondly, facilitating client completion of key therapeutic tasks through tracking progress in session and maintaining the focus on key treatment tasks whilst maintaining flexibility where necessary in order not to damage the therapeutic relationship. Thirdly, developing client responsibility and empowerment. The therapist may support the client by offering alternatives to the client regarding activities, goals and tasks provided always that the client is the expert. Compassion and support applied to painful feelings is the beginning in tolerating the negative

emotions and self-soothing and also encourages the client to create a working distance from the emotions (Greenberg, 2004, p. 8).

EFT can be divided into three stages of treatment (Greenberg & Watson, 2006): bonding and awareness; evoking and exploring and transformation creating alternatives generating new emotions thereby creating new meaning. Firstly, bonding and awareness - from the first encounter the therapist displays empathy, unconditional positive regard and acknowledges the importance of the client's feelings. A shared understanding of the client's core pain is explored together with the underlying determinants of the client's symptoms. Secondly emotions are evoked to encourage exploring as deeply as possible and intensifying the emotions where appropriate. If the client has the internal resources to deal with this the therapist can further explore and explain the core pain. Working on avoidance and interruption can also be addressed. Thirdly, transformation and alternatives are addressed having identified the core pain the client shifts to construct alternative ways of responding emotionally, cognitively and behaviourally (Pos & Greenberg, 2006). Empathic exploration and marker tasks are widely used to gain as great an understanding as possible of the client's interior world.

The therapist does not assess for veracity, suitability or psychopathology. There is no attempt to interpret configurations/patterns, motivations or defence mechanisms or to challenge irrational beliefs. Acceptance and trust in the client's self-understanding and growth tendencies is critical (Peshken & Johnson, 1997). Additionally, presence and authenticity encourage diminishing the client's sense of isolation (May & Yalom, 1989). Client and therapist will agree in session tasks and overall goals – it is, however, important to remember that ultimately it is the client who is self-determining. The therapist remains collaborative and non-expert. Therapists attend to a client's needs and current state to recognise how that client works at different times. Prominent academics have categorised emotional responses into primary

adaptive, primary maladaptive, secondary reactive and instrumental (Goldman & Greenberg, 2015). Primary adaptive is an initial emotional response to a stimulus, for example, fear is an adaptive emotion to a threat (Elliot et al. 2004 p.41). Primary maladaptive emotions derive from emotion schemes which are no longer useful or appropriate, for example insecurity or shame. Secondary reactive responses are emotions caused by the primary adaptive or maladaptive response, that is, the second emotion for example being sad about a prior reaction of sadness or it may be a defence mechanism, for example becoming angry when feeling vulnerable is a prevalent response amongst men. Instrumental emotion is a learned response which was created to elicit a specific response from another, for example crocodile tears (instrumental sadness). Maladaptive feelings are unchanging old, habitual feelings such as loneliness, sadness, abandonment, worthlessness and shameful inadequacy. Maladaptive anger can be undone by adaptive sadness which can be turned into acceptance (Greenberg, 2004, pp. 8-12). A therapist's awareness of their own shame and shame anxiety might also enable therapists to be open in acknowledging their contribution to disruptions and impasses in the therapy process (Jacobs, 1996). The fundamental principle of transformation is the replacing of one emotion for another. Emotion is the agent for change in that a maladaptive emotion can be replaced with an adaptive emotion – the maladaptive emotion is undone by a more adaptive emotion.

In order to access emotions an EFT therapist will utilize markers. Client markers indicate that the client is willing to engage with a specific problem (s) and indicates the task or work that needs to be completed to resolve the issue(s). Markers include: puzzling reactions, for example a client stating that my partner gave me a wonderful bunch of roses today but I just felt sad; bad feelings towards someone significant in their lives, for example the client confirming that they always hated their brother (unfinished business); negative feelings about themselves, for

example imposter syndrome or never feeling good enough; intense emotion, for example experiencing rage in a session and difficulty with expressing emotions during a session, for example a client who seems numb and disengaged. To these you could add vulnerability, unclear felt sense, difficulty focussing, traumatic experiences and being stuck (Elliot and Greenberg, 2018, pp. 246-247). Moreover, a therapist will attend to the client's microprocess and microprocess markers (a clients' somatic signals such as demeanour, voice and posture) to understand the client's experiencing (Elliot, 2004 p.53-54).

Research studies have demonstrated the efficacy of EFT. Elliot et al. 2004, p.47 examined five existing studies where process-experiential/EFT therapy was utilised to alleviate trauma and unresolved painful relationship issues including four controlled or comparative outcome studies. They concluded that the research provided strong evidence that the therapy was effective. However, it was also noted that the searchers were process-experiential/EFT advocates and this may have skewed the results. A twenty-session study of adults with unresolved issues of childhood abuse who were compared with a waiting list control group concluded that 100% of the participants had made clinically significant change compared with 36% of the wait list (Greenberg & Paivio, 1997). Paivio & Nieuwenhuis (2001) conducted a randomized clinical trial utilising two versions of emotion focused trauma therapy, each using a different reexperiencing procedure, imaginal confrontation and empathic exploration, and found that both were effective. Clients improved on all measures of disturbances: PTSD, low mood, interpersonal problems and resolution of issues with the individuals who had neglected and/or abused them. As Elliot et al. 2004 p.49 notes process-experiential therapy has proved itself to be effective in dealing with trauma, abuse and other interpersonal issues. Furthermore, a comprehensive study of the body of research that has examined Pascual-Leone and Greenberg's (Pascual-Leone & Greenberg, 2007) model of emotional processing concluded

that while this research area was still quite new there seems to be enough support to consider that emotion changing emotion theory may be a causal mechanism of change in psychotherapy (Pascual-Leone, 2017).

Having set out the basic concepts of EFT this next section will concentrate on PTSD or Emotion Focused Trauma Treatment EFT (“EFTT”) as it is sometimes referred to. PTSD symptoms include flashbacks (reliving the trauma in the present), intrusive images and thoughts, intense distress at real or symbolic reminders of the trauma and physical pain, nausea, sweating and trembling. Furthermore, someone with PTSD may be hypervigilant, suffer panic attacks when reminded of the trauma, becoming easily upset or angry, not be able to sleep properly, become aggressive and irritable, self-destructive or reckless, easily startled, difficulty concentrating and other anxiety symptoms. To avoid the trauma memories, sufferers distract themselves with being busy and attempt to avoid anything that reminds them of the trauma. Additionally, they may not be able to remember details of the event, feel numb and dissociated from feelings and also feel detached from their body. More general feelings include inability to trust anyone, feeling that everywhere is unsafe, thinking that nobody understands them, blaming themselves for the event and overpowering anger, shame, guilt and sadness. Clients with PTSD often also have co-morbid conditions: anxiety disorders; depression; suicidal feelings; dissociative disorders and self-harm (MIND, 2017).

The client often avoids and interrupts reexperiencing the pain which leads to isolation and emotional numbing (Elliot et al. 2004, pp. 297-304). Re-experiencing traumatic difficulties (flashbacks and nightmares) are a way of trying to resolve unfinished business specifically why the trauma occurred, who was responsible and how to prevent it happening again. The emotional injury disrupts narrative processing (Wigren, 1994). This victimisation creates a discontinuity in the life narrative and the process of making meaning of an individual. The

individual's narrative is divided to pre- and post-trauma and the narrative itself is likely to have flaws including not remembering the entire story (Wigren, 1994). Thus, the story is not complete and the pre- and post-trauma narratives do not fit well together. Moreover, much of the traumatised victim's schemes are automatic because threats activate the rapid and preverbal appraisal system (Zajonc, 1980). Indeed, the challenge for therapy is to transform amygdala reactions, for example fight, flight or freeze which are triggered by the emotional schemes of our ancestors (Greenberg, 2004, p. 4) and can often be inappropriate in modern day situations.

Complex PTSD occurs after exposure to a single or series of events of an extremely threatening or horrific nature for example, torture, slavery, genocide campaigns, continuous domestic violence, recurrent childhood sexual or physical abuse when escaping is difficult or impossible. Complex PTSD combines the symptoms of PTSD and additional symptoms which can include regular suicidal feelings, feeling disconnected from people, constant relationship issues, feelings of worthlessness, deep shame and guilt and difficulty in managing emotions (National Institute for Care and Excellence, 2018).

Unfolding was developed to resolve traumatic or difficult experiences (Rice & Saperia, 1984). In trauma cases it is often regularly used and referred to as trauma retelling. Although painful the client often has a strong need to describe what happened to them. This is consistent with my own experience. Whilst on placement in February 2020 I had a first session with a client who had been referred for body dysmorphia and anxiety. Within a few minutes of arriving the client was recounting in detail multiple episodes of sexual abuse by relatives during childhood. The client told me that the history of abuse had only been shared with one other person and seemed desperate to share the horrific experiences. Retelling enables the client to access and reprocess the trauma with the goal of improved emotional management. Indeed, trauma retelling enables the client to distinguish and recognise exactly what happened thereby

limiting the symptom triggers. Repeating the narrative can be useful as the client may disclose additional details as they come to trust the therapist. The client may also come to understand more of what happened when they retell the story of the trauma (Elliot et al. 2004, p.202). It is vitally important that the client has a safe place to escape to and/or mindfulness exercises that they can use if they are likely to become overwhelmed.

Our minds are cluttered with thoughts, emotions and worries. It can be difficult to focus on something specific. We can, however, make space in our minds by doing a body scan and gently relaxing. Mindfulness exercises can have the same affect. We can make space for reflection. This task is referred to as clearing a space. We can also put away anxious thoughts or unwanted feelings by placing the negative emotions in a box, for example, in the knowledge that we return to the box and feelings (containment). Clients who are feeling blocked or are unable to form a clear sense of their experience can be guided to their bodily senses (Gendlin, 1996).

Two chair work is effective in self-interruptive splits as it makes the interrupting part of the client explicit in order that the client can become aware of the process and challenge the self-interrupting part. Unfinished business can benefit from empty chair work where the client activates their conception of the significant other and experience and investigate and make sense out their feelings and challenge the occupant of the empty chair. Clients who carry shame and insecurity about some aspect of their experience need secure contact, empathic affirmation, validation and normalising of their experience by the therapist (Pos & Greenberg, 2006). In essence, therefore, emotion schemes must be activated to access meaning and to transform traumatic experiences.

Campbell Purton (Purton, 2014) criticised numerous psychotherapeutic modalities including EFT positing that the various psychotherapies have accumulated excessive and/or flawed theoretical baggage that deviates too much from an everyday common sense understanding of personal troubles. Purton also suggested that the effectiveness of the therapeutic tasks could be understood without the theory and that client's narratives are not well explained through the medium of emotion schemes. According to Coyne (2017) EFT lacks rigour, for example he contends that there is a high risk of researcher bias and the use of unacceptably small samples of individuals although he also pointed out that this was this is a common problem with research in therapy.

In conclusion, this essay has examined psychological trauma, introduced the fundamentals of EFT and focused on the symptoms and treatment of PTSD. EFT is a comprehensive, structured and efficacious modality for the treatment of trauma. It is an evidence-based therapy for people experiencing different types of psychological distress.

EFT draws on a body of work over a period of years on the importance of emotion in change and attending to emotions and emotional processes in therapy (Greenberg & Paivio, 1997). Knowing that we feel lonely, for example, tells us that our needs are not being met – becoming self-aware is the first step in the process of healing. One can then decide on appropriate actions. With self-awareness and practice, emotions can be owned, regulated and transformed if necessary, giving people a sense of control that encourages healthy functioning. Central to EFT is that one needs to feel. This awareness activates action tendencies which helps people achieve their goals. To misquote René Descartes: 'I feel therefore I am'. Feeling precedes thought (Bate, 2003).

The therapeutic relationship enables clients to become sufficiently secure to face the pain of their trauma. Clients become aware of their emotional experience and can manage the experiences in order for it not to become overwhelming. The alliance between the client and therapist supports the client in new ways of processing, reflecting on and transforming their emotions.

EFT stays true to the humanistic values of promoting freedom, self-determination, pluralism and egalitarianism (Elliot et al. p.11). I will leave the final word to one of the founders of EFT who wrote that: “Emotion thus regulates self and other, and gives life much of its meaning” (Greenberg, 2004, p.3).

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