



Emotion-focused therapy of depression

Leslie S. Greenberg

To cite this article: Leslie S. Greenberg (2017) Emotion-focused therapy of depression, Person-Centered & Experiential Psychotherapies, 16:2, 106-117, DOI: [10.1080/14779757.2017.1330702](https://doi.org/10.1080/14779757.2017.1330702)

To link to this article: <https://doi.org/10.1080/14779757.2017.1330702>



Published online: 05 Jun 2017.



Submit your article to this journal [↗](#)



Article views: 2086



View related articles [↗](#)



View Crossmark data [↗](#)



Citing articles: 7 View citing articles [↗](#)

INVITED ARTICLE



Emotion-focused therapy of depression

Leslie S. Greenberg

Department of Psychology, York University, Toronto, Canada

ABSTRACT

A review of emotion-focused therapy (EFT) of depression including a discussion of its evidence base is provided. EFT aims within an affectively attuned empathic relationship to access and transform habitual maladaptive emotional schematic memories that are seen as the source of the depression. These memories often involve feelings of the shame of worthlessness, anxious insecurity and the sadness of abandonment. Through the therapeutic process, adaptive emotions are accessed to transform maladaptive emotions and to organize the person for adaptive responses. This process of changing emotion with emotion is aided by the use of specific therapeutic techniques that help stimulate arousal of emotion and its processing.

ARTICLE HISTORY

Received 28 December 2016
Accepted 20 January 2017

KEYWORDS

Emotion; depression

La thérapie centrée sur les émotions en cas de dépression

Cet article présente un point de vue centré sur les émotions dans le traitement de la dépression. La thérapie centrée sur les émotions (TCE), également connue comme thérapie du processus expérientiel (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2002; Greenberg & Johnson, 1988; Greenberg et al., 1993; Greenberg & Watson, 2006), est un traitement humaniste empiriquement validé qui considère l'importance centrale des émotions dans l'expérience du soi, du fonctionnement adapté ou inadapté et du changement thérapeutique. La TCE implique un style qui combine à la fois le fait de suivre et celui de guider le processus expérientiel des clients et qui met l'accent sur l'importance des compétences autant en matière de relation qu'en matière d'intervention.

Emotionsfokussierte Therapie der Depression

Dieser Artikel stellt einen emotionsfokussierten Blick auf die Behandlung von Depression vor. Emotionsfokussierte Therapie (EFT), auch bekannt als Prozess-Experienzielle Therapie (PE) (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2002; Greenberg & Johnson, 1988; Greenberg, Rice, & Elliott, 1993; Greenberg & Watson, 2006) ist eine empirisch abgestützte humanistische Behandlung, die Emotionen für die Erfahrung des Selbst als zentral wichtig erachtet. Das gilt sowohl für das gut angepasste wie auch für das schlecht angepasste Verhalten und für die therapeutische Veränderung. EFT beinhaltet ein Vorgehen, das dem experienziellen Prozess der Klient-Person einerseits folgt, diesen andererseits aber

auch führt, und unterstreicht die Wichtigkeit der Beziehung, aber auch der Interventions-Fertigkeiten.

Terapia centrada emoción de la depresión

Este artículo presenta una visión del tratamiento de la depresión centrada en la emoción

La terapia enfocada en la emoción (TCE), también conocida como terapia experiencial de proceso (TEP) (Greenwell, Greenberg et al., 1993; Greenberg & Watson, 2006) es un tratamiento humanista empíricamente apoyado que considera las emociones como importantes en la experiencia del yo, tanto en el funcionamiento adaptativo como en el desajustado, y en el cambio terapéutico. TCE involucra un estilo que combina tanto seguir como guiar el proceso experiencial del cliente y enfatiza la importancia de las habilidades de relación e intervención.

Terapia da depressão focada na emoção

Este artigo apresenta uma Terapia Focada na Emoção (TFE) para o tratamento da depressão e que é também conhecida como Terapia de Processo Experiencial (TPE) (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2002; Greenberg & Johnson, 1988; Greenberg et al., 1993; Greenberg & Watson, 2006). Trata-se de uma terapia humanista apoiada empiricamente e que vê as emoções como tendo uma importância central na experiência do self, quer no funcionamento adaptativo, quer no funcionamento inadaptado, bem como na mudança terapêutica. A TFE inclui um estilo que combina quer o acompanhamento, quer a condução do processo experiencial do cliente e que enfatiza a importância das competências relacionais e de intervenção.

Emotion-focused therapy (EFT) of depression focuses on helping people regulate their affective functioning by helping them to process their emotional experience so that they are able to access adaptive emotional responses to situations, such as empowering anger at violation and sadness at loss, as well as alternative ways of treating the self. These adaptive emotional responses help modulate their affective reactions and help combat maladaptive depressogenic feelings of powerlessness, hopelessness, self-contempt and underlying fear, sadness and shame.

Research studies have supported the importance of emotion-focused work for major depressive disorder. EFT has been evaluated by two different research teams, in three well-designed randomized clinical trials (Goldman, Greenberg, & Angus, 2006; Greenberg & Watson, 1998; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003), Goldman et al. (2006). Two of these studies found that adding emotion-focused, process-experiential interventions to a person-centered empathic relationship led to better outcomes and lower relapse rates than a person-centered empathic relational treatment alone. Both treatments were found to be effective in reducing clients' depressive symptoms with effect sizes comparable to those reported in studies investigating the effectiveness of cognitive-behavioral and behavioral interventions for depression. In addition, Watson et al. (2003) found EFT equivalent to cognitive behavior therapy (CBT) in reducing depressive symptoms and superior in reducing interpersonal

problems. In the studies of the change process, better treatment outcome has been predicted by deeper experiencing during emotion episodes (Goldman, Greenberg, & Pos, 2005) and by higher emotional arousal during mid-treatment plus subsequent reflection on emotion to make sense of it (Warwar & Greenberg, 1999). An optimal frequency of emotional arousal of about 25% of the time during emotion episodes was found to be the best predictor of outcome, demonstrating that too much or too little emotion is not as helpful as a moderate frequency of arousal (Carryer & Greenberg, 2010).

EFT of depression

The objective of EFT is to access and transform habitual maladaptive emotional schemes that are seen as the source of the depression. These often involve feelings of the shame of worthlessness, anxious dependence, abandonment, powerlessness and invalidation. Through the therapeutic process, adaptive emotions are accessed to transform maladaptive emotions and to organize the person for adaptive responses. This process of changing emotion with emotion is aided by the use of specific therapeutic techniques that help stimulate arousal of emotion and its processing.

In an EFT of depression (Greenberg & Watson, 2006), the first three sessions are spent offering the client a person-centered empathic relationship. Therapists in the first sessions and throughout thus adopt the three fundamental relational attitudes of empathy, positive regard and congruence. The therapists respond selectively to those parts of clients' messages that seem live and poignant. At times, therapists communicate understanding of core meaning, while at other times, they focus on exploring what is not yet stated but is at the edge of clients' awareness (Greenberg, 2015; Greenberg et al., 1993).

In addition, therapists, in the early sessions, listen to and observe clients style of emotional processing and assess clients' capacity for emotional experiencing. When a safe bond and a strong working alliance have been established, therapists respond to particular markers or verbal indications from clients of various types of processing problems and suggest the use of appropriate interventions (Greenberg & Watson, 2006). Interventions include the two-chair dialog in response to self-critical conflicts and the empty-chair dialog in response to unresolved feelings toward a significant other drawn from Gestalt therapy but developed as emotion-focused interventions. In addition, focusing (Gendlin, 1996) is used in response to an unclear felt sense and systematic evocative unfolding (Rice & Saperia, 1984) in response to problematic reactions (Greenberg et al., 1993). Therapists are responsive to clients' momentary states and do not plan or structure sessions in advance. However, therapists are encouraged to implement at least one experiential intervention every two to three sessions once an alliance had been established.

In two-chair work for self-criticism, one part of the self is instructed to express the harsh criticism or negative self-statements in order to evoke the client's emotional reactions to the criticisms. These reactions such as hopelessness, fear or shame are transformed by accessing alternate more primary emotions such as sadness at loss, anger at violation and self-compassion. When more primary feelings are activated, clients are encouraged to combat the self-criticism, contempt and negative cognitions

with these and their associated needs. This leads either to a softening into compassion of the harsh criticism and/or a negotiation and integration of the two previously disparate aspects of self (Greenberg et al., 1993).

Empty-chair work for unfinished business involves emotional expression of previously suppressed primary emotion such as hurt and anger to the imaginary significant other in the chair. This leads to an expression of unmet needs. Clients take the perspective of the other at this point, which leads to the accessing of a new, often more positive view of the other. The resolution involves an assertion of the self and understanding or forgiveness of the other or holding the other accountable for their actions.

Major treatment principles

EFT operates according to two overarching major principles: facilitating a therapeutic relationship and promoting therapeutic work. These overarching principles operate throughout the different phases of treatment. Facilitating a therapeutic relationship works according to three sub-principles: presence and empathic attunement, bonding and task collaboration. The empathic attunement principle emphasizes the therapist's presence and moment-by-moment attunement to clients shifting affective experience. The focus of this principle is the therapist's state and perceptual process and specifies that it is the clients' affective experience that the therapist attends to and is in contact with. The bonding principle on the other hand emphasizes the expression or communication of what is understood. The therapist throughout conveys empathy, acceptance and genuineness. Task collaboration, the third relational principle, emphasizes moment-by-moment and overall collaboration on the goals and tasks of therapy.

Promoting therapeutic work also operates according to three sub-principles: differential processing, growth and choice and task completion. Differential experiential processing specifies that different modes of processing and different tasks need to be promoted at different times to promote deeper experiencing. At one time, a therapist may promote an internal focus, at another the active expression of a feeling, at another making sense of emotion, and at yet another moment interpersonal connection. The tasks of attending, experiential search, active expression, interpersonal contact or self-reflection are just some of the different modes of processing that might be promoted.

In addition, different tasks are engaged in at different markers of different types of emotional processing problems. Thus, for example, at one time when a client experiences unfinished business, an empty-chair dialog will be suggested. Another time, when a client is not attending to a bodily felt sense focusing will be used. Growth and choice, which privileges client self-determination, is the next work sub-principle. Here, therapists support the client's potential and motivation for self-determination, mature interdependence, mastery and self-development. The final principle is task completion. This promotes thematic attention to completion of a task that has been initiated if it is consistent with the clients' goals. However, when the task is experienced as contrary to clients' goals, therapists resort to following the moment-by-moment process to become more attuned with their clients' goals. Adopting these principles leads to a style of combining following with guiding client's moment-by-moment experience.

In the most general terms, the therapy is built on a genuinely prizing empathic relationship and on the therapist being highly present, respectful and responsive to

the client's experience. At the same time, EFT therapists also assume that it is useful to guide the client's emotional processing in different ways at different times. Therapy can thus be seen as involving islands of work within an ocean of empathy. The optimal situation in this approach is an active collaboration between client and therapist, with each feeling neither led nor simply followed by the other. Instead, the ideal is an easy sense of co-exploration. Nevertheless, when disjunction or disagreement occurs, the client is viewed as the expert on his or her own experience, and the therapist always defers to the client's experience. Thus, therapist interventions are offered in a *non-imposing, tentative* manner, as conjectures, perspectives, 'experiments' or offers, rather than as expert pronouncements, lectures or statements of truth.

The relationship always takes precedence over the pursuit of a task. Martin Buber (1958) wrote that a compassionate human face, when unadorned by pretense, role or assumption of superiority, offers more hope to another than the most sophisticated psychological techniques. Although the therapist may be an expert in the possible therapeutic steps that might be facilitative, it is made clear that the therapist is a compassionate human being who is a facilitator of client experience. Meaning thus arises from a co-constructive process rather than arrival at some therapist predetermined reality.

Following these principles, we have come to view the therapist as an emotion coach (Greenberg, 2015). Coaching in this view entails both acceptance and change. The therapist both promotes awareness and acceptance of emotional experience and guides clients in new ways of processing emotion. Following provides acceptance while guiding introduces novelty and the possibility of change. Coaching depressed clients to become aware of their emotions involves helping them verbally label emotions while they are being felt, helping them accept the emotion and talking with clients about what it is like to experience an emotion. It also involves facilitating new ways of processing the emotion and guiding them in ways of soothing or regulating the emotion. In addition, coaching depressed clients involves facilitating the utilization of adaptive emotions, usually anger and sadness to guide action and transform maladaptive emotions usually, fear, shame or anger. It is important to note that people often cannot simply be taught new strategies conceptually for dealing with difficult emotions, but rather have to be facilitated experientially to engage in the new process and only later explicitly taught what to do. For example, accessing anger or a need or goal may be very helpful in overcoming the sense of depressive hopelessness or defeat. However, explicitly teaching people that this is what they should do is not nearly as helpful as interpersonally facilitating this by asking them at the right time in the right way what it is they feel or need.

Case formulation

EFT adopts a context-sensitive approach to case formulation to help promote the development of a focus for brief treatments based on process diagnosis rather than person or syndrome diagnosis. In a process-oriented approach to treatment, case formulation is an ongoing process, as sensitive to the moment and the in-session context as it is to an understanding of the person as a case. This is both because of the respectful type of relationship one wishes to maintain and because people are seen as active agents who are in flux, constantly creating meaning. People are dynamic systems

entering different self-organizations at different times. The state the person is in at the moment and the current narrative is more determining of their experience and possibility than any conceptualization of a more enduring pattern or reified self-concept that may be constructed early in treatment. The therapist's main concern in formulation is one of following the client's pain. Emotional pain is viewed as a compass that points to the clients' core painful emotion schemes which are to become the focus of treatment. It is the identification of core pain and markers of current emotional concerns rather than a picture of the persons enduring personality or character or a core pattern that acts as a constant guide to therapist formulations.

The phases of emotion-focused treatment of depression

EFT treatment of depression begins with a *bonding and awareness phase*, which promotes a trusting relational bond, promotes the client's emotional awareness and establishes an initial collaborative focus for the treatment. The second phase involves evocation and exploration of emotionally laden material. The final phase involves generating alternative emotions and creating new narratives.

EFT works on the basic principle that to change, people cannot leave a place until they have arrived. Clients therefore need to reclaim disowned experience before they can be changed by it or change it. In this process of change, it is not that people simply discover things they did not *know* but rather that they experience in a bodily manner aspects of themselves they have not consciously felt or may have previously *disclaimed* (Greenberg & Van Balen, 1998). Clients are helped to experience what they are talking about so that they can become aware of their feelings and the impact of events. In this way, the message or significance of their feelings can be clearly and impactfully experienced, later to be utilized, transformed or reflected on to create new meaning. The goal in the evocation phase is to help people experience their core vulnerabilities by accessing core maladaptive schemes in the session. In promoting transformation, the therapist offers process expertise to help focus the client on ways of accessing new adaptive emotional responses to transform maladaptive ones and facilitates the construction of new meaning. The client generates new experience through both their emotions and their narratives. New meaning is consolidated and new explanations and narratives that help make sense of changes in peoples' experience of themselves and the world are generated.

Provide a rationale for working with emotion

It is sometimes necessary, in the early phase of therapy, to provide a rationale as to how working with emotion will help. For some clients, the importance of focusing on emotion is self-evident as they recognize that their emotions are the source of their distress; for others, it is a totally new way of viewing problems. First, a general rationale is given that emotions provide information about one's reactions to situations and about central concerns and that awareness of these, the ability to deal with them and their message, is central to healthy functioning. A useful metaphor is that emotions are like the red light on the dashboard of a car. When it lights up, it is telling you something

important and you best look into your engine to see what is happening. So emotions too often signal when things are not going well and need attention.

Rationales are offered in as individualized a form as possible, relevant to the shared understandings of the client's unique problems. The general rationale, however, is that feelings are adaptive guides to action, provide information about reactions, need to be acknowledged, and reflected on, and, if dysfunctional, need to be transformed.

Evocation and exploration

During the evocation and exploration phase the therapist establishes support for contacting emotions, evokes and arouses problematic feelings, facilitates the undoing of interruptions and helps the client to access primary emotions. Therapists before deepening emotions need to assess client's readiness for evocation and ensure the client has the internal support before evoking painful emotion. For example, some clients might dissociate, avoid their feelings or become very tense at the prospect of encountering their feelings. Therapists, if they notice that clients begin to glaze over or tense up might suggest that clients breathe deeply, put their feet on the ground or feel themselves grounded in their chairs. If the client seems to be dissociating slightly (spacing out), contact with the therapist, such as looking at the therapist or describing what they see might be suggested to promote a sense of connection with the therapist or with present reality. Establishing ways of soothing oneself, or imagining going to a safe place if things get too difficult can be practiced before evocation and arousal takes place.

With more fragile clients who have not developed a strong sense of self or boundaries between self and other, the development of awareness and evocation is more of a long-term objective. Promotion of experience and asking these clients feeling oriented questions is pointless as they have yet to develop an awareness of their internal world or they may first need to develop internal supports for deeper experience. With these more fragile clients, the relationship is seen as the point of therapeutic departure. Thus, a more relational form of work needs to be followed in which the process of contact with the therapist becomes the focus before any evocation takes place. In addition, with people who have suffered trauma or who are at risk of suicide or self-harm, external safety issues need to be dealt with as the first order of business before any type of internal exploration or evocation is attempted.

Evoking bad feelings in the session

In order to change depressive experience, the experience needs to be evoked in the session. The therapist therefore attends to process cues in the present moment in order to best intensify and evoke experience and core memories. How and which depressed feelings are activated in the session depends on the process–diagnostic assessment of the specific generating conditions. Whether it be despairing hopelessness, anxious helplessness, resignation or emptiness depends on the client. Work on evoking experience also involves work on awareness of avoidance and interruption of emotional experience which will be discussed in the next step.

Stimulating methods are often used in this phase to vivify experience. Bringing alive the experience of hopelessness, for example, often involves the use of a two-chair dialog

in which one part is a 'doom caster' and the other part the hopeless experience induced by this. Evoking involves either attending to different features of the person's experience like a sigh, a shrug or a statement of resignation, in order to amplify them, or using a more expressive method like a self-critical or an unfinished business dialog. Clients, for example, who begin to become self-critical in the session might be asked to engage in a two-chair dialog and to engage in the process of criticizing themselves. Clients will be encouraged in the critic chair to say out loud to themselves things like 'You are worthless' or 'Nothing will ever change' and elaborate on these statements. This generally begins to activate their feelings of hopelessness in the session.

Generally, it is a secondary or reactive feeling that is first evoked – the feeling the person wants to be rid of, like hopelessness, or despair. This state then is explored to get at deeper, more primary feelings, such as shame, anxiety or resentment, the blocking of which is leading to the experience of the secondary bad feeling. In the evocation process, emotional meaning also is explored, symbolized and reflected on. This newly created meaning in turn feeds back and activates further emotion schemes or moderates the existing ones. Thus, 'I feel hopeless' or anxious transforms into 'I feel empty, like I'm nothing unless someone approves of me' and then the core shame-based sense of inadequacy is accessed. Once this core emotion scheme of worthlessness is 'up and running', it is more amenable to new input and change, right then. Change will occur most effectively when the emotion scheme generating the experience is accessed and reflected upon in the session.

In the case of depressed clients whose emotions are underregulated, the goal will be to regulate rather than further arouse the already overaroused bad feeling. For example, clients who are feeling very hopeless may weep about how hopeless everything is or clients who are excessively blaming may fume in rage. Here techniques, such as breathing to reduce arousal, taking an observer's stance and describing sensations or identifying the cognitions generating the feelings, are used in the session to help regulate the overaroused emotion and establish a good working distance from the emotion. Once the secondary reactions are regulated, the primary emotion becomes more accessible. Mindless explosions or venting of emotion is not the goal of the evocation phase, rather experiencing the full impact of the emotion and symbolizing the emotion in awareness are encouraged to facilitate the lowering of clients' arousal levels and to facilitate the creation of new meaning and courses of action.

Undoing interruptions

Exploring and overcoming blocks to emotion and avoidance and interruptive processes is an important sub-task of an EFT of depression. Facing what is dreaded can be threatening, but collaboration to do this provides safety and minimizes the development of opposition, misalliances or treatment impasses.

As therapists begin to work on evoking experience, blocks to experience emerge or they may already be observable in the client's manner and narrative process. Therapists then need to focus on the interruptive process itself and help clients become aware of and experience how they interrupt their feelings or needs. As blocks to experience emerge in the session, therapists ask clients to become aware first that they are interrupting, then how they do this and only later do they become aware of the feelings

or needs that have been interrupted. Interventions explore the various ways clients block experience right in the session as the blocks occur. Blocks can range from the more extreme end of dissociation and numbness, to the changing of topics to avoid feeling, to tears that are felt but stifled.

Fear and dread of emotion often is a major issue. One client, for example, said he pulls down a blind in front of his eyes so that he does not have to look into the vortex of feelings that he fears will suck him in. Other people go numb or blank out as they approach painful emotions. Two-chair enactments often are helpful in working with self-interruption. In these, people enact the interruptive processes, and dramatize them, in order to experience themselves as agents of the interruptive process. This awareness of agency increases the probability of choosing to stop the process or, if it is totally automated, to work on becoming more aware of it. Enacting the interruptive process and becoming aware of how one interrupts experience after some time helps evoke the suppressed emotion and access the unmet need.

Also it is through the experience of personal safety and the therapist's close attunement to clients' possibilities that clients often are able let down their protective barriers, undo the interruptions and access a core affective experience. The therapist's timing in trying to access emotion also is important. It is crucial to dig where the ground is soft and only to begin to try to evoke emotion when it clearly is being felt or is near the surface but is being interrupted. Then, an appropriately timed empathic capturing of the feeling, in a form in which the therapist clearly conveys that he or she is on the clients side, such as 'I know how much that can hurt' or 'how discarded that must have made you feel' or 'no wonder you feel so afraid' will help the emotion to flow into expression.

Accessing primary emotions

The goal of the evocation and exploration is to access new primary experience as the basis of reorganization of the self. In depression, the first evoked bad feelings, as we have said, often are secondary reactions, such as feelings of hopelessness, despair or resignation. The goal once these feelings are evoked is to slow down and unpack the affective–cognitive sequences that generate these emotions and to get to underlying primary emotions and their associated automatic perceptions and appraisals and finally at the person's needs. Maladaptive painful emotions generally involve the shame of worthlessness, the fear of abandonment and the sadness of loneliness. When the needs for validation, security and connection embedded in these painful emotions are re-owned and validated by the therapist, new more adaptive emotions emerge. These transformative adaptive emotional responses are generally the energizing emotions of empowered anger or the sadness of grief or the self-soothing emotion of compassion. Thus, adaptive anger provides the action tendency to aid in overcoming obstacles. Adaptive sadness promotes reaching out for comfort that leaves one calm or allows for withdrawal and recuperation if no support is available. Self-compassion overcomes the sense of helpless isolation. This unpacking and differentiating is done through empathic understanding and exploration and through the process of enacting different aspects of the self.

As the process evolves, a client often begins to see or experience things in a new way, realizing that a self-criticism is an old parental message that a feeling of being judged by others is an attribution of one's own criticism onto them or the experience of unresolved

anger or sadness well up, unmet needs become clear and others are held accountable or forgiven (Greenberg & Watson, 2006). The client now is no longer focused on depressive symptoms or hopelessness but rather has connected with adaptive responses and developed new narratives.

The goal EFT is to acknowledge and experience previously avoided, un-symbolized, primary adaptive emotion and needs (Greenberg, 2010). However, it is not only the experience of primary emotion per se, but the accessing of the needs/goals/concerns and the action tendencies associated with them that are important. Thus a client, by acknowledging the sadness of a loss underlying a depression, may experience a blocked longing to be cared for or, and grieve the loss, a maltreated client, by experiencing anger at being robbed of dignity, may assert boundaries. The need and action tendency associated with the primary emotion leads to adaptive action. It is through the shift into primary emotion and its use as a resource that change occurs. Thus, in some cases change occurs simply because the client accesses underlying anger and reorganizes to assert boundaries, or accesses sadness, grieves a loss and organizes to withdraw and to recover, or reaches out for comfort and support. In these situations, contacting the need and action tendency provides the motivation and direction for change and provides an alternative way of responding. Action replaces resignation and motivated desire replaces hopelessness.

In many instances however in this step, it is complex *maladaptive emotion schematic experience* that is accessed at the core of the depression, rather than simply unexpressed primary *adaptive* emotions such as sadness or anger. The complexity in the process of change lies in distinguishing between adaptive and maladaptive core experience. Once people have arrived at a core experience, they need to decide whether this is a healthy experience. If it seems like the core emotion will enhance their well-being, then they can stay with this experience and be guided by the information it provides. If however they decide that being in this place will not enhance them or their intimate bonds, it is not a place to stay. When people in dialog with their therapists decide that they cannot trust the feelings at which they have arrived, as a source of good information, then the feeling needs to be transformed. Now a means to leave the place they have arrived at must be found.

Core schemes that are maladaptive result in feelings such as a core sense of powerlessness, or feeling invisible, or a deep sense of woundedness, of shame, of insecurity, of worthlessness or of feeling unloved or unlovable. It is these that are accessed as being at the core of the secondary bad feeling of depressive hopelessness. Core depressive experiences often relate either to worthlessness or to anxious dependence. At the core of the self-critical depression is a feeling of worthlessness, a failure and being bad, or at the core of a dependent depression a feeling of fragile insecurity, being unable to hold together without support. These are generated by the core bad/weak depressive self-schemes. In these instances, the primary maladaptive feelings of worthlessness, weakness or insecurity have to be accessed in order to allow for change. It is only through experience of emotion that emotional distress can be cured. One cannot leave these feelings of worthless or insecurity until one has arrived at them. What is curative is first the ability to symbolize these feelings of worthlessness or weakness and then to access alternate adaptive self-schemes. The generation of alternate schemes is based on accessing adaptive feelings and needs that get activated in response to the currently

experienced emotional distress. It is the person's response to their own symbolized distress that is adaptive and must be accessed and used as a life-giving resource.

EFT of depression thus involves exposing people's unhealthy emotions at the core of their depression to more resilient internal experiences. Helping people access their feelings of healthy sadness or anger exposes their fear and shame to new input. The maladaptive feelings and the shrinking action tendencies begin to be replaced with thrusting forward, reaching out or recuperative tendencies while their self-critical views of themselves as bad or worthless are challenged by the sense of worth accessed in healthier emotional states. People are thereby helped to integrate all parts of their experience into a new sense of self and to feel more self-accepting.

Disclosure statement

No potential conflict of interest was reported by the author.

Notes on contributor

Leslie S. Greenberg, Ph.D., is a Distinguished Research Professor Emeritus of Psychology at York University, Toronto, and primary developer of emotion-focused therapy. He has authored texts on emotion-focused approaches to treatment having published 19 books and over 100 articles. He has received the American Psychological Association award for Distinguished Professional Contribution to Applied Research, the Distinguished Research Career award of the International Society for Psychotherapy Research and the Carl Rogers award of the American Psychology Association.

References

- Buber, M. (1958). *I and Thou: Second edition*. New York: Charles Scribner's Sons.
- Carryer, J., & Greenberg, L. (2010). Optimal levels of emotional arousal in experiential therapy of depression. *Journal of Consulting and Clinical Psychology, 78*, 190–199.
- Gendlin, E. T. (1996). *Focusing-oriented psychotherapy: A manual of the experiential method*. New York, NY: Guilford Press.
- Goldman, R. H., Greenberg, L. S., & Pos, A. E. (2005). Depth of emotional experience and outcome. *Psychotherapy Research, 15*, 248–260.
- Goldman, R. N., Greenberg, L. S., & Angus, L. (2006). The effects of adding emotion-focused interventions to the client-centered relationship conditions in the treatment of depression. *Psychotherapy Research, 16*, 536–546.
- Greenberg, L. (2010). *Emotion focused therapy. Theory and practice*. Washington, DC: American Psychological Association.
- Greenberg, L., Rice, L., & Elliott, R. (1993). *Facilitating emotional change*. New York, NY: Guilford.
- Greenberg, L., & Watson, J. (1998). Experiential therapy of depression: Differential effects of client-centered relationship conditions and process experiential interventions. *Psychotherapy Research, 8*(2), 210–224.
- Greenberg, L. S. (2015). *Emotion-focused therapy: Coaching clients to work through their feelings*. Washington, DC: American Psychological Association.
- Greenberg, L. S., & Van Balen, R. (1998). The theory of experience-centered therapies. In L. S. Greenberg, J. C. Watson, & G. Lietaer (Eds.), *Handbook of experiential psychotherapy* (pp. 28–57). New York, NY: Guilford Press.

- Greenberg, L. S., & Watson, J. C. (2006). *Emotion-focused therapy for depression*. Washington DC: American Psychological Association.
- Rice, L. N., & Saperia, E. P. (1984). Task analysis and the resolution of problematic reactions. In L. N. Rice & L. S. Greenberg (Eds.), *Patterns of change* (pp. 29–66). New York NY: Guilford press.
- Warwar, S., & Greenberg, L. S. (1999). *Emotional processing and therapeutic change*. Paper presented at the International Society for Psychotherapy Research Annual Meeting, Braga, Portugal
- Watson, J., Gordon, L. B., Stermac, L., Kalogerakos, F., & Steckley, P. (2003). Comparing the effectiveness of process-experiential cognitive-behavioral psychotherapy in the treatment of depression. *Journal of Consulting and Clinical Psychology*, 71, 773–781.