Emotion in Psychotherapy: A Practice-Friendly Research Review

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This article reviews the process and outcome research on emotion in psychotherapy. Four distinct types of emotion processes are identified in the literature as useful in therapy, depending on a client's presenting concerns: emotional awareness and arousal; emotional regulation, active reflection on emotion (meaning making), and emotional transformation. Research findings are summarized to highlight the practical implications of these different emotion processes to psychotherapy. A range of selected treatments from different therapeutic orientations are addressed collectively as different types of emotion-focused, experiential therapies and are compared on the basis of how they work with emotion in session. © 2006 Wiley Periodicals, Inc. J Clin Psychol: In Session 62: 611–630, 2006.

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The idea that accessing and exploring painful emotions and "bad feelings" in a therapeutic relationship make one feel better is a widely held belief among several schools of psychotherapy. Many theorists, from Freud (1963), through Rogers (1951) and Perls (1969), to the authors in this issue, have all proposed that "emotional work" is therapeutic. Corroborating evidence is found in a recent study, examining the therapists' stance in interpersonal therapy (IPT) and cognitive-behavioral therapy (CBT) of depression. Two factors described therapists' style of engagement in these treatments: collaborative emotional exploration and educative/directive process (Coombs, Coleman, & Jones 2002). Collaborative emotional exploration, which occurred significantly more frequently in

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IPT, was found to relate positively to outcome in both forms of therapy, whereas educative/directive process had no relationship to outcome. These findings point toward exploration of emotion as centrally important to good therapy regardless of theoretical orientation.

In this article, we propose four empirically based principles to help guide therapeutic intervention for working with emotion (Greenberg, 2002, 2004; Greenberg & Watson, 2005). These are (1) awareness and arousal of emotion, (2) enhancing of emotion regulation, (3) reflecting on emotion, and (4) transforming of emotion. These principles and their supporting empirical evidence are reviewed. A review of the literature on the effectiveness of emotion-focused treatments follows.

Principles of Working With Emotion

Working with these principles involves first differentiating between emotional experiences that are adaptive or maladaptive and emotions that are primary and secondary. Primary emotions need to be accessed in awareness for their adaptive information and capacity to organize action. In contrast, maladaptive emotions need to be accessed in order to be transformed, in a process that exposes them to new experience and thereby creates new meaning. Secondary emotions need to be bypassed to get to more primary emotions.

Emotion Awareness and Arousal

The first and most general goal in working with emotion in therapy is the promotion of emotional awareness. The goal is for clients to become aware of their primary emotions and ultimately their primary adaptive emotions. *Primary emotions* are a person's most fundamental, direct, and initial reactions to a situation, such as being sad at a loss. Increased emotional awareness is therapeutic in a variety of ways. Becoming aware of and symbolizing core emotional experience in words provide access both to the adaptive information and to the action tendency in the emotion.

Awareness involves approaching and accepting emotions. Acceptance of emotional experience as opposed to its avoidance is the first step in awareness work. Having accepted the emotion rather than avoided it, the therapist then helps the client in the utilization of emotion. Clients are helped to make sense of what their emotion is telling them and to identify the goal, need, or concern that it is organizing them to attain. Emotion is thus used both to inform and to move.

This kind of awareness has been operationalized in the Levels of Emotion Awareness Scale (LEAS; Lane, Quinlan, Schwartz, Walker, & Zeitlin, 1990; Lane & Schwartz, 1987). Five levels of emotional awareness are measured. In order of increasing complexity these are physical sensations, action tendencies, single emotions, blends of emotion, and higher-order blends of emotional experience—representing the capacity to appreciate complexity in the experiences of self and other. The dynamic interactions between phenomenal experience and establishing a representation of it, elaborating that representation (e.g., identifying the source of the emotional response), and integrating it with other cognitive processes are the fundamental processes involved in the cognitive elaboration of emotion that are addressed by the levels in this measure.

LEAS has been found to correlate positively with self-restraint and impulse control. This finding, replicated in independent samples, indicates that greater emotional awareness is associated with greater self-reported impulse control. Individual differences in emotional awareness have also been found to predict recovery of positive mood and

decreases in ruminative thoughts after a distressing stimulus (Salovey, Mayer, Golman, Turvey, & Palfai, 1995).

Arousal of emotion has been shown to be important to emotional processing. However, there is a strong human tendency to avoid painful emotions, and this tendency prevents both awareness and arousal of emotion. Normal cognitive processes often distort or interrupt emotion and transform adaptive unpleasant emotions into dysfunctional behavior designed to avoid feeling. Leahy (2002), for example, found that depression and anxiety scores were related to guilt about emotions, the perception of emotions as incomprehensible and out of control, and rumination. In general, the acceptance and validation of emotion resulted in less guilt and rumination, greater understanding and control, less concern with the duration of emotions, and a less simplistic view of emotional experience.

Thus, to overcome emotion avoidance, clients must first be helped to approach emotion by attending to their emotional experience. This process often involves changing the cognitions governing emotional avoidance. Then clients must allow and tolerate being in live contact with arousal emotions. These two steps are consistent with notions of exposure. There is a long line of evidence on the effectiveness of exposure to previously avoided feelings. For example, in a series of studies on behavioral exposure (Foa, Riggs, Massie, & Yarczower, 1995; Jaycox, Foa, & Morral, 1998), positive outcome for posttraumatic stress disorder (PTSD) caused by rape was predicted by aroused expression of fear while retelling trauma memories during the first exposure session and by the attenuation of distress during exposures over the course of therapy. Such findings indicate that emotional arousal during imaginal exposure is at least a partial mechanism of change (Paivio, Hall, Holowaty, Jellis, & Tran, 2001). One practical implication of this research is the importance, early in therapy, of facilitating clients' emotional engagement with painful memories. Studies of recovery patterns in sexual and nonsexual assault victims found that, in general, long-term recovery was impeded when the indispensable emotional engagement with traumatic material in therapy was delayed (Gilboa-Schechtman & Foa, 2001). Good client process, early in trauma therapy, is particularly important because it sets the course for therapy and allows maximal time to explore and process emotion related to traumatic memories (Paivio et al., 2001).

In research on behavioral exposure, only a subgroup of individuals were found to be able to engage in the exposure task and thereby fully benefit from that approach to therapy (Jaycox et al., 1998). As one might expect, individual differences in the severity of PTSD symptoms before treatment was associated with client's having difficulty in engaging painful tasks, which was later related to poorer outcome. This finding is consistent with observations that for individuals who have been severely traumatized, facilitating their reexperiencing of distressing events can be excessively stressful (Scott & Stradling, 1997). Overall, the findings suggest a chain of influence on the degree to which a client processes emotion. First, the severity of trauma symptoms, as we have seen, sets a limiting factor in the facilitation of emotional arousal and processing; then early engagement in imaginal exposure tasks and finally the repetition of exposure tasks over the course of therapy have a successively cumulative impact on functioning at outcome (Paivio et al., 2001).

A metaanalytic review of the literature found that exposure therapy is the most effective treatment for PTSD, and that its effectiveness, based on emotional processing, is diminished when it is combined with cognitive or other additional techniques (Foa, Rothbaum, & Furr, 2003). The emotional processing hypothesis proposes that therapeutic effectiveness is achieved by the activation of the target *fear structure* (i.e., the associative network of maladaptive fear, memories, and belief) while providing new information. The empirical evidence related to exposure treatments of PTSD supports the emotional

processing hypothesis, but effective outcomes can be derailed by failure to apply the treatment with sufficient clinical skill and discipline (Foa & Franklin, 2000; Rothbaum & Schwartz, 2002).

Such findings point to the conclusion that in relation to the role of distress in successful emotional processing, the situation "gets worse before it gets better." This conclusion about the temporal patterns of distress was supported by experimental research on coping with induced dysphoria (Hunt, 1998). Those who sustained their attention to painful feelings in the short term felt better in the long run than individuals who used problem solving or avoidance as a means of coping with a negative mood induction. These findings led Hunt to title her article "The Only Way Out Is Through," which captures the essence of research findings on emotional processing.

In a study of the treatment of obsessive-compulsive disorder (OCD) (Kozak, Foa, & Steketee, 1988) treatment outcome was successful to the extent that anxiety, measured by electrodermal and cardiac responses in addition to self-report, was activated during exposure and response prevention. In a similar treatment for PTSD, emotional activation was measured by the facial expressions of clients who were observed while giving accounts of their trauma stories (Foa, Riggs, Massie, & Yarczower, 1995). Again, the findings indicated that for emotional processing to occur it is essential to activate the fear structure. Doing so predicted therapeutic outcomes.

The recipe for emotional processing from the perspective of behavior therapy is arousal plus habituation to the distressing stimulus and exposure to new information. In short, it is the experience of old distress in the presence of new information. From an experiential therapy perspective, however, approach, arousal, acceptance, and tolerance of emotional experience are necessary but not sufficient for change. Optimal emotional processing also involves the integration of cognition and affect (Greenberg, 2002; Greenberg & Pascual-Leone, 1995). Once contact with emotional experience is achieved, clients must also cognitively orient to that experience as information; explore, reflect on, and make sense of it; and access other internal emotional resources to help transform the maladaptive state.

Supporting the first aspect of this hypothesis, process-outcome research on the emotion-focused treatment of depression has shown that both higher emotional arousal at midtreatment, coupled with reflection on the aroused emotion (Warwar & Greenberg, 2000), and deeper emotional processing late in therapy (Goldman & Greenberg, 2005; Pos, Greenberg, Goldman, & Korman, 2003) predicted good treatment outcomes. Emotion-focused therapy appears to work by enhancing the type of emotional processing that involves helping people experience and accept their emotions and make sense of them. Therapists' interventions that focused more deeply were also shown to deepen clients' experience and to predict outcome (Adams & Greenberg, 1996). The importance of change through facilitating deeper in-session emotional experience that involves both a focus on bodily felt experience and the creation of new meaning is increasingly recognized (Greenberg, 2002; Samoliov & Goldfried, 2000).

A client's individual capacity for emotional processing early in therapy also was found to predict outcome, but the increase in degree of emotional processing from early to mid or early to late phase of treatment was found to be a better predictor of outcome than early level of processing or than the early alliance (Pos et al., 2003). In short, early capacity for emotional processing does not guarantee good outcome; nor does entry into therapy without this capacity guarantee poor outcome. Early emotional processing skill, although likely an advantage, appears not to be as important as the ability to acquire and/or increase depth of emotional processing throughout therapy. Other process studies also have shown a strong relationship between in-session emotional experiencing, as

measured by the Experiencing Scale (Klein, Mathieu, Kiesler, & Gendlin, 1969), and therapeutic gain in psychodynamic, cognitive, and client-centered therapies (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Orlinsky & Howard, 1986; Silberschatz, Fretter, & Curtis, 1986). These findings suggest that experiencing (as a measure of emotional processing) may be a common factor that helps explain change across approaches.

Considering *expressed* emotion and considering *experienced* emotion lead to different conclusions. A study that examined *expressed* arousal showed that a combination of visible emotional arousal and experiencing was a better predictor of outcome than either index alone, supporting the hypothesis that it is not only arousal of emotion but also reflection on aroused emotion that produces change (Warwar, 2003). Another study examining in-session client reports of *experienced* emotional intensity (Warwar, Greenberg, & Perepeluk, 2003) found that client reports of in-session experienced emotion were not related to positive therapeutic change. A discrepancy was observed between client reports of in-session *experienced* emotions and the emotions that were actually *expressed* on the basis of arousal ratings of videotaped therapy segments. For example, one client reported that she had experienced intense emotional pain in a session. Her level of expressed emotional arousal, however, was judged to be very low on the basis of observer ratings of emotional arousal from videotaped therapy segments. In a study on helpful sessions (Mackay, Barkham, Stiles, & Goldfried, 2002), in productive sessions of psychodymanic-interpersonal therapy the arousal of unpleasant emotion followed an inverted-U pattern against time, as the highest arousal of painful feelings took place in the middle of the session and had attenuated by the end of the session. The practice implication, then, is that emotional processing is best facilitated by the progressive increase and then attenuation of expressed emotional arousal over the course of a session. Part of the process involves helping clients to reflect on, and make meaning of, their feelings as they emerge in the session.

In two other studies, one on the treatment of depression and the other on the recovery of survivors of traumatic sexual abuse, the arousal and expression of anger were related to therapeutic change. In these studies arousal and expression of anger were related to the development of agency, self-efficacy, and self-assertion (Beutler et al., 1991; Van Velsor & Cox, 2001). In general, however, there are mixed findings and mixed views regarding the relationship of aroused anger (among other feelings) with therapeutic outcome with some evidence that venting of anger is not therapeutic (Bushman, 2002). It is therefore not surprising that in an analysis of cathartic emotional expression in psychotherapy (Pierce, Nichols, & DuBrin, 1983) the therapeutic usefulness of catharsis was found to be contingent on very specific circumstances and only for certain people.

There can be no universal rule about the effectiveness of arousing emotion or evoking emotional expression. Emotional arousal and expression, although helpful, are not always useful in therapy or in life (Greenberg, Paivio, & Korman, 2002). Usefulness depends first on factors such as whether the client's emotion is over- or underregulated and whether the emotion is a sign of distress or of working through distress (Greenberg, 2002; Kennedy-Moore & Watson, 1999). The role of arousal and the degree to which it may be useful in therapy also depend on which emotion is expressed, by whom, about what issue; how it is expressed, to whom, when, and under what conditions; and in what way the emotional expression is followed by other experiences of emotion and meaning making (Greenberg, 2002; Whelton, 2004). Nonetheless, the evidence suggests that emotional processing is mediated by arousal. For effective emotional processing to occur, therefore, the distressing affective experience must be activated and viscerally experienced by the client. Arousal appears to be essential but not necessarily sufficient for therapeutic progress.

Emotion Regulation

The second principle of emotional processing involves the *regulation of emotion*. Whether clients are under- or overregulated and which emotions are to be regulated and how are important issues in any treatment. Clients who have underregulated affect have been shown to benefit both from receiving validation and from learning emotion regulation and distress tolerance skills (Linehan, 1993). It is undercontrolled *secondary emotions* and *maladaptive emotion* that need to be regulated. Secondary emotions are those responses that are secondary to other more primary internal processes and, as such, may be defenses. For example, feeling hopeless is secondary when there is an unarticulated feeling of (primary) anger. *Maladaptive emotions* are learned responses, often developed through traumatic experiences, that are no longer adaptive. These types of feelings do not change in response to changing circumstance or to their expression; nor do they provide adaptive directions for solving problems. Rather they leave the person feeling stuck, often hopeless, helpless, and in despair.

The provision of a safe, validating, supportive, and empathic environment is the first level of intervention that helps soothe automatically generated underregulated distress (Bohart & Greenberg, 1997; Linehan, 1993). Emotional validation and soothing are effective as part of the treatment for borderline personality disorder (BPD) (Linehan et al., 2002). Empathy, which predicts therapeutic outcome (Greenberg, Elliott, Watson, & Bohart, 2001), seems to be particularly important in learning to self-soothe, restore emotional equilibrium, and strengthen the self. Emotion regulation skills that involve such processes as identifying and labeling emotions, allowing and tolerating emotions, establishing a working distance, increasing positive emotions, reducing vulnerability to negative emotions, self-soothing, breathing, and even distraction also have been found to help in regulating high distress (Greenberg, 2002; Linehan, 1993).

Regulation of underregulated emotion essentially involves gaining some psychological distance from overwhelming feelings such as despair and hopelessness, in the short term, and developing self-soothing capacities to calm and comfort core anxieties and humiliation, in the longer term. When one feels a maladaptive emotion such as core shame or a feeling of shaky vulnerability, one benefits from regulation in order to prevent becoming overwhelmed by those emotions, thereby creating the opportunity to make sense of them. Forms of meditative practice and self-acceptance are often very helpful in gaining a working distance from overwhelming core emotions. Mindfulness treatments have been shown to be effective in treating generalized anxiety disorders and panic (Kabat-Zin et al., 1992; Miller, Fletcher, & Kabat-Zinn, 1995), and chronic pain (Kabat-Zinn, Lipworth, Burney, & Sellers, 1986) and in preventing relapse (Teasdale Moore, Hayhurst, Pope, Williams, & Segal, 2002). Mindfulness allows for flexibility in affective-meaning processes and the interruption of automatic, habitual processes.

In short, acknowledging, allowing, and tolerating emotion are important aspects of helping to regulate it. Soothing of emotion can be provided reflexively by the individual himself or herself through internal agency and resources or by another person. Among other processes self-soothing involves diaphragmatic breathing, relaxation, development of self-empathy and compassion, and self-talk. Soothing also occurs interpersonally in the form of another's empathic attunement to one's affect and through acceptance and validation by another person. Internal security develops through the feeling that one exists in the mind and heart of the other, and the security of being able to soothe the self develops by internalization of the soothing functions of the protective other (Fosha, 2000; Schore, 2003).

It is important to make a distinction between intensity of emotion and the depth of processing of the emotion. It is not the former but the latter that is curative in therapy.

Moreover, the regulation of otherwise overwhelming emotional intensity is vital in promoting the required depth of emotional processing. Finally emotion regulation involves not only the restraint of emotion, but at times its maintenance and enhancement (i.e., down- vs. up-regulation).

Reflection on Emotion

This principle of emotional change is related to the first principle, emotional awareness, in that it involves making meaning of emotion. In addition to the value of emotional awareness as a source of information, symbolizing emotion in awareness promotes reflection on experience to create new meaning, which helps clients develop new *narratives to explain their experience* (Greenberg & Angus, 2004; Greenberg & Pascual-Leone, 1997; Guidano, 1995; Pennebaker, 1990). What we make of our emotional experience makes us who we are.

This principle applies to all types of emotion: secondary, primary, adaptive, or maladaptive. For example, understanding that one is prone to become angry at one's partner because one feels abandoned and that this anger relates to one's past history of abandonment is very therapeutic. Alternately being able to symbolize and explain traumatic emotional memories in words helps promote their assimilation into one's ongoing self-narrative (Van der Kolk, 1995). This form of putting emotion into words allows previously unsymbolized experience in emotion memory to be assimilated into the conscious, conceptual understandings of self and world, where it can be organized into a coherent story. Pennebaker and colleagues have shown the positive effects of writing about emotional experience on autonomic nervous system activity, immune functioning, and physical and emotional health (e.g., Pennebaker, 1990, 1995).

Through language, individuals are able to organize, structure, and ultimately assimilate both their emotional experiences and the events that may have provoked the emotions. In addition, once emotions are expressed in words, people are able to reflect on what they are feeling, create new meanings, evaluate their own emotional experience, and share their experience with others (Pennebaker, 1995; Rimé, Finkenauer, Luminet, Zech, & Philippot, 1998).

Both insight and reframing of emotional experience have long been viewed as ways to change emotion (Freud,1963; Watzlawick, Weakland, & Fisch 1974). Many therapists have written on the importance of changing people's assumptive frameworks in therapy (Beck, 1983; Frank, 1959, 1963). There is a vast empirical literature on the influence of attributions and cognition on emotion in general and on depression in particular (Clarke & Blake, 1997) that attests to the importance of reflecting on emotion to create meaning.

A study of ways problematic reactions to events were resolved in psychotherapy sessions (Watson, 1996) found that the vivid descriptions, emotional arousal, and reflecting on emotion interacted in complex yet orderly stages to produce therapeutic change. Theses stages allow clients to reflect on the emotion they are experiencing. In a computer-assisted study of verbal patterns in psychodynamic therapy Mergenthaler (1996) found that in key moments in therapy in which substantial shifts happened there was a frequent cooccurrence of high emotional arousal and reflection on the emotion. It seems to be the timely conjunction of emotional arousal and a thoughtful exploration of the emotion's meaning that generated change. Similarly, an intensive analysis of good client moments showed that in-session change was related to the combination of strength of feeling and higher-order reflection (Stalikas & Fitzpatrick, 1995).

In an intensive case study, sessions of a prematurely terminated psychodynamic therapy case were analyzed. Some support was found in the case for the hypothesis that

physiological and experiential bases of affect are transformed into images and words more frequently for positive than for negative feelings (Lecours, Bouchard, St.-Amand, & Perry, 2000). This processing bias likely stems from the fact that negative feelings are more difficult to tolerate and express. In segments of high and low verbalized affect from the third session of a group of clients in short-term psychodynamic therapy, it was found that in poor outcome cases therapists used more cognitive verbs during the high affect segments of the session (Anderson, Bein, Rinnell, & Strupp, 1999). Thus, in poor cases, therapists appeared to direct their client's attention away from the emotion being expressed. Attention to and reflection on emotion in therapy appear to generate a productive process related to therapeutic progress.

Emotion Transformation

The final and probably most fundamental principle of emotional processing involves the transformation of one emotion into another. This transformation applies to primary maladaptive emotions, those old familiar bad feelings that occur repeatedly and are resistant to change. The process is one of *changing emotion with emotion* (Greenberg, 2002). This important and novel principle suggests that a maladaptive emotional state can be transformed best by "undoing" it with another more adaptive emotion. In time, the coactivation of an adaptive emotion along with or in response to a maladaptive emotion helps transform the structure of the maladaptive emotion. Rather than reason with emotion, one can transform one emotion with another. This principle asserts that although thinking usually changes thoughts, only new feeling can fundamentally change emotions.

Positive emotions have been found to "undo" lingering negative emotions (Frederickson, 2001; Fredrickson & Levenson, 1998). The basic observation in this research effort is that key components of positive emotions are incompatible with negative emotions. The experience of joy and contentment was found to produce faster cardiovascular recovery from negative emotions than a neutral experience. Resilient individuals, for example, cope by recruiting positive emotions to regulate negative emotional experiences. Research found that these individuals manifested a physiological bounce back that helped them to return to cardiovascular baseline more quickly (Tugade & Frederickson, 2000). Similarly in a study of self-criticism, people who were more vulnerable to depression showed more contempt and then were less resilient in response to self-criticism than people less vulnerable to depression. Less vulnerable individuals were able to recruit assertive emotional resources such as pride and anger to combat the depressogenic contempt and negative cognitions (Whelton & Greenberg, 2004). These studies together indicate that emotion can be used as a tool to change emotion.

In addition, the in-session resolution of two tasks in emotion-focused therapy (Greenberg, 2002), resolving splits and unfinished business, that involve emotional transformation predicted outcome at both termination and 18-month follow-up. Moreover, performance in the emotional processing tasks predicted the likelihood of nonrelapse over the follow-up period (Greenberg & Pedersen, 2001). Both of these tasks involve emotional transformation, by activating and then restructuring people's core emotions, memories, and responses. In these processes clients begin by feeling anger, sadness, or hopelessness, but once alternative emotions and needs are activated, clients change their view of self or other A 2002 study of resolving emotional injuries showed that significant emotional transformations such as forgiveness and letting go were preceded by the arousal and expression of anger and sadness. Forgiveness was preceded by the expression of core personal or interpersonal needs and a shift in the perception of the other, and these components occurred

significantly less often or not at all in unresolved cases (Greenberg & Malcolm, 2002). A close analysis of a client's anger event in psychodynamic-interpersonal therapy (Mackay, Barkham, & Stiles, 1998) revealed that "staying with the feeling," coached by the therapist, helped to reorganize the client's experience of anger, letting go of elements of depression and hopelessness and transforming it into adaptive primary anger.

It is important to note that the process of changing emotion with emotion extends beyond ideas of catharsis, completion, exposure, or habituation, in that the maladaptive feeling is not purged; nor does it attenuate simply through the person's feeling it. Rather, another feeling is evoked and used to transform it. Although sustained exposure to emotion may be helpful in many therapy situations to overcome affect phobia, the substantive change actually occurs through the introduction of new feelings that are integrated into a previously warded off state—rather than simply by reducing the avoidance response. In transformation, emotional change occurs by the activation of an incompatible, adaptive experience that undoes or transforms the old response.

Clinical observation and our descriptive research suggest that emotional transformation occurs by a process of synthesizing opposing schemes to form new integrations (Greenberg, 2002; Pascual-Leone, 2006). Once maladaptive fear is aroused in therapy, it can be transformed into feelings of security by way of boundary-setting emotions (i.e., adaptive anger or disgust) or by evoking of softer feelings of compassion or forgiveness. So, maladaptive anger can be "undone" by adaptive sadness, which eventually leads to acceptance. Similarly, maladaptive shame can be transformed into self-acceptance by accessing anger at violation, self-soothing, compassion, and pride. Thus, the action tendency to shrink into the ground in shame or to flee in fear is transformed by the tendency to thrust forward as part of newly accessed anger at violation or pride at accomplishment. This sequentially ordered pattern is what actually creates confidence. On a neuropsychological level, withdrawal emotions from one side of the brain can be transformed by approach emotions from another part of the brain, or vice versa (Davidson, 2000).

The Therapeutic Relationship

In addition to the four principles of emotional change, the therapeutic relationship is the crucible of emotional processing. The link between therapeutic alliance and outcome is widely recognized (Hovarth, 2005), and there is reason to believe that a good alliance is a prerequisite to productive emotional processing. In studies across several types of psychotherapy, the role of emotional arousal has been found to be mediated by the working alliance (Beutler, Clarkin, & Bongar, 2000), such that, for example, high arousal predicted good session outcome but only when there was a strong alliance (Iwakabe, Rogan, Stalikas, 2000). It is as if the therapeutic relationship acts as a "thermostat" for the "fire" of emotional arousal. On one hand, if the client feels overwhelmed and emotion is too "hot," the relationship is soothing, validating, and adaptively regulating, and as an external thermostat, it lowers emotional activation (Fosha, 2000; Greenberg, 2002; Linehan, 1993; Paivio & Laurent, 2001). On the other hand, if the client's level of arousal is unproductively low (e.g., avoidance, intellectualization, worry), the relationship can be empathically evocative, and focusing thereby heightens emotional activity (Gendlin, 1996; Greenberg, 2002; Paivio & Laurent, 2001; Perls et al., 1951).

The Effectiveness of Emotion-Focused Treatments

A recent survey (Pilerio, 2004) investigated clients' experience of the process of affect-focused, experiential psychotherapies. The clients had participated in one of three

emotion-focused therapies: accelerated experiential dynamic therapy (AEDP; Fosha, 2000), intensive short term dynamic therapy (ISTDP; Abass, 2002a), or emotion-focused therapy (EFT; Greenberg, 2002). Clients' experiences were assessed retrospectively. Client reports of having experienced deep affect in therapy were clearly related to both satisfaction with therapy and the feeling that change had occurred. The therapist's acting as a witness to emotional experiencing was likewise related to satisfaction and change. In addition, there was a significant relationship between clients' recognition of their therapist's affect-eliciting techniques and feelings of satisfaction and change.

Overall, the perception of affect-focused, experiential therapists was highly positive. These therapists were consistently viewed as being emotionally engaged in treatment, attuned to the patients' thoughts and feelings, and actively involved in the therapy experience. Nearly two-thirds of the patients reported having intense loving and/or other positive feelings toward their therapist. This being said, it is also important to note that a smaller proportion said they occasionally experienced intense anger, resentment, or other negative feelings toward their therapist. Nonetheless, a patient's sense of emotional connectedness to his or her therapist and the therapist's attunement with the patient were strongly correlated to satisfaction and change. The conclusion from these findings (Pilerio, 2004) was that emotional experiencing may be the final common pathway to therapeutic change.

More than three-quarters of the clients indicated that they were extremely satisfied with the outcome of therapy, that they had made significant improvements in their personal well-being as a result of the therapy, and that these therapeutic gains were long-lasting. Furthermore, the significant gains emphasized by most of the respondents were increased mastery not only over specific symptoms, but also in many areas of living. Of those clients who had already been involved in a different type of therapy, two-thirds said that the affect-focused, experiential therapy was significantly better than previous therapy. It appears that from the perspective of consumers, affect-focused, experiential therapies work. Not only do patients report a decrease in presenting problems and symptoms as a result of this therapy, but also more importantly they report deep, lasting characterological changes.

A number of randomized clinical trials of emotion-focused therapies (EFTs) have shown them to be effective in both individual and couples forms of therapy (Elliott, Greenberg, & Lietaer, 2004; Johnson, Hunsley, Greenberg, & Schlindler, 1999). Process experiential (PE) therapy, a manualized form of EFT for treating depression, has been shown to be highly effective in three separate trials. Emotionally focused couples therapy (EFCT) has been found to be effective in treating couples' distress. Short-term dynamic psychotherapy (STDP) has been found effective in treating personality disorders. Emotion-focused trauma therapy (EFTT) has been found effective in treating adult survivors of childhood abuse who suffer from psychological trauma. Likewise, numerous cognitive-behavioral therapies based on exposure have been shown to be effective in treating trauma and anxiety related disorders.

Depression

In the York Depression studies (Greenberg & Watson, 1998; Goldman, Greenberg, & Angus, 2005), the effects of PE therapy and client-centered therapy were compared, in the treatment of 72 adults suffering from major depression. The PE treatment added the use of specific interventions, in particular, systematic evocative unfolding, focusing, two chair dialogue, and empty chair dialogue, to the client-centered relational conditions.

Significant differences among treatments were found at termination on all indices of change and the differences were maintained at 6- and 18-month follow-ups. These changes provided evidence that the addition of emotion-focused interventions to the foundation of a client-centered relationship improves outcome. Perhaps most importantly, 18-month follow-up showed that the PE group was doing distinctly better at follow-up. Survival curves showed that three-quarters of clients who received PE had not experienced relapse when assessed at follow-up in comparison to a rate of less than half of clients who had been in the relationship-alone treatment (Ellison, 2003). Something important seems to have occurred in the PE treatment that protected clients against relapse.

Another randomized clinical trial compared PE and cognitive-behavioral therapy (CBT) in the treatment of clients suffering from major depression (Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003). There were no significant differences in outcome on depression between the treatment groups. Both treatments were effective in relieving clients' level of depression, general symptom distress, and dysfunctional attitudes and in improving self-esteem. However, clients in PE therapy showed significantly more improvement on interpersonal problems and were being more self-assertive and less overly accommodating at the end of treatment than clients in the CBT treatment. At the end of treatment, clients in both groups had developed significantly more emotional reflection for solving distressing problems.

Couples Distress

A substantial body of research has established the effectiveness of EFCT (Greenberg & Johnson, 1988; Johnson, 2004). A metaanalysis (Johnson, Hunsley, Greenberg, & Schindler, 1999) reported on four randomized clinical trials. The mean effect size was large for psychotherapy effects and very significant. Studies have examined the impact of EFCT on distressed couples, as assessed by a wide range of indices, including psychological and dyadic adjustment, intimacy, and target complaints.

Beyond treating general relationship distress, sessions of EFCT were recently compared to pharmacotherapy in treating major depression in married women by randomly assigning treatment to couples (Dessaulles, Johnson, & Denton, 2003). The interventions were equally effective in reducing depressive symptoms of the women, although there was some evidence that women who received EFCT with their husband experienced greater improvement after termination than those women who received pharmacotherapy. Another recent study evaluated the effects of 10 sessions of EFCT for couples in whom one member had an unresolved emotional injury as a result of the partner's actions (Greenberg, Warwar, & Malcolm, 2003). Couples were compared to control subjects. At the end of treatment, couples scored significantly better than they had at the end of the waitlist control period on all indices of change.

Personality Disorders

Short-term dynamic therapy (STDP) has garnered empirical support in the treatment of cluster C personality disorders when compared to cognitive-behavioral therapy and to pure cognitive therapy (Svartberg, Stiles, & Seltzer, 2004; Winston et al., 1994). In a study that compared the effects of STDP and CT, outpatients who met criteria for one or more cluster C personality disorders and not for any other personality disorder were randomized to 40 sessions of either STDP or CT (Winston et al., 1994). On Axis I, patients mostly had diagnoses of anxiety or depression.

The whole sample of patients showed, on average, statistically significant improvements on all measures during treatment and again later at a 2-year follow-up. Moreover, effect sizes were generally large. Analyzed as a group, CT patients did not change significantly in symptom distress after treatment ended, whereas STDP patients continued to change and the difference was significant. Despite these different intragroup changes, there were no other significant differences between STDP and CT on any measure for any period. Therefore, in each group, 40% had recovered in terms of interpersonal problems and personality functioning 2 years after treatment. Similarly at the 2-year follow up, 54% of the STDP patients and 42% of the CT patients had recovered symptomatically (symptoms improved).

In another clinical trial on the treatment of cluster C personality disorders, STDP was compared to brief supportive psychotherapy, which contrasted dramatically with STDP's high reliance on active confrontation and eliciting affect. Findings showed the two treatments were equally effective. Nevertheless, there were high fluctuations in alliance ratings in STDP unlike in the supportive treatment, which had more stable alliance rating—a finding that suggests the treatments may have different change pathways (Hellerstein et al., 1998).

Monsen and associates (1995) conducted a 5-year follow-up study on personality-disordered patients who had been treated by using a psychodynamic therapy with a particular focus on patients' consciousness of affect. Both during treatment and 5 years post treatment, researchers found significant and substantial changes in the degree to which patients were aware of affect, characterological defenses, and symptoms. Moreover, at the end of treatment, nearly three-quarters of the patients who met the *Diagnostic and Statistical Manual of Mental Disorders*, third edition (DSM-III), criteria for both Axis I and II diagnoses no longer met these criteria. This finding suggests that intensive psychotherapy focusing on warded-off affect is helpful to a group of patients for whom most studies report only moderate to poor outcome.

A convincing body of outcome research also supports the efficacy of STDP in the treatment of complicated Axis I disorders. In a study of patients representing a wide range of Axis I and Axis II disorders, STDP was found to have a more beneficial effect in relieving depression, and the comparison condition, brief adaptive psychotherapy, was more effective in alleviating anxiety (Winston et al., 1991, 1994). Both groups showed significantly greater improvement from admission to outcome than a control group, but they did not differ on the summed outcome scores. Interestingly, these outcome findings were again obtained in a difficult-to-treat population of personality-disordered patients. Another study showed that the addition of brief dynamic psychotherapy to treatment with anxiolytic medication significantly reduced the otherwise high relapse rate of panic disorder compared to use of medication alone (Wiborg & Dahl, 1996).

There are several forms of STDP. *Affect phobia therapy* (APT) is a name given to McCollough's integrative form of STDP, in which systematic desensitization is believed to be the fundamental agent of therapeutic change (McCoullough et al., 2003). Similarly, intensive short-term dynamic psychotherapy (ISTDP) is a form of STDP that is distinguished by its use of technical interventions that directly challenge and openly confront patients' resistances to underlying feelings.

Office-based research has been conducted on the outcome of a large number of patients treated over 6 years of ISTDP practice (Abbass, 2002a, 2002b). Patients suffered from a broad spectrum of disorders, including severe trauma with serious perceptual, cognitive, and affective disturbances. Overall, patient self-report measures and follow-up health outcome data revealed that patients' mental health and interpersonal functioning were significantly improved after an average of 17 sessions of ISTDP. Moreover, these improvements were associated with a substantial decrease in health care utilization costs.

Childhood Abuse and Trauma

Outcome research also supports the efficacy of exposure-based therapies with diverse traumatized populations, including survivors of child abuse (e.g., Foa, Rothbuam, & Furr, 2003; Paivio & Nieuwenhuis, 2001; Shapiro, 1999). In addition, emotion-focused therapy for adult survivors of childhood abuse was developed from programmatic research on experiential therapy using the intervention of empty chair dialogue with abusive and significant others for resolving interpersonal issues from the past (Greenberg & Foerster, 1996; Paivio & Greenberg, 1995; Paivio, Hall, Holowaty, Jellis, & Tran, 2001). In these treatments imaginal confrontations are promoted through enacted dialogues with significant others. Emotion focused trauma therapy (EFTT) for adult survivors of childhood abuse posits both the therapeutic relationship and the emotional processing of trauma memories as distinct and overlapping change processes.

In a study that examined the effectiveness of EFTT with adult survivors of childhood abuse (emotional, physical, and sexual) clients who received 20 weeks of EFTT achieved significant improvements in multiple domains of disturbance. Whereas clients in a delayed treatment condition showed minimal improvements over the wait interval, after EFTT they showed significant improvements comparable to those of the immediate therapy group. On average, these effects were maintained at a 9-month follow-up (Paivio & Nieuwenhuis, 2001; Paivio et al., 2001).

A recent study of EFTT found that a therapist's competence in facilitating imaginal confrontations, by way of an empty chair dialogue, predicted better client processing. Moreover, when adult survivors of child abuse engaged in an empty chair dialogue, it contributed to the reduction of interpersonal problems, and this contribution was independent of the therapeutic alliance (Paivio, Holowaty, & Hall, 2004). These important findings are consistent with those found in research on EFT for depression, which showed that deeper levels of emotional experiencing had a curative effect independently of the alliance (Pos et al., 2003). A dismantling study is currently being done to evaluate the efficacy of EFTT with and without the empty chair dialogue (i.e., imaginal confrontation) intervention (Paivio & Jarry, 2004).

Emotional processes also have been studied in two controlled studies on resolving interpersonal difficulties that included abuse and trauma. Emotional arousal during imagined contact with a significant other was a process factor that distinguished EFT from a psychoeducational treatment and was related to outcome (Greenberg & Malcolm, 2002; Greenberg, Warwar, & Malcolm, 2003; Paivio & Greenberg, 1995). Moreover, the emotion-focused treatment was found to be superior to psychoeducation (Greenberg, Warwar, & Malcolm, 2003).

Eye movement desensitization and reprocessing (EMDR) therapy has also been found to be effective in three metaanalyses. One metaanalysis, which examined responses to psychotherapeutic and pharmacological treatments of PTSD (Van Etten & Taylor, 1998), concluded that EMDR and exposure therapies achieved similar outcomes and were superior to other psychotherapeutic treatments. However, according to the metaanalysis, EMDR studies had used fewer sessions, approximately 4, to achieve the level of change produced by 10 sessions of exposure. A second metaanalysis evaluated outcomes in 34 different EMDR studies (Davidson & Parker, 2001). It concluded that EMDR was superior to no-treatment and nonspecific treatment controls, and equivalent in outcome to exposure and cognitive-behavioral therapies. A third, more recent metaanalysis indicated that those studies that were more methodologically rigorous reported larger EMDR effect sizes (Maxfield & Hyer, 2002).

Shapiro (2001) proposes that EMDR is not based on exposure but on the linking of memory components and mindfulness. She argues that these elements differ from exposure

and that there clearly appears to be a difference in treatment process because EMDR includes frequent, brief, and interrupted exposure, as well as free association. During exposure therapy clients generally experience long periods of high anxiety that subside gradually (Foa & McNally, 1996), and clients in EMDR generally experience rapid reductions in distress early in the session. This difference suggests the possibility that EMDR's use of repeated short focused attention and free associations may invoke a different mechanism of action than that of exposure therapy, with its continual and longer exposure.

Anxiety and Worry

The work of Borkovec and colleagues on the avoidance theory of worry has received considerable empirical support (Borkovec, Alcaine, & Behar, 2004; Borkovec, Roemer, & Kinyon, 1995). In this body of work, a cogent argument is made that emotional disclosure and worry act as antithetical processes to each other with respect to emotional processing. Rather than being synonymous with anxiety, worry is understood as a cognitive response that orients individuals to a threat while insulating verbal-lingustic process from the immediacy of emotional experience. When the emotional experience is maladaptive, as in generalized anxiety disorder (GAD), worry is an avoidance behavior that engages emotional material but only at an isolated conceptual level. Thus, preservative worry blocks the natural course of emotional processing.

Other researchers are also contending that anxiety disorders are best understood as disorders of emotional regulation (Mennin, Heimberg, Turk, & Fresco, 2002). Preliminary empirical evidence supports the assertion that GAD is a syndrome involving emotion regulation deficits and an overuse of cognitive strategies (Mennin, 2004; Mennin et al., 2002).

Practice Implications

In reviewing the research on emotion in psychotherapy we draw a number of conclusions, some well established and others tentative, about what we know about the role of emotion in effective psychotherapy. Some approaches to psychotherapy more deliberately facilitate emotional processing than others, and some specific interventions have been shown to be useful in evoking emotion.

- Working with aroused emotion is predictive of positive outcome in therapy over and above the contributions to outcome of the therapeutic alliance.
- There are four distinct principles of emotional processing, and all contribute differently to therapeutic progress, depending on the presenting problems and in-session states.
- Arousal alone (catharsis) and reflection alone (rational thinking) are not sufficient for emotional processing.
- Working with emotion in therapy can address deficits in emotion awareness or regulation, and these may directly address certain presenting problems such as anxiety and some personality disorders. However, given adequate awareness and regulation, a treatment can aim actually to transform core maladaptive emotions into more adaptive emotions, and this change is distinct from regulating or attenuating of emotion, and from rational reflection.

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