THE BRUISED HEART

MUSINGS ON OPTIMAL EMOTIONAL AROUSAL AND THE IMPORTANCE OF POSITIVE AFFECTS IN EMOTION-FOCUSED THERAPY AND STDP

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Summary

This paper will compare and contrast Emotion Focused Therapy (EFT) and Short-Term Dynamic Psychotherapy (STDP) by describing the 13 session EFT of a patient presenting with problems related to inner conflict and unresolved feelings related to her divorce four years previously that interfered with her current ability to develop a romantic relationship. Those elements of the patient's emotional expression, emotional processing, experience and physiological arousal, which allowed her to resolve these issues and obtain substantial symptomatic relief and improvement in her romantic life are examined via two vignettes from different sessions. Graphs of the patient's heart rate for each vignette illustrate the intense cardiovascular arousal associated with accessing adaptive grief and sadness while also illustrating the importance of accessing positive affects to regulate and transform these intensely painful emotions which results in a rapid return of physiological equilibrium. Aspects of this case then provide an opportunity for examining issues considered important in both EFT and STDP, such as the as the importance of positive affects in transforming and making meaningful negative affects and the optimal intensity of emotional arousal necessary for therapeutic change.

Introduction

Becoming a good psychotherapist is hard work! This will not be a revelation to readers of this journal. To become a skilled craftsman one need mentors, those who have mastered the craft and are able to convey essentials of this process in a manner that helps us to hone our craft. This need for articulate, seasoned, and compassionate guidance applies whether one's craft is applying brush to canvas or, as in the case that follows, helping a woman experience, express and transform a sense of unresolved heartbreak that keeps her cut off from romantic love.

I have been fortunate in my ongoing efforts to hone my craft to have three fine mentors, two of whom, Diana Fosha (2000) and Leigh McCullough (McCullough Vaillant, 1997), were trained as STDP therapists and have contributed to the evolution of STDP theory and technique. From Diana Fosha I have gained a greater appreciation of the importance of being attuned not only to my patients' grief and rage but also to their more subtle and tender positive affects and a better appreciation of how essential these emotions are in therapeutic transformation.
It was through Leigh McCullough's work that I received my first introduction to Malan's (1995) triangle of conflict. Leigh McCullough and her colleagues (McCullough, Kaplan, Andrews, Kuhn, Wolf and Hurley, 2003) have provided a theoretical and conceptual bridge between psychodynamic and more cognitive-behavioral approaches with their articulate account of "affect phobias".

My third mentor, Leslie Greenberg, is one of the originators of Emotion Focused Therapy (EFT), (see Greenberg, 2002; Greenberg and Johnson, 1988; Greenberg and Paivio, 1997; Greenberg, Rice and Elliot; 1993). Leslie Greenberg, probably more than any single researcher or clinician has been responsible for empirically and theoretically maintaining the importance of emotional experience and expression in psychotherapy during a period when cognitive-behavioral approaches were often presented by their advocates as the only "empirically validated" form of psychotherapy (e.g., Task Force on Promotion and Dissemination of Psychological Procedures. (1995).
While they may differ in language and emphasis, each has contributed greatly to my understanding of the core emotional processes that lead to transformation in psychotherapy.

First a brief overview of EFT will be given and some of the similarities and differences in the two approaches will be outlined. The following transcripts are from the second and seventh therapy sessions with a 41 year old woman, who was still struggling with unresolved feelings related to her husband's sexual infidelity and their subsequent divorce four years ago. Heart rate graphs are presented for each vignette that allow the reader to follow the patient's intense cardiovascular arousal as core emotions of grief and sadness are accessed and then note her rapid return to physiological baseline as the therapist assists her in accessing positive affects to help regulate and transform these painful, negative affects.

EFT and STDP: some similarities and differences

Emotion-Focused Therapy, also known as Process-Experiential Therapy (Elliott, Watson, Goldman and Greenberg, 2004), is an integrative approach that includes interventions from client-centered, gestalt, psychodynamic and existential therapies, guided by basic assumptions supported by contemporary emotion theory.

Some of the basic EFT assumptions are that emotions have evolved in humans because they are fundamentally adaptive, that emotions are particularly important in forming and maintaining basic attachment relationships, and that the integration of emotion and cognition into a coherent narrative are basic to develop a sense of meaning and purpose. EFT does share with STDP the idea that much of the human suffering that brings patients into psychotherapy is caused by intrapsychic conflict and the warding off of adaptive but threatening emotions and that this internalized conflict is often related to painful experiences in early attachment relationships.

EFT differs from STDP in that it owes more of its theoretical and philosophical underpinnings to humanistic psychology and a dialectical constructivism based on Piaget's developmental theory (Elliot et al., 2003; Greenberg and Pascal-Leone, 1995), than to the meta-psychology of psychoanalytic theory. In the dialectical-constructivist view personal meaning emerges by an ongoing circular process. This process involves becoming aware of the bodily felt sensations connected with emotional experience as well as symbolizing and communicating this experience via language resulting in the integration of reason and emotion. While this process may sound somewhat abstract, some concrete examples of this dialectical process will be given in the case that follows.

Another fundamental EFT principle is the importance of making distinctions between different types of emotional experiences that call for different types of in-session intervention. In particular, Greenberg has emphasized the importance of differentiating between both primary and

secondary emotions, and between primary emotional experiences that are adaptive or maladaptive (Greenberg and Safran, 1987; Greenberg et al., 1993; Greenberg and Paivio, 1997).
Primary emotions are the person's most fundamental direct initial reactions to a situation like being sad at a loss. *Secondary emotions* are those responses that are secondary to these more primary emotions and are essentially identical to the STDP concept of defensive or inhibitory emotions such as feeling guilty when angry and then turning the anger inward. The next crucial distinction, which I think may be unique to EFT, is the importance of distinguishing between primary emotional states that are adaptive, and are accessed for their useful information, and those that are primary but maladaptive, and need to be accessed in order to be transformed. *Maladaptive emotions* are usually experienced by patients as old familiar feelings that occur repeatedly and do not change. The quality of these feelings seems much more pervasive than secondary or defensive emotions. These often include very basic but distorted senses of self and other such as a deep sense of loneliness, shameful inadequacy and the self as damaged and unlovable. This distinction between primary adaptive and maladaptive emotions is very important because primary maladaptive feelings do not resolve or provide a new sense of self or other when accessed and expressed in therapy. Instead, they tend to leave the patient feeling stuck, hopeless, helpless and in despair. It does not help simply to become aware of and express maladaptive emotions in therapy instead they need to be replaced or transformed with the therapist's help.

In EFT, there is more of an emphasis on identifying in-session "markers", such as aspects of the patient's speech, affect and behavior that suggest unresolved issues and interruptions in emotional processing and less emphasis on characterological or structural analysis. For example, a common "marker" that EFT therapists are attuned to is an "inner critic split", when the patient describes a sense that one aspect of the self is critical of, or coercive toward another aspect of the self. This has obvious parallels with the STDP emphasis on being attuned to and working with super-ego pathology. Another common "marker" suggesting "unfinished business" is when the patient blames, complains, or expresses hurt or longing in regard to a significant person from their past, usually a parent or former romantic partner. Again, there is an obvious parallel between the marker of unfinished business and the importance that STDP therapists place on working with the patient to become aware of and express unresolved anger and grief towards significant others from the patient's past.

While both EFT and STDP place a great deal of emphasis on the importance of the therapeutic alliance, EFT is heavily influenced by the work of humanistic psychologists such as Carl Rodgers and more contemporary theorists who emphasize the importance of empathy (Bohart & Greenberg, 1997). This tradition focuses on empathetic attunement as a means of developing an emotional bond between the patient and therapist, and striking a balance between empathetic reflection and validation as a means of deepening the patient's awareness of emotions, as well as providing the sense of safety and support necessary for intense and painful feelings to be expressed. There is much more of an emphasis on guiding the patient's emotional process and less focus on providing content and interpretation. While this general stance is very compatible with STDP therapists such as Alpert (1992), Fosha (2001) and McCullough (1997) who emphasize empathetic attunement, validation and affirmation, there is little emphasis in EFT on confrontation, particularly the sort of anxiety generating confrontations, characteristic of more traditional STDP approaches.

Instead of confronting a patient's defense, the EFT therapist is more apt to deal with the patient's defenses against affect by using a Gestalt Therapy technique of encouraging the patient enact the defense in session (e.g., "Why don't you move over to this chair and let yourself be that part of you that makes you feel guilty for getting angry at your father."). This helps the patient more vividly experience the punitive anger they direct towards themselves, as well as making them

very aware in the moment that are actively responsible for the inner process that causes them suffering. This is then followed by having them move back to the "self" chair and an empathetic exploration of the emotional cost of this process.

In a similar vein, while both EFT and STDP place a great emphasis on working through unresolved emotions toward figures from the patient's past, EFT therapists are more apt to suggest the patient enact both on their emotions and on those of the other in the session. For example, an EFT therapist might ask a patient to visualize his abusive father in an empty chair and to then engage in an expressive dialogue with him by moving back and forth between the chairs. While there is an obvious parallel between such an empty chair dialogue with a parent and STDP portrayals, it differs in a significant way from more traditional STDP portrayals in that the patient is instructed to switch chairs at various points and to speak as if they are the other responding to their expression of hurt, longing or anger.

This can be a powerful way to access adaptive anger and the associated physiological arousal, and action tendencies to counter depressed patients' tendencies to turn anger inward and collapse into hopeless complaint or rumination. What I have observed, time after time is a patient who is speaking to, for example, their abusive, alcoholic father in the empty chair, but doing so from a collapsed, tearful, victimized stance. However, upon switching chairs and becoming their disdainful, arrogant father, they will suddenly sit upright, adopt an expression of contempt or disgust (with a consequent sharp rise in heart rate), and shaking their finger say in a scathing tone, "You little shit, you make me sick! When are you ever going to grow up and be a man?" Fortunately, sympathetic nervous system activation, somatic markers, and the associated action tendencies associated with anger and contempt typically do not change quickly. The few seconds that it takes to switch from the "abusive father chair" to the "abused self chair" does not dampen this more physically and emotionally aroused state, and, upon their return, the formerly collapsed patient immediately sits up straighter, leans forward and with the first flash of anger in their eyes says, "Why don't you just shut up for a change! Damn you, you old drunk. You have nothing to teach me about being a man!"

Another notable difference is that while intense anger, even rage, is often accessed and expressed towards the other, there is little of the more traditional STDP emphasis that this has to be expressed as murderous rage. It is not that murderous rage is avoided if the patient expresses it, but the emphasis is more on staying with the patient's experience and honoring his unique sensations, memories, images and metaphors that allow the patient to access the adaptive aspects of anger, such as a stronger, more assertive sense of self that demands respect and will not tolerate abuse.

To summarize, while EFT and STDP differ at times in terminology and emphasis, there is a general agreement on the following as essential emotional change processes in effective psychotherapy:

1) guiding the patient to become aware of and express primary, adaptive emotions
2) directing the patient to become aware of their here and now bodily experience as a means of activating adaptive emotions
3) the importance of the therapeutic relationship in helping the patient regulate their emotions; and
4) the need to alternate experiential work with conscious reflection as a means of integrating new experience into a meaningful personal narrative (Elliott et al, 2004; Fosha, 2001).

The Patient

Ruth is a 41 year old woman who responded to an advertisement in the local media that described a research project I direct and the availability of a brief program of psychotherapy for individuals experiencing unresolved emotional issues. She came in because she was very aware that she still had lingering feelings related to the discovery four years previously of her husband's affair and the eventual breakup of their marriage.

A structured diagnostic interview and intake assessment battery revealed that she had reacted immediately after her divorce by developing a major depressive episode that was successfully treated with a selective serotonin re-uptake inhibitor antidepressant and a year of supportive psychotherapy. At the time of the intake, she had been off antidepressant medication for over three years. In addition, in her early twenties she had previously undergone four years of supportive/expressive individual and group psychotherapy to resolve various family issues. She had also arranged for several family therapy sessions during that period attended by her mother, father and a sibling that enabled her to resolve these issues and to reconnect with her parents. She reported that this therapy had been very helpful, and she currently had loving and supportive relationships with her family members.

Ruth's previous therapeutic work on her family of origin issues enabled us to make rapid progress in so few sessions while focusing primarily on her lingering, unresolved feelings related to her divorce without the need to extensively revisit and work through unresolved emotions related to her family of origin. However, it should be pointed out that Ruth's case is the exception in this respect and my own experience has been that emotion focused work related to divorce and romantic betrayals almost inevitably leads back to additional unresolved childhood and family of origin issues as is more typical in an STDP approach.

Ruth's main presenting complaint was that since her divorce, she had not been able to establish an intimate romantic relationship with a man. Although she was an attractive, articulate, and creative woman who had been pursued by several men, she was aware that, "I always hold them at arm's length. I know at some level that I just don't want to get hurt again and, although I know that I am stronger than I was during my marriage, I just can't seem to let myself really trust a man again. Some part of me always seems to be saying, "Watch out! Be careful! You don't want it to happen again!"

Ruth's intake assessment revealed that she did not currently meet full criteria for any DSM-IV Axis I or Axis II disorder, other than perhaps a V code phase of life problem. However, her responses on various self-report measures revealed moderate levels of dysphoric affect, low-levels of positive affect, and substantial dissatisfaction with her work and romantic life. Her history of a previous Major Depressive episode in conjunction with dysphoric mood, general life dissatisfaction, and lack of an intimate relationship certainly placed her at a high risk to experience another depressive episode and not simply one of the "worried well".

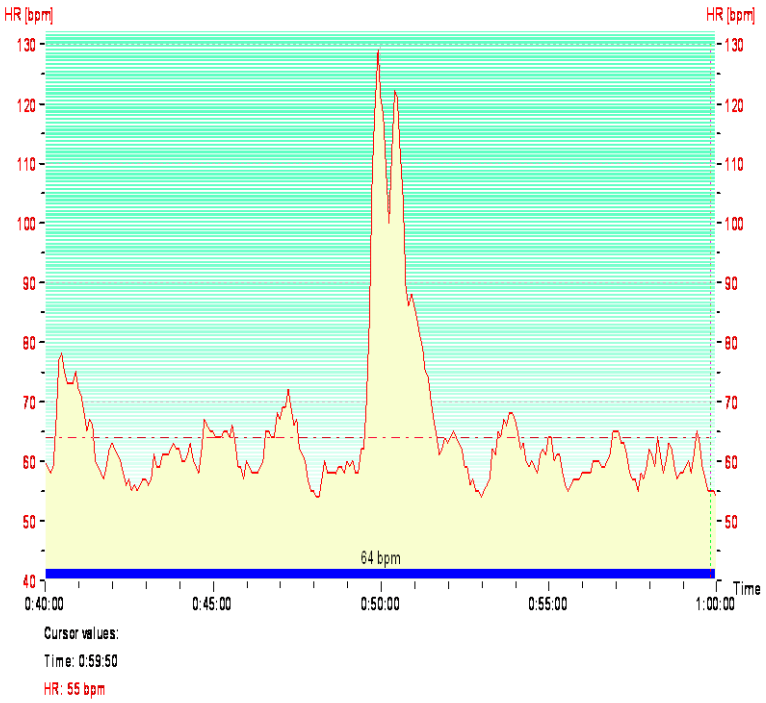
Transcripts and Comments

During our second session Ruth was led through a somatic Focusing exercise to help her become aware of the somatic and visceral sensations associated with her current emotional experience and the lingering unresolved feelings towards her ex-husband. Focusing was developed by Gendlin (1981) as a means of helping patients access a somatically based "felt sense" as a means of

increasing emotional awareness and deepening emotional processing while maintaining an optimal level of emotional arousal for therapeutic work (Elliott et al, 2004). A detailed discussion of all the steps involved in Focusing is beyond the scope of this paper, however, the reader is referred to Gendlin's original work (1981). This Vignette also serves as a good example of an EFT intervention that encourages "bottom up" emotional processing by having the patient focus on non-verbal visceral sensations, feelings and images as a way of accessing core emotions as opposed to a "top down" approach that involves more verbally mediated interventions such as interpretations or questions.

Vignette 1 (41-57 minutes of the second session)

Figure 1: Ruth's Heart Rate for Vignette 1



As this vignette begins, the patient is sitting with eyes closed and relaxed, having been led through the initial steps of focusing. At this point, the patient is encouraged to get in touch with a physical/emotional "felt sense" of what she is in feeling in the moment. Her heart rate as the transcript begins is at 60 beats per minute (bpm) and this, along with her posture, vocal tone and facial expression, suggests a relaxed but attentive state.

Th And so the first question to kind of ask yourself and to ask your body is, "How are you feeling right now? How are you feeling in this moment sitting here with me?"

Pt Umm first, the image I get and the word that comes to that question is "energy", like energy in my core, like a storm that is gathering speed. A good storm. It feels likes a circular spiral of energy that is starting to build (makes spinning motion with her hand and smiles). It's red, all excitement and energy.

Th Uh huh, so excitement and energy. So where do you feel that excitement and energy in your body?

Pt Right in here. (patient rubs her stomach)

Th So, kind of a fire in your belly?

Pt (patient immediately laughs) Yeah, yeah that's it!

Th So just let yourself kind of hang out in this area of energy in your belly. Just sit with it for a little bit… And just take your time but let me know if it stays the same or does it shift in anyway?

Pt Ah, well I feel the energy shift and flowing out my legs and dance… its very much about dancing. I guess I see it here (again makes circular motion around stomach) but as it flows down my legs it flows out and touches a lot of people in a good way (makes open back and forth dancing gesture with hand).

Th So that has a good feeling, kind of connecting you with other people.

Pt Yes. Yes, well… I don't want to be too much in my head but… its also like… Yes! Yes! Yes! This is why I'm here. (voice gets stronger, and there is a stronger, more determined set to her face as she says this)

Th So now I'm going to ask you a different question. Just stay in your body and breathe in. You're probably still in touch with the energy in your body but just let your awareness kind of move away from that a little bit and kind of roam. And the question is right now in your life what it really between you and feeling fine and good about your life?

Pt (laughs) A silly thing comes up, sleeping more consistently. But you're asking more what is in here (touches heart area).

Th Yeah, that's good, you're in touch with the process now, your mind kind of immediately pops up with "I need more consistent sleep", I'm sure you probably do, but then you just breathe into the center of your body and go back to that place and…

Pt OK, what is standing between me and… oh, it's up here. (raises hand and places it over her heart)

Th Umm, so yeah it's in your heart? So just breathe into your heart and stay with this physical sensation and see what comes.

Pt (patient's face shows sadness she gasps) Its sad!

Th So there is sadness there in your heart. Just continue to breathe into it and just stay with this and allow the feelings to come.

Pt (patient starts to tear up) It's fear and (crying softly) it's just sad. (at this point, about minute 40 on the heart rate graph, Ruth's heart rate moves from about 60 bpm to 77 bpm reflecting the sympathetic nervous system activation associated with her increased awareness of sadness and the expression of this in a soft, gentle, sort of crying. I do not consider this defensive weepiness.)

Th What's the saddest thing about what you are feeling? And really take your time… if my question takes you away from your experience go back to your experience.

Pt (touching heart again) I get the image of it still being tender here… sore still.

Th Uh huh, yeah, so it is almost like there is still almost a physical hurt quality to it

Pt Right, like "must touch lightly".

Th So your heart really has been bruised?

Pt I guess so.

Th So can you find like a word of simple phase that really describes the quality of this feeling?

Pt (long pause) I'm so out of my head that its hard to find the words but it's like, "Go slowly, tread lightly, be careful… it's not don't love, it's be careful." (note that Ruth's comments that she is out of her head and having some difficulty finding words reveals that she is involved in a much more inner directed, emotion focused, right hemisphere mediated process)

Th So there is like a cautious, be careful quality to this.

Pt Yeah.

Th So if you were to ask your heart, literally ask that area in your heart, "What is it you need in order to heal?" What would it say?

Pt (Pauses, then a big smile comes over her face and she gestures towards stomach) More of that! More of that, connected to that, focusing on this. Like (gestures towards heart) "Leave me alone for a little while," let's go somewhere that feels a lot safer, a lot more energetic, a lot more powerful. Its like she is saying, I'm healing, we know I'm healing but its almost like turning away from looking at it directly, turning the energy somewhere else, allows, helps the healing to complete. She wants to pay attention here (places hand on stomach) (Although Ruth looks and sounds more activated in her posture and voice when she shifts her direction to the more active and vital place in her stomach, her heart rate actually starts to decrease at this point. I will elaborate on research that has found that positive affects help individuals "bounce back" from the cardiovascular arousal of negative emotions later in the discussion.)

Th And is there anything she wants to ask for from that storm, that creative whirlwind in your belly?

Pt Joy. Dancing.

Th So just try this, as a different perspective. Can you just move down into that area in your belly again? And just let me know when you are there?

Pt (pause) Yeah, I'm there.

Th Does it feel like it has shifted or changed any?

Pt Umm, its more multidimensional, more colors, it's not a flat spiral, it's a three dimensional cone of energy.

Th So, what I'm going to ask you to do is to kind of stand in that three dimensional cone of energy, and when you're able to get to that place let me know.

Pt Ok, I'm there.

Th And from that place, look from that place up to your heart and just tell me what you see.

Pt (Patient pauses, a smile starts to break across her face. The smile quickly fades. Her hands come up to her face then she leans forward in the chair cradling her head between her hands and sobbing deeply. At this point her heart rate accelerates from 62 beats per minute to 129 beats per minute. She sobs for a few moments unable to talk) Oh, oh…at first I saw a big, red, bruised heart but then I looked again and I saw light. White light (gestures outward with hands) just shooting out in all directions. (continues to cry as she speaks) Which is really good… like there is a lot, there is a lot of love in there, there is a lot of energy that wants to burst out, it is bursting out already… its just a little held back by the bruises.

Th What is it your tears are telling you about what was so touching?

Pt (smiles although still crying) Seeing the light, yeah like the joy that is in my heart, the joy that is really there. That's who I really am, that's what's really in here. It's just that there is still some padding and bruises around it and some… debris. (Although her heart rate shot up dramatically when Ruth began to sob, this elevation lasted for less than 2 minutes and started to rapidly drop as she began to express the positive affects of hope and compassion associated with the image of white light bursting out of her heart.)

Th Ah, yes, yes. And if you stay with this, what is the image of the debris that comes to you? What is it composed of?

Pt Well, it's like when I first looked up it was almost like a literal heart, and it was mostly red with some purple here and there, the bruises. But as I looked deeper into the heart and that was where the light was, bursting out (gestures out with hands). And as we talked, it was like the literal heart, the organ, the red and the purple just started coming into pieces and moving out and the energy and the light was shining through. Sort of like the heart, the exterior organ. Or my head construction of it started to dissolve and just the energy and light was left. It just dissolved. Almost like in a film when the camera zooms in on something and everything else disappears from view. But if I zoom back out, there is still a tender organ, (reaches out with hands as if she is cradling her heart) a very human organ that is bruised there. But it's sweet. It's really powerful to see the light there. (sighs) Yeah. (by this point her heart rate has dropped to 53 beats per minute, the lowest point of the entire session)

Th So just one final thing, and we will kind of start to wind this experience down. Just ask yourself, what is it you really want to take from this powerful experience that you've just had? (Here I was providing a prompt to allow Ruth to reflect on and incorporate the results of the powerful experiential work. Alternating experiential and reflective work are basic tenets of AEDP (Fosha, 2000) and Emotion Focused Therapy (Elliot et al, 2004)).

Pt (smiles, sits up in chair) I liked standing in that whirlwind of energy and colors. I liked looking out from that place… out at something like my heart that was so painful. And I

thought, wow, it would be great to look at a lot of things from here, like school, dance, to look at important choices from that powerful place. Like life is more, like standing in that place, there is nothing to be afraid of, there is no reason to fear or doubt my desires. Like from there fear won't cloud my vision.

Th So just keep that with you. And just take your time but start letting yourself come back from that place, back to the room here with me.

Pt (she sits forward and slowly opens her eyes) Wow, (laughs) I don't want to leave. But I guess I can go back anytime.

Th Yeah, you can. It's always there waiting for you.

Pt (looking directly at therapist) Thank you.

Th Oh, you're welcome, you're welcome. I was very touched too.

This excerpt may serve as a good example of what Fosha (2003) describes as working with "self-at-worst" functioning. In this case her bruised heart and fear of loving again, by using the vantage point and resources associated with "self at best" functioning, the energy, strength, joy, and excitement that flowed from her solar plexus down through her legs and out to connect her with others. By following the patient's explicit statement that her bruised heart "needed more of that", the energy and vitality in her solar plexus, and having her move her awareness into her embodied "self at best" and from there lifting her gaze upward (a common expressive sign of transformational affects, Fosha, 2000).

Summary of Sessions 3-6

In our third session, Ruth related that she felt the work we had done in the last session had been deep and important. She had continued to be in touch with a sense of regret and sadness that, "To keep from being hurt I'm keeping myself from finding love." This is a good example of what McCullough (1997) calls defense recognition (i.e. the dawning awareness of how her defenses of isolation and self-sufficiency triggered by her fear of being hurt again cuts her off from an adaptive love relationship) as well as the beginnings of "mourning the self" (Fosha, 2001) that leads to an adaptive grief that motivates the relinquishment of this defense (McCullough, 1997). We used several "empty chair" imaginary dialogues with her ex-husband that initially led Ruth to get in touch with her anger that would quickly give way to the secondary emotion of guilt. We were able to work through this by having Ruth enact the inner sense that made her feel via a two chair dialogue. As she engaged in this process she began to sit forward in the chair, and at times actually shook her finger in a disapproving way while saying in a harsh judgmental voice, "He's just sick! How can you expect him to do chores, clean up when he feels this way? You should just let him off the hook. You should figure out how to help him!" When she switched back to the other chair, she became angry at this critical, guilt inducing voice and leaned forward in her chair, saying in a much stronger, more assertive voice, "He was adult too, he could have got treatment and taken care of himself like I did. And damn it, depression is no excuse for having an affair!"

After working through her secondary guilt, Ruth was much more able to access a stronger, more adaptive sense of anger at her ex-husband that held him accountable but also allowed for continued expression of grief over what they once had. By our sixth session, Ruth was experiencing a much more hopeful and positive outlook on her life. I suggested that we once

again use Focusing to explore the bruised sense of sadness that had resulted in such a powerful experience in our second session. Ruth reported a change in the sensation and feelings in her heart area which were now a mixture of "energy, excitement but still tinged by sadness." As I encouraged her to stay with these sensations and to deepen them by breathing into her heart, she began to cry softly and said, "It feels different now. I don't see that burst heart anymore. I see green and energy… now it is sort of like that big bang is giving birth to something. Like growth and newness and innocence… and hope." This put her more in touch with a renewed longing for a romantic relationship, a family and "… cultivating things, bringing new things into the world that weren't there before." Ruth then told me that she felt a resonance with these longings. She also told that a man named G. had been expressing an interest in her for some months. Her awareness of her growing attraction to G. and the fears that this brought up set the stage for the next vignette.

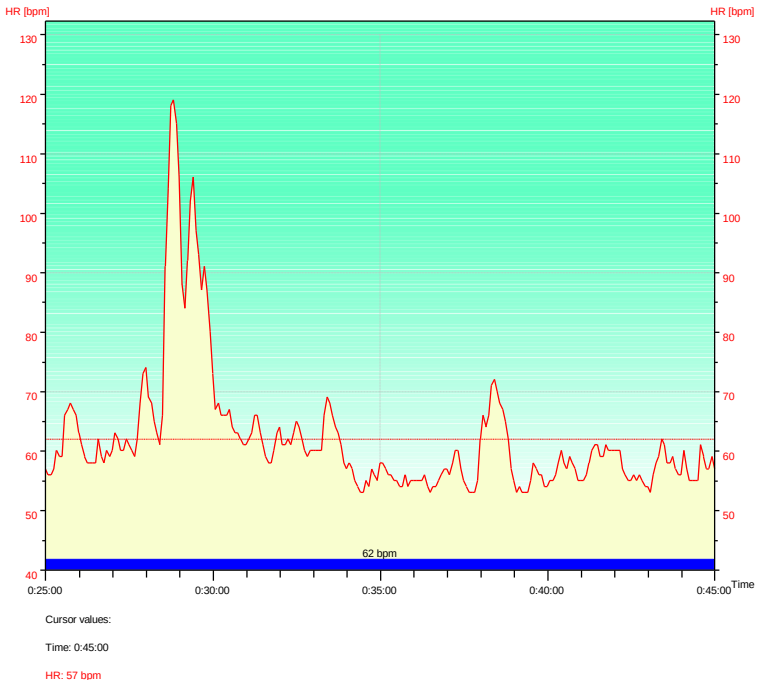
Vignette 2 (25 - 45 minutes in the seventh session)

(Dealing with Ruth's affect phobia of falling in love)

There was a two week break between our sixth and seventh session while I was on vacation. When we resumed, Ruth was excited to share that she had been on several dates with G. which she had thoroughly enjoyed. She was aware of the excitement and anticipation of romantic and sexual attraction, but also noted that in contrast to when she fell in love with her husband, "This time it feels more mature and grounded, it's like my head and heart are integrated." While the general sense was of excitement and cautious optimism, there was also a more subtle sense of anxiety and fear. As we explored this anxiety, she related this to a fear that G., who was recently, divorced himself "… might become too dependent. Maybe he still has a lot of feelings to work out with his ex. Then I would have to witness him in a lot of pain. He could become needy and dependent like my ex-husband when he was depressed, so needy and dependent it felt like I might drown." As we continued to explore this, she became aware of the conflict between the part of her that was excited and renewed about the possibility of falling in love again and the more cautious, fearful self that she dubbed "Cautious Ruth." We then moved into a two chair dialogue between these two aspects of her self.

See Figure 2 for heart rate graph of this session. As we begin this segment her heart rate is 62 beats per minute, again suggesting a relatively relaxed and attentive state.

Figure 2: Ruth's Heart Rate for Vignette 2.



Th So do you want to explore this split between the part of you that is kind of joyous and expectant and this other part that is more cautious and fearful?. (A basic tenet of EFT is that the patient and therapist cooperate both on setting general treatment goals and on the focus and interventions in individual sessions. As such, it is important to check in with the patient before beginning an exercise or intervention as to their willingness to proceed.)

Pt Do I want to explore this? Sure, oh yeah, I want to know what is behind this.

Th Ok, so this is what I am going to suggest. Come over here and sit in this chair. (the patient gets up and moves to the chair that the therapist points to.) And this is what I want you to do, I want you to… this is Ruth over here as she just came into this session (the therapist points to the chair the patient just left). She is kind of… aglow, excited about this new relationship with G. and this new kind of more mature head and heart integration. In your mind's eye can you see her sitting there that way?

Pt Uh huh.

Th And then where you are sitting now, I want you to get more in touch with the caution and the fear. And essentially what I want you to do is scare her, say the things and with the tone of voice that says to her that you say inside that gets you to that place of, "I just don't know if it's worth it." So whatever you can do to get to that place inside, adjust your posture. Use the same tone of voice that you hear "Cautious Ruth" use in your head. Sometimes this is more of an attitude or feeling that is being conveyed instead of the actual words.

Pt (begins tentatively) You could get really hurt. Getting over his divorce could be drawn out and long. You could get close to him and then have to witness him really in a lot of pain. He could get so needy and dependent on you that you feel kind of …drowned by that. You could lose your capacity to set limits and just get sort of sucked in by all this.

Th Uh huh. Just like you did with C. (ex-husband)

Pt Exactly! You could repeat the past.

Th So, switch and move back over there. (the patient moves back to the "experiencing self" chair) And for a moment try and take those words in. Cautious Ruth says, (using the same, cautious but nagging tone the therapist reflects Ruth's words back to her.) "You could repeat the past. You could get sucked in and lose yourself. You could drown. He's not out of the woods yet with his divorce." And again, just feeling inside the center of your body, what is the feeling that comes up when you hear that? (once again the therapist encourages Ruth not to immediately respond but to engage in a more somatic "bottom up" processing to bring subtle physical and emotional sensations into awareness.)

Pt I don't know what the emotion is but I feel a lot of energy in my body. It's just buzzing, like electrical energy just buzzing and going out my hands and out my feet. (the patient stretches hands out). Kind of like an adrenaline rush.

Th Uh huh. Fine, and just continue to stay in touch with that and breathe until something becomes more clear about this. And maybe… in your mind's eye just look across and describe what that part of you looks like.

Pt Oh, she's not very happy; she's got a worried look and a furrowed brow.

Th And how do you feel towards her?

Pt Kind of like I do with the old biddies (a reference to a previous session where she had described a similar sense of anxiety as a "bunch of old biddies".). There is probably a good message in there but there is a lot of negative static that gets in the way.

Th So just open your eyes and see her and tell her that, "Maybe you have a good message but…"

Pt Maybe…, I'm sure that there are good intentions there, protective intention or something like that… but there is also a lot of fear, a lot of fear that is clouding it.

Th And tell her what you start to feel when she tells you these things.

Pt Well, the first sensation is "fight or flight"… I just want to run.

Th So, it's like, "You make me want to run away."

Pt Yeah, and I get nervous and I feel like… like I'm not in the present, I'm not grounded and centered in the now.

Th So its kind of like, “You push me to extremes and I lose touch with myself and the moment.”

Pt Yeah, and when I hear that I lose touch with some part of myself that is… really wise. I lose touch with …it’s like if I just go down that path with you, there is like other important information I know that gets… chopped off. Kind of like I can’t get to that fire in my belly, that strong place, if I listen to you too long. But I do want to know what the good message is that you are trying to give me underneath there.

Th Ok switch to the other chair. (the patient moves to the other chair) And really let yourself assume the posture, the expression on your face of worried Ruth. And Ruth is saying to you that she really wants to hear the good message you are trying to give her but you are giving her a lot of static and that makes her lose touch with a part of her that is wise and important. So how do you respond to her?

Pt (the patient assumes a stiff posture with a furrowed brow. There is a pause of several seconds before she responds in a high-pitched voice.) I don’t want to go through that again! (her voice breaks as she starts to sob. She leans forward and puts her head in her hands as she sobs) I don’t want to go through that again… it was like dying! (Heart rate at this point shoots from 62 bpm to 119 bpm, see Figure 2 above)

Th Yeah, yeah. Take your time… just remind her of what that was like and why it is still so scary.

Pt (still crying) God! It took so long …to heal from that! And it took so long and so much work… (at this point she sighs deeply)… I don’t know what else to say.

Th Could you just tell her how you still feel about that?

Pt It was just exhausting… it took everything I had for a long time (tears up again)...

Th Ummm, sounds like it just drained the spirit right out of you.

Pt Yeah, and so I just feel this part of me here (pointing to the chair she is sitting in) just feels protective and…

Th Kind of like, “Don’t put us through that again?”

Pt Yeah. And kind of like it is really good to take it slowly, it is really good to err on the side of caution. It is really good to continue to press for us, me, the kid inside, the parts that make up me; it is really good to put us first this time. He’s a grown man and quite capable of taking care of himself. (Slight laugh at this point then another deep sigh). Yeah that’s it. (The rapid rise in her heart rate as she started to sob only lasts for a couple of minutes. As Ruth allows the core grief to go through her and then starts to access a more a more positive, assertive and protective sense of heart rate graph in Figure 2 resembles a wave that rapidly peaks then drops. By now her heart rate has dropped from a peak of 119 bpm and returned to 64 bpm. From this point on her heart rate continues a steady decrease that becomes the lowest of any period in the session.)

Th So it sounds like that really is the good message that you want to communicate to her. You really want her to put herself first this time and not lose touch with herself. And it is fine to want that and take your time.

Pt Yeah, it has to be fine. If it's not fine with him, then he's not the guy for me. And we know that we can do just fine without a guy! (laughs)

Th So just check in and see if there is anything else you want to say to her.

Pt Well, just don't ever forget that. That you are just fine by yourself, that losing yourself is just not worth it. You can rely on your friends and family and all these people that love you.

Th So it is almost like you want to make a vow that… never again will I lose myself that way; never again will I give myself up.

Pt Yeah. Right. And the last four days we've already shown that we can do a better job. And I feel like… I've got the tools… I've got the tools to do this… it's just a matter of staying conscious.

Th So come back to this chair (the patient moves to the "experiencing self" chair) and again just take in what Ruth has just shared. There was still a lot of pain and fear that she felt and she wants you to remember how hard it was when you lost yourself and …just how long it took to heal. And it is great and all what is happening with G. but it is ok taking it slow and to really take care of yourself. And in a good way to put yourself first for a change. How does that feel to hear that?

Pt That feels really good. Good reminders. (she smiles)

Th So once again Ruth, in your mind's eye as you look across at Ruth, how does she look now?

Pt (the patient laughs, big smile) Relaxed, like… whew! Glad I got that out! Much better. She needed to say that.

Th So see if there is anything else you want to say to her for what she has given you.

Pt Thanks… and I think you are a really powerful part of me. And thanks for the reminder about all my friends and people who love me. I never do relationships well in a vacuum. It's good to remember that. She seems to be saying, "Remember that when you are in trouble, you don't have to do it all yourself. You can reach out to others for help. And love comes from many different places and many different people, not just one relationship. (As she has continued to reflect on the breakthrough of her pain and becomes more understanding of and affirming of her "cautious" self, her heart rate had continued to gradually decrease to a low of 53 bpm, the lowest of the session and remains in this range for the rest of the session.)

Th Yeah. So maybe now just find a way to kind of sign off, say goodbye to this part of yourself knowing that you can always get back in touch with her when you need to. See if there is anything else to say to her… to kind of end this piece of work.

Pt Well… (voice becomes soft and tears start to roll down her cheeks) just that she is really brave… brave to face how scary it is.

Th And tell her how that touches you…

Pt Well, it touches me because I know… I know we are going to love again. And… it 's just like, it takes a lot of courage to do that, to admit you are scared but step forward anyway.

Th And is there anything you want to tell her about what could do to make this more helpful, so it doesn't…

Pt Terrify me?

Th Yeah, so it doesn't terrify you.

Pt Well, (addressing "Ruth") it is more helpful when you talk to me from your heart and your concern for me and not from your head. Because when you talk from your head you tend to get like this (holds fists up in a fighting pose) and when you talk from your heart it is clearer. Yeah, what is the pure emotion you feel for me not all the other stuff it might imply.

Th So just let yourself say goodbye to Ruth right now, and at your own pace let yourself open your eyes and come back into the room with me. .

Pt (the patient has open eyes and she dabs her tears away with tissue) Wow! That was good. That was very good. Yeah. I knew that was in there… but I wasn't really sure what it was. (smiles) Now I do. And it's good to realize that, while there is no guarantee, there is a way to approach this that will probably lead to a different outcome. And I'm not sure exactly what that will be … but it probably won't feel exactly like the past. And maybe it will even feel very different… and quite lovely (the patient nods her head and smiles softly).

By enacting "Cautious Ruth" in this session, Ruth was able to assess a misguided, but compassionate element of her personality that wants to protect her from ever experiencing the heartbreak and subsequent painful depression ("It was like dying!") that is at the core of her affect phobia of falling in love again. The part of her self that very much desires to fall in love again is the embodied representation of the adaptive feelings associated with love and sexuality. By activating these two schemes, via a two chair dialogue, we were able to engage an emotional and dialectical process that both altered each scheme by enhancing adaptive communication between them. Thus, "Cautious Ruth" becomes less harsh and demanding as she shares the lingering grief associated with the breakup of her marriage while "Ruth" is more able to appreciate the protective intent of "Cautious Ruth". Out of this dialogue of opposing sides emerges a dialectical synthesis that integrates Ruth's need for a certain amount of realistic caution as she embarks on a new relationship without allowing fear to dampen her excitement and sensual pleasure.

Summary of Sessions 8 - 13

This breakthrough in the seventh session that allowed Ruth to access, express, and integrate this basic conflict was a pivotal point in the therapy. Her progress in several areas accelerated after this session. Although, we continued to process remnants of this dialectical tension between her

excitement and desire and her need to be cautious and retain a sense of herself, in the tenth session Ruth revealed that that she was "falling in love with" G. She then went on to say that her anxiety was dissipating because "my head and my heart are no longer at war with each other."

In our final session, we continued to explore Ruth's mounting sensual and romantic excitement as her relationship with G. developed and her cautious hope that it could evolve into something lasting. When the therapist asked her what had been most helpful in our sessions, she noted that Focusing had been particularly helpful, " because it helped me become aware of feelings I didn't even know were there." She also noted the helpfulness of the empty and two-chair dialogues to explore unexpressed feelings and internal conflicts, and the importance of "your constant care and acceptance of whatever I was feeling".

At the end of our session, we said our goodbyes and Ruth moved to another room to complete a ream of post-treatment questionnaires. I was working in my office when she stopped in to drop off her questionnaires. As she turned to leave, she stopped for a moment and turned with tears in her eyes and touched her heart as she smiled and said, "You will always be right here." As the door closed I wasn't sure if she heard my own now choked and whispered reply, "And you too." I am sure she left before the tears had started to move down my own face as I started to fully become aware of how much Ruth's struggle and transformation had touched me.

Discussion

The first question to consider is whether Ruth's emotionally and physiologically intense experiences as described above actually led to any real transformation. While I will not bore the reader with the statistical details, suffice it to say that an examination of Ruth's pre and post treatment assessment measures using standard outcome measures (e.g., SCL-90, OQ-45, Quality of Life Inventory, etc.) revealed statistically and clinically significant decreases in the dysphoric affect she presented with, increases in positive affect and mood which related to a greater sense of interpersonal safety and security and profound improvements in her overall satisfaction with those areas of her life related to love and work. While Ruth's changes on these measures would usually qualify her as a "treatment success" by the standards of most outcome research, both she and I considered her biggest transformation to be her finally being able to take the first tentative steps since her divorce in establishing a romantic relationship. A recent six-month follow-up not only reveals that her positive changes on outcome measures have remained or continued to improve but also that Ruth shared with some delight that her relationship with G was continuing to "grow, deepen and become even more passionate and intimate."

Nothing that feels bad is ever the last step: the neglected importance of positive affects in transforming negative affects

Gendlin (1981) once wrote, "Nothing that feels bad is ever the last step," and Diana Fosha (2004) later used this quotation as the title for her paper on the essential role of positive emotions in helping regulate and make meaningful the painful and difficult emotions our patients bring into therapy. In a similar vein, Neborsky (2003) has spoken of the importance of positive affect in STDP in helping patients "metabolize" or "digest " painful emotions. The observations of these therapists have been buttressed by an enormous amount of research in the past 10 years that suggests positive affects such as love, compassion, gratitude, forgiveness, and awe are essential for adaptive functioning and healthy relationships (see Frederickson, 1998 and Keltner, 2003, for

reviews). For example, in a manner reminiscent of Fosha's (2001) emphasis on the transformative power of positive affects, personality psychologists Tugade and Frederickson (2003) have shown that healthy individuals deal with adversity and painful emotions and "…through experiences of positive emotions, people transform becoming more creative, knowledgeable, resilient, socially integrated, and healthy individuals." (p. 321). Frederickson (1998) has also noted that traditional models of negative emotion do not apply as well to positive emotions and has proposed the broaden and build theory of positive emotions which posits that, "…under stressful conditions, negative emotions narrow one's thought action repertoire, which results in cardiovascular reactivity that prepares the body for specific action. In contrast, positive emotions broaden one's thought-action repertoire, "undoing" the bodily preparation for specific action." (Tugade and Frederickson, 2003, p. 323). The "undoing" referred involves a rapid return to cardiovascular baseline that is observed with people who are able to access positive emotions to regulate and make sense of negative emotions.

Ruth's emotional and physiological process throughout Vignette 1 could be a good example of the kind of process that Frederickson describes. Ruth accesses and processes the lingering grief and sadness in her heart but then, at the therapist's suggestion, moves into the vantage point and positive affects of energy, strength, joy, and excitement that flowed from her solar plexus down through her legs and out to connect her with others. Note that the therapist did not interpret Ruth's explicit statement that her bruised heart "needed more of that" as an attempt to avoid experiencing her grief but instead viewed this as an opportunity to access what Fosha (2000) calls the "self at best" in order to work with the "self at worst". As Ruth continues to process her felt experience on seeing her bruised heart she not only allows a deep experiential and physiological wave of grief to break through but also starts to report shifts in the quality of her feelings that are also consistent with Fosha's (2001) description of transformational, positive affects. These include tears that are a blend of happiness and sadness, explicit comments of a felt sense of sweetness and tenderness, and a sensation of partial resolution and hope. Furthermore, Ruth's spontaneous and unexpected experience of light bursting forth from her heart is a startling and powerful example of what William James (1902) called "photisms", or light-seeing phenomena, another hallmark of transformational affects (Fosha, 2001).

Note also that Ruth's ability to access positive transformational affects while staying in touch with her grief and pain help her to not only tolerate and regulate these painful feelings but to also find a positive and more hopeful meaning than she had been able to access before. This sequence of Ruth being able to access positive emotions to help regulate and "broaden" the meaning associated with her grief and the subsequent rapid return of her cardiovascular activity to baseline (a pattern evident in both Figure 1 and 2) shows a remarkable similarity to the emotional and physiological patterns that Tugade and Fredrickson (2004) have found in resilient individuals.

What is the optimal level of emotional arousal that leads to a "corrective emotional experience"?

An idea that is shared by therapists from a variety of orientations is that there is an optimal balance of emotional arousal and cognitive processing for effective psychotherapy. Gendlin (1981) terms this the "working distance", while Greenberg (2002) refers to an "optimal level of arousal", and Sigal (1999) refers to the "window of tolerance," within which "various intensities of emotional arousal can be processed without disrupting the functioning of the system" (1999, p. 253). In a similar vein, Neborsky, (2004) speaks of the STDP emphasis of working with imagery in portrayals as a means of containing affect via a "…semi-intellectualized way of working through unconscious affect and detoxifying the anxiety and guilt producing capability." The

general idea is that when arousal remains within this optimal zone, a person can integrate his emotional experience in session with more cognitive, language mediated processes into a coherent narrative. The idea of an optimal level of emotional arousal to perform particular tasks is familiar to most of us who took an introductory psychology course as the "Yerkes-Dodson Law" which hypothesized an inverse U shaped relationship between arousal and performance of complex tasks. After an optimal level of arousal has been passed performance starts to deteriorate along with a subjective shift from motivated interest to one of anxiety or feeling overwhelmed.

While such a notion has some intrinsic appeal and some empirical support in terms of the effectiveness of behavioral exposure therapies with traumatized patients who are experiencing symptoms related to excessive arousal (see Littrell, 1998 for a review), a review of Ruth's transcripts and heart rate graphs reveals that the interplay between her physiological arousal, emotional expression, and the interaction between positive and negative emotions in her experiential processing does not follow such a simple formula.

In the vignettes above there are certainly moments when Ruth "breaks down" and expressively and physiologically shows very intense levels of arousal. As noted, for short periods she is sobbing so deeply that she is unable to speak. However, as we follow her account of her experience it becomes obvious that her inability to speak during these periods does not in any way suggest that she was overwhelmed, flooded, or had been pushed beyond her "window of tolerance". On the contrary, as she continues to process what she experienced during those moments and the aftermath it becomes clear that these were moments not so much of "breaking down" as "breaking through" to a newer, more complex, compassionate, adaptive and meaningful understanding of herself and the lingering heartbreak over the breakup of her marriage and fear of experiencing such heartbreak again.

My reason for focusing on this question of the optimal intensity of emotional arousal is out of a concern that a simplistic interpretation could lead to the mistaken notion that this optimal level has static parameters that need to be maintained by interventions from the therapist. My own experience and research data shows that most patients have highs and lows of arousal and expression at various points in any one session and over the duration of therapy. In supervision with graduate students and other therapists I have noted at times that they can maintain an excessive focus on keeping the patient within a hypothetical optimal level of arousal via repeated questions, interpretations, etc. that interferes with the kind of adaptive action tendencies and non-verbal emotional processing that Ruth was able to access. While some patients certainly can become overwhelmed by re-experiencing traumatic or other primary maladaptive emotions, the things that I have found most important to attend to are the quality and depth of the emotional processing as evidenced by the emergence of a new sense of self or others and the often subtle shift towards a more positive emotional tone.

Finally I hope that this article has been helpful in introducing basic EFT principles to those in the STDP community that are not as familiar with this approach.
As stated at the start of this paper: becoming a good psychotherapist is very hard work.
As I think back to Ruth touching her heart and saying, "You will always be right here," I feel a much deeper shift within me and feel how thankful I am to have found such work. And how grateful I am to Les, Diana and Leigh for helping me hone my craft.

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