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ORIGINAL PAPER

Emotion-Focused Therapy for Generalized Anxiety Disorder: An Overview of the Model

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Abstract Generalized anxiety disorder (GAD) is a severely debilitating disorder characterized by high comorbidity and a negative impact on overall well-being. Cognitive-behavioral therapy (CBT) is the most recognized psychological treatment of GAD. Although CBT is well-established, it is also shown that not all clients benefit from it. The goal of this paper is to highlight an emerging model of working with GAD patients from the perspective of emotion-focused therapy. It is comparable to mainstream CBT theories in so far as it proposes that the client is not avoidant of emotional experience or of its processing in general, but rather, that it is specific triggers that the client is afraid of. Contrary to mainstream CBT theories, change is not facilitated through emotional habituation to difficult triggers (or emotions), but rather through the restructuring and transformation of problematic emotion schemes through a sequence of emotional processing steps. These steps include overcoming emotional avoidance, differentiation of, and staying with, core painful feelings (such as loneliness/sadness, shame, and terror/fear), articulation of the unmet needs contained in those feelings and the expression of an emotional response to those feelings/needs, typically compassion and healthy, boundary setting, protective anger. A case illustration is provided.

Keywords Emotion-focused therapy · Generalized anxiety disorder · Case conceptualization · Anxiety disorders

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Introduction

Generalized anxiety disorder (GAD) is a severely debilitating disorder characterized by excessive anxiety and worry and other symptoms such as restlessness, being easily fatigued, difficulty concentrating, irritability, muscle tension, and sleep disturbance (American Psychiatric Association 2013). Its 1-year prevalence in community samples is around 3 % and its lifetime prevalence around 5 % (Kessler et al. 2005b). It usually starts in early adulthood but can have an earlier onset (Kessler et al. 2005a). GAD also has very high co-morbidity (Carter et al. 2001) and is also associated with a high economic burden (Wittchen 2002).

A variety of psychopharmacological interventions exist that appear to be moderately effective in the treatment of GAD. They include several antidepressants (some selective serotonin re-uptake inhibitors and serotonin–norepinephrine reuptake inhibitors) and an anticonvulsant drug, pregabalin (cf. National Institute for Health and Clinical Excellence [NICE] 2011). According to NICE, cognitive-behavioral therapy (CBT) is the most widely recognized psychological treatment of GAD. CBT for GAD is well studied and is shown to be more effective than waiting list controls and somewhat more effective than non-CBT therapies, although there are very few such comparisons (Cuijpers et al. 2014; Hanrahan et al. 2013; Hunot et al. 2007; National Institute for Health and Clinical Excellence 2011).

There are several, relatively complementary, cognitive-behavioral models of GAD and its treatment (Borkovec et al. 2004; Dugas and Robichaud 2007; Mennin 2004; Newman and Llera 2011; Wells 2006) which latterly have also incorporated elements of mindfulness and acceptance of experience (Roemer and Orsillo 2014). All of these

models see worry, the central feature of GAD, as an unproductive avoidance mechanism employed by the GAD sufferer in an attempt to avoid unbearable emotional experience, but which directly contributes to the amount of anxiety (Behar et al. 2009). The models differ in their emphasis on the centrality of faulty cognitive processes (in relation to worry) or the incapability of staying with and processing emotional experience (Behar et al. 2009). Some models, in particular, emphasize the importance of working on emotional processing either, (1) through mindfulness practice and engaging in action that would be otherwise avoided (Roemer and Orsillo 2014) or, (2) through teaching emotional regulation strategies and subsequent exposure to otherwise avoided, difficult, but potentially rewarding contexts in and outside the session (Mennin et al. 2015).

CBT treatments based on those GAD models include a number of interventions, however, they also significantly vary among themselves (Behar et al. 2009). In general, various models of treatment utilize several components/interventions and a thorough case conceptualization. Most of them use psychoeducation and cognitive restructuring of beliefs around worry. Some of them also use problem solving (which might replace unproductive worrying), some monitoring and shaping of the worry process, whilst some use relaxation training and experience-focused interventions, encouraging clients to stay with their emotional experience (for useful comparison see Behar et al. 2009).

While CBT appears to be well-established, it is also shown that not all clients benefit from it (less than 50 % recover at the end of the treatment and long-term follow-up data are sparse; Hanrahan et al. 2013). A Cochrane review of psychological therapies for GAD recommends that "further studies examining non-CBT models are required to inform health care policy on the most appropriate forms of psychological therapy in treating GAD" (Hunot et al. 2007; p. 2). Research on preferences for therapies for other disorders shows that some patients prefer other psychological therapies to CBT (King et al. 2000), therefore, it may be interesting to develop other psychological treatments that could then become available to patients. The development of a new treatment for GAD may also show that this treatment may be differentially effective when compared to CBT (see example in depression; Watson et al. 2003).

The goal of this paper is to highlight an emerging model of working with GAD patients from the perspective of emotion-focused therapy (EFT). Why EFT for GAD? Firstly, EFT is well established as a treatment of depression (Greenberg and Watson 1998; Goldman et al. 2006; Watson et al. 2003), a condition that is highly comorbid with GAD. Secondly, several CBT models of GAD, mentioned above, acknowledge that difficulty in staying with, experiencing and processing emotional experience is at the core of GAD (e.g., Borkovec et al.'s model, Mennin's model, Newman's model, Roemer and Orsillo's model). Some of these CBT models incorporate interventions resembling the tasks developed in EFT. It is therefore interesting to see whether a fully-fledged, emotion-focused model can bring extra value to understanding GAD and its treatment. This paper presents the conceptualization developed by the authors in a currently running program of research into the development of EFT for GAD (Timulak et al. 2014; Note. We were aware that there was also a parallel development in the work of Watson, e.g., Watson and Goldman 2012, which we had limited knowledge of at the time of writing).

Emotion-Focused Perspective on GAD

Emotion-focused therapy (EFT; Greenberg et al. 1993), in its individual therapy form, is a well-established experiential treatment, in particular for depression (Greenberg and Watson 2006) and complex trauma (Paivio and Pascual-Leone 2010). EFT's theory of psychopathology assumes that the client is either not fully harnessing adaptive information present in their emotional experience or, experiences chronic, maladaptive, emotions that are activated through emotional memory-based schematic processing (Greenberg 2011). These chronic maladaptive emotions, and specifically, the problematic emotion schemes that lead to them, then have to be accessed in therapy and restructured (transformed) by the activation of adaptive emotional experiences (cf. Greenberg 2011). EFT presents a complex, research-informed theory of psychopathology, but also a sophisticated compendium of therapeutic strategies that aim to facilitate transformation of in-session presented emotional processing problems (Elliott et al. 2004). EFT also bases its strategies on a flexible case conceptualization (Goldman and Greenberg 2014; Timulak and Pascual-Leone 2014) that centers on the client's most painful emotions (core pain).

Our understanding of GAD, from an EFT perspective, was shaped in an ongoing research program (see for instance Timulak et al. 2014) that aims at developing EFT for GAD. Our conceptualization of the disorder is embedded in initial case observations (O'Brien et al. 2012), but also draws on the general literature on EFT (for instance EFT for anxiety, Elliott 2013; Shahar 2014). We also considered relevant CBT models and the experimental literature built in this tradition (e.g., Behar et al. 2009; Newman and Llera 2011; Roemer and Orsillo 2014). We conceptualized our understanding of GAD and subsequent treatment using a framework developed on the basis of research on emotional transformation in experiential treatment of depression (original work by Pascual-Leone and Greenberg 2007;

Pascual-Leone 2009 and in-depth case studies McNally et al. 2014) and recently, specifically for GAD (e.g., Keogh et al. 2014). The framework (see also Fig. 1) was recently presented as a tool for case conceptualization of depression, anxiety and trauma related difficulties (Timulak and Pascual-Leone 2014), here it is presented specifically for GAD.

Emotion-Focused Conceptualization of GAD Dynamic

Triggers of Emotional Pain

We propose that the triggers of problematic emotional processing in GAD are typically current situations (often

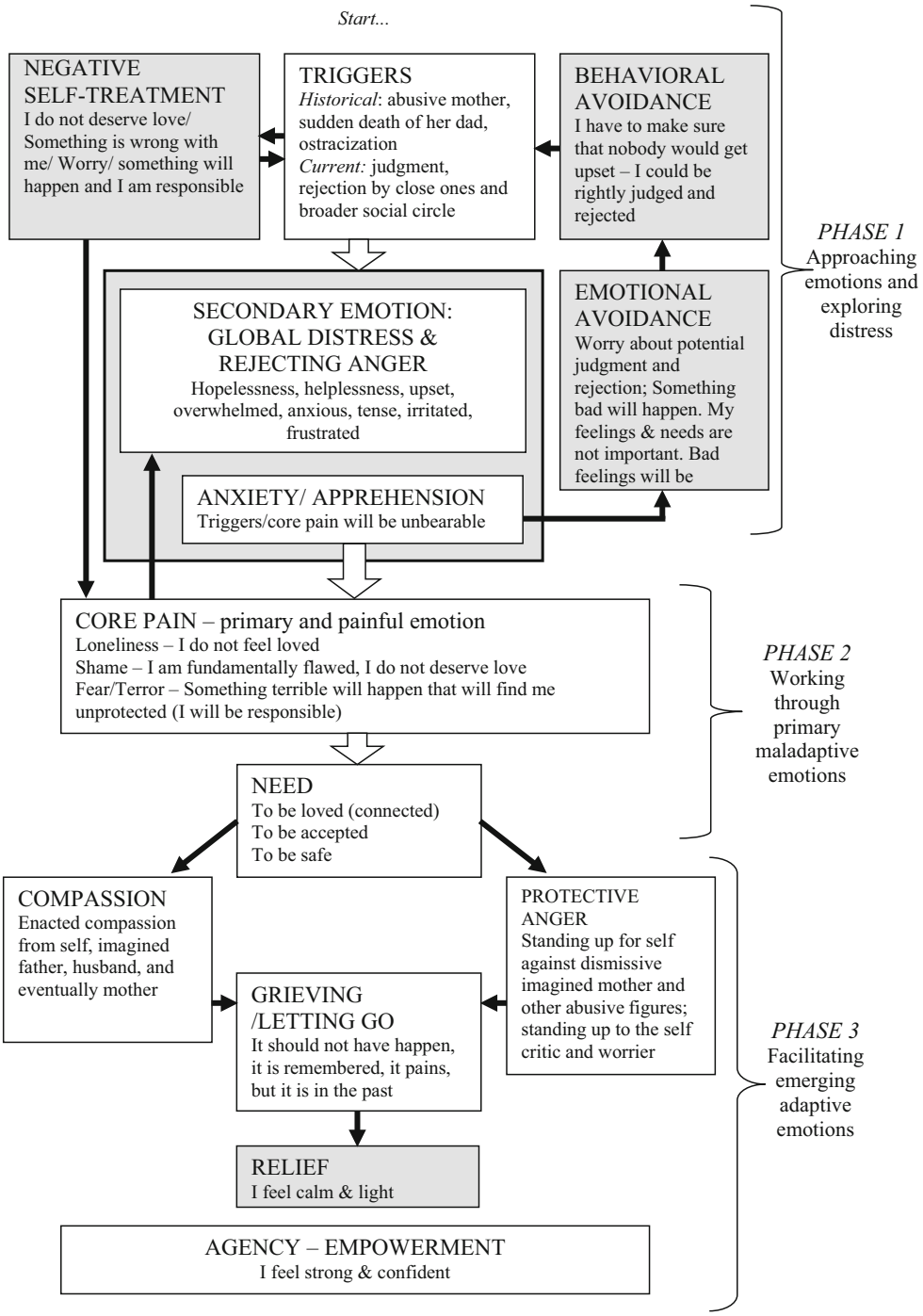

Fig. 1 Tina's case conceptualization and transformation (for similar conceptualisation see Timulak and Pascual-Leone 2014). Based on New Development for Case Conceptualization in Emotion-Focused Therapy. Ladislav Timulak and Antonio Pascual-Leone. Clinical Psychology & Psychotherapy. John Wiley and Sons, 2014

interpersonal in nature) that resemble the situations which led to developmentally significant emotional injuries that the person was not able to emotionally process, particularly in times (such as childhood) when the person did not have sufficiently strong inner resources or social support. Emotional schematic processing (Greenberg 2011) builds on memories of unsuccessful processing of difficult situations, leading to chronic maladaptive emotional experiences. Observing current triggers bringing painful emotional experiences reported by GAD patients in our project (O'Brien et al. 2012; Timulak et al. 2014), it appears that many of these triggers resemble the ones reported by clients with depression and complex trauma. They include a perception of repeated and chronic, hurtful actions by emotionally salient others such as rejection, invalidation, humiliation, blaming, omission, neglect, unavailability, etc. We have also, however observed situations of chronic lack of support that could have forced the client to assume an early, unwanted and overwhelming, sense of responsibility in their formative years (cf. Cassidy et al. 2009). Many clients reported historical experiences of a sudden nature (O'Brien et al. 2012), such as the 'sudden' (or even violent) death of a significant other (parent, sibling) or other 'sudden' traumatic experiences such as witnessing the epileptic seizures of a sibling in childhood. Some of the GAD dynamic could thus be seen as an attempt to avoid potential 'sudden' unbearable events (cf. Newman and Llera 2011), however, this hypothesis needs to be further examined.

Global Distress

Potential threats (triggers) are omnipresent for the person that does not have an inner trust that he or she will be able to process them without being overwhelmed (traumatized) by them. Furthermore, efforts to avoid the triggers or cope with them do not totally avoid the emotional pain and on the contrary, lead to exhausting anxious apprehension. GAD clients thus present with hopelessness, helplessness, tiredness, depletion, depression, constant anxiety, irritability, etc. These emotions are secondary to more primary unbearable and unprocessed core painful feelings (see below). They are typified by low differentiation of various feelings and a corresponding lack of coherent narrative and meaning (see Timulak and Pascual-Leone 2014) and an overall global sense of being distressed.

Negative Self-treatment

We observed that clients with GAD attempted to deal with distress or potential distress by controlling or preparing for the distress, and also by punishing themselves, or being negative towards the self. In the context of problematic triggers (e.g., negative judgment by others) the clients could be preparing the self (e.g., *I need to be tough.*) by beating themselves up or preventively judging the self (e.g., *I am weak.*) and in this way trying to improve their own coping or at least prepare themselves for the pain. Typically, they might make the self responsible for any potential disaster (e.g., *It is my responsibility to protect my family.*). There can be also genuine dislike and non-acceptance of self (e.g., *I am a fraud.*). On a more superficial level, it may show in the non-acceptance of GAD and other related symptoms (e.g., *I should not have an anxiety problem.*). We hypothesize (cf. Timulak and Pascual-Leone 2014) that negative self-judgment can be either an introjected criticism from significant others or a habitual treatment of the self developed in childhood as an attempt to control unresponsive or problematic other (if the child attributes the responsibility for the other's adverse treatment to the self then the child may have an illusion of control of the other's behavior—e.g., *If I behave better, mum will be more responsive.*). Although negative self-treatment may have a self-protective function (*No weakness is allowed, so you will be stronger against feared triggers.*), its punitive and often contemptuous nature exacerbates experienced distress.

Anticipatory Anxiety, Emotional and Behavioral Avoidance

Feared triggers and the emotional pain they bring are also controlled through emotional avoidance (mainly through worry in GAD) and corresponding behavioral avoidance. The fear of triggers, or of the emotional pain they bring, is a superficial fear (anticipatory anxiety) that has to be distinguished from a more primary fear (see core pain, below) that has more of a 'terror' quality (Timulak and Pascual-Leone 2014). It is the fear that we see as a main feature of anxiety disorders, however it is not the core of the experience, rather a difficulty that obstructs processing of the experience.

EFT does not see this anticipatory anxiety as being as central as it is presented in CBT approaches; neither in the understanding of GAD nor for its treatment. This anticipatory anxiety plays a role in negative self-treatment, but mainly appears in the self-interruption of experience (Greenberg et al. 1993) or, as we conceptualize it, in emotional avoidance (cf. Timulak and Pascual-Leone 2014). Worry is the most typical example of how the client engages with the triggers and manages their emotional experience by trading constant anxiety (through cognitive interaction with possible triggers) for not being shocked if the triggering situation should occur (avoidance of emotional contrast—Newman and Llera 2011). Other avoidance strategies include distraction, dismissal and minimizing of one's own experience and associated needs, but also the use of secondary emotions (e.g., running into anger rather than staying with the hurt).

Emotional avoidance, particularly in the form of worry, then leads to behavioral avoidance, i.e., the suffering person takes steps to avoid potential painful triggers by avoiding situations (e.g., avoiding taking any personal responsibility for various activities so they cannot be blamed) or controlling situations (e.g., keeping children indoors, so that no disaster can befall them). Both emotional and behavioral avoidance, as observed in CBT theories (Behar et al. 2009), contribute to omnipresent anxiety (danger is always there) and overall exhaustion, as clients not only over-prepare for, but are also constantly aware of, and focused on, the danger.

Core Emotional Pain

We hypothesize that, similarly as in other related psychological problems at the core of the GAD dynamic, there are emotion schemes centered on painful emotions that are chronic, overwhelming, excessively painful and not informing any adaptive action (primary maladaptive emotions—Greenberg 2011) and thus the client wants to avoid them. We further hypothesize (and our observations so far confirm it—cf. O'Brien et al. 2012) that these emotions are shame-based (e.g., *I am worthless.*), loneliness/sadness-based (e.g., *I feel profoundly alone, abandoned.*), and fear/terror-based (e.g., *I am terrified.*) experiences (cf. Timulak and Pascual-Leone 2014). Often the client's pain represents an idiosyncratic mixture of shame-based, loneliness/sadness-based, and terror/fear-based emotions. The emotion schemes containing these chronic painful feelings were typically built at early developmental stages in the client's life. These were emotional injuries (typically interpersonal) that the client did not have the resources to process, due to the interplay of the natural vulnerability of childhood, lack of social support and biological vulnerabilities (cf. Timulak and Pascual-Leone 2014). The core painful feelings are (in the present) activated by triggers resembling the original difficult situations. The client can be also sensitive to his or her close ones finding themselves in similar problematic situations (identification with the close ones' pain).

Unmet Needs

The experienced core pain signals that the client's needs are not fully met (Greenberg 2011). The needs corresponding with shame-based emotions include, for instance, the need to be valued, acknowledged, respected, etc. The needs corresponding with loneliness/sadness-based emotions include, for instance, the need to be loved and love, to be connected to, etc. The needs corresponding with primary terror/fear-based emotions include, for instance, the need for safety and protection, etc. The emotional pain, thus, informs the client whether his or her fundamental needs are fulfilled (for more on the unmet needs see Timulak and Pascual-Leone 2014).

Transformation of Emotional Pain—Resolving GAD Dynamic

The focus of EFT treatment for GAD is on transforming core emotional pain through generation of adaptive emotional responses to unmet needs. In particular, it is compassion (self-compassion) and protective anger that are generated. They respond to unmet needs by conveying a sense of acceptance and validation (counteracting shame), love and connection (counteracting loneliness) and an offer of protection and generation of resolve (counteracting fear). Compassion provided by the therapist, but also self-compassion generated through experiential tasks (see below) bring connection, acceptance and protection (although it also brings grieving for the hurt; see Pascual-Leone and Greenberg 2007; McNally et al. 2014), the generation of protective anger through the therapist's validation and again through the experiential tasks builds a sense of value, deserving and resolve to face the difficult triggers. The client's vulnerability, avoided and experienced in the core pain, is thus counterbalanced. Emotional flexibility and emotional resilience are being built (Pascual-Leone 2009), leaving the client more resourceful and with a sense of confidence. This leads to a decrease of the fear of triggers and emotional pain and thus also to the decrease of emotional and behavioral avoidance strategies, as well as less self-criticism and punitive self-control.

Emotion-Focused Treatment for GAD

Building Therapeutic Relationship and Safety

As in any emotion-focused therapy, the focus on the therapeutic relationship is central to EFT for GAD. The EFT therapist offers, and tries to build, a warm, caring and truly client-centered relationship. The therapist is not only a professional, but is also a very humane person that does not hide their own experience (obviously this does not take focus from working on the client's difficulties). The therapist may convey caring feelings towards the client openly (e.g., *I am moved by what you went through.*), which may be particularly evident when the client touches on the core, most vulnerable painful feelings of loneliness, shame or primary fear.

The therapist also builds the relationship through technical means. The EFT therapist provides a clear treatment rationale for therapy early on in treatment and throughout the therapy as it evolves. The therapist also openly uses case conceptualization (see Fig. 1 and the part above) and

explains to the client how anxiety may be overcome by addressing avoidance, and by increasing one's capacity to stay with painful feelings. The therapist further explains why it is important to articulate unmet needs and how painful feelings can be transformed by generating adaptive emotional experiences, which address unmet needs.

Use of Case Conceptualization

The sharing of conceptualizations is, contrary to classical humanistic therapies. Here we see it as a central and share it with the client throughout the therapy. Case conceptualization may be used as a rationale for therapy or for the use of specific treatment tasks (e.g., imaginary dialogues with the parts of the self or with emotionally salient others). It may however, be used, as in CBT, for psychoeducation. EFT psychoeducation, however, typically uses a 'hot teaching', which means that is used close to the client being engaged in experiential tasks (e.g., imaginary dialogues) that raise emotional arousal and activate the client's emotion schemes. The therapist in thinking about the in-session as well as overall therapy strategy also uses case conceptualization strategically. For instance, if the client cannot stay with painful loneliness, the therapist may think of imaginary dialogues that could help the client to access the loneliness. Similarly if the client cannot generate self-compassion, the therapist may suggest imaginary enactment in which the client reaches out to an imagined person (child) towards whom compassion would be possible (for more on that see Timulak 2015). Or, the therapist may be aware that the client has difficulty in accessing healthy, boundary-setting anger and may focus on building it over a sequence of sessions.

Overcoming Avoidance and Accessing Core Pain

While the EFT therapist always acknowledges the client's global (secondary) distress, he or she consistently focuses on the underlying pain. The therapist empathizes with hopelessness, anticipatory anxiety, tiredness, etc., but also constantly tries to address what lies underneath those secondary feelings. For instance, the therapist focuses on the feelings that preceded hopelessness and resignation (e.g., *I do not feel love and thus I experience resignation and feel that it will never change.*). With regard to the anticipatory anxiety, the therapist focuses on whatever emotional experience the client dreads the potential trigger might bring. For instance, rejection might bring shame. The therapist then focuses on the feelings the dreaded triggers might bring. The access to core (avoided) painful feelings is usually achieved through the enactment of triggers (usually interpersonal) in the chair dialogues (such as an empty chair dialogue for unfinished business—see Elliott et al. 2004; Greenberg et al. 1993) or through the enactment of self–self processes in the context of a dreaded trigger (e.g., self-criticism in the context of being responsible for something).

We learned that work on overcoming emotional avoidance has to involve explicit work on the worry process. Currently there exists a tentative model of working with worry (for empirical analysis see Rowell et al. 2014) in the form of imaginary chair dialogues, in which the client takes in one chair, the part of the Worrier and in the other, the role of the impacted Experiencer. In the Worrier chair the client is asked to enact the worry, but also to reflect on the function of the worry (e.g., to prepare the Experiencer for the potential disaster), in the Experiencer chair, the client is first led to feel the impact of the worry (usually tension, anxiety, tiredness, but sometimes also the underlying feared core painful feeling such as shame, sadness or primary fear) and then to articulate the need directed at the Worrier part of the self. The need is typically focused on being freed from the Worrier and living a freer and less restricted life. The work then continues on seeing whether the Worrier softens and is capable of being more compassionate towards the impact it leaves, or on building a resolve (protective anger) in the Experiencer to stand up to the Worrier. The work typically spans several sessions and is supplemented by awareness and consolidation homework (see Greenberg and Watson 2006), in which the client observes the worry process outside of the therapy session and tries to implement changes that he or she experienced in the session (i.e., softening of the worry or standing up to the worry).

Finally, the work on overcoming emotional avoidance may also involve work on enhancing the client's emotional regulation. Some GAD clients (particularly ones with emotional dysregulation) are particularly overwhelmed by fear, tiredness, hopelessness and helplessness. For them, particularly early on in therapy, it may be good to work on soothing the emotional experiencing explicitly. Tasks such as Clearing a Space (see Elliott et al. 2004) can be used for this purpose. In this task the client is asked to articulate the content of worry, see its experiential impact and then is instructed to put it aside in imagination. The process is repeated cyclically until all upsetting (worrying) issues are put temporarily aside. Again, clients can practice this task on their own. Sometimes (early on in therapy), the distress may be soothed also through a more superficial use of imaginary chair dialogues in which the client enacts the person that he or she nominates as capable to soothe their upset. The client then imagines the self in the Experiencer chair and as the other soothes him or her self.

Differentiating Underlying Pain and Articulating Unmet Needs

While the work on overcoming avoidance and the worry process is clearly important for clients with GAD, as with other studied conditions (e.g., depression and complex trauma), EFT for GAD focuses on working with the underlying painful maladaptive emotions which are so dreaded by the client. Through the use of empathic exploration, and particularly through the use of imaginary dialogues (with emotionally salient others or the self in the context of the dreaded trigger), the client accesses previously avoided, core painful feelings. The therapist helps the client to stay with those feelings, differentiate their nuances and eventually articulate the unmet needs they point to.

Transforming Core Pain

Once the pain is fully felt and expressed and the unmet needs articulated and expressed, the therapist guides the client to see what the response is (e.g., in the imagined other or critical self chair) to the pain and unmet needs. Highlighting of the pain and unmet needs is typically used to elicit compassion, for instance in the other or self (in the self–self dialogues) chair that observes the pain in the Experiencer chair [the Experiencer chair is the chair in which the client is invited to feel the impact of the dreaded trigger]. Highlighting the violation and mistreatment in the emotional injury situation is typically used for building a healthy and protective anger in the client's self (again usually in the imaginary dialogues in the Experiencer chair).

Once compassion is expressed, its impact needs to be felt and appreciated. The therapist invites the client to let in compassion and see what impact it has. If successful, the impact of compassion is relief, but it is also closely followed by sadness and grieving that such a caring response had not been there earlier (see Pascual-Leone and Greenberg 2007). This grieving is, however, healthy and adaptive grieving that allows the client to let go of painful experiences. Experiences of protective anger on the contrary lead to a sense of agency and empowerment that the therapist wants the client to savor and be aware of. All of these experiences, compassion, grieving, healthy anger and empowerment are very important adaptive experiences that transform chronic dreaded and avoided feelings in GAD clients.

The work on generating compassion and building assertive anger is a complex process and takes most of the main part of therapy (for the complexities of this process see Timulak 2015). Successful therapies evince a better and better quality of compassion, with protective anger being accessed more easily and for longer periods of time. The distress and injury do not disappear; however, we can see the growth of the client's emotional resilience and flexibility (Pascual-Leone 2009).

GAD Specifics

EFT for GAD is very similar to EFT for other conditions for which it was studied, such as depression or complex trauma. The main work focuses on the transformation of chronic maladaptive feelings that are at the center of problematic emotion schemes developed as a result of various emotional injuries. Transformation of chronic feelings in the therapy sessions (and consolidation work outside the sessions) thus leads to the transformation and restructuring of problematic schemes themselves. What then, are the differences between EFT for GAD in comparison to EFT for those other conditions? They could be perhaps summed up in the following: work on the worry process and other forms of avoidance has to be explicit and focused (repeatedly worked on); case conceptualization is used throughout and also as a base for 'hot' psychoeducation; the homework is used to increase the client's awareness (particularly of the avoidance and worry process) and for consolidation of in-session changes (e.g., the client is explicitly encouraged to use the in-session experiences that mobilize him or her to stand up to the worry or overcome behavioral avoidance).

Case Example

One of the authors saw the client Tina (pseudonym—some potentially identifying facts about the client are also altered), in her late forties, for sixteen sessions of emotion-focused therapy for GAD (Timulak et al. 2014; see also Keogh et al. 2014). Tina was formally diagnosed with GAD and comorbid depression using the Structured Clinical Interview Diagnosis for Axis I disorders according to DSM-IV (SCID-I; First et al. 1997). Tina had been taking Citalopram (a SSRI) prescribed by her general practitioner for 4 months prior to commencing emotion-focused therapy. She had no prior history of being in psychological therapy. She presented with high levels of anxiety, worry, overall tiredness, agitation and a sense of being down, depressed. Her initial scores on the principal measures of anxiety (GAD-7 and Generalized Anxiety Disorder Severity Scale) and depression (Beck Depression Inventory) at the beginning of EFT were in clinical range and dropped to non-clinical range post-treatment and stayed as such at 6 months follow-up.

Triggers

The client referred to several historical as well as current triggers that brought her distress. The historical triggers included the early, sudden death of her father. The client was just under 6 years old when her father died and she recalled seeing the body. She then stayed with her mother and later on, with a stepdad. The relationship with the mother was, however, very difficult. The mother constantly criticized her and was very contemptuous of her. This left Tina isolated and doubting herself (she was also ostracized by her peers and therefore withdrew from interactions with them). It was very difficult for Tina to find any coherent reasons for why her mother behaved like this; however, she knew her mother was quite unhappy in her life. Two years before therapy started her mother died, which brought further distress as it left Tina with the sense that their relationship never improved and the problem had not resolved. Some of the current triggers that contributed to Tina's problems were conflicts with her teenage children as well as her husband's difficult job situation. Tina was working (in a caring profession), but was quite stressed at work and afraid of criticism from her superiors.

Negative Self-treatment

In the context of past triggers (such as mum's constant criticism) or current potential conflict, Tina chastised herself for deserving that criticism. She had a sense that there was something fundamentally wrong with her and that she did not deserve any love. She was exceptionally self-contemptuous, calling herself *weirdo, weak, stupid,* etc. It appeared to be language her mother had used with her when she was growing up. She also pushed herself to cover all angles so that she was not criticized, thus never gave herself any break. She also criticized herself if she got emotional (*I should be strong, I should not be depressed, I have no right to feel tired.*). She was aware of how she over-did everything due to her anticipatory anxiety and criticized herself for that as well (*I am a control freak.*).

Global Distress (Secondary Emotions)

Tina reported various signs of global distress, in the sessions as well as during the week. She felt down and low most of the time. She was very anxious, apprehensive of criticism coming either from her husband, children, neighbors, or colleagues/superiors at work. She was constantly overdoing things (e.g., constantly cleaning the house). Although she did not sleep well she did not allow herself any break. In the early sessions of therapy she reported feeling upset and tearful without any clear reason. Although she mainly presented as anxious and depressed, in certain contexts (her children and husband) she could come across as irritable and angry.

Anticipatory Anxiety and Emotional/Behavioral Avoidance

As mentioned above Tina was constantly apprehensive of triggers that could bring painful emotions. She dreaded triggers that would bring criticism similar to that which she had received from her mother when she was growing up. She was afraid that she would be put down. She dreaded experiencing shame, as it was unbearable, she was afraid of any sudden trauma and loss (see the death of her father), and she also dreaded her feelings of loneliness. This led her to keep busy, overdo and avoid any potential criticism (behavioral avoidance). She avoided dreaded feelings by worrying and mentally running from the experience. Emotional avoidance in the sessions showed in the form of her changing the topic or trying to dampen the arousal by distraction.

Core Emotional Pain

Underneath the secondary distress and anticipatory anxiety Tina eventually (as therapy progressed it was easier and easier for her), revealed the dreaded primary feelings. These were particularly feelings of shame. She felt *worthless*, unworthy of love. She also felt very empty, isolated and lonely despite having a good relationship with her husband. She had a sense that *nobody can reach her*. She chronically longed for a relationship with a caring other (she almost did not remember the dad who was so caring in her memories and always longed for her mother to be close to her). She also dreaded sudden trauma such as the trauma (terror/primary fear) she experienced when her father died. She was afraid that something could happen to her close ones (e.g., difficult job situation of her husband).

Unmet Needs

Tina's chronic sense of shame clearly pointed at the unmet need of being accepted, acknowledged, and recognized (*I need to get a bit of praise I suppose.*). Her chronic sadness and loneliness pointed at a strong longing for connection and love (*I so much want to be loved.*). Finally her primary fear and terror in the face of any sudden difficult and/or traumatic event pointed at her unmet needs of security, protection and stability.

Transforming Core Emotional Pain and Apprehensive Anxiety

The therapist (one of the authors) used the conceptualization described above in forming his strategy for individual sessions as well as overall therapy, although sessions took a typically experiential form, i.e., the therapist invited the client to bring an issue they could focus on in the session. The therapist, from the first minutes of therapy, worked on building a strong therapeutic relationship, through the provision of a validating and warm, caring presence that mainly showed in the form of empathic exploration and communication of empathic understanding. Tina at this point primarily showed global distress comprising hopelessness, helplessness, anxiety and irritable anger.

Core painful feelings of worthlessness, loneliness, and primary fear were accessed repeatedly from session 3 onwards, mainly through the use of experiential tasks (Elliott et al. 2004; Greenberg et al. 1993) such as self-critic (self–self) dialogue and unfinished business (self-other) dialogue. In self–self dialogues, Tina was invited to enact omnipresent self-contempt and to see and feel the impact it had on her (sense of shame, worthlessness). In self-other dialogues Tina mainly enacted her criticizing and rejecting mother (as she remembered her), which in the Experiencer chair (the chair in EFT in which the client expresses the feelings towards the imagined other) brought feelings of rejection, loneliness and fear. Early on Tina also had an imaginary dialogue with her father, in which she felt and expressed a loss, of not having him around in her life. Some of the dialogues also involved children, husband and colleagues at work. In these, the enacted imagined others (early on) in the dialogues were typically critical and unhappy with Tina (Tina enacted the others in the form of the feared triggers they represented).

As Tina initially accessed primary painful emotions her emotional avoidance typically strengthened. The therapist redirected her distractions and avoidance of painful topics, by gently focusing on the edges of what was most painful or missing for her. A lot of avoidance showed in the form of worry. In such cases the therapist focused on the worry in so-called worry dialogues (there were four of them for Tina) during the course of therapy. In the worry dialogues, Tina was asked to enact the Worrier (worry agent) part of the self in one chair and see the impact of the Worrier on the self (sat in the Experiencer chair). The worries enacted by the Worrier brought tiredness, pressure and anxiety and occasionally, through the therapist's facilitation, a more primary sense of vulnerability, more primary fear, loneliness (*I am on my own to cope with it all.*) as worrying about the triggers made them more real. The therapist then focused on the unmet need in this impacted self, which was hope for freer living, having a break from worry and engagement in the activities that Tina liked. As the dialogues progressed (within and across the sessions), Tina was able to stand up to the Worrier (*I need and will have a break from you.*). She also expressed to the Worrier that she is no longer afraid of the triggers that were so scary before (*I'm not afraid. I'm not… You know? I'm actually not afraid of some confrontation now.*). Tina in the Worrier seat also softened and admitted that it was painful to see such a tired, anxious and vulnerable self. She also admitted vulnerability in the Worrier self (*Nobody likes me when I am a control freak.*), which brought a reciprocal compassion from the Experiencer chair (*I will keep my boundary with you, but it does not mean I do not care about you.*).

The fact that Tina was increasingly able to access and stay with core painful feelings and overcome avoidance, meant that she was (with the help of the therapist) ever more clear and articulate about her unmet needs. She needed acceptance, protection and care. These needs were poignantly responded to in the dialogues by an enactment of compassion. Tina enacted compassion in the form of her imaginary husband caring for her, in the form of her adult self caring for her younger self (*I love you. Little girl I want to hug you. Make you happy.*) and eventually in the form of her imaginary mother softening (*I know I was wrong to you in a lot of ways but you know I love you really don't you.*) followed by Tina forgiving her (*I can forgive you, of course I can.*).

Expressions of compassion that were let in by Tina were typically followed by expressions of grieving as in the case of a dialogue with her imagined dad who, enacted by Tina, expressed that he wanted to be there for her for longer in her life so he could offer her support and care. In response to which Tina said (to imagined dad): *I can even remember you when I was very, very small. I can remember you.*

Tina also transformed her pain through accessing her protective anger, such that it supported her need for approval, connection and safety. In the imaginary dialogues, she not only stood up to her Worrier (see above), but also to her Critic (*I am thinking to myself, I am worth it.*) and, in the middle of therapy, also to her mother (*I won't allow you to hurt me anymore.*). These experiences and expressions of healthy, protective and assertive anger led to her overall sense of empowerment and agency.

By the end of therapy, as expressed in the post-therapy research interview and pre-post measures, Tina's anxiety and depression significantly lowered (*I've noticed that I'm not flying off the handle. Em, I'm handling situations better.*). Her relationship with her close ones improved as well (*I've eased off and life's better because of it. I'm not as controlling now.*). She started to feel more confident and relaxed at work (*I don't feel that I'm worthless. I feel that I'm worth something now.*). She also allowed herself to have more breaks and to take things more easily at home (*I*

understand that I don't have to have the perfect… clean house every day.). With regard to the therapy process, Tina particularly valued her relationship with the therapist whom she found *very, very calming* and the actual chair-work *talking about things from an early age and reliving all that stuff… It's sort of unknotted all the tensions in me…* [experiences] *that it actually isn't your fault and that you are worth this.*

Conclusion

We presented here an emotion-focused model of working with GAD. While this model shares many attributes with the existing cognitive-behavioral models (Behar et al. 2009) such as seeing the GAD dynamic (particularly worry, but also behavioral avoidance) as an effort to avoid difficult emotions, it adds that the avoided emotions are chronically difficult emotions embedded in idiosyncratic emotion-schemes developed over the course of the client's personal history. The main differences are then particularly seen in the actual therapeutic work. CBT models (Behar et al. 2009; Newman et al. 2013) (1) use collaboration and psychoeducation to help the client to engage in therapy and get an insight into GAD dynamic, (2) address anxiety through teaching of the coping skills such as relaxation, (3) address worry through monitoring and shaping the worry process so it is more benign and (4) address the avoided dreaded emotions through exposure and theorizes a subsequent habituation. The EFT model, on the other hand, builds (1) soothing relationship, (2) overcomes avoidance (worry) through experiential tasks that highlight the cost of the worry and the obstruction of the needs, which leads to the resolve to fight the worry, and (3) transforms chronic dreaded painful feelings (sadness/loneliness, shame, and primary fear/terror) through experiential tasks that respond to the chronic emotional pain and unmet needs in it through compassion and protective anger and thus restructure problematic emotion schemes. Psychoeducation is less central in the EFT model, but may play a role in consolidating emotional transformation or in the development of tasks agreement in therapy. The EFT model presented here is thus compatible with CBT models, however, it focuses more on the transformation of the underlying chronic painful feelings than just overcoming chronic (but more secondary) apprehensive anxiety that leads to worry and other forms of emotional and behavioral avoidance. The EFT work on the underlying painful emotions is thus similar to well-established EFT work with depression (Greenberg and Watson 2006) and complex trauma (Paivio and Pascual-Leone 2010).

Despite the long history of psychodynamic conceptualizations of anxiety there is less empirical work done on the effectiveness of psychodynamic therapies for GAD (although there are now a few outcome studies; e.g., Crits-Christoph et al. 2005). If we compare our conceptualization of the EFT work with GAD to psychodynamic conceptualizations (Crits-Christoph et al. 2004), we can see some similarities. We share the perspective that most of the dreaded triggers in clients with GAD are of an interpersonal nature and these are colored by idiosyncratic personal histories. We also see anxiety as more secondary to more dreaded feelings and we also recognize the centrality of the unmet needs (wishes in psychodynamic terminology). The main differences can be seen in the theories of change. While psychodynamic theories put a lot of emphasis on self-understanding and corrective experiences in the therapeutic relationship, we focus on emotion transformation, i.e., activation of the aroused affect, focus on the primary painful feelings and in particular generation of adaptive experiences (compassion, protective anger) in the client. We see insight/understanding as important, but rather, playing a role in the consolidation of transformative experiences.

We presented here, an EFT model for working with GAD, which is currently in development. The model is currently being tested in an open trial (Timulak et al. 2014), and the first, very promising, results have been presented at conferences. There have been several calls in the literature for the development and study of therapies other than CBT for treatment of GAD (e.g., Hunot et al. 2007) and recognition of the need for further development of well-established (CBT) therapies (Newman et al. 2013). Although there have been preliminary attempts to use interventions, perhaps inspired by EFT (Newman et al. 2008), these were not done by EFT theorists and were used only as add-ons to CBT. We, therefore, attempted here to provide an EFT perspective, based on our experiences with the currently running treatment development program.

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