A CRITICAL REVIEW
OF
EMOTIONALLY FOCUSED TREATMENT
FOR DEPRESSION
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Emotionally Focused Therapy for working with individuals and couples has developed out of the research and classification of emotions (Greenberg & Safran, 1987; Greenberg & Johnson, 1988; Safran & Greenberg, 1991; Greenberg & Paivio, 1997; Greenberg, Watson & Lietaer, 1998; Johnson, 2002; Greenberg & Watson, 2006). More recently, a treatment guide to depression using the Emotionally Focused approach has been published that explores the nature of depression, the role of emotions, and a manualised treatment schedule (Greenberg et al., 2006; Greenberg, 2006).

This review begins by exploring Emotionally Focused therapy, its traditions and assumptions underlying the treatment of depression, before outlining the manualised treatment schedule. The critical appraisal involves considering the approach and its limitations by reviewing the research findings that explore aspects of the approach as well as the research outcomes that compare the approach with other evidenced-based treatments.

Traditions and assumptions

The Emotionally Focused approach comes under the banner of the emotion-focused therapies, an integrative label for a variety of approaches that focus on emotion (Elliott, Watson, Goldman & Greenberg, 2004, p.25). Other approaches listed under the emotion-focused group are some psychodynamic therapies (Fosha, 2000; McCullough, 1991), some cognitive behaviour therapies (Linehan, 1993; Foa &
Kozak, 1986), and the experiential/humanistic work of the process-experiential approach (Greenberg, Rice, & Elliott, 1993) and emotionally focused work (Greenberg, 2002).

Emotionally Focused Therapy is an approach that deals with clients’ emotional experiences, their feelings towards the environment, including others, as well as their feelings towards themselves. In addition, the approach has a dialectical constructivist orientation whereby the processing of individuals’ emotional experiences is understood to be influenced by the interactional effect of many variables such as environmental, contextual, familial, relationship and personality factors (Greenberg et al., 2006, p.37).

Emotionally Focused therapy has its origins in experiential therapy, mainly Client-Centered therapy (Rogers, 1951) and Gestalt therapy (Perls, 1976; Greenberg et al., 1998). More recently there has been some acknowledgement of the influences of structural family therapy (Minuchin & Fishman 1981), narrative therapy (White & Epstein, 1990) and psychodynamic approaches particularly relating to attachment theory (Johnson, 2002).

Underpinning the basis of Emotionally Focused work are the assumptions about emotion and how emotion influences individuals and effects interactions in relationships (Greenberg & Johnson, 1986, 1988; Greenberg et al., 1987, 1997). Emotional experiences were initially classified into four discrete categories: primary, secondary, instrumental and maladaptive emotions (Greenberg et al., 1987). Later elaborations of these classifications became more complex with the categories of primary, secondary and instrumental emotions being further divided into adaptive-
maladaptive or maladaptive–other, as well as types, with primary emotions being divided into discrete emotions, feelings and bodily sense, and emotional pain; primary maladaptive emotions classified as bad and complex; while instrumental became classified as dysfunctional and other. (Greenberg, 2002; Greenberg et al., 1997, p.36-37).

In Emotionally Focused work, depression, defined as a complex biosocial phenomenon, is an experience that varies from individual to individual (Greenberg et al., 1998, p.228; 2006. P.4). Depression is regarded as a reaction to sadness, despair and a sense of loss, failure or inadequacy (Johnson & Greenberg, 1994). The determinants of depression are varied, ranging from loss, self-criticism, experienced meaninglessness, role disruptions, trauma and prior abuse, to isolation or powerlessness (Greenberg et al., 1998, p.229).

Depression is classified as secondary emotional experience; a reactive experience when primary adaptive experiences are denied or avoided. Depression is viewed as being the result of incomplete processing of emotional experiences (Pos, Greenberg, Goldman & Korman, 2003). Depression is the organismic response to the perceived futility of effort in a situation (Greenberg et al., 1987, p.186), and results in the narrowing of experience (Elliott et al., 2004, p.289). Central to depression is the evaluative or meaning component about the situation, self and other. The emotion schemes, defined as integrated affective-behavioral-cognitive structures that form the foundation of the self, are generally negative in depression, constellated around a weak or bad sense of self (Greenberg et al., 2006, p.49). Consequently, individuals experience depression when they feel disempowered and lose their ability to act
effectively on their own behalf, or organize their experience in a hopeful and active manner (Greenberg et al., 1998, p.230).

**Manualised treatment schedule**

Emotionally Focused Therapy has developed a manualised treatment for moderate depression for the individuals functioning at a day-to-day level, where neither the severity of disturbance nor the fragmentation of self is too great so that accessing and experiencing painful emotional experiences can be tolerated (Greenberg et al., 1998, p.228; 2006, p.9; Elliott et al., 2004, p.296).

The goals of Emotionally Focused work are articulated as the integration of affective experience into a person's existing organisation of their experience (Greenberg et al., 1997, p4). Emotional processing is regarded as the important therapeutic task, goal and change process (Pos et al., 2003). The goal of treatment for depression is “to restore spontaneity of the self”s ability to function and to access and support the existing resources of the personality” (Greenberg et al., 2006, p.44). Change is achieved with emotional processing, whereby individuals become aware of their emotional experience, by focusing on, then deepening their emotional experience, before symbolizing or putting into words their experience and then finding adaptive action (Greenberg et al., 1997, 2006).

Whereas therapy from the behavioral tradition views depression as an outcome of interpersonal skill deficit and employs techniques such as pleasant event scheduling, skills training and assertion training, interpersonal psychotherapy focuses on current interpersonal problems and explores new strategies to handle difficulties, and cognitively oriented approaches focus on the role of dysfunctional cognitive processes
and work to modify faulty thinking (Frank, 1991; Safran et al., 1991; Blanco, Lipsitz & Caligor, 2001). Emotionally Focused approaches view emotion as being the fundamental aspect of depression and so targets emotion and emotion schemes. The aim of Emotionally Focused therapy is to facilitate clients’ emotional processing of experiences with a particular focus on the vulnerability of the disempowered self (Elliott et al., 2004, p.292).

In Emotionally Focused work, the two main principles in the treatment of depression are the promotion of therapeutic work aimed at emotional processing and experiencing, and the establishment and maintenance of the therapeutic relationship (Greenberg et al., 1997, p.84; 1998, p.234). With the therapeutic work aimed at emotional processing and experiencing, the general process steps involve entering and tracking the client’s depressive experiencing, expressing empathy, caring and presence, facilitating task collaboration, promoting emotional awareness and regulation, facilitating tasks to address treatment of self, and fostering self-development (Elliott et al., 2004, p.292-294).

While there are a number of key therapeutic tasks for the treatment of depression: empathic exploration of the sources of depression, focusing for overly conceptual or blocked experiencing, two chair work for depressive splits, empty chair work for unfinished interpersonal issues, and other common tasks (Elliott et al., 2004, p294-296), three have mainly been employed. These are evocative unfolding for problematic reactions, two-chair dialogue for self-evaluative and self-interruptive conflicts splits, and empty chair dialogue for unfinished business (Goldman, Greenberg, Pos, 2005; Elliott et al., 2004).
Three types of schematic processing problems are targeted in these therapeutic tasks: intrapersonal conflict of a self-critical nature; the evocation of emotional memories that the person is unable to fully process and express, such as unresolved grief or dependence issues; and emotional or behavioural reactions that the client finds problematic as a result of the activation of schemas that may not be adequately differentiated (Greenberg et al., 1993; Watson & Greenberg, 1996). Verbal and non-verbal markers in the clients’ dialogues are used to assess the nature of the emotional processing difficulty, and used as a starting point to intervene in resolving these difficulties (Watson et al., 1996; Greenberg et al., 2006, p.104).

With evocative unfolding of emotional experience, unfinished emotional processing is targeted and completed in order for the emotions to be experienced and expressed, for new adaptive emotions to emerge, and for the integration of a new affective-cognitive sequence following the arousal of the self-schemes that can be articulated and modified (Greenberg & Safran, 1984 cited in Greenberg et al. 2006, p.207). In contrast to incomplete emotional processing, denied or disowned aspects of self-experience are accessed using two-chair dialogue for self-evaluative and self-interruptive conflicts splits. In the two-chair dialogue self-criticism and self-contempt is targeted by evoking both the self-criticisms and the negative emotional reactions that are activated. By staying with the emotional experiences of hopelessness or helplessness, therapists can encourage the emergence of the primary experience or foster any emerging comments that indicate protest, agency or strength as a pathway towards articulating needs as a way of strengthening the self (Greenberg et al., 2006, p.226).
Finally, treatments using empty-chair dialogue or two-chair enactments deal with self-interruptive splits or unfinished business. Enactments between the experiencing and the self-interruptive aspects, such as helplessness, resignation, and feeling trapped, facilitate awareness, provide an emotional experience and an opportunity for fears to emerge and be dealt with, and for agency to emerge to allow the continuation of the interrupted emotional experience (Greenberg et al., 2006, p.254). Similarly with unfinished business, treatment using two-chair enactments allows unresolved loss and negative emotional reactions such as humiliation and shame as a result of difficult interpersonal interactions to be expressed and dealt with (Greenberg et al., 2006, p.254).

**Critical Appraisal**

Depression is neither a monolithic experience nor a single entity (Parker, 2004, p.xiv). The symptoms and reasons for depression vary widely from individual to individual. Depression is classified under mood disorders in the DSM-IV as the second sub-category and is distinguished from mood episodes and bipolar disorders (APA, 1994). Within the depressive disorders there are a further three sub-categories: major depressive disorder; dysthmic disorder; and depressive disorder not otherwise specified. A major depressive disorder needs to be distinguished from other problems such as mood disorders due to a general medical condition; adjustment disorders with depressed mood; bereavement; and periods of sadness (APA, 1994). The Black Dog Institute distinguishes three types of depressive disorders: non-melancholic depression; melancholic; and psychotic depression as well as distinguishing between unipolar and bipolar depression (Parker, 2004, p.17).
The current research and treatment of depression tends to view depression as a single entity and uses level of severity of depression as a distinguishing feature (Parker, 2004). Based on the number of symptoms and the level of functional impairment, depression can be classified as mild, moderate or severe (WHO, 2004, p.147). Emotionally Focused treatment for depression specifies suitability for cases of moderate depression where day-to-day functioning is not impaired (Greenberg et al., 2006). This description of depression appears to be at odds with the definition of moderate depression that is generally distinguished from mild depression by having six or seven symptoms as compared to four or five in mild depression, and eight to ten in severe depression (WHO, 2004, p.147). In addition, moderate depression is generally characterised by significant difficulty in completing work and domestic activities (WHO, 2004, p.147; PDM Task Force, 2006, p110).

Further, the manualised treatment schedule does not include application and discussion of psychological testing for depression, the need for and the interaction effect of medication on treatment, psycho-education about depression, or how to manage symptom behaviour in the early phases of treatment. Between session management of symptoms can include behavioural strategies of self-care, exercise, emotional support, encouragement of authentic relationships; emotional strategies of emotion regulation by breathing, journaling, and developing sensate awareness; and cognitive strategies of self-talk, reframing experience, noticing and challenging thinking, and thought-stopping (Barr, 2007).

Research into the efficacy of treatment has revealed that results comparing a number of approaches including the Emotionally Focused treatment of depression are similar. In addition to research exploring the depth of experiencing, pathways of change and
empowerment events in the treatment of depression (Missirlian, Toukmanian, Warwar & Greenberg, 2005; Pos et al., 2003; Watson et al., 1996; Timulak & Elliott, 2003), Emotionally Focused treatment and the therapeutic alliance has been compared to cognitive-behavioral psychotherapy and client-centered therapy (Pos et al., 2003; Watson, Gordon, Stermac, Kalogerakos, Steckley, 2003; Greenberg et al., 1998; Goldman, Greenberg, Angus, 2006; Watson & Geller, 2005). A comparison of cognitive-behavioral psychotherapy and Emotionally Focused therapy showed both to be efficacious with no difference between the two types of therapy. With respect to therapeutic alliance, while there were differences in ratings of positive regard in favour of Emotionally Focused therapy, there were no differences in empathy, unconditional acceptance and congruence between the therapies.

Similarly, comparisons between Emotionally Focused and client-centered therapies revealed that there were no differences in reducing symptomology at both termination and a six month follow-up. Although the Emotionally Focused group had superior effects mid-treatment this advantage was not sustained. These results mirror other research comparing cognitive-behavioral and interpersonal therapies (Roth & Fonagy, 1996). Research using couples reveals comorbidity with relationship problems, and that thirty percent of couples report clinically significant levels of depression, stress and anxiety (Carmady, Knowles & Bickerdike, 2006), and that couple work can significantly reduce depression symptoms (Johnson & Greenman, 2006; Dessaulles, Johnson & Denton, 2003).

The results have consistently shown that client-centered, interpersonal psychotherapy, cognitive-behaviour therapy, and Emotionally Focused therapy have efficacy of treatment without significant differences. A number of possible explanations have
been offered: therapist and researcher bias (Greenberg et al., 1998; Goldman et al., 2006); small number of client subjects (Pos et al., 2003; Greenberg et al., 2006); self report measures being used (Greenberg et al., 1998; Missirlian et al., 2005); and the capacity of subject clients to engage in emotional processing (Pos et al., 2003; Missirlian et al., 2005).

In addition to questioning whether there is merit in developing a specific manualised treatment when there is great heterogeneity in the depressed clinical population (Greenberg et al., 1998), there is also the matter of equivalence of treatments (Stiles, Shapiro & Elliott, 1986; Greenberg et al., 1998). Three different meanings suggested for the problem of similar outcomes in therapy research can be applied to the research in depression: whether the treatment yields from the approaches are indistinguishable from others, whether the subject behaviour in-session is similar, or whether the different treatments employ similar principles for psychological change (Stiles et al., 1986). The recommendations for more sophisticated and fine-grained research at a process level as well as examining the interacting matrix of therapist-researcher-subject influences can be applied to the future research in Emotionally Focused treatment for depression. For example, a recent study investigating the treatment of depression by comparing interpersonal and cognitive-behaviour therapy, with attachment styles as a moderator of treatment outcomes, showed that individuals with an avoidant attachment style did better with cognitive behaviour therapy (McBride, Atkinson, Quilty & Bagby, 2006).

Emotionally Focused treatment for depression involves working with incomplete emotional processing and this requires an ability to be able to work with painful experiences and to benefit from the experiencing and reflection. With the
acknowledgement that depression involves emotion schemes of the weak/bad sense of self, some treatments may need to be adjusted for clients whose emotion schemes are unable to be modified during short-term therapy. It is the author’s clinical experience that the treatment of depression often requires medium and long-term treatment that involves a more sustained psychotherapeutic experience (Lewis, Amini & Lannon, 2000) in order to access and transform deeply embedded self-experience.

In summary, Emotionally Focused treatment for depression is an evidenced-based, short-term approach that is a viable alternative to other manualised therapies for depression. The treatment involves emotional processing and experiencing. The efficacy of treatment is comparable to a number of other manualised approaches in reducing symptoms at termination and at follow-up as well as similar results in the ratings of the therapists’ alliances. However, there are some limitations to the approach. The manualised treatment for depression is only recommended for moderately depressed individuals, and has not provided detailed discussion about the application of psychological testing and medication, and the provision of psycho-education about depression or the management of symptom behaviour in the early phases of treatment.

References


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