Single-Case Investigation of an Emotion-Focused Therapy Group for Anxiety and Depression

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Abstract:

Emotion-focused therapy (EFT) is an evidence-based treatment for depression and trauma and has shown promise for other presentations including anxiety. Minimal research exists investigating the outcomes of emotion-focused therapy in a group setting. The current research presents a mixed-method single-case study of one client's experiences and outcomes following a nine-week EFT group for depression and anxiety. Weekly measures of session-feelings evaluations were collected. Follow-up measures, including a qualitative interview, were administered one year post-treatment. Pre-, post-, and follow-up measures assessed depression, anxiety, and emotional regulation. Results showed clinically significant improvements in anxiety, depression, and emotional regulation over time. Indirect and direct evidence of client change were detected. Five super-ordinate themes with sub-themes emerged from the qualitative analysis.

Key Words: emotion-focused therapy, group therapy, single-case, anxiety, depression

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Individual emotion-focused therapy (EFT; also referred to as process-experiential therapy; Elliott, Watson, Goldman, & Greenberg, 2004) has been identified as an evidence-based treatment for depression (American Psychological Association [APA], division 12; Angus, Goldman, & Mergenthaler, 2008; Greenberg & Watson, 1998; Greenberg & Watson, 2006) and trauma (APA, division 56; Courtois & Ford, 2009; Greenberg, 2010; Paivio & Nieuwenhuis, 2001; Paivio & Greenberg, 2001), and has shown promise for the treatment of eating disorders (Dolhanty & Greenberg, 2007; Greenberg, 2010), interpersonal problems (Greenberg, 2010; Pascual-Leone & Greenberg, 2007;

Pos & Greenberg, 2012), and anxiety disorders (Cisler, Olatunji, Feldner, & Forsyth, 2010; Greenberg, 2010; MacLeod, Elliott, & Rodgers, 2011; Pascual-Leone & Greenberg, 2007).

Traditional EFT provides a client-centred relational framework and integrates emotion-focused and gestalt techniques to resolve affective-cognitive problems in therapy. Evidenced in affective neuroscience (Damasio, 1994; LeDoux, 1996), EFT recognizes the adaptive function of emotion (as an alert system to situations important to one's deep concerns and as a preparatory system to take action toward meeting one's needs; Greenberg, 2011; Greenberg & Warwar, 2009) as well as the potential for learning and formation of new neural organizations called emotion schemes. Such emotion schemes are automatic and often out-of-awareness, yet hold tremendous influence over an individual's emotional processing (Greenberg, 2010, Greenberg, 2011, Greenberg, Rice, & Elliott, 1993). In depression, for example, common emotional schemes involve core shame-based worthlessness, secondary hopelessness, "anxious dependence, powerlessness, abandonment, and/or invalidation" (Angus et al., 2008, p. 630, Johnson, & Denton, 2002; Dessaulles, Johnson, & Denton, 2003; Greenberg, 2010; Greenberg & Watson, 2006; Greenberg, Watson, & Goldman, 1998; Greenberg & Pascual-Leone, 2006, Pascual-Leone, 2009; Paivio & Pascual-Leone, 2010; Sicoli, 2006).

EFT does not attempt to extinguish or regulate problematic emotions explicitly. Rather, problematic emotions are seen as the source of the habitual maladaptive emotion scheme (Greenberg, et al., 1998) and thus need to be processed (accessed, symbolized, and made meaning of) in order to be transformed into an adaptive emotion (Greenberg & Safran, 1987; Pos & Greenberg, 2007). Specific interventions are used, such as the two-chair dialogue when the client demonstrates a self-evaluative conflict; the empty-chair dialogue for unfinished business with a significant other and the two-chair enactment for a self-interruptive split wherein one part of the client's self interrupts or constricts emotional experience and expression (Elliot et al., 2004; Greenberg, 2008; Greenberg, 2010; Greenberg, 2011; Greenberg & Watson, 2006; Pos & Greenberg, 2007).

To date, minimal research exists that examines EFT delivered in a group-based context (Pascual-Leone, Beirman, Arnold, & Stasiak, 2011). In addition to the obvious financial benefits, group therapy adds elemental factors to the therapeutic environment that are not found in individual therapies (Dugas, Ladouceur, Léger, Freeston, Langolis, Provencher, & Boisvert 2003; Fehr, 2012; Guttmacher, & Birk, 1971; Tiuraniiemi & Karhola, 2009; Scott, 2011; Yalom & Lesczc, 2005). As such, as part of a larger study the current research seeks to explore group-based EFT for anxiety and/or depression through the experiences and outcomes of a single participant.

METHODOLOGY

The case of Sally

The client, Sally (pseudonym) reported a family history of depression as well as a *"hard life growing up."* Sally has a post-secondary education. She is a middle-aged single mother and grandmother who loves her family deeply. Over the years Sally lost significant figures in her life, ended an abusive relationship, and went through a divorce. At the time of the group, she reported having struggled with depression for 14 years after a physical trauma that significantly affected her physical mobility and left her without employment. Sally reported that in the years prior to the EFT group, she had become increasingly depressed and she *"wanted to die"*, although she would not take her own life in order to protect her family - *"they were the only thing that I lived for"*. Prior to the group Sally did not handle her emotions well and described coping by *"becoming a hermit"*, staying indoors, playing computer games and sleeping all of the time (e.g. *"some days I would sleep for 24 hours"*) in order to *"forget everything and make the day go by"*. She stated that she had *"no self-confidence"*, ate poorly, felt sorry for herself, and *"[cried] all of the time"*. She also described an urge to be in control of everything, exhibited perfectionist traits and harsh self-criticism. Six months prior to the group, Sally was admitted to a hospital for severe depression. There, Sally participated in transitional group therapy focused on *"adjust[ment] from the hospital to[the] home*". Once discharged, Sally was in a second therapy group, which "*wasn't as much is therapy as it was, teaching you to speak effectively*". Despite the group therapies, prior to the EFT group, Sally stated that she had no sense of her own emotional needs and craved more self-work. When she received the phone call asking if she would like to participate in the EFT group, she immediately agreed. During the time of the EFT group, Sally was taking anti-depressant medications and was in regular contact with a psychiatrist for the monitoring of her medication. She was not engaged in any other therapies during the course of the group.

Recruitment

Sally was one of ten participants recruited through a wait-list from a regional hospital's outpatient service in Ontario, Canada to participate in the study. Eight participants agreed to participate. Exclusion criteria included documented personality disorder diagnosis, active suicidality, and/or substance abuse. Ethics approval was obtained from the appropriate institutions.

Group & Follow-up

Nine two-hour weekly EFT group sessions were held. The first session was conducted individually and involved pre-measures and psycho-education about emotion (i.e. the nature of emotion, emotions and their associated needs, the difference between primary and secondary emotion, and the ways in which emotions are implicated in psychopathology). Subsequent group sessions

consisted of: 1) a review of the past week and participant updates, 2) single participant chair-work session (approximately 45 minutes) with other participants observing (one therapist facilitating the piece of chair-work with a participant while the other therapist monitored the group for reactions), 3) reflections on the participant's chair-work, and 4) weekly end-of-session questionnaires. This structure allowed for each participant to engage in one chair-work session over the course of the therapy group. The ninth and final session also consisted of a discussion of termination issues and the completion of the post-measures. Sally completed follow-up measures one year later and participated in a semi-structured interview which was audio recorded, transcribed verbatim, and reviewed for accuracy. The follow-up meeting time was approximately 2.5 hours.

Measures

Psychological measures. The *Beck Depression Inventory 2nd Edition* (BDI–II; Beck, Steer, & Brown, 1996) is a 21 item measure that is widely used to assess depression and has been found to be reliable and valid for the purpose of assessing depression severity (Beck et al., 1996). The *Beck Anxiety Inventory* (BAI; Beck, Epstein, Brown, & Steer, 1988) is a 21 item measure that assesses physiological and cognitive symptoms of anxiety. The BAI is a reliable and valid tool for assessing the severity of anxiety (Beck et al., 1988). The *Difficulties in Emotion Regulation Scale* (DERS; Gratz & Roemer, 2004) is a brief 36-item self-report questionnaire designed to assess multiple aspects of emotion dysregulation. The DERS items reflect difficulties within the following dimensions of emotion regulation: awareness of emotions (Awareness); understanding of emotions (Clarity); acceptance of emotions (Non-acceptance); ability to engage in goal-directed behaviour (Goals) and refrain from impulsive behaviour (Impulse) when experiencing negative emotions; access to emotion regulation strategies perceived as effective (Strategies). Higher scores indicate difficulties with emotion regulation with scores ranging from 36 to 180. This scale has been shown to be a reliable and valid tool for assessing emotion regulation difficulties (Catanzaro & Mearns, 1999; Gratz & Tull, 2010).

Weekly session questionnaires. The *Session Feelings Questionnaire* (SFQ; Greenberg, Wnuk & Dolhanty, 2007) is a 12 item measure that was developed to explore the participants' experience of emotion (e.g. emotional attunement, expression, level of emotional processing) and self-efficacy following each session. The SFQ is an experimental tool that has been used in EFT research (Wnuk, 2010). The *Group Session Evaluation Questionnaire* (Wnuk, 2010), is a modified version of the Session Evaluation Questionnaire (SEQ; Watson & Greenberg, 1998) and it is a tool to evaluate session-by-session change and perceived helpfulness of the session. The original SEQ has been validated (Watson & Greenberg, 1998).

Qualitative interview. Construction of the semi-structured interview was based on qualitative interview guidelines outlined in the literature (Creswell, 2007; Creswell, 2003; Merriam, 2009), phemenological perspectives (Creswell, 2007; Creswell, 2003; Smith & Eatough, 2007; Smith & Osborn, 2008), and interview schedules employed in Kimball, Weiling, and Brimhall (2009) and Seamoore, Buckroyd, and Stott (2006) case study research of group therapy for divorced women and binge-eating, respectively. The preliminary interview schedule was pilot tested on eight cases. The interview schedule was not prescriptive; rather, it served as a basis for conversation with Sally and aimed to keep her engaged, talking freely, and sharing all thoughts about her experience (Creswell, 2007; Merriam, 2009).

Data Analysis

Quantitative results were observed via general observation of patterns and trends. Changes between pre-to post-group and post-group to follow-up were also analyzed using the Reliable Change Index (RC; Jacobson & Truax, 1991). The RC demonstrates how much and in what direction an individual has changed, and whether the change observed is both reliable and clinically significant. When the RC value is greater than 1.96, it is unlikely that the post-group/follow-up score does not reflect real change.

Qualitative data were analyzed using Interpretative Phenomenological Analysis (IPA; Smith & Eatough, 2007; Smith & Osborn, 2008) and a modified Hermeneutic Single-Case Efficacy Design (HDCED; Elliott, 2002). IPA aims to explore in detail individual lived experience and to examine how people make sense of their personal and told experiences (Smith & Eatough, 2007). IPA outlines specific steps for analysis, from transcription through thematic coding to validity measures. To support the credibility and trustworthiness of the qualitative research findings, various procedures were employed (e.g. member checking, triangulation; Maxwell 1992; Merriam, 2009). HSCED is a rigorous single-case analysis mixed method that systematically examines the casual role of therapy in bringing about client change (Elliott, 2002). HSCED requires: (1) at least two of five direct evidence links between the therapy process and outcome be found; (2) a “good-faith effort” to find external processes that could account for client change (e.g. statistical, relational, or expectancy artifacts; Elliott, 2002, p. 7). The current study met five out of the six criteria for HSCED. The criterion unmet by the current research included therapist process/session notes and videotapes of the therapy sessions which were unavailable to the research team.

RESULTS

Quantitative Results

Scores from the BDI, BAI, and DERS are presented for the pre-group, post-group, and one-year follow-up group (Table 1).

Table 1
BDI, BAI, & DERS: Participant scores

Measure / Subscale	Pre	Post	Follow	RC Pre - Post	RC Post – Follow
BDI Total *(clinical range)*	41 *(severe)*	29 *(severe)*	6 *(minimum)*	-5.53	-10.6
BAI Total *(clinical range)*	25 *(moderate)*	10 *(mild)*	9 *(mild)*	-7.58	-0.50
DERS Total	158	93	53	-6.40	-3.94
Nonacceptance	25	12	8	-3.49	-1.07
Goals	28	16	12	-3.08	-1.03
Impulse	25	15	7	-2.44	-1.96
Awareness	28	16	11	-3.26	-1.36
Strategies	22	19	9	-1.03	-3.45
Clarity	20	14	5	-2.50	-3.75

BDI, BAI, and DERS. Scores on all measures decreased from pre- to post-group, and again from post-group to follow-up. Specifically, total BDI scores went down 12 points from pre to post. Although at both times, scores were technically in the clinically severe range (the range is 29-63), the RC value exceeded the criterion of 1.96 indicating that the pre- to post-group scores reflected reliable and clinically significant change. The BDI score further improved with clinical significance to the minimum clinical range at follow-up. In terms of the BAI, the pre-group total score, which fell in the moderate clinical range, improved with clinical significance to the mild clinical range at post-group. This improvement remained stable at follow-up. The pre-group DERS score, which fell above the clinical range at the beginning of the group (e.g. Generalized Anxiety Disorder [GAD] samples 95-100; Roemer, Salters-Pedneault, Erisman, Orsillo, & Mennin, 2009; Salters-Pedneault, Roemer, Tull, Rucker, & Mennin, 2006; Post-traumatic Stress Disorder [PTSD] samples 100-105; McDermott, Tull, Gratz, Daughters, & Lejuez, 2009; Tull, Barrett, McMillan, & Roemer, 2007), improved at post-group with clinical significance. The follow-up score improved with clinical significance and fell below non-clinical population averages (e.g. college student and community adult samples average 75-80; Gratz & Roemer, 2004; Salters-Pedneault et al., 2006; Vujanovic Zvolensky, & Bernstein, 2008).

Improvements were found on the DERS subscales across all time points. Specifically, the Impulse (ability to refrain from impulsive behaviour when experiencing negative emotions) and Clarity (understanding of emotions) subscales improved with clinical significance from pre- to post-group and from

post to follow-up. The scores on the Goals (ability to engage in goal-directed behaviour when experiencing negative emotions), Non-acceptance (acceptance of emotion), and Awareness (awareness of emotion) subtests improved with clinical significance between pre- to post-group scores. The Strategies (ability to access emotion regulation strategies perceived as effective) subscale improved with clinical significance at follow-up.

Weekly Session Measures. On the day that Sally personally engaged in chair-work, most of her scores on the SFQ items were elevated relative to every other session, indicating a productive emotional experience. There were exceptions with lowest scores relative to every other session on items pertaining to emotional difficulty (Table 2). The highest relative ratings on the following items were reported in Sally's chair-work session ("In this session I…"): paid attention to how I felt; let my feelings come out freely; realized my feelings were valid and important; felt free to express my emotions; allowed myself to express my emotions; acknowledged my feelings; delved into my feelings to better understand them; had difficulty making sense of my feelings. Conversely, Sally felt "confused about what I was feeling" and "experienced my feelings as overwhelming and out of control" more so in her chair-work session than any other session.

Scores on the SEQ[1] items suggested an elevated trend on the day that Sally personally engaged in the chair-work relative to every other session. On this day, she reported feeling best about the session she had just completed, that the therapists were very helpful, that a great deal of progress had been made; that something had moderately shifted for her personally, and that she would like to deal with something differently as a result of the session to a moderate degree.

Table 2
SFQ Rating on Chair-Work Day Relative to All Other Sessions

Item	Rating on Chair-Day Relative to Other Sessions
Paid attention to how I felt.	Highest (4)
Let my feelings come out freely.	Highest (4)
Realized that my feelings were valid and important.	Highest (4)
Felt free to express my emotions.	Highest (4)
Allowed myself to express my emotions.	Highest (4)
Acknowledged my emotions.	Highest (4)
Delved into my feelings to get a thorough understanding of them.	Highest (4)
(r) Had difficulty making sense of my feelings.	Highest (4)
(r) Was confused about what I was feeling.	Lowest (2)

[1] SEQ was completed in six sessions (session 2, 3, 6, 7, 8, and 9)

(r) Experienced my feelings as overwhelming and out of control.	Lowest (3)

Note. Response scale: 1 ("Not at all"); 2 ("A little bit"); 3 ("A medium amount"); 4 ("A lot"); Reverse items (r) scale: 1 ("A lot"); 2 ("A medium amount"); 3 ("A little bit"); 4 ("Not at all")

Qualitative Results

Qualitative themes emerged via IPA that illustrated Sally's experience of the EFT group. The themes corroborate with, and add richness to the quantitative results. Table 3 demonstrates the identified super-ordinate and sub-themes.

Table 3
Summary of Super-ordinate and Sub-themes

Super-ordinate Theme	Sub-theme
1. "[Group intervention] is the best one of all"	Attributions of most significant changes to group Positive reflections on the group
2. "[Group] changed my whole life"	Improved independence & responsibility Enhanced relationship with self Improved emotional processing and mood Newfound pride, gratitude, and hope Intergenerational sharing and healing
3. "The group would have been nothing without..."	Importance of every component to learning Powerful vicarious processing Universal group emotions Excellent therapists
4. "For me that group was a commitment ... and connection"	Commitment Connection with others "Safe" place Pain felt for group members who struggle
5. "That chair system was brutal, but ... that's where you learn the most."	Paradoxical feelings toward chairs Chairs as powerful Waves of lasting emotional change

1. "[Group intervention] is the best one of all". Sally described her recovery as gradual over the course of one year and that the EFT group propelled her forward more than any other intervention (i.e. "*One-on-one I never could have gone that far... [the group] started the evolution of being able to open up inside... that is the best one of all*"). She spoke very highly of the group: *'I enjoyed every minute of it ... [the group] meant a lot to me"; "That [group] is something that everybody should go through, everybody!"*

2. "[Group] changed my whole life". With enthusiasm, Sally expressed that "*today life is totally different because of that group*" Since the EFT group, Sally has increased her emotional independence (e.g. *"I was over 50 and I was still thinking 'oh my God what is my mom going to think.' Like that is a horrible feeling... I never had that independence. And I finally took it"*), and physical independence and responsibility:

> *After the therapy group I was doing even better. I would go out, I would eat [healthy foods] a lot more... giving me more strength... I had this scooter because of my [physical ailment], I could not walk, I had a little dog at home so I would take her for walks, I would go out more, and after I got the car... then I decided to go back to work. ... So I applied at three different places, I went for three interviews, and I got three jobs.*

Sally walked into the follow-up interview, no longer requiring a wheelchair or scooter due to her improved physical health. Many of these changes were reported by Sally as "*firsts*" in at least 14 years. The group instilled a heightened self-confidence for Sally that was rooted in her newfound understanding of the reasons behind her emotions, replacing self-pity with self-confidence, *"I had no self-confidence whatsoever. And that the group gave me self-confidence. When you can build self confidence in yourself, you can achieve anything."*

Sally described dramatic change in her ability to process emotions due what she learned in the group: Sally carefully continued to "*tune into*", "*allow*", and "*accept*" her emotions, particularly in stressful times, in order to regulate and maintain the emotional health that she had established. Such emotional processing removed the blame, guilt, perfectionist, and controlling urges that she had carried for many years on her shoulders: *"the guilt was lightened 100 percent."* Sally described regulating her emotions differently as a result of the EFT group:

> *I learned to cope with things. I am not saying that I don't feel anxiety, I do. And when I do, I go back to my computer (laughs out loud). But I don't stay there, I don't stay there... When I'm coping with something now, let's say that I'm feeling really sad and really alone and shitty and, I can say 'no' to myself 'okay, that's the way you feel today, fine, if you want to go to bed to go to bed.' And sometimes I'll go to bed or sometimes I'll just say, 'well okay so today I'm feeling like this and tomorrow will be a different day' and tomorrow is a different day. I can accept the feelings that… I'll tune in to my feelings.*

And she continued to strive daily to recognize and prioritize her own emotional needs: "*I realized that I have to be ... like there are not only my children and my grandchildren and my mom and dad, I have to find Sally.*"

Sally described her experience of newfound pride in her achievements in the group ("*It was very hard work and I am very proud that I did it*"), in achievements outside of the group (e.g. employment success) and in her *"stronger"* significant relationships, particularly with immediate family members. She also expressed gratitude for the amount of experiential learning she endured

in the group - "*I'm glad I found all of that out before I died*. The group instilled a new found sense of hope in Sally: "*the more we went along, during the group session the moods were more, they were hopeful. It was as if you could see the light at the end of the tunnel during the group."*

Sally described intergenerational sharing and healing. She reported that she shared everything that she had experienced, learned, "*and what it did to me*", with her family (i.e. mother and children). In fact, after her own chair session in the group, "*[she] really continued [her] chair session with [her] daughters and then [she] sat down with [her] mom.*" By doing so, Sally helped her family to understand, accept, and respect her on a deeper level (e.g. "*I felt myself that my mother is respecting me more and understood me, more to the fact that I am my own person").* Sally's children "*saw the change ...they saw everything, they saw their Mom come back.*" A few of her family members were even inspired to undergo their own emotion self-work in therapy, including her own mother.

Sally learned a tremendous amount about the way her family has dealt with emotions across generations - *"I strongly think that that group helped me accept people for who they are",* and about ways to interact with, and "*support*" family members - *"helped me better react at not reacting"*. She continues to be careful to validate others' emotions and feelings when they were upset, particularly her grandchildren, and believed that "*emotional education should be mandatory in the schools!*"

3. "That group would have been nothing without..." Significant group processes stood out in Sally's experience of the EFT group. Vicarious processing during chair-work was a powerful experience - "*Seeing others go through it, you lived it with them, oh you totally lived it with them*" - and pivotal in self-growth:

> *If I would've been there just listening, I would remember everything that was said in there. But no, I don't remember the problems of the others because I was working on me, with the group, I wasn't there by myself, and I needed the group there.*

Sally was surprised to become aware of previously blocked emotions by watching others in the chairs:

> *I had lots of feelings that I did not accept. And some that I didn't even know that I had. And I was able to identify them through that group... because when somebody else was talking, it would sometimes wake up feelings in me that, 'Oh my God, I do have that feeling too!' … And it made me go even further into myself.*

Due to the experience of vicarious processing, the sessions were intense and "*exhausting*":

> *The intensity was getting bigger and bigger and bigger by each session... It gradually got stronger and stronger because you learn more"... "Every session we had I would go home so drained I would have to go to bed and sleep at least four hours...*

Sally realized early on that the emotions in the group were universal: "*in each and every person I realized that whatever the other person was going*

through, we all were going through, the subject was just different" making Sally feel *"not alone."* The therapists were also described as excellent guides who created a sense of safety and acceptance in the group:

> *[The therapist] was a fabulous guide. Fabulous, she is something else. I have utter praise for her... I really loved [therapist 1] and [therapist 2], they were fantastic. And they had my complete trust so you know. I felt really safe and that they acknowledged me as a person and that they accepted me and they were able to do that for each and every one of us.*

4. "For me that group was a commitment ... and connection". Sally adamantly expressed that "*all of these changes came from me giving my full commitment to the group ... And to take all that I could from the group to help myself and to let myself be helped."* Commitment was imperative for success, "*I would recommend that group to a friend! But I would tell them, 'if you don't commit you'll get nothing out of it.'*" The experience of connection with other group members was also paramount in her positive experience of the group:

> *At first, you don't know them. And the more that you get to know them, the more you start feeling for them as they, as people that… You know… You can feel their pain or you can… And when we got together it was nice to hear how they're week went and you are hoping or if, they did not have a good week, you try to encourage them… You know the people that let themselves be open to others, there was, camaraderie...I had a very big connection with ... I'd would say mostly a little bit more than half of the group.*

This connection strengthened her personal growth in the group and had stayed with her:

> *By the time I left there, I missed it! I really, I was really sad the last day... And when I think of it, it makes me sad (chokes up) because I… As hard as it was, it was a real big boost and to see that I was not alone ... I still think about them. And I wonder how they are ... I would love to see the other group members again.*

This connection made the group a "*safe environment*", where Sally felt accepted and that she could be honest in expressing her true feelings without the risk of hurting anyone. It was difficult for Sally when a few group members struggled to access or work with painful emotions during their chair session:

> *That hurt me... I could only imagine how bad that thing was inside of her not to be able to get it out. So I hope, I really do hope and pray for that person that, it does come out one day... That was, that was hard to take (tearing up), it brings back tears to my eyes because, she was struggling so hard and she couldn't get it out. It hurt me, I felt so sad for her.*

5. "*That chair system was brutal, but ... that's where you learn the most.*" Sally felt *"doubt"* about the apparent effect of chair work the first time she

witnessed the process. Simultaneously, Sally feared the chairs: "*The first time I saw the chair session, it really scared me ... I was afraid of not being able to open up or not knowing what to say."* Over time, "*the more I believed in the chairs. And the more I could see how they could help you."* When Sally's turn finally came in week seven, she described how her words and emotions "*came out naturally*" and that she was so focused on her piece of work that the other group members faded into the background: *"You totally forget, you're totally, not in a trance, ahh, but you don't realize the other people are around you... when it flows out it's as if your whole body has taken over."* Overall, the chair work in the sessions was powerful, "*the main tool*", and "*awesome*". The chairs felt unpredictable in what they would reveal and were, by far, the most intense therapeutic tool in the sessions. Sally's own chair work was the most challenging component of the group: *"You concentrate, there's just you and that chair in front of you and [the therapist], just saying words, to help you start to say what you want to say. And it's just so intense…"*

Waves of emotional changes were experienced "*gradually*", beginning with the first time Sally experienced chair work via vicarious processing:

> *The more the sessions went on the more intense the changes were coming. The more liberating I felt, and even more so after the session was finished because I just continued on ... It was a continual feeling, it was the start, and it just continued to feel that way.*

In her own chair work session, the largest emotional shifts related to a new understanding of the origin of her emotions as well as expressing previously unexpressed assertive anger (i.e. "*it took a lot of anger outside of me*"). These emotional shifts brought tremendous relief: "*It was very very very healing. So light. I felt like 1000 pounds had just lifted off of my shoulders*").

The following experiences did not emerge as super-ordinate or sub-themes, yet provided valuable information. Sally described a few areas of emotional work that she continues to pursue since the EFT group: "*the only thing that I still need to work on is to work on trying to have a life for myself outside of work. I don't have that yet, but I'm working on it*". In addition, Sally provided two critiques of the group process. She found the sessions to be "*too short*", which caused her to feel rushed at the end of the session (when she was still processing emotions) while completing the weekly questionnaires:

> *We would come in, by the time everybody had added to their week, then it was the chair, it takes a little bit of time before the person in the chair really gets into it, and were living this really hard thing with them and all of that, and all of a sudden the session is supposed to be, like there's 20 minutes left and you still have to have the group's reflection... and to answer that questionnaire. It was always in a rushed manner because we never had enough time.*

The last session was particularly difficult – *"we had gone through so many emotions, it was really hard to answer ... I was really sad the last day"*. Finally, when a group member who did not attend regularly came into the group, Sally was not able to process emotionally because it felt like there was a "*stranger*" in

the group, eliminating the sense of "*safety*": "*It made me feel cheated of one session... because he wasn't a part of our group anymore because we didn't build together"*.

Results based on HSCED

The application of an analytic method based on HCSED (Elliott, 2002) was conducted using: (1) basic facts about Sally (demographics, diagnoses, presenting problems, therapeutic approach); (2) qualitative outcome measure (interview at follow-up and weekly SEQ qualitative components); (3) qualitative outcome data about Sally's descriptions of change experienced over the course of the therapy and her descriptions of attribution for those changes (the interview); (4) weekly outcome measure (the SFQ); (5) measure of Sally's perceptions of significant therapy events (the SEQ).

Direct Evidence

Three direct sources of evidence supporting the therapy – change link were found (Elliott, 2002). *Retrospective attribution* (Elliott, 2002) (or clear support for Sally's attribution of significant emotional change to the EFT group processes) was evidenced in the consistency among the qualitative descriptions of change, the clinically significant improvements in depression, anxiety, and emotional regulation, and the positive weekly outcome measures of productive emotional processing, change, and evaluation; all of which were heightened in her own chair-work session. The second piece of evidence pointing to Sally's improvement was *process-outcome mapping* (Elliott, 2002). Sally's reported drastic emotional changes from the group that continued to alter her life post-therapy that corresponded with significant events in-session involving the processing of emotion (vicariously or in her own chair-work). *Event-shifting sequences* (Elliott, 2002) depict direct evidence of change as an important therapy event. Sally's participation in the group, and in particular her personal chair work preceded a (logically related) stable shift in her experience of maladaptive emotions (i.e. self-loathing and hopelessness, stable for at least 14 years), which appeared to transform into adaptive emotions (i.e. assertive anger, self acceptance and agency), positively influencing her relationship with herself and her family.

Indirect Evidence

Non-therapy processes that could have accounted for the observed and reported changes in Sally were considered (Elliott, 2002). (1) *Non-improvement.* Trivial or negative change was not applicable as improvements were found and reported by Sally in both the quantitative and qualitative data. (2) *Statistical Artifacts*. Although the clinically significant changes in the measures of depression, anxiety, and emotional regulation may have been influenced due to the statistical phenomenon of regression to the mean, the criterion of clinical

significance employed allowed for the conclusion that the degree of change observed was beyond that attributed to chance. *(3) Relational Artifacts*. It is important to evaluate the plausibility of Sally's reported attributions of change. A credible client's account of a therapy's influence is typically elaborated on, contains specific details about the changes, general descriptions are backed up by supportive detail, and there is a mixture of negative and positive and neutral descriptions of the therapy rather than highly tentative or overly positive feedback (i.e. interpersonally-driven relational artifacts; Bohart & Boyd, 1997; Elliott, 2002). Sally's reports of the therapy were mostly positive; however, her descriptions about the changes were described with intricate detail. As such, the concerns of interpersonally driven artifacts in Sally's reports are minimized. The validity of Sally's accounts were enhanced due to the fact that the researcher (rather than the therapists) conducted the interview and encouraged thoughtful self-reflection, group criticisms, recommendations, and openness. However, if Sally perceived the researcher as someone whom she would have liked to please, a relational response tendency (Elliott, 2002) is possible. Although it is doubtful that the researcher was perceived in an authoritative light by Sally, the researcher was close in age to Sally's children and worked closely with one of the therapists from the EFT group. Sally spoke highly of, and expressed gratitude toward the group. During the interview, the researcher also showed enthusiasm in response to Sally's accounts of her experience. As such, it is possible that Sally illustrated a more positive image of her experience from the EFT group or down-played negative aspects of her change (or lack thereof) due to these relational aspects. *(4) Apparent changes are the result of client expectations or wishful thinking.* Expectancy artifacts include cultural or personal expectations or wishful thinking that may influence the degree of "client change" (Elliott, 2002), Sally's descriptions and choice of wording were idiosyncratic, self-reflective, detailed, and thoughtful. During the interview, at times, Sally experienced emotional and reflective pauses. In fact, she teared up several times when describing her experiences in the group and related improvements. The descriptive, affect-laden, and self-reflective style that Sally used in the interview suggests that her reports were credible and grounded. *(5) Self-correction processes.* Sally was posed the specific question, "*to what else do you attribute these changes?"* in order to assess non-therapy change explanations (Elliott, 2002). Sally immediately replied: "*All of these changes came from me giving my full commitment to the group. And to take all that I could of, from the group to help myself, and to let myself be helped*". When prompted for any other influencing factors, Sally responded, *"changes do come from the whole process. From going to the hospital, to now. To going to all of the different kinds of therapies, that was the most profound one, the group. That was the best one of all."* Self-help appears to have had a significant impact on the degree of change experienced in that Sally was committed to improving her life. However, the EFT group seems to have had an influence on Sally's level of commitment, as well has her improvements in various domains. *(6) Extra-therapy events.* Since the EFT group, Sally's health improved to a point where she is now independently mobile

(without a wheelchair or scooter) and she gained employment. She was also given a car. Sally spoke with pride and gratitude about these extra-therapy events and acknowledged the positive influence that they had on her mental health. The researchers consider these extra-therapy events to have had a bidirectional influence on Sally's positive changes reported in the follow-up interview and measures. In other words, a cyclical process may have occurred where Sally's emotional improvements (that were attributed to the group) may have positively influenced her physical health and in turn, her improving physical health (e.g. increased mobility) may have positively influenced her emotional health. *(7) Psychobiological factors.* Apparent changes can also be attributed to medication or herbal remedies or recovery from medical illness (Elliott, 2002); which in Sally's case included improved physical health, strength, and walking ability. Sally attributed her positive lifestyle changes (e.g. improved nutrition) to the emotional work that she did in the EFT group, however, such significant physical recovery undoubtedly played a role in her follow-up reports. *(8) Reactive effects of the research.* Sally expressed a desire to help others and consented to participate in the current research study in hopes that its publication could help others gain access to an EFT group. As such, it is possible that Sally's altruistic motivation may have had reactive effects on the follow-up data collection. Then again, her enthusiasm to participate may also have been related to a genuine desire to increase opportunities for others to experience life changes.

Overall, there is support for three types of direct evidence to support the attribution of change to the EFT group: retrospective attribution, process-outcome mapping, and event-shifting sequences. In terms of negative evidence, there is support for a role of non-therapy explanations including relational artifacts (relational response tendencies due to researcher's age and proximity to group therapist as well as Sally's gratitude to the group). Self-correction processes (motivated to make positive change in her life), extra-therapy events, psychobiological factors (i.e. improved mobility and physical health), and reactive effects to the research (i.e. altruism) are also important supporting influences, but not at the exclusion of the impact of the therapy group. In summary, considering both the indirect and direct source of evidence, the authors feel that the analysis supports the attribution of a degree of unique change to the EFT group, in addition to the positive and potentially bi-directional influence of non-therapy factors.

DISCUSSION

The participant, Sally, attributed significant changes in her emotional being to her involvement in the EFT group, including improved emotional processing, emotional clarity, mood, independence, responsibility and new found hope, gratitude and pride. These changes were reflected in her clinical improvements in depression, anxiety, and emotional regulation from pre- to post-group and at one

year follow up. Moreover, at the one year follow-up the participant's scores in depression further improved, as did her scores on many of the subscales of emotional regulation measures, suggesting ongoing and relatively long-lasting change. Intergenerational emotional healing and growth occurred as Sally shared what she had experienced and learned in the group session– by –session with her significant family members. Not only did this improve her close relationships (i.e. deepened levels of acceptance, understanding, and respect), but it also inspired some of her family members to pursue their own emotion work in therapy. Sally's strong conviction in her attribution to the group for all of these changes and her clinically improved depression, anxiety, and difficulties in emotional regulation provide clear and direct evidence for the group playing an important role in her change.

The therapeutic approach of the group was process-experiential. Beyond the psycho-education in the first session, which consisted of information about emotions and emotional problems, the focus and target of the group was to work with emotions using EFT techniques (i.e. chair-work). Emotional regulation and coping skills were not formally addressed in the group. Despite this approach, Sally reported learning emotional regulation skills and coping skills; which, were evidenced in the her clinically significant improvements in DERS subscales at post-group and follow-up (e.g. improved effective strategies to regulate and deal with emotions, effective regulation of previous impulsive behaviours and improvements in affective goal setting in the face of negative emotions, acceptance of emotions, and clarity around her emotions). She reported that she continues to use emotional regulation strategies learned in the group in her everyday life. It appears as though Sally acquired emotional regulation and coping strategies through the group despite such skills never being directly addressed, a similar process reported in individual EFT studies (Macleod, et al., 2012).

Sally's chair-work session generated seemingly contradictory experiences in terms of emotional processing. In this session, Sally reported feeling the most confused and overwhelmed (in ratings on the SFQ), relative to every other session. However, on this day she also reported (through SFQ and SEQ ratings) the least amount of difficulty understanding her emotions and the highest amount of emotional attunement, expression, and processing. In addition, this session was experienced as the most productive in terms of her emotional shifts and the overall helpfulness of the session. Research indicates that depth of experiencing or emotional arousal is a significant predictor of therapeutic outcome (e.g. of depression among others; Warwar, 2003) and an optimal frequency of aroused emotional expression is thought to be about 25% (Carryer & Greenberg, 2010). Sally's experience suggests that she may have been processing her emotions above the optimal level in her chair session as evidenced by her experience of her emotions as out-of control, overwhelming, and confusing (Carryer & Greenberg, 2010; Warwar & Greenberg, 1999), yet she reported (both in-the-moment and one year later) an ability to process her emotions quite deeply, and reported significant benefit from the experience. These findings are inconsistent

with the optimal level of processing outlined in the literature and are worth further investigation as Sally was able to process deeply and productively during highly emotive, "*intense*", "*challenging*", "*confusing*" and "*overwhelming*" emotion work.

Some important non-direct evidences of external or non-therapy influence on Sally's improvement in the group were highlighted through the analysis. However, direct evidence was also found in terms of retrospective attribution (e.g. clinically significant improvements in depression, anxiety, and emotion regulation difficulties that corresponded with Sally's qualitative attribution of emotion change to the group), therapy process-outcome linkages, and therapeutic events in session preceding emotional shifts or changes (Elliott, 2002). Considering all of data, we believe that a degree of change and improvement in Sally's depression, anxiety, and emotional regulation difficulties can be attributed to her involvement in the EFT group.

One may question the benefit of offering EFT in a group format, particularly because the group members only experience the "chairs" on a single occasion. Sally's descriptions of being able to *"live"* the emotional experiences with other group members in combination with the clinically significant improvements she made in emotion regulation difficulties, anxiety, and depression pre to post-group suggests that she not only processed her emotions in her own chair work, but she could effectively process emotions through others' experiential work. In fact, Sally added that she did not think that chair-work would be as effective in individual therapy because she would not be able to process emotions vicariously through others' chair work and subsequently have hidden emotions awaken and brought into her awareness. Based on Sally's experiences and outcome, we believe that EFT can be delivered in a group format. Moreover, it appears that the combination of group therapy and EFT adds a unique therapeutic modality not found in traditional group or emotion-focused therapies.

Limitations and Future Directions

The current single-participant case study was the first of its kind and provides a foundation for the delivery of EFT in group format. Despite this contribution, important limitations must be acknowledged. Specifically, the study could have been strengthened by administering the quantitative measures of depression, anxiety, and emotion regulation difficulties at more frequent intervals (i.e. bi-weekly) in order to look for any spikes or dips in the participant's trajectory of change (Stiles, Osakuke, Glick, Mackay, 2004). Similarly, a pre-group interview would have deepened the case-record. Although the therapist's process notes and video-tapes of therapy sessions were not available, these sources of data would have been beneficial in order to pin-point, corroborate, or clarify issues or contradictions elsewhere in the data. Finally, the use of multiple raters to argue for and against the attribution of client change to the EFT group would have improved the results' validity surrounding attribution of client change (Elliott, Partyka, Alperin, Dobenski, Wagner, Messer, Watson, & Castonguay,

2009). Although generalizations cannot be made from a single case, based on the promising preliminary results from the current single-participant case study, the authors suggest exploring group EFT via a randomized control design where individual differences and extra therapy events can be controlled.

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