INTRODUCTION

Generalized anxiety disorder (GAD) is a serious disorder that impairs functioning and has high social and economic costs (American Psychiatric Association, 2013; World Health Organization, 2016). Hoffman, Dukes, and Wittchen (2008) observed that GAD contributes to significant impairments in role functioning as well as decrements in quality of life. The impairment of persons with comorbid disorders is even more severe. For people with GAD, the condition negatively impacts their general health, including their physical and mental health, vitality, and social functioning, which leads to increased use of health care resources and loss of productivity due to absenteeism (Porensky et al., 2009; Revicki et al., 2012). It has been noted that the costs from health care and lost productivity exceed those of other patients. Moreover, there is the impact of intergenerational transmission, as people with GAD communicate and share their anxious worrying behavior with their offspring and other family members.

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Emotion-Focused Therapy for Generalized Anxiety, by J. C. Watson and L. S. Greenberg

GAD is the most common anxiety disorder and is underrecognized, with only 20% to 32% of patients receiving adequate treatment (Porensky et al., 2009; Revicki et al., 2012). To make matters worse, studies have found that GAD can be treatment resistant. Although approximately 50% of patients respond to short-term treatment, a large percentage either do not respond at all or relapse after treatment (Borkovec, Newman, Pincus, & Lytle, 2002; Hanrahan, Field, Jones, & Davey, 2013). As a result, numerous researchers and clinicians have called for improved and different treatments for the condition (Craske & Waters, 2005; Hofmann & Smits, 2008; Roemer & Orsillo, 2002). In this book, we provide an understanding of GAD from an emotion-focused therapy (EFT) perspective and present alternative treatment strategies that mental health practitioners can use to help clients with GAD maintain positive, long-term changes.

Until recently, EFT has focused on depression (Greenberg & Watson, 2006), trauma (Greenberg & Paivio, 1997; Paivio & Pascual-Leone, 2010), and couples therapy (Greenberg & Goldman, 2008; Greenberg & Johnson, 1988; Johnson, 2004), with no theory of anxiety or, more specifically, no theory of GAD. In EFT in general, dysfunction is seen as arising from the activation of core painful maladaptive emotion schemes of fear, sadness, and shame and the associated vulnerable self-organizations resulting from the synthesis of these schemes together with the inability to symbolize and regulate the ensuing painful affect (Greenberg, 2002, 2011; Kennedy-Moore & Watson, 1999, 2001; J. Watson, 2011). In EFT, when people experience anxiety, the self is organized as scared and vulnerable because of the activation of emotion schematic memories of harmful and painful experiences in the absence of protection and support. As a result, people do not internalize self-soothing strategies and instead develop negative ways of relating to the self and modulating emotions.

Developmentally, the experience of intense distress combined with the absence of soothing, care, protection, and support results in the inability to adequately regulate and symbolize emotional experience, leading to painful experiences being interrupted and blocked to protect the self from feared dissolution and disintegration. Without adequate protection, soothing, and succor, negative ways of regulating emotional experience and coping with challenging and distressing life circumstances are internalized. These negative ways of relating to one's experience include dismissing the experience, invalidating it, silencing the self, blaming the self for the negative experience, and rejecting the self as unworthy of being loved and supported. Thus, as a result of an intensely painful experience and in an attempt to manage feelings, there is a constriction of awareness such that individuals have difficulty representing and symbolizing their experience in consciousness. Instead, people with GAD experience a sense of *undifferentiated distress*—a vague feeling in the

body at the edge of awareness. The combination of the inability to symbolize painful emotions and experiences, negative ways of treating the self, and an inability to soothe the resulting overwhelming emotions leads to a fear of dissolution and compromises the individual's affect regulation capacities. People end up worrying in an effort to protect the self from falling apart because of an inability to cope with the underlying painful feelings of fear, sadness, and shame.

GENERALIZED ANXIETY DISORDER

Estimates of the lifetime prevalence of GAD in the general population range from 1.9% to 5.4%. GAD is more common in women than in men by a ratio of 2 to 1 (Andlin-Sobocki & Wittchen, 2005; Brown, O'Leary, & Barlow, 2001). Among the elderly, estimates are even higher, with some researchers suggesting that 17% of elderly men and 21.5% of elderly woman require treatment for the disorder (Brown et al., 2001; Salzman & Lebowitz, 1991). More than half of those individuals diagnosed with GAD experience onset during childhood and adolescence, although later onset does occur after the age of 20 (Andlin-Sobocki & Wittchen, 2005).

Symptoms are often worse during periods of stress. Most people with GAD report that they have felt anxious and nervous all their lives, which underscores the important role of early life experiences in its etiology and development. Anxiety disorders, and specifically GAD, have been found to be comorbid with other Axis I disorders from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (American Psychiatric Association, 2013), including other anxiety disorders (e.g., social anxiety disorder, post-traumatic stress disorder, panic disorder), mood disorders, addictions, and eating disorders (Carter, Wittchen, Pfister, & Kessler, 2001; Craske & Waters, 2005; Kessler, Ruscio, Shear, & Wittchen, 2009). Unipolar depression is 4 times more common in GAD than is bipolar depression, with incidence being 67% and 17%, respectively (Judd et al., 1998). Overlap has also been found with Axis II disorders, including avoidant and dependent personality disorders (Mauri et al., 1992). Some researchers have suggested that given its early onset, anxiety should be viewed as temporally primary among the other disorders with which there is high comorbidity. They have suggested that early detection and treatment of anxiety might have implications for the onset of other disorders (Kessler et al., 2009).

Unlike some of the other anxiety disorders (e.g., social anxiety, phobias), GAD has no clear precipitants. It is not associated with a particular stimulus (e.g., heights, snakes) but is activated by a variety of different situations and stimuli (American Psychiatric Association, 2013; World Health Organization,

2016). The early onset of GAD suggests that it is a condition that develops early in development and may be consolidated during core developmental years. Studies looking at early childhood factors associated with GAD point to a negative early climate characterized by parental rejection and criticism, lack of parental warmth and acceptance, and a sense that family dynamics were unfair. This may be compounded by other negative life experiences and events for which people may have had insufficient protection, support, and care.

The research literature shows that not all clients respond to short-term treatments, although some clients clearly progress and their symptoms remit after several weeks (Borkovec et al., 2002; Elliott & Freire, 2010; Hanrahan et al., 2013); other individuals may require a longer length of treatment. The exact length will vary in terms of the severity of clients' early life conditions, as well as the individual capacities that clients bring to therapy (see Chapter 5, this volume). Some individuals may need time to build greater confidence in themselves and to develop an adequate understanding of what has transpired in their lives that has made them feel so vulnerable, reject their experience, and unable to regulate their emotions. As they gain a better understanding and acknowledge their experiences, they can begin to see what was so challenging and negative for them and appreciate what was lost and not received. This enables them to symbolize previously disclaimed painful experiences and identify the negative behaviors and ways of processing their experiences that were internalized as they tried to cope with intensely distressing events. This understanding points to aspects of their experience that they can change. Clients with GAD come to recognize that they do not adequately process their emotions and bodily experience, fearing that they will "disintegrate" because of the intensity of the pain. There is a recognition that they need to become more aware of their bodily experiences and emotions, experience their painful emotions, learn how to accept them, symbolize them and put them into words, and finally, with the help of the therapist, access new, more empowering emotions to transform their painful maladaptive feelings. Feeling stronger and more resilient, they are better able to modulate their distress, soothe their painful feelings, and express their emotions and needs to others.

MAIN PROCESSES IN EMOTION-FOCUSED THERAPY

EFT emphasizes the important role of the therapeutic relationship and provides suggestions and ways of working with clients to resolve how they relate to the self and others. Although therapy is a complex, multilayered interaction, we have distilled five main processes and tasks that are woven sequentially and in parallel throughout the treatment. These processes include

the following: (a) providing clients with an empathic, accepting, and prizing relationship to build a stronger sense of self so that they feel more trusting of their emotional experience and perceptions, become more confident in their interactions with others, become more self-compassionate and self-nurturing, are able to tolerate and soothe their emotional experience, and modulate the expression of their emotions and needs to others; (b) working with clients to experience disclaimed painful emotions and develop an understanding of their life story or narrative to make sense of life events and their impact; (c) working with clients on identifying and changing the negative ways in which they relate to the self using two-chair tasks; (d) working with clients to transform painful maladaptive emotions by healing past emotional injuries experienced in interaction with significant others using empty-chair tasks to resolve unfinished business; and (e) working with clients to develop capacities to self-soothe using imaginal transformation and two-chair dialogues to resolve emotional suffering.

Although these processes and tasks are described as following a sequential order in treatment, they generally occur in parallel and are woven throughout the treatment process after the therapist has begun to build a positive therapeutic relationship and a positive alliance with the client in the first few sessions. So, although the therapist may focus on one of the these tasks more than the others at different times in therapy, or on additional tasks such as initially building a therapeutic alliance, developing a case formulation, or building a stronger sense of self, the process remains fluid.

Once the EFT therapist introduces chair dialogues, she or he continues to work on the relationship by providing empathic attunement, acceptance, and prizing in a sincere and congruent manner to continue to strengthen clients' sense of self and to facilitate awareness of clients' emotional experience and help clients represent it in words. Labeling their emotions, learning to regulate and modulate their intense feelings of distress, and transforming core painful maladaptive emotions enable clients to acquire the capacities to regulate and express their emotional experiences more optimally and develop more positive ways of caring for the self. Throughout therapy, as clients work to change their core painful emotions, undo their negative self-treatment, as well as to resolve their attachment injuries, they cycle in and out of tasks that focus on how they relate to the self using two-chair dialogues and how they address emotional injuries with an imagined other using empty-chair dialogues. Although working on self–self and working on self–other relationships are conceptualized as two parallel tracks, it is highly likely that to fully resolve emotional injuries with an imagined other, clients may need to have consolidated changes in how they relate to the self and their emotions so that they feel deserving and entitled to assert their needs and receive loving care and protection from others.

CASE EXAMPLE[1]

In the following case example, we provide an overview of the EFT process for GAD. Monica came to therapy after her first child was born. She and her husband had immigrated to North America from South America so he could pursue graduate studies in engineering. Five years after immigrating, they had their first child. The couple had waited to have children until Monica's husband had permanent work and they felt more settled. Before their first child was born, Monica had worked part-time with a Spanish importing company. In addition, she focused on developing and mastering her English and taking care of the home. She recalled it as a fun and carefree time. Although her husband was in school, they had sufficient money and enjoyed a relaxed lifestyle, as they made friends and put down roots in their new country. Monica had limited contact with her family of origin. Her parents had split up when she was 16 years old. Her father had remarried, and Monica did not get along with his new wife. Her mother had become angry and rejecting of her children, blaming them for her husband's desertion.

After the birth of her baby, Monica felt very stressed. She worried that she would not be a good mother, that her husband would leave her, and that she would be deserted in her new country—alone, penniless, and without support. When she first entered therapy, Monica focused on her physical symptoms of anxiety, including the feeling of tightness in her chest. She felt overwhelmed caring for her baby and constantly fretted that she could not manage. She had a sense of doom and foreboding and a fear that she was about to disintegrate. At first Monica spoke about what was transpiring in her current life. Her husband was working long hours and she often felt alone and isolated at home with the baby.

Her therapist explored the difficulty Monica had making the transition to motherhood, as well as her sadness at losing connection with her friends at work. It was difficult to stay in touch because they were still working and she found it difficult to socialize and care for the baby at the same time. Monica constantly second-guessed herself. She did not trust her judgment and sought reassurance. She would compare herself with her mother, whom she described as having been very critical and cold when she was growing up. Her mother favored her brother, whereas Monica was expected to do all the chores in the house, taking care of her mother and little brother. Her father was an ambitious man who traveled and worked long hours. He was distant and not very involved in the home.

[1]Client information in this book has been changed to protect confidentiality.

Building a Therapeutic Relationship and Clients' Emotional Processing Capacity

Her therapist noted that Monica was not clear about her feelings. She was easily overwhelmed and often tearful and afraid but did not know why. From the beginning her therapist focused on being empathic, accepting, and prizing of her client's experience, working with her to put it into words. In the beginning Monica found it hard to believe that her therapist was not blaming her for her difficulties, as she herself did. Slowly she came to trust that her therapist believed her and was an ally. Growing more trusting, Monica began to share more of her childhood experience of being neglected and criticized. Her therapist empathically reflected what Monica shared of her experiences, reflecting aspects of the narrative as well as Monica's feelings and experiences of her home life. Together they began to build a picture of a cold, critical, and negative climate at home; a home in which Monica felt alone, unloved, and overburdened, and where her feelings and needs were overlooked.

Working With Negative Treatment of the Self in Two-Chair Dialogues

Initially, to deal with Monica's presenting problem, the therapist introduced a *worry split*. Monica would catastrophize and imagine her baby and her husband becoming ill. She would constantly second-guess herself and worry that she had made a mistake. Noting these markers of worry, the therapist asked Monica how she made herself feel anxious and had Monica enact this in a two-chair dialogue. Monica gained a heightened sense of self as an agent acting on herself by worrying rather than being a passive victim afflicted with worry. Seeing the toll the worry took on her, Monica asked the worrier self to stop. However, the worrier self collapsed in distress, feeling sad and angry that Monica was silencing and rejecting that part of herself, leaving her alone with her feelings of loneliness and pain. The negative way she related to her experience, as well as the pain and fear of rejection from her early childhood experience, became clear. This focused the therapy, as she and her therapist began to work on these two tracks using two-chair and empty-chair dialogues.

Working in two-chair dialogues, it became clear that Monica was very self-rejecting and saw herself as responsible for making everything turn out well. She saw herself as incompetent and was critical when things did not go right. Initially, Monica minimized her mother's behavior toward her. She said she deserved her mother's criticism because Monica was careless and stupid, and her little brother needed more attention from her mother. As she shared her memories and the therapist reflected these experiences empathically, Monica began to acknowledge and recognize the fear of rejection and

pain she experienced in childhood. She began to allow herself to experience her feelings and become more aware of them; she became more aware of how lonely and rejected she felt. However, before Monica was able to fully acknowledge her pain, she had to recognize that she was dismissive of her feelings and blamed herself for the way her mother treated her. Monica would tell herself that if she had been more lovable or more competent, then her mother would have loved her more. She would remind herself of how her mother's life was difficult without allowing that, as a child, she needed attention and care from her mother. The therapist would reflect these blaming statements by asking, "Do you think it was fair to blame the little girl?" or "Do you think it is fair for a child to take care of her parents?"

Working With Relational Injuries in Empty-Chair Dialogues

It was clear that Monica was immersed in her mother's perspective and had not developed her own unique view and experience of the world. An important aspect of EFT is that although the therapist shares some of his or her observations or suggests that certain behaviors are harsh, he or she does not insist that clients accept this view. Rather, the therapist is patient and accepting of clients' experience, waiting until they are willing and able to adopt a different perspective and accept their own experience without seeing themselves through the eyes of a caretaker. Once clients agree that these ways of being are problematic and express a wish to change them, then the therapist moves ahead with tasks like two-chair dialogues to resolve negative treatment of the self or empty-chair dialogues to resolve attachment injuries. Monica needed to feel strong enough to face how she had been treated as a child. She needed to feel she was able to hold her mother accountable and that she deserved more care, attention, and support than she had been given. All of this demanded that she feel deserving of having her needs met and take a stance opposed to her parents and move outside the radius of their protection.

With time, and as Monica slowly internalized her therapist's empathy, warmth, concern, and acceptance, she began to access her anger and sadness. This helped Monica acknowledge that she had been treated unfairly and that she had needed and deserved more love and protection. She saw her mother as rejecting and neglectful. This was an important shift for Monica and allowed her to attend to her own experience and needs. It took time for this perspective to coalesce as Monica oscillated between seeing herself as deserving of love and support or as deserving of her mother's blame and criticism. To work with the self-blame, the therapist introduced two-chair dialogues. As Monica became stronger and better able to process her feelings of anger and sadness and her fears of rejection, she came to validate her own experience and feel like she could stand alone.

In EFT, it is posited that as clients internalize their therapist's positive attitudes of respect, warmth, empathy, and acceptance, they begin to build a stronger sense of self and believe that they are deserving of love, protection, and support. As Monica began to acknowledge how her mother had treated her, she engaged in empty-chair dialogues with her mother to express her pain about how she had been treated and to assert what she had needed from her mother when she was a child. Once she was able to differentiate her emotions and allow herself to feel sadness and grief at what she missed, and to feel anger to protest her emotional abandonment, she was able to set boundaries with her mother. Monica was able to integrate her own needs with those of her mother's once again. She recognized that her mother had been very limited and handicapped by her own life experience. However, Monica was clear that her mother should have found other ways to address her pain and taken better care of Monica.

As this example shows, clients can cycle in and out of empty-chair dialogues and two-chair dialogues across different sessions. These processes are parallel tracks as clients move from working with negative ways of treating the self and then back to focus on the hurt experienced at the hands of another and back again to continue working toward new ways of relating to the self and others. All this work continues in the context of the therapist's remaining empathically attuned and working with clients to help them become aware of their inner experience, label it, give it words, and develop new ways to modulate and express it.

Developing Self-Soothing

In EFT for GAD, it is important that clients develop self-soothing. This occurs initially by internalizing the therapist's attitudes of empathy, acceptance, and prizing, and by learning that the clients can reduce and modulate their distress by attending to their feelings and putting these feelings into words. In addition, clients are provided with more concrete strategies and experience engaging in self-soothing using two-chair dialogues to modulate their painful feelings. An important indicator of change is when clients can effectively modulate their distress in the moment and reassure themselves when feeling distressed, thereby effectively providing comfort. This is often in the form of self-talk as well as activities and redirection of attention to more pleasant and present-focused concerns. Clients learn to interrupt the cascade of negative thoughts and instead are able to reassure themselves that they can cope, that they are not fully responsible for outcomes, and that they can turn to others for support. In the case of Monica, she developed greater confidence in herself, began to trust her perceptions and feelings more, and was able to turn to her husband for support when she was feeling overwhelmed.

She also developed ways to self-soothe, including reading and listening to music. Most important, she learned to be more compassionate toward and less demanding of herself. By the end of therapy, her anxiety had moderated considerably, she was more aware when the demanding castigating voice of her mother emerged, and she would reassure herself that there was no need to be worried. She recognized that she was "fine just the way she was" and that her husband was there to talk with her and was someone with whom she could work out her problems. By the end of therapy, she had internalized her therapist's compassion and developed different ways of self-soothing so that she felt more confident and joyful about her life.

KEY TERMS

Some key terms that are used in EFT are briefly defined as follows.

- *Emotion schemes*: The connections that form among a situation/event/interaction, people's bodily felt sense, their emotions and feelings, their attendant action tendencies, and the meaning or interpretation that they attribute to the experience. Emotion schemes allow individuals to interpret and react to events. They give rise to action tendencies or ways of responding to our environment.
- *Emotion types*: There are four different types of emotion identified in EFT: primary adaptive, primary maladaptive, secondary, and instrumental.
- *Primary adaptive emotions*: The innate, most basic emotional responses to a given situation. These enable people to process and perceive their environment rapidly, automatically allowing for an immediate and adaptive behavioral response. For example, sadness signals a need for comfort, and inclines people to seek nurturance and solace from others.
- *Primary maladaptive emotion*: Primary emotional responses that were originally adaptive responses in harmful, neglectful, and negative environments but have become maladaptive in current contexts. For example, negative life experiences may contribute to neutral and positive stimuli becoming associated with feelings of fear, shame, and sadness as opposed to more pleasurable emotions of joy and contentment.
- *Secondary emotions*: Reactions to primary emotions. Examples include feeling and expressing anger or shame when sad. These types of emotional expressions are maladaptive in that they

prevent the full processing of primary emotions as well as access to the adaptive information provided by primary emotions.

- *Instrumental emotions*: Emotions that do not reflect an innate biological response to the environment. They are not authentic but learned responses that are enacted in interaction with the environment to elicit a specific response from another. Thus, they are used to influence and manipulate the behavior of others. For example, using the expression of anger to intimidate and force someone to submit.
- *Emotional processing*: From an EFT perspective, this is defined as approaching, attending, accepting, tolerating, regulating, symbolizing, expressing, and transforming emotion when necessary.
- *Task*: EFT uses this word to refer to specific client processes in the context of specific interventions that were developed from intense process analysis of small episodes of client and therapist interaction that indicated clients had resolved a specific problem—for example, when clients resolve a conflict between two opposing courses of action, interrupt negative self-talk, and become more compassionate and self-soothing. The main tasks covered in this book are two-chair dialogues for working with negative treatment of the self, including splits; empty-chair dialogues for unfinished business; self-soothing dialogues for emotional pain; empathic-relational work for strengthening the vulnerable self; and relational ruptures for tears in alliance.
- *Two-chair dialogue*: Self–self dialogues that are suggested by the therapist to resolve opposing sides within clients. First used and studied to resolve conflict splits, two-chair dialogues are now used to work with any negative treatment of the self, including self-criticism, self-blame, self-neglect, and worry, among others. Clients speak to an aspect of the self that is imagined in another chair. These dialogues refer to work with self–self processes. Resolving them fully requires negotiation.
- *Empty-chair dialogue*: Self–other dialogues that are suggested by the therapist for clients to express their feelings and needs to an imagined other. Clients are invited to visualize an imagined other sitting opposite them and then to express their feelings and to assert their needs to the other. The primary objective is to facilitate clients' full expression of their feelings and needs to resolve relational injuries and attachment wounds. Although there may be limited opportunity for the other to respond, a short response can provide additional information about the other. If the other's response is empathic and accepting of the

client's position this is helpful and can be validated and supported, as it can be experienced as healing. However, if the other's response is negative, then the therapist is quick to name the negative behavior and shift the client back to his or her own chair. The therapist then provides an empathic response and works with clients to process and express their feelings toward the negative other more fully so as to hold the other accountable.

- *Worry split*: A two-chair dialogue, specifically to access clients' worry messages. It can differ from the usual two-chair dialogue in that vulnerability can often be experienced in both chairs. Therapists need to be aware of this so that they remain empathically attuned and responsive to both chairs.
- *Experiencing chair*: The chair in which feelings are expressed. In two-chair dialogues, a negative process (e.g., worry, self-criticism, self-blame) is activated in one chair to evoke the emotional, bodily felt response in the other chair. It is by accessing clients' primary emotional responses that they are able to access their needs and develop other ways of treating the self that are more self-enhancing and self-protective. In GAD, this process often differs from depression as the worrier self, after being told to stop and relax, may dissolve in distress because it feels that it is being dismissed and invalidated. This reveals the deeper underlying negative treatment of the self, which dismisses painful feelings in an attempt to self-protect.
- *Strengthening the self*: Building a stronger, more resilient sense of self and a positive self-organization that is characterized by feelings of self-worth, self-esteem, self-compassion, self-acceptance, and self-protection. This is a basic process in EFT that is developed through the internalization of the therapeutic relationship conditions of empathy, acceptance, prizing, and congruence along with enhanced ways of processing and regulating emotions and more positive ways of treating the self and experience.

OBJECTIVES OF THIS BOOK

One of the primary objectives of this book is to outline the treatment process in EFT for GAD. The first three chapters provide an overview of EFT and GAD. Chapter 1 articulates an emotion-focused theory of GAD. The etiology of the disorder is described, as well as the cycle of anxiety and worry in which clients routinely engage. Chapter 2 discusses the role of

emotion in GAD and explores different theoretical perspectives that have been advanced to explain and conceptualize the disorder. Important EFT concepts are introduced, including emotion schemes and different types of emotions. Their relevance to an EFT conceptualization of GAD is clarified. Chapter 3 outlines the steps of treatment, including case formulation, developing a therapeutic relationship, building a stronger sense of self, working with anxiety splits, changing negative ways of treating experience, resolving emotional injuries, and developing self-compassion and self-assertion to soothe and protect the self.

The following two chapters focus on the therapeutic relationship—how it is developed and the particular qualities of the relationship that are important to healing. Chapter 4 focuses on how the therapist can facilitate the therapeutic relationship to ensure that it is positive and healing, and on how the therapist can be optimally present in the relationship. Chapter 5 explores the impact of the therapeutic relationship from the client's perspective. The different ways that the therapeutic relationship facilitates healing and support as well as changes in how clients relate to the self and others are explored.

The final chapters focus on specific tasks in EFT and ways of working with clients to treat GAD. The use of chair dialogues to resolve negative treatment of the self and emotional injuries is also discussed. Chapter 6 describes how the EFT therapist uses the worry split to help clients work directly on the worry symptoms and turn the experience of worry into something clients do rather than something that is done to them. In this process, clients either assert their need for rest from the constant pressure of the worry or access the underlying, painful feelings of fear, sadness, and shame that drive the worry process. Chapter 7 focuses on working with negative treatment of the self in two-chair dialogues. These dialogues focus on the ways that clients disregard and dismiss their painful experience and distress. As a result, they fail to symbolize their feelings clearly and are unable to soothe and care for themselves. This chapter addresses how the therapist can work with these processes so that clients can begin to develop more positive ways of relating to the self, including being more self-compassionate, self-protective, and self-nurturing.

Chapter 8 explores how the EFT therapist works with clients with GAD to resolve their underlying relational and attachment injuries using empty-chair dialogues. These dialogues focus on accessing clients' core emotion schemes developed in interactions with the imagined other. To resolve their emotional attachment injuries, clients are asked to visualize an imagined other in an empty chair, express their core pain at their negative treatment, and assert their unmet needs to the imagined other. In the process of accessing and expressing their feelings and identifying their needs, clients become more differentiated and separate from the other. In the process, they validate

their feelings and perceptions and learn to be more self-protective with regard to others. To resolve these injuries fully, clients need to feel strong enough to stand independently and free of the other's influence, to protect and care for the self. Therefore, clients need to have internalized their therapist's attitudes and to have modified their negative treatment of the self to be more attentive to their feelings and deserving of their needs. This helps clients access new emotional responses to old situations. Once they feel more deserving and are able to assert their needs and grieve their losses, they become more self-compassionate and self-protective as well as more self-accepting, self-valuing, and self-caring.

The final chapter, Chapter 9, discusses how clients can develop and consolidate the capacity to self-soothe. A number of alternative strategies are presented, including ways of regulating physiological processes in the moment, as well as more transformational strategies, including seeing the self as a "wounded child." The capacity to self-soothe and feel confident in handling stress develops through the internalization of the therapist's attitudes and ways of being with clients, as well as more concrete self-soothing strategies to relieve distress in the moment. The capacity to self-soothe is the final capstone in the treatment of GAD, leaving clients with ongoing resources to counter stressful life events and take care of themselves when they feel challenged and in need of comfort and support.

This book is intended to appeal primarily to clinicians, psychologists, social workers, nurses, psychiatrists, and other mental health professionals and students who wish to learn more about EFT and specifically its application to the treatment of GAD. It offers a humanistic and experiential perspective of the disorder that provides a distinctive EFT approach to treatment. For those who work with GAD and find it treatment resistant, this book might be especially appealing, illuminating as it does the chronicity and developmental trajectory of the disorder that can make it difficult to treat in short-term therapy. The authors offer recommendations for how to work with clients who do not respond quickly, and we provide guidance to beginning therapists, as well as suggestions and alternative perspectives for more seasoned and experienced health care providers.