

EMOTION REGULATION ACROSS PSYCHOTHERAPY MODELS:

A UNIFYING CONCEPT?

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Abstract

The concept of “emotion regulation” has received increased attention in clinical psychology research and practice over the past three decades. Notable practitioners in the field have recently proposed psychotherapy models that place emphasis on “emotion regulation” as a treatment goal in psychotherapy, including Marsha Linehan (Dialectical Behavior Therapy, DBT, 1993a), David Barlow (Unified Protocol for Transdiagnostic Treatment of Emotional Disorders, UP, 2010), Leslie Greenberg (Emotion-Focused Therapy, EFT, 2002), and Diana Fosha (Accelerated Experiential Dynamic Therapy, AEDP, 2000). Despite the increasing importance of this construct, a review of the relevant literature suggests that it is inconsistently defined and operationalized. This dissertation clarifies how the construct of “emotion regulation” has been conceptualized by different authors. More, it considers the question: Does the shared focus on “emotion regulation” across diverse psychotherapy models represent a convergence of theory and practice among traditionally distinct schools of thought? In the service of answering this question, this project critically examines and compares the four psychotherapy models listed above (DBT, the UP, EFT, and AEDP) and their distinct positions on “emotion regulation.” Because this comparative work does not yet exist in the literature, this project sheds new light on the above questions. Namely, it shows that, despite their diverse theoretical foundations, DBT, the UP, EFT, and AEDP are all based on two main ideas regarding the genesis and treatment of psychopathology: 1) maladaptive cycles involving negative arousal, anxiety, and emotion avoidance play a principle role in the genesis and maintenance of “emotion dysregulation,” and 2) the way to treat “dysregulation” is to break those negative cycles by undoing avoidance. This dissertation also shows that there is significant convergence among the four models regarding their theories of therapeutic action: all four model focus on helping patients develop their

capacities for mindfulness, metacognition, and viscerally experiencing emotions. This dissertation considers to what extent these theoretical convergences translate into practice and comments on the clinical implications and utility of this study. It concludes with questions and future directions for research in this rapidly developing field.

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TABLE OF CONTENTS

CHAPTER I: Introduction	1
Emotion Regulation in Psychotherapy Literature: An Introduction	3
Emotion Regulation: A Research Construct	7
Emotion Regulation: From Research to Clinical Application	8
Emotion-Related Constructs: Definitions	10
Summary and Chapter Outline	13
CHAPTER II: Theory	17
Introduction	17
The Four Models	17
Dialectical Behavior Therapy (DBT)	17
Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP)	21
Emotion-Focused Therapy (EFT)	24
Accelerated Experiential Dynamic Psychotherapy (AEDP)	27
Chapter II: Discussion	30
Theories of Intervention	31
The Unconscious	33
Individual and Dyadic Functioning	35
Making Meaning	36
Summary	36
CHAPTER III: Emotion as Process	38
Introduction	38
Definitions and Use of Emotion-Related Constructs	39
DBT	39
UP	40
EFT	41
AEDP	42
Summary	43
Models of Emotional Processing	44
DBT	44
UP	45
EFT	47
AEDP	50
Chapter III: Discussion	51
Emotion as Multicomponential Process	51
Emotion as Dynamic Process	53
Emotion Generation	54
Summary	55
CHAPTER IV: Emotion Dysregulation: Genesis, Maintenance, and Treatment Target	56
Introduction	56
Theories of Development and Psychopathogenesis	58
DBT	58
UP	60

EFT	62
AEDP	63
Chapter IV: Discussion, Part 1.....	65
Emotions: Function and Dysfunction	73
DBT.....	74
UP	77
EFT	79
AEDP	81
Chapter IV: Discussion, Part 2.....	82
The Adaptive Function of Emotions.....	82
Secondary Responses and Emotional Dysfunction.....	83
Summary and Implications	90
CHAPTER V: Therapeutic Action and Mechanisms of Change.....	93
Introduction.....	93
DBT: The Four “Change Procedures”	94
UP: The “Core Strategies”	99
EFT: The “Three Principles of Change”	106
AEDP: Affective Competence and the Affective Model of Change	113
Chapter V: Discussion	117
Four Points of Theoretical Convergence	117
Points of Divergence.....	120
Insight and the Unconscious	121
Conclusions.....	124
CHAPTER VI: Conclusions, Implications for Practice, and Future Directions.....	125
Summary and Conclusions	125
From Theory to Practice	133
Implications for Practice: An Argument for Integration.....	147
Limitations	149
Future Directions	152
References.....	156

LIST OF FIGURES

Figures	Page
1. The modal model of emotion.....	11
2. The process model of emotion regulation.....	12
3. Emotion-Focused Therapy: Greenberg's model of emotion.....	48
4. Triangle of conflict.....	87
5. Triangle of defensive response: Defense-drive functioning.....	87
6. The four models: Common and distinguishing features.....	133

CHAPTER I: Introduction

The concept of “emotion regulation” has received increased attention in clinical psychology research and practice over the past two decades. Indeed, two authors have recently described research on “emotion regulation” as one of the fastest growing areas in the field of psychology, signaling the importance of this subfield in contemporary psychological discourse (Gross, 2014b; Tamir, 2011). Recent developments in psychotherapy theory and practice have contributed to the expanding literature on emotion regulation: since the 1990s, the field has seen a dramatic increase in the number of psychotherapy manuals and models that place significant emphasis on emotion regulation as a mechanism of change and treatment goal in psychotherapy, as well as the proliferation of such manuals across a variety of treatment settings (Barlow, Allen, & Choate, 2004; Fonagy, Gergely, Jurist, & Target, 2002; Fosha, 2001; Greenberg, 2004; Linehan, 1993a, 1993b).

One notable feature of this trend is that it cuts across the traditional, theoretically distinct schools of thought in the field of psychotherapy. That is, authors of diverse theoretical orientations, including cognitive behavioral, experiential, and psychodynamic,¹ have proposed

¹ Cognitive-behavioral and psychodynamic theories have been two of the most dominant theories that inform psychotherapy practice. Here, “cognitive-behavioral” is an umbrella term that refers to a range of therapy models that are based on the ideas that cognitions (automatic thoughts, core schemas, cognitive styles) and maladaptive learned behaviors are at the root of psychopathology and that modifying cognitions (via cognitive restructuring) and behaviors (via operant conditioning/learning) is curative. “Psychodynamic” is also an umbrella term that refers to a range of different treatment models that are based on the ideas that unconscious conflict within the mind is at the root of psychopathology and that understanding and resolving conflict is curative. Experiential theory has grown out of the humanistic tradition, which represents another school of thought that has had growing influence on psychotherapy theory and practice since the middle of the 20th century. “Experiential,” like “cognitive-behavioral” and “psychodynamic,” is

psychotherapy models that share an emphasis on the role of emotion regulation in psychopathology and its treatment. This raises an important question about the construct of emotion regulation and the roles that construct plays in psychotherapy theory and practice: *Does the shared focus on emotion regulation across different schools of thought in psychotherapy represent a convergence of theory and practice among those traditionally distinct (even, at times, polemically oppositional) schools of thought?*

In order to answer this question, it is necessary to examine distinct psychotherapy models and to ask the following questions:

- *Do the various authors who write about emotion regulation define, operationalize, and use emotion-related terms in the same ways? What is the impact of the various authors' diverse theoretical and philosophical assumptions on how they conceptualize emotion-related phenomena? How much overlap/divergence is there between how different authors understand the nature of emotion-related processes (i.e., emotion, emotion regulation/dysregulation)?*
- *How much overlap/divergence is there between how different authors understand the role that emotion regulation and dysregulation play in the genesis, maintenance, and treatment of psychopathology? How does this influence the ways in which different authors define the targets of psychotherapy treatment?*
- *How much overlap/divergence is there between how different authors understand the mechanisms of psychotherapeutic action, or the ways in which psychotherapy can help transform emotion dysregulation? Does the shared focus on "emotion*

an umbrella term that refers to a range of therapy models that are based on the idea that when people are able to fully experience themselves and their internal and external worlds, when they are able to have a deeply felt sense of what is happening in a given moment, this releases inner adaptive potential and growth.

regulation” across different psychotherapy models point to a convergence in theories of therapeutic action across those different models?

- *To what extent do the theoretical convergences and divergences between the diverse models translate into similarities and differences in the application or practice of those models?*

This dissertation will consider the above-stated questions through the close study of four psychotherapy models that derive from different schools of psychotherapy thought: Dialectical Behavior Therapy (DBT; Linehan, 1993a, 1993b), the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (the UP; Barlow et al., 2010), Emotion-Focused Therapy (EFT; Greenberg, 2002), and Accelerated Experiential Dynamic Therapy (AEDP; Fosha, 2000).² The aim of this project is to describe and critically examine these models’ various and distinct positions on emotion regulation and to what degree there is overlap and/or divergence among them. This study begins here with a review of how the history of the concept of “emotion regulation” and its incorporation into the psychotherapy literature.

Emotion Regulation in Psychotherapy Literature: An Introduction

While the core construct of emotion regulation was first developed and used by developmental researchers in the 1980s, publications on the topic of the role of emotion regulation in psychopathology and psychological interventions have become more common in journals of clinical psychology over the past two decades (Fonagy et al., 2002). In 2007, for

² It is for practical reasons (limitations of time, space, resources), not theoretical ones, that this dissertation is limited to studying four psychotherapy models. The theme of emotion regulation is a focus of a wide range of psychotherapy models and manuals, and there are many other models that could be cited and studied here as part of this project. For example, two well-known therapies that could be included here but are not are Stephen Hayes’ Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 2011) and Leigh McCullough and colleagues’ treatment for “affect phobia” (McCullough, Kuhn, Andrews, Kaplan, Wolf, & Hurley, 2003).

example, the journal *Clinical Psychology: Science and Practice* published a special edition with the aim to detail “efforts to consider the concepts of emotion and emotion regulation in relation to clinical assessment and psychopathology intervention efforts across the lifespan” (Ehrenreich, Fairholme, Buzzella, Ellard, & Barlow, 2007). Collaborations between clinical psychologists and the leaders of the emotion regulation field have also emerged recently: the 2014 second edition of *The Handbook of Emotion Regulation*, edited by James J. Gross, includes several contributions by clinical psychologists that bridge the disciplinary boundaries between clinical psychology and emotion regulation.

Unlike many phenomena in the field, the clinical interest in emotion regulation has not been limited to the domain of research, and it also has not been limited to clinical psychologists of any one theoretical orientation. Rather, both researchers and practitioners from across the field’s major theoretical orientations have contributed to the growing theoretical and empirical literature regarding the relationship between emotion regulation, psychopathology, and psychological treatment (Whelton, 2004). One consequence of this trans-theoretical interest in emotion regulation has been the development of numerous, distinct psychotherapy models that propose that failures in emotion regulation (i.e., emotion dysregulation) play a role in the genesis and maintenance of psychopathology and that successful emotion regulation plays a role in mental health and the treatment of psychopathology. These models thus present emotion regulation as a central treatment goal in psychotherapy.

Today, the psychotherapy models that present emotion regulation as a treatment goal are diverse. In the cognitive-behavioral tradition, for example, the concepts of emotion regulation and dysregulation feature prominently in Marsha Linehan’s conceptualization of the pathogenesis, maintenance, and treatment of Borderline Personality Disorder (BPD), as she

explains in her training manual for Dialectical Behavior Therapy (DBT; Linehan, 1993b). More recently, Linehan and colleagues proposed that emotion dysregulation underlies “etiological and maintenance mechanisms for a large number of mental health problems,” including mood disorders, anxiety disorders, substance use disorders, eating disorders, schizophrenia, and other Axis I disorders (Neacsiu, Bohus, & Linehan, 2014, p. 496).

Another leading figure in the cognitive-behavioral tradition, David H. Barlow, has also proposed that emotion dysregulation plays a role in the development and maintenance of a wide range of psychopathology (Barlow, 2010; Barlow et al., 2004; Barlow et al., 2010; Farchione et al., 2012). Barlow and colleagues argue that the nosological system presented in the *Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition* (DSM-IV; APA, 1994) is problematic in that it “splits” diagnoses that likely have common etiologies and “latent structures,” thus emphasizing the differences and obscuring the similarities among those disorders. These authors argue for a common syndrome that is related to unregulated negative affect (a “general neurotic syndrome” or “negative affect syndrome”) that manifests as the various “emotional disorders.” While these authors have focused their research so far on anxiety and unipolar mood disorders, they theorize that these same etiological factors may also play a role in bipolar, somatoform, dissociative, anger-related, and eating disorders (Barlow et al., 2004; Barlow, 2010; Barlow et al., 2010). These authors thus propose that a “unified treatment for emotional disorders” that targets that underlying general neurotic syndrome may be more effective in treating emotional disorders than the many disorder-specific psychotherapy treatment manuals that have emerged since the publication of DSM-IV (Barlow et al., 2004; Barlow et al., 2010; Farchione et al., 2012).

The concept of emotion regulation also appears in the writing of authors who identify with the experiential psychotherapy tradition. For example, Leslie Greenberg argues that, while failures in emotion regulation lead to dysfunction, successful emotion regulation is a key component of mental health and positive outcome in psychotherapy. In a 2004 article on Emotion-Focused Therapy (EFT), a treatment with growing empirical support, Greenberg proposed that Emotion Regulation, along with Emotion Awareness and Emotion Transformation, constitute three “empirically supported principles of emotional change” (Greenberg, 2004a, p. 1).

Another author who draws from the experiential tradition but also has roots in the psychodynamic tradition, Diana Fosha, similarly contends that affect regulatory problems contribute to “the chronic difficulties in functioning and living that we view as psychopathology” (Fosha, 2001, p. 230). She further argues that affective experience and its regulation are “key transformational agents” in psychotherapy and that one of the aims of psychotherapy is to repair affect regulatory difficulties. These are key components of Fosha’s (2000) Accelerated Experiential Dynamic Therapy (AEDP).

The above-cited authors all highlight the important, if not primary, role that emotion regulation failures and successes play in the development and treatment of psychopathology. This emphasis represents a shift away from traditional cognitive and behavioral conceptualizations of the development or etiology of psychopathology, and it suggests that there is some agreement among these authors, despite their diverse theoretical allegiances, regarding what psychopathology is and how to treat it.³

³ Here, “traditional cognitive therapies” refer to those, like Beck’s (1976), that focus on the pathogenic role that dysfunctional cognitions play in emotional disorders and on “correcting” peoples’ distorted perceptions, thoughts, and beliefs through cognitive restructuring (i.e., eliminating the distortions in and improving the “accuracy” of cognitions).

It would be premature, however, to declare theoretical convergence or consensus among these authors without critical examination of their psychotherapy models. Researchers in the fields of affective science and clinical psychology have pointed out that there is significant variation in how terms related to emotion and emotion regulation are understood and used in the clinical literature (Ehrenreich et al., 2007; Fonagy et al., 2002; Rottenberg & Gross, 2007). This variation calls into question whether the various treatment models that target “emotion regulation” for change actually target the same underlying phenomena. This dissertation seeks to clarify whether the apparent consensus among the treatments proposed by Linehan, Barlow and colleagues, Greenberg, and Fosha is actually borne out through a careful study comparing those treatments.

Emotion Regulation: A Research Construct

The core construct of emotion regulation was first developed and used by developmental researchers in the 1980s. Over time, this subfield has developed into its own relatively distinct research domain (Gross, 1999). It has also become increasingly interdisciplinary, with research contributions from affective scientists as well as developmental and clinical psychologists.

Many of these researchers identify a problem in the field: in the literature on emotion regulation, there are no universally used or accepted definitions of basic terms, including affect, emotion, affect regulation, and emotion regulation (Ehrenreich et al., 2007; Fonagy et al., 2002; Gross, 1999; Gross, 2014b; Gross & Thompson, 2007; Rottenberg & Gross, 2007; Thompson, 1994). Many authors craft their own idiosyncratic definitions of emotion-related constructs, and so there is significant inconsistency and conceptual ambiguity in how these terms are used (Ehrenreich et al., 2007; Fonagy et al., 2002; Gross, 2014b; Rottenberg & Gross, 2007). Two authorities on emotion regulation research, James J. Gross (an affective scientist) and Ross A.

Thompson (a developmental psychologist), have published several articles and book chapters in which they offer definitions of many emotion-related constructs with the aim of establishing a common language for emotion-related phenomena that will reduce the conceptual ambiguity that plagues the field (Gross, 1999; Gross, 2014b; Gross & Thompson, 2007; Rottenberg & Gross, 2007; Thompson, 1994). Though these researchers and their definitions of emotion-related constructs are widely cited by authors who write about emotion regulation, not all who write about emotion regulation have adopted their language, and so the conceptual ambiguity in the field remains.

Emotion Regulation: From Research to Clinical Application

The conceptual ambiguity described above is one reason that several affective scientists and clinical psychologists have cautioned against the hasty translation of emotion and emotion regulation research into clinical and applied interventions. It is useful to point out here that defining terms and developing a language that accurately and clearly captures the complexities of emotion-related processes is no easy task. Fairholme et al. (2010) write that, “A concise, all-inclusive definition of emotion is often elusive because discrete emotions themselves represent a wide and incredibly variable array of experiences” (p. 285). The task is doubly difficult because different classes of emotional experiences can be very closely related (e.g., acute anxious emotion in response to a distinct stimulus vs. anxious mood), and making hard and fast distinctions between them for the sake of linguistic clarity may seem false. Here Wittgenstein’s (1953/2009) concept of “family resemblances” surely applies: different affective/emotional experiences share many features and characteristics, and so the category boundaries between them are fuzzy and hard to define. It is important to acknowledge that failures in translating such

experientially-based and textured phenomena into scientific language may be inherent to the task itself.

Despite these challenges, some general consensus about the meanings of various emotion-related terms is needed so that both clinicians and researchers can effectively communicate about these concepts. Clinically, for example, treatment planning involves identifying treatment goals and objectives that are related to emotion, affect, and/or mood. It may be important for both clinicians and patients to distinguish between these terms for the sake of clarity and precision in defining those treatment goals and objectives (e.g., if a patient's presenting problems include angry and destructive outbursts or panic attacks, emotion regulation interventions may be called for; if a patient's presenting problems include prolonged depressive episodes, mood regulation interventions may be most appropriate). This clarity and precision is also of the utmost importance in the development of treatment models and the measures used to evaluate them. Ehrenreich and colleagues (2007) point out, for example, that when designing clinical interventions to address emotional dysfunction, definitional and conceptual clarity regarding the underlying emotion-related constructs is particularly important so that the intervention's targets of change are clearly defined. Without clearly defined targets of change, it is not possible to assess the efficacy of a treatment. That is, one must define the targets of change of a given intervention in order to identify the constructs and processes that should be the focus of assessment as well as the measures with which those constructs may be assessed.

While there is no single set of definitions that is universally accepted or used in the emotion regulation literature, those offered by Gross and colleagues are the most widely cited and utilized in recent years (Gross, 2014b; Gross & Thompson, 2007; Rottenberg & Gross, 2007). The definitional system proposed by these researchers illuminates the many facets of

emotion-related concepts and provides a useful framework for examining the various therapies that include emotion regulation as a point of focus, and so it will be reviewed here.

Emotion-Related Constructs: Definitions

First, it is essential to differentiate between the most basic emotion-related terms, such as affect, emotion, and mood. These differentiations are particularly important for translating these constructs into the clinical literature and for defining targets of change, as mentioned above (Ehrenreich et al., 2007). While some researchers use the terms emotion and affect interchangeably, many emotion theorists argue for distinguishing between the two terms. Drawing from the work of Eckman (1992) and Frijda (1986), Rottenberg & Gross (2007) write that the term affect is an umbrella category that encompasses all valenced states. Emotion is a special case of affect, a relatively brief response to a specific external or internal stimulus that involves the experiential, behavioral, and physiological systems. Mood is another affective state that lasts longer, is less intense, and is less tied to specific stimuli than is emotion.

Just as it is important to distinguish between affect, emotion, and mood, it is also important to distinguish between different forms of self-regulation. Rottenberg & Gross (2007) use the term “affect regulation” to denote a range of different emotion-related regulation strategies. They describe four different types of affect regulation: emotion regulation refers to “attempts individuals make to influence which emotions they have, when they have them, and how these emotions are experienced and expressed.” Coping refers to “the organism’s efforts to manage its relations with an environment that taxes its ability to respond,” including non-emotional actions like studying to pass an exam. Mood regulation refers to attempts to alter moods. Last, psychological defense refers to “relatively stable characteristics of an individual

that operate outside of awareness to decrease the subjective experience of anxiety and other negative affects” (p. 325).

According to these definitions, “emotion” and “emotion regulation” are fairly specific phenomena that are related to but distinct from other affective phenomena. They are also complex and heterogeneous concepts. Gross (1999, 2014) explains that “emotion” is a multicomponential process involving changes in subjective experience, behavior, and physiology. In order to capture this multicomponential nature of emotion, Gross proposes a “modal model” of emotion. This model is based on the idea that emotional responses unfold in time: a *situation* (an internal or external stimulus) draws an individual’s *attention*, that *attention* leads to an *appraisal*, and that *appraisal* gives rise to experiential, behavioral, and physiological changes, or *responses*. Those changes often lead to a new *situation*, and the cycle starts over again (Gross, 2014b). This modal model is often presented visually in order to illustrate the sequential and cyclical nature of the emotion process (see *Figure 1*).

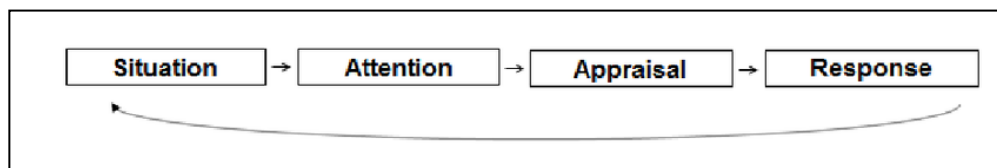


Figure 1: The modal model of emotion (Gross, 2014b)

Like emotion, Gross conceptualizes emotion regulation as a process that includes several component parts. This “process model” of emotion regulation is based on the modal model of emotion: each point in the modal model is a potential target for regulation (Gross, 2014b). A visual representation of the emotion regulation process illustrates how emotion and emotion regulation processes are related (see *Figure 2*).

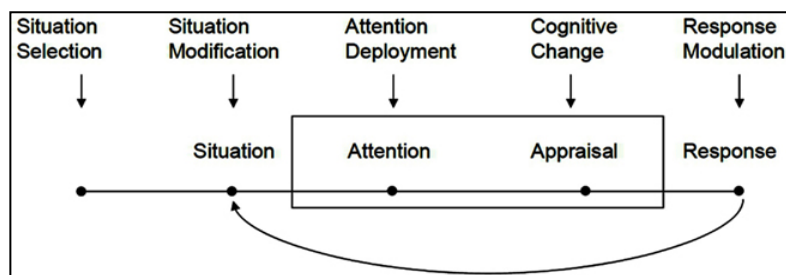


Figure 2: The process model of emotion regulation (Gross, 2014b)

As can be seen in *Figure 2*, *situation selection* and *situation modification* are two emotion regulation processes that involve manipulating an individual's relationship to emotion-provoking situations (in the case of *situation selection*, an individual seeks out or avoids situations that give rise to certain emotions, and in the case of *situation modification*, an individual attempts to modify situations so as to change their emotional impact). *Attentional deployment*, or directing one's attention towards or away from emotion-provoking stimuli, is another process that can be used to change the emotional impact of a situation. The emotional impact of a situation can also be changed through the process of reappraisal, or *cognitive change*. Last, once an emotional response is initiated, *response modulation* can be used to influence the experiential, behavioral, or physiological components of the emotion response (Gross, 2014b).

In addition to breaking down the emotion regulation process into these various subprocesses, Gross also identifies two different types of emotion regulation. One is intrinsic emotion regulation, which refers to regulating one's own emotions. The other is extrinsic emotion regulation, or regulating another's emotions. While intrinsic emotion regulation has been the focus of most research and clinical interventions related to adult populations, extrinsic emotion regulation (in particular, the parental regulation of infant emotions) has been the focus of much developmental research (Gross, 2014b).

Gross' intricate definitional system of emotion-related terms reveals how complex and multidimensional emotion-related processes are. The complexity of these processes makes them challenging to study and research, and as the emotion researchers cited above have pointed out, these problems with conceptual clarity and definitional consistency exist in all literature on emotion regulation, from the theoretical to the applied.

This dissertation will examine how the conceptual and definitional issues described above impact the clinical literature and the interventions that focus on emotion regulation. For the sake of clarity and consistency in this project, unless otherwise specified, this dissertation will use emotion-related terms as Gross (2014b) defines them.

Summary and Chapter Outline

This dissertation seeks to assess to what extent the shared focus on emotion regulation across different psychotherapy models represents a unifying factor, or theoretical and practical convergence, among those different models. As we have seen, the terms “emotion” and “emotion regulation” refer to a multiplicity of processes, and just because two or more interventions purport to treat emotion dysregulation does not mean that those interventions necessarily target the same underlying phenomena, nor does it mean that they necessarily aim for the same treatment goal. For example, a cognitively-oriented therapist may focus treatment for emotion dysregulation primarily on the appraisal/cognitive change points (see *Figures 1 and 2*) in the emotion/emotion regulation processes. An experientially-oriented therapist, on the other hand, may focus treatment for emotion dysregulation on the response/response modulation points in the emotion/emotion regulation processes. Though both treatments may aim to target emotion dysregulation and improve regulatory skills and capacities, these two treatments may be quite different in both theory and practice. The cognitive one would primarily address the cognitive

appraisals and distortions that contribute to emotion dysregulation, while the experiential one would primarily address the patient's subjective experiences of the emotion response. The chapters that follow each focus on a different feature of DBT, the UP, EFT, and AEDP in order to identify points of theoretical and practical convergence and divergence among these treatments.

Chapter II: Theory

The aim of Chapter II is to compare and contrast the underlying theoretical and philosophical positions and the main bodies of research that influence DBT, the UP, EFT, and AEDP. To that end, this chapter provides an overview of each of these four psychotherapy models as well as summaries of the main theoretical, philosophical, and research underpinnings of each model. Outlining the similarities and differences between these different theoretical and philosophical positions will set up a foundation upon which to compare and contrast how the various treatment models conceptualize emotion and emotion regulation processes, which will be the focus of the following chapters.

Chapter III: Emotion as process

Chapter III seeks to answer the following questions posed by this dissertation: *Do the various authors who write about emotion regulation define, operationalize, and use emotion-related terms in the same ways? How much overlap/divergence is there between how the different authors understand the nature of emotion-related processes (i.e., emotion, emotion regulation/dysregulation), and what is the impact of diverse theoretical and philosophical assumptions on how they conceptualize emotion-related phenomena?*

To that end, Chapter III provides a close study of how DBT, the UP, EFT, and AEDP define and use emotion-related constructs. This chapter will address whether the authors under consideration here are clear and consistent in their use of emotion-related constructs, or whether

vague or inconsistent use of terms make it difficult to determine precisely what these authors mean when they claim to target “emotion regulation” in treatment. This chapter also provides an overview of how each treatment under consideration here understands emotion as a process. Beyond the question of whether or not each treatment model distinguishes between emotion-related terms, this chapter asks how much theoretical overlap there is in how the different models understand how experiential, physiological, behavioral, and other factors interact to produce emotional responses. This will further elucidate how these authors conceptualize emotion and emotion-related process, and it will provide an important background for the following chapter, which will take a closer look at the similarities and differences in how the various treatment models studied here understand emotion dysregulation and emotion regulation as targets of treatment.

Chapter IV: Emotion dysregulation: Genesis, maintenance, and treatment target

Chapter IV seeks to answer the questions: *How much overlap/divergence is there between how different authors understand the role that emotion regulation and dysregulation play in the genesis, maintenance, and treatment of psychopathology? How does this influence the ways in which different authors define the targets of psychotherapy treatment?* In addition, it aims to answer one of the central questions posed by this dissertation: *To what degree do theoretically diverse psychotherapy models that target “emotion dysregulation” for change in treatment target the same phenomenon or phenomena?*

In order to answer these questions, Chapter IV compares how the concept of “emotion dysregulation” is understood across DBT, the UP, EFT, and AEDP. This chapter begins with a comparative study of the developmental accounts offered by Linehan, Barlow and colleagues, Greenberg, and Fosha that explain the genesis and maintenance of “emotion dysregulation.” This developmental perspective provides the background for the second part of this chapter,

which examines the similarities and differences between how the authors studied here characterize adaptive emotional functioning as well as how they characterize dysfunctional affective processes, or the targets of change for psychotherapy treatment.

Chapter V: Therapeutic action and mechanisms of change

Chapter V compares and contrasts DBT, the UP, EFT, and AEDP with respect to how each of these treatment models conceives of the mechanisms of therapeutic action and change in psychotherapy. That is, what are the processes by which psychotherapeutic interventions help dysregulated individuals develop the capacities to tolerate and regulate a full range of affective experiences? As such, this chapter aims to answer one of the questions driving this dissertation: *Does the shared focus on “emotion regulation” across different psychotherapy models point to a convergence in theories of therapeutic action across those different models?*

Chapter VI: Conclusions, implications for practice, and future directions

One aim of this chapter is to synthesize the information provided in the previous chapters in order to draw conclusions about the extent to which the focus on emotion regulation in DBT, the UP, EFT, and AEDP represents a unifying factor or point of convergence among these four theoretically diverse psychotherapy models. Another aim is to consider the theoretical and practical implications of the conclusions of this study, including whether these conclusions point towards the possibility of theoretical or practical integration among the diverse therapy models studied here. In addition, this chapter will consider how these conclusions can inform clinical practice. Finally, this dissertation will conclude with a set of questions and recommendations for future research that have emerged from the present study.

CHAPTER II: Theory

Introduction

The aim of this chapter is to compare and contrast the underlying theoretical and philosophical positions as well as the main bodies of research that influence Dialectical Behavior Therapy (DBT; Linehan, 1993a, 1993b), the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP; Barlow et al., 2010), Emotion-Focused Therapy (EFT; Greenberg, 2002), and Accelerated Experiential Dynamic Therapy (AEDP; Fosha, 2000). To that end, this chapter provides an overview of each of these four psychotherapy models, including a summary of the main theoretical, philosophical, and research underpinnings of each model. Outlining the similarities and differences between these different theoretical and philosophical positions will set up a foundation upon which to compare and contrast how the various treatment models conceptualize emotion, emotion regulation, and emotion dysregulation in the chapters that follow.

The Four Models

Dialectical Behavior Therapy (DBT)

Introduced in 1993 with two major publications by Marsha M. Linehan, DBT is an early example of a psychotherapy treatment that presents “emotion regulation” as a core goal in the treatment of psychopathology. The theoretical foundations of DBT are based on cognitive-behavioral principles and also on Eastern spiritual concepts, such as the practice of “mindfulness” deriving from Zen meditative practice (Linehan, 1993a, 1993b). The implementation of DBT, a manualized treatment, is divided between individual therapy and group or individual psychosocial skills training. The skills training focuses on four core “Life

Skills”: *Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and Distress Tolerance*.

The individual therapy focuses on “motivational issues” and on helping patients integrate the skills they learn in skills training into everyday life (Linehan, 1993a).

One of the central aims of DBT is to decrease “emotion dysregulation” that is associated with psychopathology. Linehan originally conceived of DBT as a treatment for individuals with Borderline Personality Disorder (BPD) who engaged in parasuicidal behavior. In her now classic 1993 text, Linehan thoroughly spells out how emotion dysregulation plays a major role in both BPD and parasuicidal behavior. In that text, Linehan tentatively suggested that, though there was not yet research evidence to support using DBT with other populations, the treatment would likely be effective for individuals who present with different diagnostic and behavioral problems. In the two decades since the publication of that text, the DBT literature has expanded enormously, and the treatment has been employed in different treatment settings, both outpatient and inpatient (see, e.g., Bohus et al., 2004; Swenson, Sanderson, Dulit, & Linehan, 2001).

In a 2014 article, Neacsiu, Bohus, & Linehan more confidently assert that DBT’s applicability extends beyond BPD to diverse diagnostic categories, including “BPD with several comorbidities and other psychological disorders in which problems in emotion regulation lead to psychopathology.” They even state that DBT emotion regulation skills have the “potential to serve as a transdiagnostic intervention” (p. 491). They explain that DBT emotion regulation skills are broadly applicable to psychiatric illness and mental disorder because emotion dysregulation is an underlying, pathogenic feature of many Axis I disorders, such as mood disorders, anxiety disorders, substance use disorders, eating disorders, and even schizophrenia and psychotic disorders. That is, because emotion dysregulation is a transdiagnostic

phenomenon, emotion regulation skills serve as a transdiagnostic intervention (Neacsiu, Bohus, & Linehan, 2014).

Emotion dysregulation that is associated with BPD and other psychopathology is thus an important target of DBT treatment. The following sections of this chapter will examine the theoretical and research background upon which DBT is based.

Theoretical influences. *Behaviorism.* Linehan situates DBT in the cognitive-behavioral tradition. The behavioral foundation of DBT is clear in many of the theoretical and practical features of the treatment. For example, in her theory of psychopathogenesis, Linehan focuses on how learning experiences, particularly operant conditioning (patterns of reinforcement and punishment), shape peoples' (often maladaptive) thoughts, feelings, and behaviors. Consistent with this theory, many DBT interventions involve behavioral analysis and behavioral modification through contingency management (i.e., increasing the frequency of desired behaviors through reinforcement and decreasing the frequency of undesired behaviors through withholding reinforcement or through punishment) to address problematic or ineffective behaviors. The theoretical justification for skills training, a central component of DBT practice, also stems from behavior theory, specifically from the behavioral deficit model of dysfunction. Linehan (1993a) explains that this deficit model "assumes that failure to use effective behavior when it is needed is the result of a deficiency; that is, relevant, effective behaviors (i.e., actions plus knowledge of how and when to use them) are absent from the individual's behavioral repertoire" (p. 280). Thus, DBT theory and practice are both firmly rooted in behaviorism.

Cognitive theory. DBT's relationship to cognitive theory is more complex. Linehan (1993a) explicitly distinguishes her theory from traditional cognitive theory: "in contrast to cognitive theories (e.g., Beck, 1976, Beck et al., 1973, 1990), DBT does not view behavioral

dysfunction, including emotion dysregulation, as necessarily resulting from dysfunctional cognitive processes” (p. 38). That is, Linehan does not adopt the basic premises of cognitive theory, the ideas that underlying cognitive schemas and dysfunctional cognitive processes *necessarily* cause behavioral dysfunction and emotional disorder. However, she does acknowledge that cognitive distortions and faulty information processing can contribute to and exacerbate behavioral and emotional problems. Because DBT does not assume that cognitive schemas are responsible for dysfunction, DBT interventions do not necessarily aim to uncover such underlying schemas. Rather, DBT focuses on assessing how individuals’ cognitions and cognitive processes (e.g., their cognitive styles, typical distortions, and maladaptive interpretations/beliefs) trigger and maintain dysfunction. Once the dysfunctional cognitions/cognitive processes are identified, they can be targeted for change with cognitive modification procedures like cognitive restructuring. So, though she does not adopt the focus on underlying cognitive schemas that is present in many cognitive therapies, Linehan does incorporate some cognitive therapy techniques into DBT practice.⁴

Eastern (Zen) meditation. Linehan also breaks from traditional cognitive and behavioral theories in incorporating principles of Eastern (Zen) meditation into DBT theory and practice. Mindfulness practice, for example, is a core component of DBT that derives from Zen concepts. In DBT, mindfulness practice is used to help patients develop awareness of experience and to “experience the moment” and participate in it with awareness. An important tenet of DBT is to

⁴ In a chapter on the evolution of CBT and the rise of psychological acceptance and mindfulness in CBT theory and practice, Herbert & Forman (2011) offer a helpful formulation of how so-called “third wave” CBT treatments like DBT that incorporate acceptance and mindfulness conceptualize the relationship between cognition, behavior, and dysfunction. They write that many of these theories propose that “cognitions can participate in causal chains, but are not granted full causal status with respect to other behaviors” (Herbert & Forman, 2011, p. 16). This helps elucidate how it is possible to reject the basic causal premise of cognitive theory while still retaining elements of cognitive theory and practice.

approach experience as an active observer with a nonjudgmental stance and to experience whatever is happening in the moment without labeling it as “good” or “bad.” The goal of such practice is to develop the capacity to experience emotions rather than avoiding or inhibiting them (Linehan, 1993a).

Dialectics and functionalism. As its name suggests, DBT embraces a dialectical worldview. Linehan (1993a) explains that DBT does not value claims of what is “right” or “accurate,” or other affirmations that assume the existence of an absolute truth.⁵ Instead, DBT values the process of constructing meaning through the transcendence and synthesis of seemingly opposite positions, or the resolution of paradox. In addition to dialectical thinking, Linehan promotes functional thinking. In practice, this means that DBT evaluates individuals’ thoughts and behaviors based on measures of “effectiveness” and functionality.

Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP)

Another manualized CBT treatment for emotional disorders that focuses on emotion regulation as a key mechanism of action in the treatment of psychopathology is the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP), developed by David H. Barlow and colleagues (Barlow et al., 2010; Barlow et al., 2011). The treatment is based on CBT principles but also integrates principles and techniques informed by research on emotion regulation, including interventions focused on examining how thoughts, feelings, and behaviors interact to generate internal emotional experiences (Barlow, 2010). UP treatment interventions

⁵ Linehan argues for the adoption of a dialectical worldview in DBT, but in her writing she seems to make claims that her own ideas (e.g., her ideas about the development and treatment of psychopathology) are “right” and “accurate.” While Linehan’s stance as author does not always seem to fully reflect the dialectal worldview, DBT interventions are quite consistent in that the basis for evaluating thoughts and behaviors is their effectiveness and not their “truth” value. One exception to that, however, is that one of the DBT mindfulness skills involves “checking the facts” about events and basing one’s response to those events on the “facts” rather than on “interpretations” of or “opinions” about the events (1993a).

are broken down into separate modules that each target a different aspect of the emotion regulation process.

The UP aims to help people modify their maladaptive emotion regulation habits and by learning how to “confront and experience uncomfortable emotions” and how “to respond to their emotions in more adaptive ways” (Barlow et al., 2010, p. 17). The therapist guide for the UP, which outlines the theoretical and conceptual foundations of the UP and also includes the UP treatment protocol, states that the UP is designed to address “all of the anxiety and mood (depressive) disorders such as panic disorder with or without agoraphobia, social anxiety disorder, generalized anxiety disorder, post-traumatic stress disorder, obsessive-compulsive disorder and depression” and also “hypochondriasis and other problems associated with excessive anxiety focused on health concerns, as well as many disorders where the experience of dissociation (feelings of unreality) is a principal complaint” (Barlow, 2010, pp. vi-vii). According to the therapist guide, the common factor that links all of these “emotional disorders” is emotion dysregulation, which they describe as an “excessive or inappropriate emotional responding accompanied by a sense that one’s emotions are careening out of control” (Barlow, 2010, p. v). Like Linehan, Barlow and colleagues argue that emotion dysregulation is a transdiagnostic phenomenon and that it plays a major role in the development and maintenance of certain mental disorders. Also like Linehan, Barlow and colleagues propose a “transdiagnostic” treatment for those disorders with special emphasis on the development of emotion regulatory skills (e.g., developing mindful, nonjudgmental awareness of emotions and the physical sensations that go along with them; labeling emotions; relaxation techniques) to combat emotion dysregulation. Emotion dysregulation is thus an important target of UP treatment.

Theoretical influences. According to Barlow et al. (2010), the UP “capitalizes on the contributions made by cognitive-behavioral theorists by distilling and incorporating the common principles found in existing empirically supported psychological treatments” (p. 3). The UP also draws from recent research in “emotion science” and emotion regulation.

Behaviorism. Behavior or learning theory provides an important foundation for the UP. The UP uses the principles of operant conditioning throughout assessment and treatment. Functional assessment, for example, is a “common thread” throughout treatment used to identify patterns of reinforcement that maintain maladaptive behaviors. Results of such assessment shape treatment planning and interventions, including behavioral modification interventions that target problem behaviors.

Cognitive theory. Cognitive theory also provides an important theoretical base for the UP that shapes interventions. While the UP rejects traditional “dual-processing models” that posit that conscious cognitive processes control automatic emotional processes in a unidirectional or top-down manner, their view of emotional processing assigns an important role to “controlled, cognitive processes and behaviors in the production of emotion” (Fairholme et al., 2010, p. 286). Consistent with this position, in the UP maladaptive cognitions are seen as contributing to emotional and behavioral dysfunction, and the treatment involves modules dedicated to cognitive change and reappraisal interventions.

Functionalism and empiricism. Like DBT, the UP evaluates behaviors based on measures of “effectiveness,” adaptation, and functionality. Consistent with this approach, the UP is based on treatments and techniques that have been shown to be “effective” in research studies, and the authors of this treatment emphasize the empirical basis of the UP’s theory and practice. As mentioned above, the authors distilled and incorporated “existing empirically supported

psychological treatments” in developing the UP (Barlow et al., 2010, p. 3). Indeed, UP interventions are diverse, incorporating techniques derived from cognitive, behavioral, and experiential or emotion-focused therapies.⁶ The common theme among these techniques is not that they derive from a common theory, but rather that they all in some way or another have been “empirically” derived or supported.

Emotion-Focused Therapy (EFT)

EFT, developed primarily by Leslie S. Greenberg, is another therapy that includes emotion regulation as an important mechanism of action in the treatment of psychopathology. The aims of EFT include helping people approach, tolerate, regulate and accept emotions (Greenberg, 2002). Theoretically, EFT draws from the experiential, person-centered, and gestalt psychotherapeutic traditions as well as from attachment theory.

Though manuals for disorder- and population-specific EFT treatments have emerged in the last decade (e.g., Greenberg and Watson’s [2005] *Emotion-Focused Therapy for Depression* and Greenberg and Johnson’s [2010] *Emotionally Focused Therapy for Couples*), EFT was originally conceived as a treatment for a nonspecific (i.e., transdiagnostic) clinical population. Like Linehan and Barlow, Greenberg views emotion dysregulation as a major pathogenic factor across a variety of mental disorders and proposes that emotion-focused interventions can serve as a transdiagnostic treatment for such disorders. Thus, emotion dysregulation is an important target of EFT treatment.

⁶ Though they do not explicitly make this point, it is important to note that Barlow and colleagues are selective in the research from which they draw to inform the development of the UP. While they seem open to research from the cognitive-behavioral and experiential/emotion-focused schools, they generally stay away from that from psychodynamically-oriented schools (e.g., David Malan’s (1976b) or Elsa Marziali’s (1984) research demonstrating the positive association between the use of interpretive/insight-oriented techniques and favorable psychotherapy outcome).

Theoretical influences. *Client-centered and Gestalt theories.* In his 2002 book, Greenberg describes the many theories that influenced him on his path to developing EFT, including client-centered, Gestalt, family, psychodynamic, and cognitive approaches to therapy. EFT borrows concepts from all of these approaches. The client-centered and Gestalt approaches are the most obvious influences on EFT, as EFT focuses above all on emotional and other experiential phenomena. Greenberg is also clear that these two therapeutic approaches were particularly influential in determining what the therapist's stance in EFT should be. While the client-centered approach promotes a view of the therapist as facilitator rather than expert, Gestalt therapy promotes a more directive role for therapists. Greenberg (2002) explains that EFT balances these two views and ultimately supports a therapeutic stance that involves "both leading and following" (p. xi).

Cognitive theory. The influence of cognitive theory is also present in EFT. EFT interventions include those aimed at regulating emotions through cognitive modification, reappraisal, and problem solving techniques. Though EFT does include such interventions, they are not the primary focus of treatment. Greenberg (2002) argues that "rational approaches in which an expert therapist sees the errors in clients' thinking and helps clients to be more rational [...] lack depth and an appreciation of the complexity of consciousness." In contrast to such approaches, Greenberg advocates for an approach that emphasizes integrating emotion and reason. Thus, EFT includes treatment strategies that promote emotional arousal and reflection and help people "become aware of when to change emotion and when to be changed by it" (p. xi).

Interpersonal/relational theory. Psychoanalytic theory, particularly the interpersonal and relational schools of thought, also exerts an important influence on EFT's theory of

development. Citing psychoanalytic theorist Daniel Stern (1985), for example, Greenberg (2002) writes that “the self is formed at the boundary between self and other” (p. 79). He elaborates: “Recognition from others is one of the crucial components of a new sense of self. People need confirmation from at least one other person. It is important to recognize that this need is a core ingredient of personal development” (p. 99). In EFT, relational bonds are seen as developmental needs, imperative for and constitutive of identity, personhood, or self.

Understanding EFT’s interpersonal/relational theory of development is important for understanding how emotions are conceptualized in EFT. For Greenberg, emotions are “fundamentally relational.” That is, emotions are not simply tools that can be used for communication, as signals between individuals. Instead, they are the basis of the bonds between individuals, and they are also the foundations upon which an individual’s sense of self develops. This is because empathy—the recognition of one’s emotions by an other—has a “strengthening effect” on an individual’s sense of self. That is, it is through empathic recognition that an individual’s self-experiences are strengthened, confirmed, and made meaningful. In Greenberg’s (2002) words, “People’s selves developed out of such interaction in a co-constructive process in which each party added an ingredient and the mixture provided the recipe for the as-yet-unformulated sense of self” (pp. 37-38). In statements like these, we see that, for EFT, emotional experiences and the sharing of those experiences with others play central roles in the development of a healthy sense of self and thus in healthy functioning.

Emotion theory and research. Greenberg is himself an important emotion theorist, and his contributions to the field of emotion theory are acknowledged by authors across theoretical orientations, including Linehan (1993a), Barlow et al. (2010), and Fosha (2000). His model of emotion is based largely on his own work in this field. In addition, he cites the influence of

emotion researchers Frijda (1986) and Zajonc (1980) who both write about the functional, organizing potential of emotions and about the place of emotion in motivation.

Constructivism. In both theory and practice, EFT focuses on how meaning is co-constructed in dyads, or between two subjectivities. In treatment, the therapist is seen as accompanying the client as a “coparticipant in an exploratory process” and “co-constructor in reality” (Greenberg, 2002, p. xii). These exploratory, constructive processes and the meanings that emerge from them are highly valued.

Accelerated Experiential Dynamic Psychotherapy (AEDP)

Developed by Diana Fosha, AEDP is a psychotherapeutic model that promotes the “dyadic regulation of affect” as an important mechanism of change and treatment goal in psychotherapy. As the title of this model indicates, the theoretical foundations of AEDP are based in the experiential and psychodynamic traditions. AEDP principles are also drawn from attachment theory and research, affective neuroscience, and body-oriented therapies (Fosha, 2000).

Fosha frames AEDP as a treatment for a nonspecific clinical population. Like the other authors mentioned here, she sees problems in affect regulation as underlying a wide range of emotional disorders. Affect dysregulation is thus a primary target for AEDP treatment.

Theoretical influences. *Experiential theories.* The theoretical influences on AEDP are varied. AEDP considers the roles that experience, affect, attachment, anxiety, and conflict play in psychological health. Theories regarding the roles of experience and affect in psychic functioning are particularly important for AEDP, as the experiential domain is a primary focus of treatment. To support this focus, Fosha (2000) draws from diverse scientists, philosophers, psychologists, affect theorists, and psychoanalysts who emphasize the importance of subjective

experience and the felt sense of emotions in adaptive functioning and identity development, including Charles Darwin (1872), William James (1902), Eugene Gendlin (1991), Silvan Tomkins (1962, 1963), Christopher Bollas (1989), and Daniel Stern (1985). Perhaps the most important influence on Fosha in this realm, however, was Habib Davanloo's (1980) Short-Term Dynamic Psychotherapy (STDP). Davanloo's model capitalizes upon the power of the visceral experience of emotion to transform the self. AEDP embraces STDP's idea that affective and visceral experiences have transformative potential, which is a core tenet of AEDP. However, AEDP theory also rejects much of the theoretical foundation of STDP (which Fosha describes as a "received drive-superego theory") in favor of relational and attachment-based theories.

Attachment theory. The role of attachment bonds in psychic functioning is another important focus in AEDP. Citing the work of John Bowlby (1982), Fosha (2000) asserts that the attachment bond is a "primary mechanism" by which individuals regulate their sense of safety. This idea is at the root of Fosha's concepts of psychological health and psychological disorder. For Fosha, when attachments are secure and strong, people have a sense of safety and resilience in dealing with the events of life, be they pleasant or unpleasant. When attachments are insecure or disturbed, on the other hand, people feel overwhelmed and unable to cope with those same events.

Clinical developmental theory. In addition to Bowlby, Fosha (2000) cites the work of clinical developmentalists like Lachmann & Beebe (1992) to argue that it is through our attachments and connections with others that our anxieties are allayed and that we feel empowered to deal with the events of life and the full range of emotions they elicit. Like Greenberg, Fosha conceptualizes emotions as fundamentally relational. Fosha calls emotion a "dyadic phenomenon," and she explains that emotions are "dyadically constructed." Emotional

phenomena do not reside in one member of a dyad or another; they emerge from the interaction between the two.

Psychoanalytic theory. Another important influence on AEDP is psychoanalytic theory. Fosha's theory of psychopathogenesis, for example, is largely indebted to Freud's (1926) concept of signal anxiety, the idea that anticipated trauma triggers signal anxiety, which in turn activates defenses that protect against the feared trauma. Fosha draws from this idea, arguing that when individuals sense that their own affective experiences may threaten their attachment bonds with caretakers or significant others (i.e., when they anticipate that their affective experiences will lead to relational trauma), this triggers "aversive signal affects" (e.g., shame, helplessness, pain, fear). These "signal affects" in turn activate defenses that inhibit or exclude the original, genuine affective experiences that posed a threat to their attachment bonds. In AEDP, these defenses against experiencing genuine core affect are viewed as pathogenic, the roots of intrapsychic conflict.

Short-term dynamic therapies, including but not limited to Davanloo's (1980) STDP mentioned above, also influenced Fosha's conceptualization of the role of conflict in psychic functioning. In order to illustrate how anxiety-driven conflict operates, Fosha draws from the work of David Malan, who uses the "triangle of conflict" to show how an emotional response to a stimulus (e.g., pain over loss) triggers anxiety, which then triggers defenses to reduce both the anxiety and the emotion that triggers the anxiety. Fosha (2000) describes this triangle of conflict as the "main tool" of the experiential or psychodynamic clinician in understanding psychological symptoms and syndromes. According to Fosha, AEDP's focus on defense and conflict, and particularly its focus on the defensive inhibition or exclusion of affective experiences, is part of what makes AEDP a psychoanalytically-informed or dynamic psychotherapy.

Emotion theory and research. In developing AEDP theory and practice, Fosha draws from several different strains of emotion-related research. She points to Darwin (1872) and James (1902), for example, as important pioneers of emotion research who showed that emotions are adaptive and functional and that they have transformative potential. She also points to researchers of the late 20th century who worked to elucidate how cognitive, physiological, and behavioral systems interact to produce emotions and action tendencies (e.g., Ekman, 1984; Frijda, 1986, 1988; Goleman, 1995; Lazarus, 1991). Theorists who emphasize the degree to which emotion is rooted in the body, in visceral experience, have also been particularly influential for Fosha. She cites Darwin (1872) as an important forebear in this regard but also draws from more recent neuropsychological research (e.g., Damasio, 1994, 1999) to support her focus on the body.

Constructivism. Like in EFT, AEDP focuses on how meaning is co-constructed in dyads, or between two subjectivities. AEDP treatment is conceived of as a process of constructing meaning and experience in which therapist and patient mutually influence each other.

Chapter II: Discussion

The four psychotherapy models studied here share a few important features. For example, they all propose that problems in emotion/affect regulation are transdiagnostic phenomena and that emotion dysregulation plays a role in the development and maintenance of a range of emotional disorders as well as personality disorders. They all also focus on improving “emotion regulation” or “affect regulation” in treatment. Because they focus on this phenomenon that underlies such a wide range of psychological disorders, each model is designed

to serve as a treatment for a wide range of psychological disorders.⁷ This represents a departure from the trend of developing disorder-specific psychotherapy treatments, which has dominated psychotherapy literature and research over the past couple of decades, especially since the publication of DSM-IV (APA, 1994).

Despite the similarities between the psychotherapy models presented here, it is clear that the models depart from different theoretical, and philosophical positions and make different fundamental assumptions about the nature of human behavior. The following sections will consider the implications of those differences.

Theories of Intervention

DBT and the UP are both cognitive-behavioral therapies and so are both influenced by cognitive and behavioral theories of clinical intervention. This means that there is significant overlap in the theory and practice between these two treatments: both embrace a behavioral deficit model of dysfunction and conceptualize psychopathology largely in terms of skills deficits in the cognitive, behavioral, or emotional domains. Interventions thus target maladaptive cognitive, behavioral, or emotional functioning and work to build skills in these areas. Both DBT and the UP also depart from traditional cognitive-behavioral theories and therapies⁸ in that

⁷ As mentioned above, though DBT was first developed to treat BPD, Linehan has always speculated that it could be used to treat a wider range of psychological disorders. Indeed, since the publication of her 1993 texts, DBT has been used in a variety of treatment settings and with a variety of populations, and Linehan and colleagues have endorsed this wider application of the treatment (e.g., Neacsiu, Bohus, & Linehan, 2014).

⁸ The “traditional” cognitive-behavioral therapies included those “first-wave” therapies that focused on behavior modification via operant conditioning and “second-wave” therapies that also considered how individuals’ perceptions, interpretations, and appraisals of their worlds shape their experiences and emotions (Herbert & Forman, 2011).

they emphasize the role of emotion and experience in the development, maintenance, and treatment of psychopathology more than do those traditional therapies.⁹

This emphasis on emotion and experience brings DBT and the UP closer in theory and practice to EFT and AEDP, which both have roots in experiential theory. These four therapy models draw from diverse sources to support their emotional/experiential focus. The experiential aspects of DBT are based primarily on Eastern, especially Zen, principles. Those of the UP are based primarily on interventions that have been “empirically supported,” or those that have demonstrated efficacy in psychotherapy research. EFT relies on client-centered and Gestalt theories, and Fosha cites emotion researchers from Darwin and James to Damasio. Though these authors draw from different sources to support their focus in this area, the four treatments’ emphasis on emotional awareness and experience constitutes an important theoretical and practical similarity between the four therapies.

There are also important differences between the different therapies. The most obvious one is that EFT and AEDP are distinct from DBT and the UP in that they are not primarily based in cognitive-behavioral theories. Though EFT includes elements of cognitive-behavioral theory and practice, those elements are incorporated into a treatment that is at its foundations experiential. That is, rather than focusing on cognitive or behavioral processes in conceptualizing psychological function and dysfunction, EFT focuses on experiential and emotional processes as the roots of psychological disorder as well as the roots of psychological healing. Like EFT, AEDP is an experiential therapy and so places far more emphasis on the experiential domain than on the cognitive or behavioral domains.

⁹ The greater emphasis on experience and emotion in the cognitive-behavioral field is not unique to DBT and the UP; it is characteristic of many so-called “third-wave” cognitive-behavioral treatments (Herbert & Forman, 2011).

Though the four models studied here all acknowledge the importance of experiential and emotional processes in psychological functioning and so address these processes in therapy, the theoretical foci of the therapies is different across the different models. Chapter III will address how these different areas of focus impact each model's conceptualization of emotion and emotion regulation processes. Chapter IV will address how these different areas of focus impact the ways in which each model conceptualizes how psychological treatment can target dysregulated emotional processes.

The Unconscious

AEDP is set apart from the other theories because of its roots in psychoanalytic theory and its focus on unconscious intrapsychic conflict and defense in the development and maintenance of psychopathology.¹⁰ This focus on psychodynamics reflects a qualitative difference between AEDP and the other therapies studied here. AEDP proposes that unconscious phenomena, including conflict, are important facets of psychological functioning and motivation and so require attention in psychological treatments. She makes clear that unlocking and working through unconscious conflict is a central aim of AEDP and paves a path towards psychic healing.

In contrast to Fosha, Linehan (1993a) rejects the notion of the unconscious and particularly the notion of unconscious intent or motivation. She emphatically asserts that behaviors are controlled by outcomes (behavioral and environmental) and that to propose that they are motivated by unconscious intent is a logically untenable position. Identifying herself as a cognitive-behaviorist, she explains that:

¹⁰ Though EFT is influenced by psychodynamic theories, the position Greenberg takes on whether conflict and defense are *unconscious* is ambiguous, a point that will be explored more below.

Cognitive-behavioral therapists would not suggest that when behaviors are not under the control of conscious choice or intent, they must be under the control of unconscious intent. Indeed this may be a tautological statement. Instead, the cognitive-behavioral view is that the absence of a connection between intent or choice, and action is the problem to be solved. Such a connection must be learned. It is learned when reinforcing outcomes follow actions that fit previous intent to act or choice. (p. 328)

In addition to rejecting the idea that unconscious intent drives behavior, Linehan explains why people might (mistakenly, in her view) attribute behavior to such intent: according to Linehan, most people are not aware of the contingencies that influence or cause their behavior. When these influences or causes are not clear, people tend to construct reasons to explain their behavior (e.g., that they are unconsciously motivated). She rejects the value of such constructed explanations, as they do not accurately capture the contingencies that control behavior and so cannot be used to change behavior. In her view, such constructions are potentially harmful in that they can obscure the function that maladaptive behaviors actually do have and block the path to changing them when it is adaptive to do so.

Whereas Linehan explicitly rejects the idea of the unconscious, Barlow and colleagues (2010) do so implicitly. Like Linehan, they focus on the ways in which outcomes influence and control behavior. They do not entertain the possibility of unconscious processes influencing behavior, nor do they attempt to refute it.

Greenberg (2002) also does not explicitly articulate a position on the unconscious. He asserts that “people process information at many levels, only some in full consciousness” (p. 36), and throughout his book he makes several references to emotional processes that unfold in “preconsciousness” or “out of awareness.” He also writes about emotions that are not

“symbolized consciously,” and a central aim of EFT is to help people express previously unsymbolized experiences in words (i.e., to help people integrate emotion and cognition). It is not clear whether these statements assume or imply an unconscious.

The different positions that these authors take with regard to the unconscious represent another important theoretical rift between the therapy models that they propose. This theoretical difference is significant in that it has implications for how each treatment conceptualizes psychopathogenesis and the mechanisms by which psychotherapy works. For example, one of the mechanisms of change that Fosha identifies in AEDP is the psychodynamic concept of “making the unconscious conscious,” an idea that is clearly not taken up in DBT or the UP, and may or may not be taken up in EFT depending on how one understands Greenberg’s text. These differences and how they lead the authors studied here to different ideas regarding mechanisms of change in psychotherapy will be further examined in Chapter IV.

Individual and Dyadic Functioning

Another factor that sets EFT and AEDP apart from DBT and the UP is that they conceive of humans as fundamentally relational beings whose attachments play a central role in psychological functioning. EFT and AEDP both propose that emotions are fundamentally relational, that they are dyadic phenomena and emerge when two subjectivities connect and interact. Thus, an individual’s emotional and behavioral functioning cannot be understood apart from that individual’s interpersonal context. This emphasis on dyadic, interpersonal, and intersubjective processes rather than on individual processes represents a major difference in how the treatments studied here conceptualize human functioning. Whereas DBT and the UP focus on the individual (in the context of environmental contingencies) as the primary unit of study, EFT and AEDP focus on the dyad, or the individual as indivisible from an interpersonal

matrix, as the primary unit of study. This difference has significant implications for how the different treatment models conceptualize emotion, its regulation, and its dysregulation, as will be explored further in Chapter III. This difference also has implications for how the different treatment models conceptualize the development, maintenance, and treatment of psychopathology, which will be further explored in Chapter IV.

Making Meaning

Another difference between the four treatment models studied here is their assumptions about how people make sense of their worlds and derive meaning from their experiences, which influences how they conceptualize the process and goals of psychotherapy. Barlow and colleagues take an empiricist stance, assuming that people can make meaning of the world through “accurate” perceptions of external “reality.” Linehan proposes that individuals make meaning of the world through dialectics (i.e., the synthesis of seemingly opposite positions). In contrast, both EFT and AEDP propose that meaning is constructed dyadically, in the intersubjective space created by the meeting and connection of two individuals. These differences have important implications for how each model conceptualizes emotional functioning, which will be explored further in Chapter III.

Summary

This chapter identifies several similarities and differences between the theoretical foundations on which DBT, the UP, EFT, and AEDP are based. The common thread that runs through all of these treatment models is an emphasis on emotion theory and the role of emotions in psychological functioning. The differences between the models are notable: they draw from different clinical traditions as well as different theories of development. Furthermore, the different models are based on different conceptualizations of metapsychology as well as different

assumptions about how people draw meaning from their experiences. While some of these ideas may seem very abstract, they have important implications for how each model conceptualizes emotional functioning. That is, an understanding of the differences between the various models' theoretical foundations provides essential background for understanding differences in how the various models conceptualize emotions and emotional functioning (which will be further explored in Chapter III) as well as the mechanisms by which psychotherapy works to treat dysfunctional emotional processes (which will be further explored in Chapter IV).

CHAPTER III: Emotion as Process

Introduction

A common theme among the different psychotherapy models studied in this dissertation is that they acknowledge and address the role of emotion and emotion regulation processes in the development, maintenance, and treatment of psychopathology. As such, they all explicitly name “emotion regulation” as a target of treatment. This chapter provides a close study of how Dialectical Behavior Therapy (DBT; Linehan, 1993a, 1993b), the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP; Barlow et al., 2010), Emotion-Focused Therapy (EFT; Greenberg, 2002), and Accelerated Experiential Dynamic Therapy (AEDP; Fosha, 2000) define and use emotion-related constructs. As explained in Chapter I, a review of the clinical emotion regulation literature reveals that some of the most basic terms related to emotion regulation, including the terms emotion, affect, and mood, are variously defined by different authors or not defined at all. There is also little consistency in how the term “emotion regulation” is defined. Thus, this chapter will address whether the authors under consideration here are clear and consistent in their use of emotion-related constructs, or whether vague or inconsistent use of terms make it difficult to determine precisely what these authors mean when they claim to target “emotion regulation” in treatment.

This chapter also provides an overview of how each treatment under consideration here understands emotion as a process. Beyond the question of whether or not each treatment model distinguishes between emotion-related terms, this chapter asks how much theoretical overlap there is in how the different models understand how experiential, physiological, and behavioral factors interact to produce emotional responses. This will further elucidate the areas of

convergence and divergence in how DBT, the UP, EFT, and AEDP conceptualize emotion and emotion-related processes.

Definitions and Use of Emotion-Related Constructs

DBT

This section examines how emotion-related terms and constructs are used in the foundational DBT texts (Linehan, 1993a, 1993b). Because “emotion dysregulation” is a major target of DBT interventions, it is an important term that is used throughout these texts. While Linehan most commonly uses the terms “emotion” and “emotion dysregulation” to describe the phenomena that DBT interventions target for change, she also occasionally uses the terms “affect,” “affect regulation,” “mood instability,” and “mood reactivity.” There is no point at which Linehan explicitly defines these terms. She does, however, explain that she uses the term “affect” in a “global sense” that involves multiple emotional response systems.

Linehan’s understanding of affect as a “global” concept that encompasses other emotion-related phenomena is similar to Gross’ definition of affect as an overarching umbrella category that includes all valenced states. Her use of other terms is not consistent with Gross’ taxonomy of emotion-related terms, however, and she uses some emotion-related terms inconsistently within her texts. One term that she uses inconsistently is “emotion.” At one point, she describes “emotions” as “relatively brief, lasting from seconds to minutes” (Linehan, 1993a, p. 44). At other points, however, she applies the term “emotion” to a range of affective phenomena, not just to “relatively brief” ones. For example, she includes intense frustration, frequent anger, depression, and anxiety as different forms of “emotional lability” (Linehan, 1993b). While anger, frustration, and anxiety are all “relatively brief” affective phenomena that fit within Gross’ definition of emotion (i.e., a relatively brief response to a specific external or internal

stimulus that involves the experiential, behavioral, and physiological systems), depression (and sometimes anxiety) are not usually so fleeting and better fit within the category of “mood” as Gross defines it (i.e., an affective state that lasts longer, is less intense, and is less tied to specific stimuli than is emotion) (Gross, 2014b).

The inconsistency of Linehan’s terminology makes it difficult to pinpoint which affective phenomena DBT targets. It seems that the targets of DBT treatment are not limited to emotion alone, but rather to a broader range of affective phenomena. Further study of the theory and practice of DBT is required in order to determine what the precise targets of the treatment are.

UP

This section examines how emotion-related terms and constructs are used in the UP Therapist Guide (Barlow et al., 2010) and Workbook (Barlow et al., 2011) and in a chapter on the role of emotion and emotion regulation in the UP (Fairholme et al., 2010). Like in DBT, “emotion dysregulation” is a target of UP interventions, and emotion-related terms are used throughout the UP literature. The UP authors draw heavily on the research and writing of Gross (e.g., Gross & Thompson, 2007) in defining their emotion-related language, and for the most part they employ the definitions that Gross offers for emotion-related terms. Like Gross (who draws from the work of Frijda, 1986), these authors use “affect” as an umbrella term that refers to the category of valenced states, and “emotion” and “mood” as special cases of affective states: “emotion” is a relatively brief response to specific external or internal stimuli, and “mood” is an affective state that lasts longer than emotion. They also use the word “feeling” throughout their texts to refer to the subjective experience of an affective state. The UP literature also draws on Gross’ conceptualization of emotion regulation. Barlow et al. (2010) define emotion regulation

as “the strategies individuals use to influence the occurrence, experience, intensity, and expression of a wide range of emotions” (p. 15).

The authors of the UP are quite explicit about targeting *emotion* regulation in treatment; they do not discuss targeting other affective phenomena, at least in theory. This raises questions about how, if the UP interventions are limited to targeting emotion regulation alone, the UP can effectively treat such a wide range of anxiety and mood disorders that involve difficulties in regulating a wider range of affective phenomena not limited to emotion. A closer study of how these authors conceptualize emotion regulation is necessary in order to clarify what processes the UP targets for change.

EFT

As is the case with much of the literature on emotion, the literature on EFT lacks definitional and conceptual clarity with regard to emotion-related terms. In his writing on EFT, Greenberg appears to use the terms “feeling” and “affect” interchangeably with “emotion.” For example, in the title of his 2002 handbook on EFT, *Emotion-Focused Therapy: Coaching Clients to Work through Their Feelings*, he uses the word “*feelings*” to point to the target of *Emotion-Focused Therapy* (my emphasis), suggesting that he uses the terms feelings and emotions interchangeably.

Greenberg offers a clearer definition of mood, which is consistent with Gross’ (2014b) definition. He characterizes mood as “an emotion state itself, one that endures over a longer period of time than emotional reactions” (Greenberg, 2002, p. 27). Even within this definition of mood, though, the term “emotion” seems to be used in two different ways. First, the phrase “emotion state” is used to denote a category that includes mood. Second, the phrase “emotional reaction” is used to denote an “emotion state” of shorter duration than mood. Based on his use

of these terms, it appears that Greenberg at times uses the term “emotion” as Gross (2014b) uses the term “affect.” That is, Greenberg sometimes (but not always) uses “emotion” as an umbrella term that encompasses different emotion-related constructs, including mood and feelings. He uses the phrase emotion regulation in a similar fashion. At times, he uses the phrase to refer to the regulation of a wide range of affective phenomena. At other times, he uses the term to refer to the regulation of emotion in the more limited sense of the term. Here Wittgenstein’s (1953) concept of “family resemblances” can help us understand that the affective phenomena that Greenberg writes about have so many overlapping features that it is difficult to categorize and define the boundaries between them, but we can also see how this difficulty translates into trouble pinpointing the affective targets of EFT. It seems that the targets of EFT treatment are not limited to emotion alone, but rather to a broader range of affective phenomena. Further study of the theory and practice of EFT is required in order to determine what the precise targets of the treatment are.

AEDP

One of the central aims of AEDP is to “repair affect regulatory difficulties” (Fosha, 2001). While Fosha most often refers to “affect,” “core affective experience,” and “affect regulation” as the targets of AEDP treatment, she also sometimes uses the terms “emotion” and “emotion regulation” to describe those targets (Fosha, 2000, 2004). Indeed, she explicitly states that in her writing “*affect* and *emotion* are used interchangeably” (Fosha, 2000, p. 16).

Though Fosha (2000) does not distinguish between the terms affect and emotion, she does differentiate several other emotion-related terms that she uses throughout her text. One term is “categorical emotions,” by which she means “those distinct universal emotions such as fear, anger, joy, and sadness, with their characteristic physiological signatures and wired-in

adaptive action tendencies” (p. 16). Fosha further differentiates between these categorical emotions and what she calls feelings: “Categorical emotions are primal, universal, and visceral; feelings, broadly defined, are idiosyncratic and laced with personal meaning, a cognitive-affective mix” (p. 144).

Yet another term Fosha (2000) uses to describe affective states is “core affective experience,” which she defines as “all aspects of emotional life experienced directly and viscerally, in the absence of defenses and anxiety” (p. 16). The concept of “affective experience” in AEDP is thus very broad and refers to a wide range of affective phenomena, not just “emotion regulation” as Gross defines it. Fosha does not follow Gross’ taxonomy of emotional terms, but she does make clear that AEDP targets a full spectrum of affective experiences and states. Further study of AEDP in contrast to DBT, the UP, and EFT will illuminate whether AEDP targets the same types of affective experiences as those other treatments.

Summary

Most of the authors under consideration here do not distinguish between basic emotion-related terms like emotion, affect, and feeling. They are not precise or consistent in how they define and use these core terms. Because of this ambiguity, it is not clear what exactly they mean when they use the term “emotion regulation,” nor is it clear what it means that the various psychotherapy models target “emotion regulation” for change in treatment. A closer study of how these authors conceptualize emotion regulation is necessary in order to clarify which processes the psychotherapy models target for change. This study begins below with a description of each treatment’s model of emotional processing.

Models of Emotional Processing

DBT

Linehan (1993a) proposes that emotions are integrated, full-system responses involving three subsystems: the motoric, cognitive-verbal, and physiological systems. She further elaborates that emotion involves “phenemological [sic] experience (cognitive system), biochemical changes (physiological system), and expressive and action tendencies (physiological plus motor systems). Complex emotions might also include one or more appraisal activities (cognitive system)” (p. 38). In the model of emotion that Linehan proposes, complex interactions between the cognitive, physiological, and motoric systems produce emotions, and emotions then in turn impact subsequent cognitive, physiological, and motor behavior.

Linehan’s conceptualization of emotion bears many similarities to Gross’. That is, both models understand emotions as multicomponential phenomena that involve changes in phenomenological experience/cognition, physiology/biochemistry, and motoric behavior (Gross, 1999, 2014; Linehan, 1993a). While the similarities between Linehan and Gross’ models are substantial, there is an important distinction to be made between the two models. Gross’ (2014b) model (see Chapter I, *Figure 1*) proposes that emotional responses unfold in a linear sequence. As described in Chapter I, a *situation* (an internal or external stimulus) draws an individual’s *attention*, that *attention* leads to an *appraisal*, and that *appraisal* gives rise to experiential, behavioral, and physiological changes, or *responses*. Those changes often lead to a new *situation*, and the cycle starts over again. This model clearly proposes that cognitive appraisal mediates experiential, behavioral, and physiological responses.

Linehan (1993a), on the other hand, argues against the idea of a “linear causal” model of emotion. She proposes that emotional events do not necessarily unfold in a set or definitive

sequence but instead “are always the outcome of complex causal configurations at the same and at many different levels” (p. 38). In rejecting the linear causal model of emotion and proposing a non-linear model of emotion, Linehan also rejects the idea that appraisal necessarily mediates emotional responses and the corollary idea that cognitive processes play a, if not the, primary role in the development of emotion. She sums up this point: “in contrast to cognitive theories (e.g., Beck, 1976, Beck et al., 1973, 1990), DBT does not view behavioral dysfunction, including emotion dysregulation, as necessarily resulting from dysfunctional cognitive processes” (p. 38). Here, Linehan explicitly distinguishes the DBT model of emotion from traditional cognitive theories.

Linehan’s nonlinear interactionist model of emotion is the basis of her conceptualization of proper emotional functioning. This model proposes that all of the emotional subsystems (motoric, cognitive-verbal, and physiological) contribute to adaptive emotional functioning and that no one of these subsystems is primarily responsible for emotional dysfunction. In Linehan’s (1993a) words, “DBT does not assume that any particular behavioral system, such as actions, cognitions, physiological/biological responses, or sensory responses, is intrinsically more important than another in the elicitation and maintenance of problematic behavior” (p. 265).

UP

In the UP Therapist Guide, Barlow and colleagues (2010) describe the UP as “anchored within the three-component, modal model of emotion” (p. 20). Barlow and colleagues conceive of emotion as a multicomponential process involving the experiential, physiological, and behavioral systems. The authors explicitly draw from Gross’ work and adopt Gross’ 4-point model of emotion (situation, attention, appraisal, response) and 5-point model of emotion regulation (situation selection, situation modification, attentional deployment, cognitive change,

and response modulation) (see Chapter I, *Figures 1* and *2*). Indeed, they use Gross' breakdown of emotion regulation into these five separate components to structure the UP. That is, "each of the five emotion regulation components identified within Gross' process model are directly targeted" in the UP (Fairholme et al., 2010, p. 288).

The UP also draws from new developments in emotion research, influenced by the findings of neuroscientific studies, which "extend" the modal model and emphasize that emotions emerge from *dynamic interactions* of cognitions, behaviors (or action tendencies), and physiological sensations (e.g., Barrett et al., 2007; Siemer et al., 2007). The emphasis on the dynamic, interactive nature of emotion is important in the UP. The UP authors reject traditional "dual-processing models" that view emotions as the outcomes of two separate and distinct processing systems ("automatic" emotions and "controlled" cognitions). Instead, they propose that emotion processes are better conceptualized as the results of "parallel processing along an automatic-controlled continuum" (Fairholme et al., 2010, p. 285). That is, they argue that "automatic" (physiological, emotional) and "controlled" (cognitive) processes are not always entirely distinct, and that it is not possible to attribute emotion generation to *either* automatic *or* controlled processes. Instead, the full range of automatic and controlled processes (including cognitive, physiological, and behavioral processes) contribute to emotion generation.

This concept is fairly abstract, and the UP authors do not offer clear examples to illustrate their points. However, it seems that their message is that emotion generation cannot be understood as a linear, unidirectional process, whether top-down (stimulus/situation \Rightarrow cognitive appraisal/interpretation \Rightarrow physiological arousal \Rightarrow emotional response) or bottom-up (stimulus/situation \Rightarrow physiological arousal \Rightarrow cognitive appraisal/interpretation \Rightarrow emotional response). These authors thus use the "parallel processing model" of emotion to show that both

top-down and bottom-up emotion generation processes are possible. That is, “bottom-up, stimulus driven and top-down, goal-driven processes comprise a heterogeneous network that together form coherent interpretations of events and determine plans of action. In this model, emotions represent the final ‘solution’ arrived at through parallel processing networks” (Fairholme et al., 2010, p. 286). Although the UP model of emotional processing acknowledges that emotions can be generated from the cognitive, behavioral, or physiological domains, it emphasizes the role of controlled, cognitive processes in the production and regulation of emotion. The UP departs from traditional cognitive therapies in that it rejects the notion of distinct controlled/cognitive versus automatic/emotion processes. However, the UP also resembles cognitive theories in that it retains an emphasis on the importance of cognitive interpretation and appraisal in the development and regulation of emotions.

EFT

Much like Gross (2014b) and the other authors mentioned above, Greenberg understands emotion to be a multicomponential process. His idea of how emotion unfolds as process, though, is quite different from Gross’. In Greenberg’s (2000) model of emotion, affect, motivation, cognition, and behavior constitute interactive, interdependent, and inextricably linked facets of a dynamic emotion process. Greenberg criticizes models like Gross’ that suggest that the various components of emotion can stand alone, that they happen independently of each other, and that they unfold in linear causal sequences. For Greenberg, an emotion response is not composed of a series of distinct component parts. Rather, an emotion is better described as an “integrated response package” or a “synthesized whole.” He elaborates:

Interpretations, subjective feeling, and visceral and motor responses, however, are not primary indivisible elements; rather, they are processes that unfold over time.

There is no reason to believe that all of one's bodily feedback should reach the brain before any subjective feeling results, or that the interpretation of the situation must be completed before the body can begin to respond, or that a complex emotional experience must occur before interpretation can begin.

Instead, interpretation develops over time, as does feeling, in a continuously interactive sequence, often a very rapid one. The process thus is one in which many elements are constantly being synthesized to construct what one feels.

(Greenberg, 2002, pp. 26-27)

A visual depiction of Greenberg's model of emotion process is presented in *Figure 3*.

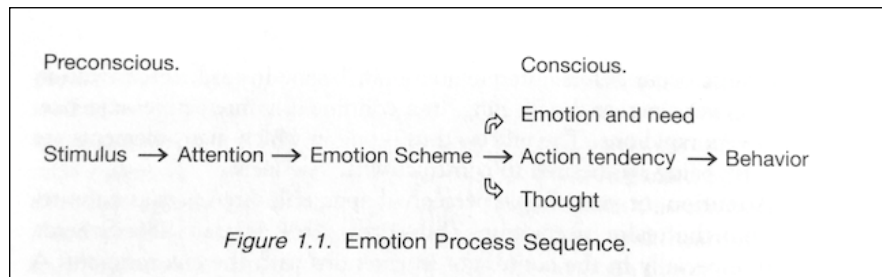


Figure 3: Emotion-Focused Therapy: Greenberg's model of emotion (Greenberg, 2002)

A comparison between Gross' model (see Chapter I, *Figure 1*) and Greenberg's model reveals two important distinctions. First, Gross' model is linear and sequential, beginning with attention to a stimulus, which leads to an appraisal, which then leads to an emotion response. Greenberg's model, on the other hand, does not follow this same sequential order. In Greenberg's model, attention to a stimulus activates an emotion scheme, which then leads to three simultaneous processes: emotion and need, action tendency, and thought. These three processes interact to produce a behavioral response.

The second distinction to be made between the emotion models presented by Greenberg and Gross is that in Greenberg's model, activation of the emotion scheme precedes thought, a shift away from Gross' model in which cognitive appraisal precedes the emotional response. Greenberg writes at length about the ongoing debates in emotion literature regarding the primacy of cognition, bodily responses, or affect in creating an emotion response (see, e.g., the classic debate between Lazarus [1982, 1984] and Zajonc [1980, 1984] about the role of appraisal in emotion). He argues that these debates are of limited value and that a dynamic, interactive understanding of how emotion emerges from its various component parts eliminates the need for the debate. He proposes "an integrative view in which human beings are viewed as actively constructing their sense of reality, acting as dynamic systems that self-organizationally synthesize many levels of information to create their experience" (Greenberg, 2002, p. 27). This, he argues, is a representation of emotional processes that is more accurate than ones that privilege the cognitive or affect systems and also sidesteps the need for polemical debate over the issue.

Greenberg (2002) also argues that his integrative view of emotion is more clinically useful than one that focuses on any one component of emotion. He writes, "In psychotherapy, thinking about how the cognitive and affective systems work together and how each is blended with the other appears far more profitable than ascertaining which comes first" (p. 28). He adds a pointed critique of traditional cognitive models that promote the primacy of cognition in emotional processes, arguing that they can point people in the wrong direction:

What is clear, however, is that the simple linear sequence—cognition leads to emotion, one of the cornerstones of the classical cognitive therapy view of emotion (Beck, 1976)—covers only the most simple means by which emotion is

generated. This oversimplification can be misleading in attempting to understand the complex interactions of emotion, cognition, motivation, and behavior, for people often are not witness to the internal processes by which they become emotional. (Greenberg, 2002, p. 28)

The message Greenberg communicates here is not that emotional responses precede cognitive ones or that emotion is more primary than cognition in psychic life but that an appreciation for the complexity, interaction, and dynamism of the affective and cognitive systems serves us best in helping us understand emotion and its disorder. He also argues that it is the most clinically useful model of emotion; that is, the dynamic model of emotion is most helpful in understanding how it is possible to intervene with emotional disorder and dysfunction.

AEDP

According to Fosha (2000), “affect is a multifaceted phenomenon” (p. 14). She describes the experience of affect as a cycle that involves attention, appraisal, experience (including visceral experience and physical sensations), expression, motivation (or adaptive action tendencies released by core affects), communication, and mutual coordination. Fosha’s conceptualization of the unfolding of an emotion response has significant overlap with the modal model of emotion presented by Gross. Both are presented as cycles with attention, appraisal, and response as key points in the cycle.

There are also important ways in which Fosha’s model represents a departure from Gross’s. Fosha’s model is fundamentally a relational model. This can be seen in a number of ways. For one, Fosha’s (2000) model includes not only expression of emotion (i.e., the emotion “being put out”) but also communication of emotion (i.e., “reception [of the emotion] by the

other”) (p. 25). For Fosha, expressing emotion is not the end of the story; the emotion must be received by an other in order to complete the cycle.

Additional evidence of the relational nature of Fosha’s model is captured in her inclusion of “mutual coordination” as part of the emotion cycle. Fosha (2000) explains,

“Reaching a state of affective coordination with an other releases adaptive relational tendencies [...] that foster further development of the relationship, deepen the bond, promote intimacy and closeness, and within it, deeper knowledge of the other and the self. Security of attachment is enhanced, strengthening exploration and psychic resilience. (p. 28-29)

Fosha conceives of the individual as inseparable from his/her relational matrix. Even the act of appraisal in Fosha’s (2000) model is imbued with the fundamental relational nature of human experience: she describes appraisal as “a refined, relationally informed appraisal of the meaningfulness of a situation for the individual” (p. 24).

Fosha does not explicitly articulate whether she envisions the various steps in the emotion cycle as being distinct, divisible entities or whether she sees them more like Greenberg, as indivisible, interdependent, and interactive. She also does not specify if she sees them as unfolding in linear sequence.

Chapter III: Discussion

Emotion as Multicomponential Process

DBT, the UP, EFT, and AEDP all conceive of emotion as a multicomponential process. In line with emotion researchers like Gross (2014b), DBT and the UP posit that emotion emerges from the interaction of the cognitive, physiological, and behavioral domains (Barlow et al., 2010; Linehan, 1993a). Greenberg’s (2002) model is similar, but in EFT emotion is seen as emerging

from the interaction of affect, motivation, cognition, and behavior. Fosha (2000) proposes that attention, appraisal, experience (including visceral experience and physical sensations), expression, motivation (or adaptive action tendencies released by core affects), communication, and mutual coordination all interact to produce emotions.

Both Greenberg and Fosha present models of emotion that depart from the formulations offered by Gross, Linehan, and Barlow and colleagues. These departures represent significant theoretical rifts between their models and the cognitive-behavioral ones and so will be examined here. First, Greenberg includes “affect” as a component of emotional processes. He does not explain exactly what he means by this inclusion, and this is an example of how conceptual ambiguity and lack of definitional precision make this author’s writing on emotion somewhat difficult to understand. One can only speculate as to what he means in this case (e.g., perhaps he means to suggest that affect is not *secondary* to or just a *product* of cognitive, behavioral, and motivational factors but is instead another fundament of human experience; or perhaps he means that one’s other affective states—one’s mood, for example—contributes to the emotional process). Whatever he does mean by including affect as a component of the emotional process, his inclusion of affect as a basic element of functioning makes clear that he sees affective experience as being at the heart of human functioning, as basic and fundamental to human functioning as are cognitive, behavioral, and physiological processes. This view is consistent with his experiential, emotion-focused theoretical orientation, so here is one example of how theoretical orientation impacts an author’s conceptualization of emotion.

Second, both Greenberg and Fosha include motivation in their formulations of emotion. Including motivation as a component of emotional process suggests that behavior is controlled not only by outcomes or consequences, as in behavioral or learning theory, but that behavior may

also be controlled by other conditions, like needs and desires. Greenberg and Fosha both emphasize the importance of attachment needs and desires in motivation, reflecting their relational, attachment-based views of humans. In EFT and AEDP, individuals cannot be understood apart from their interpersonal or relational matrices. Humans incline towards connection and attachment, and that inclination infuses all of human experience. Thus, Greenberg and Fosha include this very fundamental human motivation in their formulations of emotion.

Fosha's model is also distinct from the others in that she includes not only expression but also communication and mutual coordination as core components of emotional processing. Again, this inclusion reflects Fosha's vision of humans as fundamentally relational.

Emotion as Dynamic Process

The ways in which the models of emotion processing proposed by DBT, the UP, EFT, and AEDP are similar are also worthy of note. The different treatments espouse slightly different formulations of the various component processes that contribute to an emotional response, but all agree that "emotion" is a dynamic, multicomponential process. In doing so, they all reject linear, causal models of emotion generation. These models all also reject the ideas that appraisal always precedes an emotional response and that appraisal *necessarily* mediates emotional responses.

Greenberg is the author who most explicitly identifies and discusses the shift in the field of affective science away from linear, causal models of emotion and towards dynamic, interactive models. He situates this shift within a historied debate about the primacy of cognition, bodily responses, and affect in generating emotion responses that has represented a controversial and polarizing split in the field (e.g., Lazarus, 1982, 1984; Zajonc, 1980, 1984).

Linehan, Barlow and colleagues, Greenberg, and Fosha all seem to avoid taking one of the polarized positions and instead adopt integrative views about how cognitive, behavioral, and physiological processes generate emotion. The consensus between these authors of different theoretical orientations, some more cognitively oriented, some more emotionally and experientially oriented, seems to represent a paradigm shift in this regard. Rather than continue the polemical debate, they all embrace the idea that the emotional subprocesses are in constant dynamic interaction and reject the idea that any one subprocess is primary.

Emotion Generation

While there seems to be theoretical consensus among the treatments studied here regarding the dynamic nature of emotional processes, the different treatments still emphasize the role of cognitive processes (i.e., appraisal) in emotional functioning to varying degrees. Linehan, Greenberg, and Fosha espouse models of emotional processing that deemphasize the role of appraisal in emotion and promote instead an orientation towards the body and the experiential domain. Barlow and colleagues, in contrast, adopt a parallel-processing model of emotion generation that emphasizes the role that appraisal can play in emotion generation at least as much, if not more, than it emphasizes the role that “automatic,” physiological processes can play. Thus, the UP differs from DBT, EFT, and AEDP in its emphasis on cognitive processes in emotion generation.

Whether a treatment emphasizes the role of experience in emotion generation, as DBT, EFT, and AEDP do, or whether it emphasizes the role of appraisal in emotion generation, as the UP does, has implications for both theory and practice. As will be explored in more detail in the following chapters, these different emphases translate into differences in how each treatment conceptualizes the immediate causes of dysregulation (i.e., some models place greater weight on

the role that cognitions play, while others place greater weight on the role that other experiential phenomena play in triggering dysregulation), how they conceptualize the mechanisms of action of treatment, and what kinds of interventions they use to effect change in treatment.

Summary

In addition to the theoretical and epistemological differences identified in Chapter II, this chapter identified several ways in which DBT, the UP, EFT, and AEDP differ with regard to how the various treatments conceptualize emotion itself: DBT and the UP define emotion as an experience that takes place within an individual as that individual interacts with the environment, and they both posit that emotional phenomena can be best understood in the context of their antecedents and consequences. In contrast, EFT and AEDP define emotion as an intersubjective phenomenon that is often shaped by attachment-based needs. According to Greenberg and Fosha, emotional phenomena can only be understood in their relational contexts. Another difference between the various treatments is the degree to which they emphasize the role of cognitive processes in emotion generation. The following chapters will explore how the differences identified here translate into theoretical and practical differences in how DBT, the UP, EFT, and AEDP conceptualize the etiology and treatment of emotion dysregulation.

CHAPTER IV: Emotion Dysregulation: Genesis, Maintenance, and Treatment Target

Introduction

Chapter II of this dissertation identified several ways in which the theoretical foundations of the four psychotherapy models studied here—Dialectical Behavior Therapy (DBT; Linehan, 1993a), the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP; Barlow et al., 2010), Emotion-Focused Therapy (EFT; Greenberg, 2002), and Accelerated Experiential Dynamic Psychotherapy (AEDP; Fosha, 2000)—differ. Chapter III examined the ways in which those differences in theoretical positions lead to different conceptualizations of emotion in each treatment model. This chapter follows with a comparison of how emotion dysregulation is understood in each model. As such, this chapter aims to answer one of the central questions posed by this dissertation: To what degree do theoretically diverse psychotherapy models that target “emotion dysregulation” for change in treatment target the same phenomenon or phenomena?

In order to answer this question, this chapter begins with a comparative study of the developmental accounts offered by Linehan (1993a), Barlow and colleagues (2010), Greenberg (2002), and Fosha (2000) that explain the genesis and maintenance of “emotion dysregulation.” Differences between the models will be highlighted, including the differences in how the models understand the roles that operant conditioning, internalized objects/object relations, and interpersonal experiences (e.g., validation, empathic attunement with others) play in the development of the self and in the development of one’s capacities to tolerate and modulate affective experiences.

This developmental perspective provides the background for the second part of this chapter, which examines the similarities and differences between how the authors studied here characterize functional and dysfunctional affective processes. The aim of this section is to clarify to what degree the authors' ideas about emotion dysregulation overlap or diverge, and by extension, to what degree their ideas about the targets and aims of emotion-focused treatment overlap or diverge. One area of overlap that will be explored, for example, is the consensus among all of the authors that affective avoidance is a central factor in psychopathogenesis and that undoing avoidance (i.e., experiencing affects fully) is an essential step in easing the symptoms and distress associated with affective dysregulation. An important point of divergence that will be examined is the authors' differing ideas about the nature of affective avoidance and whether it stems from skills deficits, efforts to preserve important attachment bonds, or unconscious psychic conflict. Understanding these differences is important, as they lead the various authors to different conclusions about *how* to undo pathogenic affective avoidance. These differences—differences in the theorized mechanisms of therapeutic action—will be explored in the following chapter.

Emotion regulation skills, strategies, capacities: A note on terminology. This dissertation uses the word “skill” to denote the cognitive, emotional, and behavioral response repertoires that are necessary to produce effective or adaptive outcomes (Linehan, 1993a). In the context of emotion regulation, “skills” refer to the response repertoires that promote emotion regulation rather than dysregulation. While the term “skills” is only applied to those repertoires that lead to adaptation and regulation, the term “strategies” can be applied to repertoires that are

either effective/adaptive or ineffective/maladaptive.¹¹ That is, certain response repertoires (e.g., bringing awareness and mindfulness to affective experiences) are effective or adaptive emotion regulation strategies, while others (e.g., emotion avoidance) are ineffective or maladaptive emotion regulation strategies that ultimately fail. Other related phrases that are used in this dissertation are “regulatory capacities” or “capacity for regulation.” Rather than referring to a set of responses or repertoires, this phrase refers more broadly to the ability to tolerate and modulate affective experiences.

Theories of Development and Psychopathogenesis

DBT

In her foundational DBT texts, Linehan (1993a, 1993b) proposes a biosocial theory of emotional development. She contends that emotion regulation difficulties can be attributed to the interaction of biological and social variables: biological differences make some individuals more vulnerable to emotions than others, and environmental differences can make it easier or more difficult for individuals to develop the skills to regulate their emotions. When individuals who are biologically more vulnerable to emotion grow up in dysfunctional or invalidating environments that do not provide the scaffolding or modeling they need to learn effective emotion regulation skills, they are more likely than others to develop chronic problems with emotion dysregulation. Linehan explains that her developmental model, which she calls “dialectical or transactional,” is distinct from a diathesis-stress model. While a diathesis-stress model may assume the independence or autonomy of individual and environment, Linehan’s dialectical/transactional model proposes that biological and environmental factors are continuously interactive and interdependent and so constitute an indivisible system.

¹¹ This is a distinction I make for the sake of clarity in this dissertation; it is not a clear distinction that is made in the literature.

Linehan (1993a) elaborates on what constitutes emotional vulnerability: it is a temperamental predisposition towards having high sensitivity to emotion stimuli, emotional intensity, and slow return to emotional baseline. This combination generally leads individuals to experience high levels of emotional arousal for prolonged periods of time. While acknowledging that the biological mechanisms of emotion dysregulation are unclear, Linehan points to research that highlights problems in limbic system reactivity and attention control as potential sources of emotional dysfunction.

Linehan also elaborates on what constitutes environmental dysfunction. She focuses most on the concept of the invalidating environment, one in which a child's expression of private experiences is met by inappropriate responses. For example, when children are teased for crying, they learn that there is shame in sadness. Some parents shrink away from their children's anger, which communicates that anger is terrifying and uncontrollable. Both of these reactions send the message that emotions are trivial or unacceptable, and it may have a punishing effect on children's willingness and ability to experience and express emotion.

In invalidating environments, children do not learn basic emotion regulation skills such as how to label arousal or tolerate emotional distress, and they instead learn to avoid emotional experiences in order to steer clear of the aversive consequences that come with them. Invalidating environments also fail to teach children to trust their own responses to events. That is, by communicating to children that their responses to events are inappropriate, the invalidating environment casts doubt on children's ability to assess and respond to different situations, which they internalize. Furthermore, because moderate expressions of emotion rarely elicit attention or helpful responses in invalidating environments, children who grow up in such environments must express their emotions in extreme ways in order to get the attention or responses they need.

In such environments, moderate expressions of emotion are not reinforced and so are effectively extinguished, while extreme expressions of emotions are reinforced. As such, children learn that extreme expressions of emotions are more effective in getting them what they need than are modest or moderate ones.

It is important to note that, according to Linehan's formulation, invalidating environments need not be hostile or intentionally invalidating. Citing mother-infant research by Malatesta & Haviland (1982), Linehan (1993a) writes, "parents' tendencies to imitate an infant's emotionally expressive behaviors constitute an important factor in optimal emotional development" (p. 54). She further argues that while mirroring an infant's expressions of emotion is validating, failing to imitate or mirror an infant's expressions of emotion may be invalidating.

DBT's theory of how emotion dysregulation emerges in the context of psychic and emotional development, then, is that biologically-based emotional vulnerability interacts with invalidating environments, which leads to emotion regulation skills deficits and, thence, emotion dysregulation. This theory of pathogenesis is based on behavior theory; that is, people suffer from emotion dysregulation because their maladaptive and ineffective attempts to cope with stress (e.g., extreme expressions of despair, including suicidal threats) are reinforced while more adaptive attempts at coping (e.g., self-soothing) are punished or not reinforced. In consequence, their behavioral repertoires include more maladaptive than adaptive coping strategies.

UP

Like DBT, the UP attributes emotion dysregulation and related psychopathology to skills deficits. This idea is clearly articulated in the UP therapist guide: "Deficits in adaptive emotion regulation skills are a core feature of these disorders, as individuals with anxiety and mood

disorders often use maladaptive regulation strategies that contribute to the persistence of symptoms” (Barlow et al., 2010, p. 4).

In explaining the factors that contribute to the development of emotional disorders, Barlow and colleagues propose a “triple vulnerabilities theory.” According to this theory, emotional disorders develop in individuals who have both biological vulnerabilities (i.e., temperamental inclinations towards negative affect) as well as “generalized psychological vulnerabilities” (i.e., early life experiences that make them more susceptible to negative affect, such as disruptive or traumatic experiences through which they learn that they cannot predict or control events in the world). This theory proposes that generalized biological and psychological vulnerabilities do not generally lead to dysfunction until they are activated by stressful life events. Once activated, an individual may experience the emotional dysregulation associated with emotional disorders like depression and anxiety. Barlow and colleagues also propose that there is a third vulnerability to emotional disorder, a “specific psychological vulnerability,” or the learning of irrational fear responses (i.e., learning that certain situations or objects are dangerous even when they pose no objective threat) (Barlow et al., 2010).

Barlow and colleagues’ theory of pathogenesis is both a diathesis-stress theory and a behavioral deficit theory. The theory emphasizes how failing to learn effective coping skills (or learning ineffective coping skills)—through modeling and operant conditioning—contributes to the vulnerabilities or diatheses that, in the presence of stress, lead to emotional disorder. The implication is that people suffer from emotion dysregulation because they never learned the skills to cope with stressful circumstances and so do not have them readily available in their behavioral repertoires.

EFT

Like in DBT and the UP, in EFT successful emotion regulation is framed as depending in part on emotion regulation skills. Greenberg (2002) uses a developmental, relational model to explain how emotion regulation skills develop. According to this model, under optimal developmental conditions children develop emotion regulation skills through interactions with empathic, affectively-attuned caretakers. These caretakers can recognize, validate, and support the full range of their children's emotions. These caretakers can also soothe their children when necessary. Through the process of internalization, the children develop the capacity to provide these regulatory functions for themselves. Thus, for Greenberg and EFT, the origins of emotion regulation are in the dyadic regulation of affect.

When developmental conditions are suboptimal and children do not have the opportunity to interact with affectively-attuned caretakers, the development of regulatory functions is stunted. Suboptimal developmental conditions involve caretakers who cannot recognize, validate, or support the full range of their children's emotions. For example, children's emotions, especially when intense, may elicit their caretakers' discomfort, withdrawal, or attack. Children who face these kinds of reactions become aware that their emotions can disrupt their connections with important others, and they associate the expression of their emotions with unwanted and unbearable emotional aloneness. Rather than experiencing and developing the capacity to regulate emotions, then, such children "defend" against the emotions that their caretakers cannot tolerate (i.e., they avoid, blunt, or mask those emotions) in order to preserve their attachments with their caregivers.

These suboptimal conditions can be pathogenic. People who have limited capacity to regulate their emotions are vulnerable to dysregulation in the face of both major and minor threats to their security. In Greenberg's (2002) words,

Some people may feel unable to self-soothe, because they lack the internal emotional structures or processes to relax and to calm or nurture themselves.

They might not have received enough of this as children and might not have built an internal, nurturing parent representation on which to draw. When relationships are momentarily disrupted, such people feel desperate and have difficulty holding onto the sense of security generated by the lived history of the relationship. Then it is difficult for them to buffer even minor disruptions, and they are unable to project a vision of a secure future to the relationship. They thus experience tremendous threat, or a sense of violation, as though the distance or slight rupture means the relationship is over. (p. 270)

This passage provides a summary of Greenberg's theory of psychopathogenesis and highlights the role of internalized representations of nurturing parents and relational security in the development of healthy and effective internal emotional structures and processes.

AEDP

Like EFT, AEDP's theory of psychopathogenesis focuses primarily on how relational factors contribute to the development of problems with emotion regulation. Also like EFT, AEDP's theory draws heavily from attachment theory (e.g., Bowlby, 1980). Fosha's (2000) theory highlights the "pathogenic force of aloneness" as well as the self-affirming and curative power of sharing experience with attuned and empathic others (p. 7). Fosha proposes that, under optimal developmental conditions, children develop the capacities to regulate their own affect

through experiences of dyadic affect regulation. In dyadic regulation, the caretaker and child are engaged and open with each other, and they achieve a state of mutual affective attunement, termed the “mutual coordination of affective states.” This mutual coordination allows the dyad to tolerate difficult emotions together. Difficult emotional experiences that may be too overwhelming for either partner of the dyad to handle alone are handled through the pooled resources of both partners. A caretaker may offer a child structure, guidance, support, physical contact, affection, or understanding in order to help buttress the child’s regulatory capacities in the face of difficult situations. Both caretaker and child can then internalize these regulatory experiences, a process that expands their individual regulatory capacities. The end result of dyadic regulation is that the attachment ties within the dyad are preserved and both partners can better experience, express, and make use of their emotions, which contributes to the development of a healthy and integrated self (Fosha, 2000, 2001).

When developmental conditions are not optimal and children do not experience the dyadic affect regulation that is so crucial to the development of their own regulatory capacities, they experience problems with affect regulation. Fosha (2000) writes,

Psychopathology is rooted in the failure of the individual’s emotional environment—either through errors of omission (neglect, inadequacy) or errors of commission (outright abuse, humiliation, rejection)—to facilitate the regulation of his affective experience when he is unable to do so alone. (p. 71)

The effect of such environmental failure, according to Fosha (2000), is that children feel anxiety—“the mother of all psychopathology” (p. 47). When unable to turn to others to ease their anxiety, children are forced to become their own caretakers. They often attempt to protect themselves from overwhelming emotions by reducing their exposure to such emotions. This

requires avoiding certain emotional experiences and ultimately restricting their emotional repertoire. Fosha refers to these protective maneuvers as “defenses.” Though they originate as efforts to adapt to challenging circumstances, defenses can end up limiting and constricting an individual’s emotional life and psychic development when they are overused. The consequence, according to Fosha, is excessive and pathogenic anxiety that hinders effective emotion regulation. In Fosha’s (2000) words, “Here is the seed of psychopathology: when reliance on defenses against emotional experience becomes chronic as a result of the failure of the emotional environment to provide support, psychic development goes off course” (p. 5).

Chapter IV: Discussion, Part 1

Theories of development and psychopathogenesis. All of the psychotherapy models studied in this dissertation recognize that both diatheses (e.g., biological factors, temperament) and environmental conditions (e.g., stress, caregiver responsiveness) play roles in psychic development, but there are differences in how the various models explain how each factor impacts development. Barlow and colleagues’ (2010) diathesis-stress model, for example, proposes that generalized biological and psychological vulnerabilities generally do not lead to dysfunction unless they are activated by stressful life events, such as trauma. This formulation emphasizes the unidirectional influence of the environment on the individual: external stress activates internal vulnerability.

Linehan (1993a) proposes a dialectical/transactional theory of development, which accounts for the ways in which individuals and environments mutually influence each other. According to Linehan’s model, overtly traumatic or stressful environmental conditions are not the only triggers for later emotional dysfunction. Rather, emotional dysfunction may emerge when emotionally vulnerable individuals grow up in environments ill equipped to manage their

particular emotional vulnerabilities. Linehan considers not only the ways in which environments stress vulnerable individuals, but also the ways in which vulnerable individuals (i.e., those who are biologically predisposed to intense and highly reactive emotions) stress their environments. When child and environment mutually stress each other, the child often fails to learn “how to label and regulate arousal, how to tolerate emotional distress, and when to trust her own emotional responses as reflections of valid interpretations of events” (Linehan, 1993a, p. 42).

Greenberg (2002) also embraces the idea that, over the course of development, the nature of the relationship between individuals and their environments is mutually influential. Unlike Linehan, however, he focuses not only on whether the environment is validating or invalidating, but also on the quality of attunement and attachment between children and their caregivers. Greenberg’s theory of development is at heart a relational one: it is premised on the ideas that humans’ primary motivation is to be in relationships with others and that in order to feel safe in the world, people must trust and have confidence in the security of their relationships. Children develop this trust, confidence, and security in their attachments when they have experiences with their caregivers in which the caregiver is able to empathically attune to and tolerate the child’s emotions. Children who are secure in their attachments feel safe and trust that they will not be left alone with unmanageable emotions. They internalize soothing, nurturing, and stable parental representations so that even when they find themselves alone, they can draw upon their internalized representations to help them cope with intense emotion. Trauma can disrupt this process of optimal development, as can poor fit, or the inability for child and caregiver to establish a secure attachment. The result of such suboptimal development is that children do not form secure attachments and so do not internalize nurturing objects that they can draw upon, even in the absence of those objects, to soothe themselves and help regulate their own emotions.

Fosha's (2000) stance on development is similar to Greenberg's. Like Greenberg, she bases her theory of development on the premise that the primary human motivation or drive is to be in relationships with others, and she also highlights the importance of attachment and internalized psychic representations in the development of adaptive regulatory capacities. Her ideas depart subtly from Greenberg's in that she argues that what is important in the development of regulatory capacities is not the internalization of an other, or an object, but the internalization of a relationship, or an object relationship. That is, under optimal developmental conditions, children internalize their experiences of relating to nurturing others, mutual coordination, and dyadic regulation, and these internalized dyadic experiences are what individuals (both children and caregivers) draw upon to sooth themselves and regulate their emotions. Without experiences of mutual coordination and dyadic regulation, individuals do not have the opportunity to internalize such experiences and so lack the inner resources to effectively manage their emotions.

When considering their respective theories of development, it is clear that the behavior theory that shapes DBT and the UP is different from the attachment-based one that shapes EFT and AEDP. As explained in Chapter III, the attachment-based theories are founded on the idea that humans have an innate drive to be in relationships with other people and that that drive is the primary motivator of human behavior. DBT and the UP, on the other hand, do not share this idea that interpersonal relating is *necessarily* the primary motivator of human behavior and so do not privilege or prioritize relating/relationships in the same way that EFT and AEDP do in their theories of development.

Learning versus internalization. The ideas that regulatory capacities develop through the internalization of objects and object relationships, embraced by Greenberg (2002) and Fosha

(2000), also set their theories of development and pathogenesis apart from behavioral theories of development, like those of Linehan and Barlow and colleagues. Linehan (1993a) and Barlow and colleagues (2010) hold the view that emotion regulation skills are like any other behaviors: they are learned and maintained via modeling and operant conditioning. Following the rule of behavioral theories, DBT and the UP explain how emotion regulation skills develop with reference to only overt, observable behaviors. Greenberg and Fosha do not deny that modeling and learning play a role in the development of emotion regulation capacities, but they contend that the internalization of objects or object relationships is the primary way through which people develop the capacity to self-regulate. Both Greenberg's and Fosha's accounts of development assume and depend on the existence of internalized psychic representations, an idea that behavioral theorists generally regard as "unobservable," not something that can be assumed, and as such an idea that cannot be used to understand or shape behavior.¹² Here again it is clear that the theoretical premises that underpin DBT and the UP are incompatible with those that underpin EFT and AEDP.

Self/identity. Another topic on which DBT, EFT, and AEDP differ from the UP is that of whether the concepts of selfhood or identity are factors to be considered in the context of psychic development and emotion regulation. While the concept of the self is absent from the UP literature, Linehan (1993a) writes about how confusion around self or identity leads to emotion dysregulation. She explains that, for individuals who experience identity confusion, every moment is "experienced in isolation, and thus is variable and unpredictable rather than stable. In addition, there is no other moment in time to modulate the impact of the current

¹² Attachment theorists and researchers (e.g., Mary Ainsworth, Mary Main, Peter Fonagy, Beatrice Beebe, Frank Lachmann) would argue that such internalized representations *are* observable and can be measured through procedures like the Strange Situation (Ainsworth & Bell, 1970) or the Adult Attachment Interview (Main, 2000).

moment.” These individuals experience every negative interaction or feeling as if it were “infinite reality,” and so those experiences become overwhelming and impossible to manage (p. 36). The inevitable result is emotion dysregulation.

In the EFT literature, Greenberg (2002) writes about how a strong sense of self or identity is a prerequisite for adaptive emotion regulation. When one’s sense of self is strong, one “feels clear, excited, and strong” and so can “arrive in a definite manner at what he or she is experiencing.” Arriving at an experience is important in EFT and is a major component of emotion regulation, for, as Greenberg says, “one cannot leave a place until one first arrives there” (p. 79). That is, one must arrive at an emotion, acknowledge it, and allow oneself to experience it before one is able to move on from that emotion and onto other experiences and emotions.

The concept of self is also important in Fosha’s writing on AEDP. Fosha (2000) draws on the work of Harry Stack Sullivan to explain how problems in maintaining a cohesive self lead to problems with emotional processing and thus pathology:

When the individual’s affective needs exceed the affective competence of his others, the self must compensate for the environmental failure. The self divides, of necessity becoming its own caregiver, and much effort becomes invested in security operations (Sullivan, 1953, 1956). The individual needs to develop defenses, the adaptive goal of which is to restrict the impact of affects, feared to be unendurable and overwhelming to the psyche. The consequences of internalizing these defenses and building affective restriction into psychic structure is what pathology is—and what therapy seeks to undo. (p. 71)

Here, Fosha describes the consequences of environmental failure and the fate of a divided self. Elsewhere in her text, she describes the alternative, a healthier developmental path: when the environment and caretakers are “good enough,” a true, essential, or authentic self is able to develop. According to Fosha, when accessed, that essential self “knows what’s right and true” and so can manage intense and difficult affect (p. 32).

Though Linehan, Greenberg, and Fosha offer different accounts of healthy and unhealthy self-development, they share the idea that individuals’ quality of self- or identity-development influences their capacities to regulate their emotions. The UP stands out in this study as the only treatment model that does not share this idea (Barlow et al., 2010). This difference has implications for how the different therapy models view the role of relational experiences in development (including the development of regulatory capacities), which will be addressed below.

The role of relational experiences in development. As with the concept of selfhood, the idea that relational experiences uniquely influence development is absent from the UP literature. Barlow and colleagues (2010) do not seem to distinguish relational experiences as qualitatively different from any other type of experience. In this model, skills or behaviors are learned because they are reinforced. Reinforcement may come in the form of relational experiences (e.g., affection, praise, validation), but it need not.

In contrast, in the DBT literature Linehan (1993a) suggests that interpersonal interactions play a formative role in the development of one’s own sense of identity. She writes, for example, that “people form a sense of identity through their own observations of themselves as well as through others’ reactions [to] them” (p. 61). When this process goes awry, people fail “to

experience their essential relatedness with other people,” which contributes to identity confusion, as is often seen in individuals with borderline personality disorder (p. 36).

According to Linehan (1993a), experiences of validation by others are unique in the interpersonal landscape and play a special role in healthy self-development. As noted above, invalidating environments tend to lead to emotion dysregulation and psychopathology. Validation, on the other hand, strengthens individuals’ trust in their emotional responses “as reflections of valid interpretations of events” (p. 42). The sense of trust and confidence in one’s own perceptions that comes from validation is a prerequisite for the development of effective emotion regulation skills and thus for adaptive functioning.

Greenberg (2002) and Fosha (2000) also recognize relational experiences as unique facilitators of healthy development; indeed, for these authors relational experiences are the *sine qua non* of adaptive development and emotion regulation. Their ideas about how such experiences contribute to development, however, differ from Linehan’s. Whereas Linehan emphasizes the role of validation, Greenberg and Fosha emphasize the role of experiences of being recognized and mirrored by empathically-attuned others. Fosha (2000) describes the effects of empathic attunement: “By seeing one’s affects outside oneself, so to speak, in the countenance of the other, they become more real,” and, “Seeing one’s affects thus mirrored outside oneself deepens their resonance and multiplies their associations; they become more alive and differentiated” (p. 22).

Empathic attunement versus validation. Though they seem like similar phenomena and are often used synonymously in psychotherapy literature, there is a meaningful difference between what Linehan calls validation and what Greenberg and Fosha call empathic attunement. According to Greenberg and Fosha, empathic attunement involves a dyad in which one member

not only recognizes the other's feelings but also *feels* the other's feelings and reflects them back to the other. In this process, the members of the dyad share an affective experience. Fosha (2000) offers a clinical vignette that illustrates this phenomenon:

Patient: So that's kind of like the best way I can describe the feeling.

Therapist: Oh, it's very eloquent. It's very eloquent. You know, and I think that's what makes me feel hopeful, very hopeful about our working together. I think it's a sense of connection, you know, I mean you've just expressed it to me in a very deep way, and I have felt it as well with you. (p. 184)

In her commentary on the case vignette, Fosha (2000) writes that in this moment the therapist comments on the "affects they [patient and therapist] just shared" (p. 184). She contends that these experiences of sharing affect are transformative in the contexts of both development and psychotherapy: they help children/patients learn about and understand their affective lives and so play a role in constituting a strong sense of self and identity.

Validation, on the other hand, does not necessarily involve one member of a dyad feeling the other's feelings. Validation is a comment on and response to an other's emotional experience. It may involve the therapist's *sympathy* for the patient, but it need not be affectively charged at all. The point of validation is not for both members of a dyad to share an affective experience but rather for one member to confirm that the other's affective experiences are reasonable and well-grounded responses to events. For example, the statement "Given all that you have been through, it makes sense that you would feel angry right now" is a validating statement.

According to Greenberg and Fosha, empathic attunement is an intersubjective, co-constructed phenomenon. Greenberg (2002) describes a dyad's experience of empathic attunement as "a co-constructive process in which each party added an ingredient and the mixture provided the recipe for the as-yet-unformulated sense of self" (pp. 37-38). This idea leads him to conclude that "the self is formed at the boundary between self and other" (p. 79). Fosha (2000) takes a similar stance, arguing that both members of a dyad are active "partners in constructing the individual's psychic structure" (p. 124) and that "experience co-constructed through the interaction of dyadic partners promotes optimal development" (p. 61). Linehan's theory of development and how validation contributes to it is not an intersubjective or co-constructive model. It emphasizes how caretakers can support their children's intrapsychic development by reassuring them—from the outside, from a position of separation and otherness rather than one of coordination and attunement—that their emotional responses to events are valid.

This chapter has so far identified several ways in which the therapeutic models studied here differ with regard to their theories of development and psychopathogenesis. It continues below with an explication of the differences between how each model conceptualizes adaptive emotional functioning, emotional dysfunction, and the targets of emotion-focused psychotherapy.

Emotions: Function and Dysfunction

In 1872 Darwin wrote *The Expression of Emotion in Man and Animals*, in which he argued that emotions serve adaptive functions for the organisms that experience them: they provide information about the environment and play an important role in helping organisms adapt to changing circumstances. A classic example of the adaptive function of emotions is the

valuable information conveyed through the experience of fear: fear alerts organisms that they are in danger and activates the sympathetic nervous system so that they can either fight off threats or flee from them (the fight or flight response). Without fear, organisms would not know when to take protective measures against environmental threats and would likely not be able to survive changing circumstances. The idea that emotions can be functional and adaptive (when properly regulated) has been adopted by most modern emotion theorists and is a keystone of the theories that drive DBT, the UP, EFT, and AEDP. Thus, all four models argue that emotions become dysfunctional when their adaptive potential is blocked. The following sections examine how each of the four models understand the processes through which the adaptive potential of emotion is blocked and emotions become dysfunctional.

DBT

In the DBT literature, there is significant emphasis on the ways in which emotions can promote adaptation. Linehan (1993a) argues that healthy emotional functioning occurs when the adaptive potential of emotions can be realized and maximized. Emotions become dysfunctional, on the other hand, when they interfere with adaptation rather than promote it.

For Linehan, then, there are two categories of emotion. The first, called primary emotions, are instinctual, “authentic” responses to internal or external stimuli that provide useful information to individuals about present and changing circumstances and so are functional and promote adaptation. Secondary responses—reactions to primary emotions—are, in contrast, learned. While some secondary responses can be adaptive, Linehan focuses on the maladaptive ones (e.g., secondary shame in response to primary fear, or secondary anxiety in response to primary anger). These maladaptive secondary responses can mask primary emotions and can cause people to deny, avoid, and/or inhibit primary emotions. When people inhibit their primary

emotions because of aversive secondary responses, they miss out on the adaptive and functional information that primary emotions provide.

Linehan (1993a) argues that, even though primary emotions can be negative and uncomfortable, they are not the chief source of emotional distress in emotionally dysregulated individuals. Instead, secondary responses (including shame and emotion inhibition) are the major contributors to such emotional dysregulation. The distress associated with primary, adaptive emotions is generally containable. The distress associated with the ascendancy of secondary responses, however, feels uncontainable and out of control and leads to the dysregulation and high emotional reactivity that characterizes BPD and other affective disorders.

According to Linehan's (1993a) formulation, the mood and emotion dysregulation that we see in many different forms of clinical and personality disorders stem from secondary responses to primary emotions, including secondary responses that involve attempts to inhibit, avoid, or otherwise control primary emotions. That is, an individual's attempts to rigidly control emotions and to reduce contact with or felt sense of emotions have a paradoxical effect. While this strategy may effectively reduce the individual's experience of uncomfortable emotions in the short-term, it inevitably increases the experience of uncomfortable emotions in the long-term. Linehan argues that, rather than reducing emotional reactivity, emotion inhibition actually increases emotional reactivity. Clinically, this can manifest as the emotional lability that characterizes BPD and other emotional disorders, including "difficulties with episodic depression, anxiety, and irritability, as well as problems with anger and anger expression" (Linehan, 1993a, p. 11).

Because secondary responses such as emotion inhibition and other forms of excessive emotional control paradoxically *increase* rather than decrease emotional reactivity, such

problematic inhibition and control processes are among the main targets of DBT treatment.

Linehan differentiates between maladaptive emotion *control* and adaptive emotion *regulation*.

DBT does not aim to help individuals better “control” which emotions they have and which ones they do not or to eliminate the experience of negative or uncomfortable affective experiences.

On the contrary, DBT aims to help individuals develop awareness of the full range of their primary adaptive emotions, and to effectively manage or regulate their responses to them. This involves working across the three emotional subsystems (cognitive, phenomenological, and motoric), and it often involves *increasing* rather than decreasing contact with and experience of primary emotions, including uncomfortable ones like grief.

One aim of DBT treatment is therefore to reduce the distress and dysfunction associated with secondary responses and to unlock and realize the adaptive function of primary emotions through effective emotion regulation rather than ineffective emotion control. This does not mean that individuals must always and endlessly be in touch with feelings of grief and disappointment. One characteristic of primary emotions that sets them apart from secondary responses is that they have a contained lifespan. Secondary responses can last interminably, but primary emotions, when sufficiently attended to, have a natural endpoint. Thus, in DBT, “The synthesis toward which the therapist works in the patient is the ability both to grieve deeply and to end grieving; the ultimate goal is for the patient to build and rebuild her life in the light of current realities” (Linehan, 1993a, p. 93). This statement communicates an important aspect of DBT theory: accessing and experiencing primary emotions “deeply” allows people to move on from those emotions and to focus on building a life worth living in the present.

UP

For Barlow and colleagues, the inability to cope with one's emotions is a problem because such difficulty prevents one from being able to experience the function and benefits of emotions. Like Linehan, Barlow and colleagues (2010) distinguish between primary emotions (the "first" emotional reactions that provide information about present circumstances, or "nature's clever way of signaling to us what is going on in our world right now") and secondary responses (like DBT, the UP focuses on maladaptive secondary responses, which are usually negative, judgment-laden reactions to primary emotions and have to do with past or future concerns—not present concerns) (p. 71).

Because they are negative and judgment-laden, maladaptive secondary responses can make people feel like primary emotions are threatening and unwanted and can lead people to avoid or inhibit their primary emotions. Furthermore, because these maladaptive secondary responses are often not based on present circumstances, they provide information that is often irrelevant to the present, and they can even obscure or distort the realities of the situation at hand and thus interfere with an individual's ability to adapt to changing circumstances. Thus, secondary reactions are more likely to lead to emotional disorder than functional primary emotions. Primary emotions can be uncomfortable, but because they provide valuable information about the environment, they generally promote adaptive functioning rather than hinder it.

Like DBT, the UP targets maladaptive secondary responses for change and aims to reduce the degree to which they interfere with the experiencing and processing of primary emotions. The UP focuses in particular on emotion avoidance, a type of secondary response that involves suppressing, hiding, or ignoring emotions. Barlow and colleagues (2010) explain that

emotion avoidance is maladaptive because, though people use strategies like avoidance to decrease contact with their emotions, these strategies often backfire. Emotion avoidance has a paradoxical effect: rather than helping an individual get rid of an unwanted emotion, it often prevents the individual from gaining any healthy distance from the emotion and so prolongs the negative and unpleasant effects of the emotion. According to these authors, experiential avoidance develops into a “pattern that may erupt in a vicious cycle of increased physiological and emotional arousal, leading to more unsuccessful attempts at suppression or avoidance, which in turn contributes to growing psychological distress” (p. 15). This pattern is the root of emotion dysregulation.

In focusing on increasing emotion regulation, the UP does not prescribe eliminating or even reducing exposure to emotions. On the contrary, the UP recognizes that excessive attempts to control emotions lead to increased distress and dysregulation. The UP *does* prescribe increasing awareness and experience of primary emotions, which is one of the main aims of treatment. In the words of Barlow and colleagues (2010), the UP is “an emotion-focused treatment approach” that is “designed to help patients learn how to confront and experience uncomfortable emotions, and to respond to their emotions in more adaptive ways” (p.17). Thus, the goal of the UP is not to eliminate uncomfortable emotions. Adaptive emotional functioning, as it is conceived by Barlow and colleagues, does not exclude emotional discomfort. The UP regards uncomfortable emotions as inevitable and even potentially adaptive (when they are primary emotions and not secondary reactions), and so the UP aims to bring “emotions back to a functional level, so that even uncomfortable emotions can be adaptive and helpful” (Barlow et al., 2010, p. 17). In the UP, then, emotion regulation involves strategies that promote awareness

and experience of primary emotions coupled with strategies that reduce the anxiety, distress, and dysfunction associated with secondary responses.

EFT

As in DBT and the UP, EFT makes a distinction between adaptive emotions and maladaptive emotions. According to Greenberg (2002), adaptive emotions convey important information about the environment and an individual's relationship to it, and they are important for survival (e.g., fear tells us that we are in danger and need to escape, anger tells us that we are being violated and would benefit from some change in the environment). Without these emotional cues, or "core gut responses," we would have trouble adapting to and surviving changing circumstances. Thus, adaptive emotions have an organizing influence on individuals; they help mobilize the self for action and so constitute the main source of what Greenberg calls our "emotional intelligence."

Maladaptive emotions, on the other hand, do not effectively help organize or mobilize individuals for action. Instead, they make people feel disorganized, confused, overwhelmed, and stuck. Greenberg (2002) writes that maladaptive emotions come in three different forms: primary maladaptive emotions, secondary maladaptive emotions, and instrumental emotions.

Primary maladaptive emotions originate as adaptive emotions. They are core gut responses to threatening stimuli that become maladaptive when they persist in the absence of the threatening stimuli. Primary maladaptive emotions are often present in those who suffer from trauma. For example, a soldier's adaptive and appropriate fear of loud noises that sound like gunshots when in battle becomes maladaptive and disorganizing when that fear of loud noises persists in non-combat contexts. Secondary emotions, on the other hand, do not originate as primary adaptive emotions. They are not core gut responses; they are responses to or defenses

against primary adaptive feelings. A secondary emotion, for example, could be uncontrollable and overwhelming anger triggered by loss, sadness, or grief. Secondary emotions are problematic because they often mask or obscure primary adaptive emotions and thus strip those primary emotions of their organizing, mobilizing potential.

The third category of maladaptive emotions, instrumental emotions, are emotions that people use to influence or manipulate others (e.g., crying in order to elicit sympathy or experiencing and displaying anger in order to intimidate others). Instrumental emotions tend to be global and nonspecific; they “represent a style of interacting with others to get what is wanted or needed” that is often consistent across different types of situations (Greenberg, 2002, p. 115). Because such emotions can put unwanted and excessive demands on others, they can have negative interpersonal consequences, such as driving others away.

According to Greenberg’s (2002) theory, then, emotion dysregulation involves the blocking of adaptive primary emotions and the experience of maladaptive emotions (primary, secondary, or instrumental). Greenberg points out that emotion dysregulation usually presents clinically in one of two ways. Some individuals present as emotionally under-regulated: they experience high emotional reactivity stemming from maladaptive emotions, along with the distress and behavioral dysfunction that goes along with chronically high levels of emotional arousal. Other individuals present as emotionally over-regulated: they rigidly defend against their emotions and so are overly constricted, unable to access their primary adaptive emotions and thus unable to benefit from their functional and adaptive potentials. Like in DBT and the UP, the aim of EFT is not to eliminate uncomfortable emotions but instead to reduce the degree to which maladaptive emotional responses interfere with the functioning of adaptive primary emotions.

AEDP

According to Fosha, when functioning efficiently, affective experiences have great adaptive and even transformative or healing potential. Like Linehan (1993a), Barlow and colleagues (2010), and Greenberg (2002), Fosha (2000) draws on emotion theorists (e.g., Darwin, 1872; Fridja, 1986; James, 1902) to support her idea that, when fully and appropriately processed, emotions are “self-regulating” and functional; they are sources of liveliness and energy. She uses the term “core affect” to describe spontaneous affective experiences that unfold in the absence of defenses; these vital and authentic affective experiences activate adaptive action tendencies and have “the power to engender a potentially healing state transformation” (p. 15).

In addition to their intrapersonal functions, emotions also serve interpersonal functions. Fosha (2000) defines “affective competence,” her term for the ability to regulate emotions adaptively, as “feeling and dealing while relating” (p. 42). That is, affective competence is a tripartite skill set involving *feeling* (i.e., experiencing emotions fully without the interference of psychological defenses), *dealing* (i.e., maintaining integrity of self and functioning without being overwhelmed), and *relating* (i.e., maintaining connections to important attachment figures). Feeling without dealing results in high emotional reactivity that threatens one’s integrity and ability to function. Dealing without feeling involves “eradicating” feelings (and their adaptive functions) in order to cope. Relating is important because people cannot fully experience the adaptive, transformative, and healing functions of emotions when they feel alone and isolated. Here is more evidence of the relational foundations of Fosha’s (2000) model: maintaining attachment is an essential part of AEDP’s vision of optimal emotional functioning.

According to AEDP theory, experiencing core affect and achieving affective competence is impeded by the use of defenses against emotional experiencing and processing. Chronic use of these defenses blocks the adaptive functions of emotions and leads to psychopathology. In Fosha's (2000) words, "People disconnect from their emotional experience, afraid of being overwhelmed, humiliated, or revealed as inadequate by the force of feelings, only to pay the price later in depression, isolation, and anxiety" (p. 13). For Fosha, this emotional disconnection and the consequent depression, isolation, and anxiety are hallmarks of emotion dysregulation.

According to Fosha's theory, emotion dysregulation has its origins in defense against emotion, or emotion avoidance. Emotion dysregulation may involve feeling without dealing (under-regulated emotion), dealing without feeling (over-regulated and constricted emotion), or the absence of gratifying relationships and consequent loneliness and isolation. Like in DBT, the UP, and EFT, the aim of AEDP is to reduce the degree to which maladaptive responses to emotion (defenses) interfere with adaptive emotional functioning. Also like DBT, the UP, and EFT, the goal of treatment is not to eliminate uncomfortable emotions but to reduce patients' reliance on defenses and enhance their capacity to access core affect and experience its adaptive, transformative, and healing powers.

Chapter IV: Discussion, Part 2

The Adaptive Function of Emotions

An important common feature of the four psychotherapy models discussed in this dissertation is that they all view emotions as central to adaptive psychic and behavioral functioning. This view is consistent with a recent shift away from the idea that emotions are irrational and that they undermine adaptive decision-making, which dominated Western thought for much of its history, and towards the idea that instinctual "gut" emotions provide important

information that facilitates adaptive decision-making (Damasio, 1994). DBT, the UP, EFT, and AEDP all propose that the key to adaptive functioning is not to replace irrational emotion with rational thought, but rather it is to effectively regulate emotions so that the adaptive functions of emotions can be optimized.

Secondary Responses and Emotional Dysfunction

Another common feature of the four psychotherapy models discussed here is that they all identify anxiety-fueled secondary responses to primary or instinctual emotions as principal causes of emotional dysfunction. In the literature reviewed here, emotion avoidance (e.g., emotion inhibition, suppression, or denial) is understood to be a strategy that people use to regulate anxiety and other distressing secondary emotions. Avoidance is often effective at reducing distress in the short run, but it is maladaptive in the long run because it obscures the important information that primary emotions provide and prevents people from fully experiencing the “gut” emotions that lend authenticity and personal meaning to human experience. More, avoidance tends to have a paradoxical effect: rather than decreasing the impact of emotions on the psyche, avoidance intensifies and prolongs them so that they feel uncontrollable. This makes emotions feel more unmanageable instead of less, and it exacerbates psychic distress, anxiety, and behavioral dysfunction. When used chronically as an emotion regulation strategy, avoidance triggers a cycle of increased emotional arousal, further attempts to avoid it, and increased anxiety.

Avoidance as defense? Despite their diverse theoretical allegiances, Linehan (1993a), Barlow and colleagues (2010), Greenberg (2002), and Fosha (2000) all agree that emotion dysregulation is at the heart of a range of psychopathological conditions and that emotion avoidance plays a central, causal role in emotion dysregulation. Evidence of these authors’

different theoretical allegiances, however, can be found in the language that the different authors use to describe avoidance as a regulatory strategy. Namely, Greenberg (2002) and Fosha (2000) refer to avoidance as a psychological “defense,” while this word is absent from the writings of Linehan (1993a) and Barlow and colleagues (2010). This section explores whether this difference in language and labeling reflects a conceptual difference between the models or a semantic one.

Rottenberg and Gross (2007) define “psychological defense” as “relatively stable characteristics of an individual that operate outside of awareness to decrease the subjective experience of anxiety and other negative affects” (p. 325). This definition of “psychological defense” is compatible with learning theory. Indeed, Linehan’s (1993a) and Barlow and colleagues’ (2010) behavioral conceptualizations of emotion avoidance can easily be understood as “psychological defense” if Rottenberg and Gross’ definition of the term is used. The antecedent, behavior, and consequence are all clearly identifiable: the anxiety/negative affect that emerges in response to overwhelming emotion (antecedent) triggers emotion avoidance (behavior), which leads to an immediate (though short-lived) reduction in anxiety/negative affect (reinforcing consequence). The effect of the behavior (i.e., the avoidance) is naturally reinforcing and so increases the likelihood that the behavior will be repeated, thus developing into a characteristic pattern.

The term “defense,” however, is traditionally associated with theories of psychodynamics, which are based on the idea that defenses are borne of psychic conflict. For example, Freud’s structural model, the archetype for such psychodynamic theories, proposes that the mind is composed of three structures (id, ego, and superego) and that there is ongoing conflict between the id (basic instinctual drives) and the superego (moral standards imposed by

society, culture). The ego manages this conflict by activating defenses that block the expression of unacceptable id impulses, thus reducing the intrapsychic conflict.

Harry Stack Sullivan offered a different understanding of defense. He theorized that an individual is a “self system” that develops a set of “security operations,” which protect the self from anxiety and threats to self-esteem. One way that security operations work is to split off or dissociate the parts of the self that pose overwhelming and unmanageable threats to one’s sense of safety and self worth. These dissociated parts of the self become what Sullivan calls the “not me.” The security operations ensure that the “not me” remains split off from and inaccessible to the other parts of the self. Both Freud’s and Sullivan’s formulations explain how people defend against the experiences or parts of themselves that are for one reason or another unacceptable to the self, and both assume that behavior must be explained with reference to unobservable psychic structures, an assumption that is incompatible with learning theory.

So, when Greenberg and Fosha call emotion avoidance a “defense,” do they use the term in a psychodynamic sense that is incompatible with the theories that underpin DBT and the UP? Or do they suggest that emotion avoidance is a defense in the way that Rottenberg and Gross define the term, which is compatible with behavior theory?

In the case of AEDP, Fosha (2000) explicitly espouses Sullivan’s metapsychology of a divided self. In one of her descriptions of defenses and how they develop, she writes:

The self divides, of necessity becoming its own caregiver, and much effort becomes invested in security operations (Sullivan, 1953, 1956). The individual needs to develop defenses, the adaptive goal of which is to restrict the impact of affects, feared to be unendurable and overwhelming to the psyche. The consequences of internalizing these defenses and building affective restriction

into psychic structure is what pathology is—and what therapy seeks to undo. (p. 71)

In this passage, we see that there are several points that distinguish Fosha's understanding of emotion avoidance from the behavioral one. First, Fosha's formulation cannot be fully understood without understanding the background against which all human processes unfold (according to Fosha): the drive to be in relationships with others. In Fosha's formulation, avoidance is not simply triggered by negative affect; rather, it is *motivated* by the human drive to maintain attachment bonds and is activated by anxiety that emerges when affective experiences threaten those bonds.

Second, Fosha's formulation depends upon the notion of a divided self. Fosha's theory draws from both the Sullivanian and Freudian notions of conflict and defense.¹³ That is, in addition to referring to Sullivan's divided self and security operations, she uses the construct of the "triangle of conflict" (see *Figure 4* below) to explain the dynamics of psychic conflict. The triangle of conflict, which derives from Freud's structural model, is a foundational construct in short-term dynamic psychotherapies (for more on the triangle of conflict, see Ezriel, 1952; Malan, 1976a, 1979; Menninger, 1958; Messer & Warren, 1995).

¹³ Some theorists (e.g., Bromberg, 1996) argue that Freud's structural model and theory of intrapsychic conflict is incompatible with Sullivan's self system model and theory of multiple, split selves—a point which Fosha (2000) does not take up. A major point of distinction between the two models is that while Freud proposes that defenses emerge from conflict *within* the self and that they work to block unacceptable experiences from that self's consciousness, Sullivan proposes that security operations create and maintain splits between multiple, distinct selves. This latter formulation does not suggest that conflict occurs *within* the self or that unacceptable experiences are unconscious but contained within the self; rather, it suggests that unacceptable experiences are split off, exiled to a "not me." For the purposes of this dissertation, this difference and potential theoretical inconsistency does not affect the argument made here, for both the Freudian and the Sullivanian models propose that defense is linked to conflict or splits between unobservable psychic structures, a proposition that is incompatible with behavior theory.

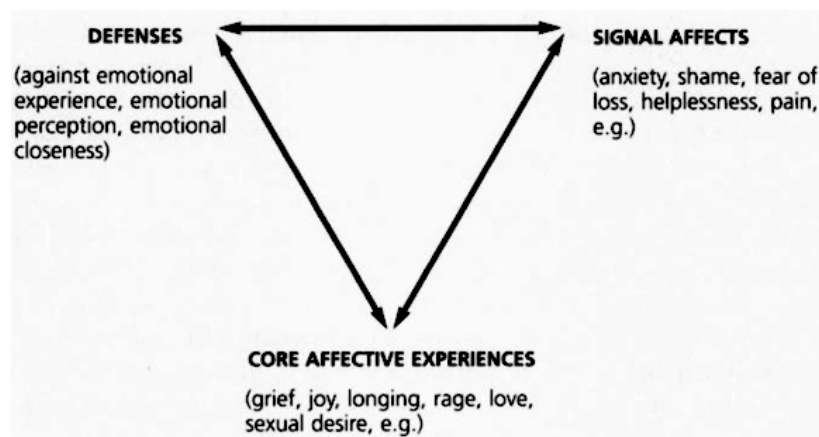


Figure 4: Triangle of conflict (Fosha, 2000)

Fosha (2000) also uses the “triangle of defensive response” (see Figure 5 below) to illustrate how defenses create barriers to experiencing core affective experiences.

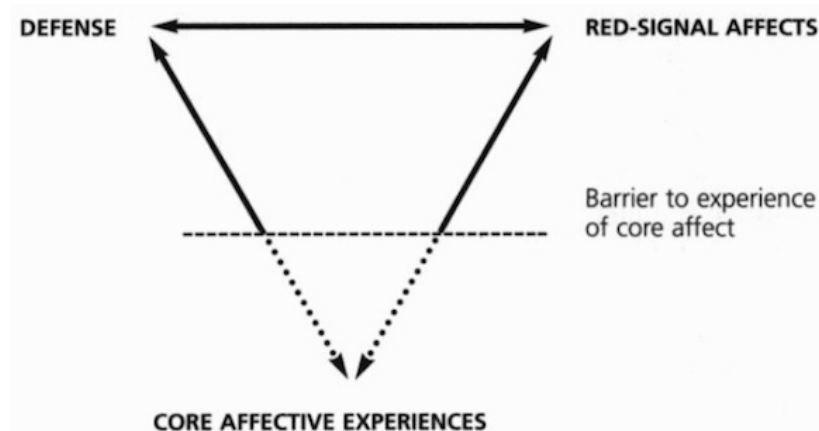


Figure 5: Triangle of defensive response: Defense-drive functioning (Fosha, 2000)

Fosha (2000) writes, “The triangle of conflict depicts the intrapsychic structuring of emotional experience in terms of a feedback loop that arises among *core affective experiences*, the *signal affects* they generate, and the *defense mechanisms* used to avoid what is anxiety-provoking” (p.

104, italics original). Here she makes clear that emotion avoidance reflects underlying psychic structure shaped by conflict and defense.

Like Fosha, Greenberg (2002) describes emotion avoidance as motivated by the need and drive to maintain attachment bonds. He writes:

Often, instead of eliciting a caregiver's help and support, a person's emotions have elicited the caregiver's discomfort, withdrawal, or even attack. The emotions, intense and overwhelming to begin with, thereby became further aversive as they disrupt the connection with the primary emotional caregiver (Fosha, 2000). The unwanted emotional aloneness that results when overwhelming emotions are not met with empathic attunement is so unbearable that people learn to avoid their emotions at all costs. Because intense emotional experiences are overwhelming and threaten one's bond with the other, people find ways to blunt, postpone, mute, mask, or distort their experiences of emotion. Instead of experiencing feelings, and using them to navigate through life, people therefore develop protections against feeling. They develop processes such as avoidance, numbing, squeezing, and selective focusing on certain emotions at the expense of others. (p. 76)

Unlike Fosha (2000), Greenberg (2002) does not explicitly state that the conflict and defenses that emerge from efforts to maintain attachment bonds in the face of overwhelming affect are necessarily unconscious, nor that the psyche is structured by dynamic conflict around affect. He does comment on the existence of conflict around emotion and emotional expression, but he describes such conflict in behavioral and cognitive terms rather than in terms of unconscious processes: "It also is helpful to *look for conflicts* and to focus on the emotions in each part of the

conflict. Look for splits between different tendencies, particularly between ‘I want to, but I’m afraid (or I can’t)’ and ‘I should, but I can’t (or won’t)’” (p. 190, italics original).

As mentioned in Chapter III, Greenberg’s (2002) position on the unconscious is ambiguous. He acknowledges that “people process information at many levels, only some in full consciousness,” but he stops short of suggesting that information that is not processed in full consciousness—including those avoided primary emotions—is actually inaccessible to the conscious mind (i.e., that it is unconscious) (p. 36). Indeed, he seems to suggest that such information and emotions are available to the conscious mind if they are only looked for. He does not suggest that the mind is in conflict. In this sense, Greenberg’s idea about how conflict and defense shape human behavior is distinct from Fosha’s. In its emphasis on attachment and motivation, it is also different from Linehan’s and Barlow and colleagues’.

While DBT, the UP, EFT, and AEDP all point to emotion avoidance as a maladaptive or pathogenic emotion regulation strategy, they offer different theories about what triggers/causes and maintains the avoidance. The differences described here are conceptual, but they have important implications for psychotherapy practice that aims to treat psychopathology via undoing avoidance. In brief, the learning models that regard avoidance as a behavior like any other, one that is a function of its consequences, aim to undo avoidance by manipulating the events that precede and follow the avoidance. The attachment-based models that attribute avoidance to an instinctual drive to seek and maintain interpersonal relationships aim to undo avoidance by creating a relationship between therapist and patient that resembles the relationship between caregiver and child: therapists offer their patients nurturing experiences that the patients can internalize and then later draw upon to help them tolerate and modulate a full range of affects. These are very rough descriptions of how each treatment model aims to undo avoidance.

While this chapter identified *what* each treatment model aims to change in treatment (the targets of treatment), the following chapter will identify *how* each treatment model aims to change its target (the theorized mechanisms of change for each treatment).

Summary and Implications

Treatment targets and aims. One aim of this dissertation was to assess to what degree theoretically diverse psychotherapy models that target “emotion dysregulation” for change in treatment target the same phenomenon or phenomena. This chapter examined the developmental accounts offered in DBT, the UP, EFT, and AEDP that explain the genesis and maintenance of “emotion dysregulation” in order to tease apart the similarities and differences between how the various models conceptualize that construct. The most salient point of convergence among the different accounts is that they all consider emotion avoidance (including emotion inhibition, suppression, and denial) to be a central factor in the genesis of psychopathology.

All of the models studied here also argue that undoing emotion avoidance is a central aim of psychological treatment. That is, they all aim to help individuals more fully experience their adaptive, primary emotions—uncomfortable ones as well as comfortable ones—so that they can reap their benefits and steer clear of the dysfunctional cycle that avoidance sets in motion. The goal for all of these treatments is not to increase rigid control of emotion (which inevitably backfires), but rather to help people develop capacities to tolerate and modulate their emotions. This is a process-oriented goal; it focuses on *how* people think and feel rather than *what* they think and feel. The different treatment models studied here focus to varying degrees on how the contents of people’s thoughts and feelings—the *what* of thinking and feeling—can cause and maintain dysfunction, and how changing that content (e.g., through cognitive restructuring) can be curative. It is notable, though, that all also recognize that emotional and cognitive

processes—the *how* of thinking and feeling—can also cause and maintain dysfunction, and that psychotherapy must address those pathogenic processes in addition to the pathogenic content. This point will be further explored in the next chapter.

A third point of convergence among these models is that, while they recognize the importance of treating the symptoms associated with *emotion* dysregulation, they all also target the root cause of the dysregulation (i.e., avoidance) in order to treat other types of affective dysregulation, such as poor mood regulation, or mood disorder. This dissertation began by highlighting how lack of definitional clarity of emotion-related terms leads to conceptual ambiguity in psychotherapy literature, especially in the literature related to emotion regulation. One of the questions posed in the introduction to the dissertation was: what do authors mean when they say their treatments target “emotion dysregulation?” Here we see that in addition to emotion regulation (“attempts individuals make to influence which emotions they have, when they have them, and how these emotions are experienced and expressed”), these treatments actually target the other three types of affect regulation that Rottenberg & Gross (2007) identify as well: mood regulation (attempts to alter moods), coping (“the organism’s efforts to manage its relations with an environment that taxes its ability to respond”), and psychological defense (“relatively stable characteristics of an individual that operate outside of awareness to decrease the subjective experience of anxiety and other negative affects”) (p. 325). It is interesting, then, that the term emotion regulation has become so much more common in the literature than affect regulation.

This chapter also identified several points of divergence between how the different authors studied here understand the developmental factors that lead to emotional dysfunction and the psychic factors that maintain the dysfunction. The different authors have different ideas

about the roles that relational experiences, learning, internalization, validation, and empathic attunement play in the development of the self and in the development of the capacities to tolerate and modulate affective experiences. They also have different ideas about the nature of emotion avoidance—whether it is motivated, unconscious, or a compromise formation that emerges from internal psychic conflict. These areas of divergence lead Linehan (1993a), Barlow and colleagues (2010), Greenberg (2002), and Fosha (2000) to different conclusions about how to effect change in affective disorders, or about how to help people abandon avoidance as a regulation strategy and more fully experience their emotions. These differences—differences in the theorized mechanisms of therapeutic action and change—will be explored in the following chapter.

CHAPTER V: Therapeutic Action and Mechanisms of Change

Introduction

Chapter IV examined the similarities and differences between how Dialectical Behavior Therapy (DBT; Linehan, 1993a), the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders (UP; Barlow et al., 2010), Emotion-Focused Therapy (EFT; Greenberg, 2002), and Accelerated Experiential Dynamic Psychotherapy (AEDP; Fosha, 2000) understand what “emotion dysregulation” is and how it develops. It concluded that one salient point of convergence among the different accounts is that they all propose that primary (instinctual or gut) emotions aid adaptive functioning while emotion avoidance (i.e., maneuvers taken to prevent emotional responses) and many secondary responses to emotions (e.g., shame, rage, suppression/inhibition/denial of emotions) are maladaptive and lead to emotion dysregulation and emotional disorder. They all argue that undoing emotion avoidance and minimizing the impact of maladaptive secondary reactions are essential tasks and central aims of the psychological treatment of emotional disorders.

This chapter follows with a study of how Linehan, Barlow and colleagues, Greenberg, and Fosha conceive of the mechanisms of therapeutic action and change in psychotherapy. This chapter aims to shed light on the primary question posed by this dissertation: to what extent does the focus on affect and affect regulation that DBT, the UP, EFT, and AEDP all share represent theoretical convergence among these psychotherapy models? In order to assess how similar these various psychotherapy models are, it is important to understand how similar their theories of therapeutic action are, as such theories are at the core of what distinguishes one psychotherapy model from another. Thus, this chapter begins with a description of the explanations offered by

these authors regarding *how* their respective treatments undo the avoidance that leads to emotional disorder, and how they help dysregulated individuals develop the capacities to tolerate and regulate the full range of their adaptive affective experiences. It then continues with a discussion comparing and contrasting the theories described.

DBT: The Four “Change Procedures”

Linehan (1993a) outlines four “change procedures” that operate in DBT to help people transform maladaptive emotion regulation strategies so that they can more fully experience their primary emotions: behavioral skills training, contingency procedures, exposure-based procedures, and cognitive modification. In addition to these four “change procedures,” Linehan also attributes some of the benefit that comes from psychotherapy to the relationship between therapist and patient. The following pages provide a review of Linehan’s theory regarding how these procedures and the therapeutic relationship lead to therapeutic change.

Behavioral skills training. Following the behavioral deficit model, Linehan (1993a) proposes that emotion dysregulation results from emotion regulation skills deficits. She further asserts that the way to treat dysregulation is by remedying the skills deficits, and the way to remedy the skills deficits is by *teaching* behavioral skills. The therapist in DBT thus takes on the role of a teacher who explains to patients (their “students”) what behavioral skills are, how to use them, and when to use them—and the therapist uses traditional didactic tools (e.g., worksheets, homework) to do so.

In order to understand what behavioral skills training is and what it means to use it in therapy, it is important to understand exactly what a “skill” is, or how it is operationalized in the DBT literature. Linehan (1993a) explains her use of the word:

The term ‘skills’ in DBT is used synonymously with ‘abilities,’ and includes in its broadest sense cognitive, emotional, and overt behavioral (or action) response repertoires together with their integration, which is necessary for effective performance. Effectiveness is gauged by both direct and indirect consequences of the behavior. Effective performance can be defined as those behaviors that lead to a maximum of positive outcomes with a minimum of negative outcomes. (p. 329)

Through behavioral skills training, individuals learn how to replace ineffective or maladaptive behavior with skillful behavior, which leads to “effective performance” and “positive outcomes.” The criteria by which outcomes are evaluated as “positive” are not clear, nor is it clear how those criteria are established. What is clear, though, is that behavioral skills training targets *overt behavioral repertoires*. According to Linehan, it is making changes to these repertoires that leads to improvements in emotion regulation and positive change in psychotherapy.

“Life skills.” Which behavioral repertoires or skills minimize dysregulation and maximize adaptive functioning? DBT focuses on four sets of “life skills,” which are taught in distinct modules: *Mindfulness*, *Distress Tolerance*, *Emotion Regulation*,¹⁴ and *Interpersonal Effectiveness*. *Mindfulness*, the “core” DBT skill, involves non-judgmentally observing and describing whatever is going on in the current moment as well as fully participating in that moment, or “experiencing” it, without self-consciousness or divided attention. This allows people to bring together their “hot,” emotion-driven behaviors (“Emotion Mind”) with their

¹⁴ Linehan’s use of the term “emotion regulation” to label one of the DBT life skills is confusing, as all of the life skills include exercises meant to improve emotion regulation skills. Here is an example of how the inconsistent use of emotion-related terms can cause some confusion (see Chapters I and III for more on this point).

“cool,” logical and rational behaviors (“Reasonable Mind”) so that they can achieve a balance between the two (“Wise Mind”) (Linehan, 1993a, 1993b).

The other three “life skills” involve applying *Mindfulness* skills to various types of situations or events. The *Emotion Regulation* module teaches people to apply mindfulness skills to emotional experiences so that they can recognize, identify, and label their emotions as well as transform negative emotions into positive ones. DBT’s *Distress Tolerance* module teaches people how to apply mindfulness skills to intense emotional experiences in moments of crisis. These skills involve engaging in both physical behaviors (relaxation and breathing exercises, self-soothing through the five senses, controlling emotions with facial expressions¹⁵) as well as cognitive ones (radical acceptance, distraction, visualization/imagery, making meaning of difficult situations, thinking of pros and cons, taking a willing rather than a willful stance towards a situation). These skills help people “bear pain skillfully” rather than be overwhelmed by it (Linehan, 1993b, p. 96). Finally, *Interpersonal Effectiveness* skills help people set boundaries with others, ask for what they need from others, and cope with interpersonal conflict, all while maintaining relationships and self-respect. All of these “life skills” aim to help people learn and use skills that directly contribute to their ability to regulate affective experiences (i.e., to experience primary emotions, reduce maladaptive secondary responses, and transform negative emotions into positive ones) (Linehan, 1993a, 1993b).

Contingency procedures. DBT recognizes that some people know how to act skillfully in distressing situations but nevertheless fail to do so. In order to get people to *use* the adaptive skills that they know, contingencies must be set up so that the use of adaptive behavioral skills is

¹⁵ Linehan writes, “Emotions are partially controlled by facial expressions. By adopting a half-smile—a serene, accepting face—people can control their emotions somewhat. They can feel more accepting if their faces express acceptance” (Linehan, 1993b, p. 101).

reinforced and maladaptive strategies are not reinforced. Contingency procedures are based on the principles of operant conditioning, namely the idea that reinforcement increases and punishment decreases the likelihood of a behavior being repeated. DBT uses two types of contingency procedures in order to get people to behave in a skillful manner: formal ones (i.e., behavior plans that spell out planned contingencies to increase desired behaviors and decrease undesired ones) and informal ones (i.e., the continuous and ongoing interaction between therapist and patient, including the therapist's positive/reinforcing or aversive/punishing responses to the patient's behavior).

Exposure-based procedures. DBT theory posits that emotion exposure—whether in the form of structured behavioral exposures or mindfulness exercises—offers a way out of the cycle of negative arousal, anxiety, and avoidance that characterizes affective dysregulation. The theory behind exposure as a mechanism of therapeutic action is that avoidance behaviors are learned and can be “unlearned” and replaced by emotion regulation skills through exposure and applied behavior analysis. That is, exposure exercises are a special case of contingency management wherein avoidance behaviors (i.e., the undesired behaviors) are punished and skills that allow people to fully experience their primary emotions (i.e., the desired behaviors) are reinforced. The process of habituation also operates here: people build tolerance for experiencing their primary emotions when they are repeatedly exposed to them and do not suffer aversive consequences.

Cognitive modification. In DBT, every act—whether cognitive, behavioral, or emotional—is understood to be a functional link in a causal chain that leads to effective (healthy) or ineffective (pathological) outcomes. The aim of cognitive modification techniques is to replace the cognitive links in these causal chains that lead to pathological outcomes with those

that lead to healthy outcomes. The foundation of cognitive modification is cognitive self-observation, a type of mindfulness practice, which makes it possible for people to observe their own cognitive acts in order to identify and then change ineffective cognitive content (e.g., self-critical thoughts) as well as ineffective cognitive styles (e.g., overly rigid or ruminative thinking). Changing ineffective content involves “checking the facts” about an event and basing one’s response to that event on the “facts” rather than on “interpretations” of or “opinions” about the events.¹⁶ Changing ineffective cognitive styles involves stepping outside of oneself and reflecting on thinking and appraisal processes (Linehan, 1993a). One way that DBT fosters therapeutic change, then, is by teaching people metacognitive skills, which enable them to identify and modify their dysfunctional cognitive acts.

The therapeutic relationship. Linehan (1993a) spells out two ways in which the therapeutic relationship can be used in treatment: the “relationship as therapy” approach and the “therapy through the relationship” approach. The theory behind the “relationship as therapy” approach is that a therapist’s compassionate, nonjudgmental, and accepting stance towards the patient provides a context in which “the wounds of the patient’s past experiences will heal; her developmental deficiencies will be rectified; and her innate potential and capability for growth will be stimulated” (p. 514). In the “therapy through the relationship” approach, on the other hand, the therapeutic relationship is seen as a means to an end. From the point of view of this latter approach, “wounds heal only because of active exposure of the patient to similar but benign situations; deficiencies are rectified by the acquisition of coping strategies; and growth occurs because it is made more rewarding than other alternatives” (pp. 514-515). These two

¹⁶ Linehan’s emphasis on “checking the facts” and eschewing “interpretations” and “opinions,” which she frames as *Mindfulness* skills, contradicts with the dialectical, constructivist epistemology that she espouses (described in Chapter II), which rejects the idea of objective reality.

approaches represent a dialectic, and DBT therapists must strike “an appropriate balance between these two approaches at each moment” (p. 515).

Linehan (1993a) argues that the relationship between therapist and patient is both curative and the mechanism through which change can be brought about in treatment and so assigns that relationship an important therapeutic role. She credits the relationship with helping the patient develop a more solid and confident sense of self, which is especially important with those patients who experience pathological identity diffusion. Through validation, therapists provide an outside point of view that shows patients that their thoughts and feelings are based on valid interpretations of events. This helps patients develop trust in their interpretations, which bolsters their sense of self.¹⁷

In her theory of therapeutic action, Linehan (1993a) attributes the bulk of behavioral change to learning through operant conditioning. Though Linehan says that DBT balances the “relationship as therapy” approach with the “therapy through the relationship” approach, she makes clear that these two approaches do not affect the same type of change. While the “relationship as therapy” approach leads to the consolidation and healing of a diffuse and wounded self, the “therapy through the relationship” approach—the approach through which the four “change procedures” described above work—is the one that leads to the behavioral changes by which DBT measures therapeutic outcome and success.

UP: The “Core Strategies”

The UP uses five core strategies to promote adaptive emotion regulation: awareness/mindfulness, cognitive reappraisal, modifying maladaptive action tendencies, interoceptive exposure, and engagement in emotional exercises. According to Barlow and

¹⁷ This process parallels the way in which caretakers in validating environments help and support their children develop senses of self and identity, according to Linehan’s biosocial model.

colleagues (2010), these core strategies decrease the impact of peoples' secondary reactions and the maladaptive action tendencies associated with them so that they can access their primary emotions and adaptive action tendencies.

Awareness/mindfulness. For these authors, emotion awareness/mindfulness involves focusing on one's emotional experiences in the moment as they are, in addition to one's reactions to those emotions, without judging them as good or bad or trying to change them. To help people achieve this awareness, Barlow and colleagues (2010) recommend that people use a "three-point check" to observe and identify the thoughts, physical sensations, and behaviors that make up their emotional experiences and their secondary responses to those experiences. They recommend that therapists teach patients to ask themselves, "What are my thoughts right now? What emotions and physical sensations am I experiencing right now? What am I doing right now?" (p. 73). The goal of the "three-point check" is to help people "step outside" and take a more "objective view" of their emotional experiences so that they can recognize the cognitive, physiological, and behavioral patterns that maintain their dysregulation. That is, "patients may be able to recognize how a catastrophic thought leads to heightened autonomic arousal, which may fuel further catastrophic thoughts, causing them to engage in escape or avoidance" (p. 81). Through this awareness and mindfulness, people should learn to distinguish their primary emotions from their secondary reactions, and they should develop tolerance and acceptance of their primary emotions.

Cognitive reappraisal. Cognitive reappraisal, which involves identifying and challenging negative appraisals of external or internal events, is another core element of the UP. According to Barlow and colleagues (2010), the process of reappraisal leads to increased cognitive flexibility, which in turn leads to improved emotion regulation. The goal of reappraisal

is not to *eliminate* negative thoughts or beliefs, but rather to help people learn that there are many different ways to interpret a single event, and that a negative appraisal that overestimates the threat or danger associated with an event may trigger anxiety and a dysfunctional cycle of avoidance and dysregulation. That is, if people can recognize that their negative or catastrophizing appraisals of a given stimulus (e.g., “My heart is beating hard; I must be having a heart attack”) can coexist with other appraisals (e.g., “My heart is beating hard because I am exercising, and I am physically healthy”), that stimulus is less likely to trigger overwhelming anxiety, maladaptive avoidance, and dysregulation.

In order to “teach” cognitive flexibility, Barlow and colleagues (2010) suggest using an exercise that involves having patients look at an ambiguous picture and come up with multiple interpretations of what is going on in the picture. The point of this exercise is not for patients to come up with any one “correct” interpretation, but is rather for them to recognize that there are multiple valid interpretations of the one stimulus. Negative appraisals are not viewed as “wrong” or “bad,” but they are viewed as problematic when they overestimate threat and cause anxiety and dysfunction. Though these authors do not emphasize “correctness” with regard to interpretations, they do emphasize “objectivity”: goals of cognitive reappraisal include that patients “objectively reappraise” (p. 142) situations and “take a more objective stance towards their emotions” (p. 85). They do not explain what they mean by “objectivity” in this context, but it seems that they use this term to denote a position from which one is able to recognize and acknowledge multiple interpretations of an event or stimulus rather than viewing the event or stimulus from a single perspective.

“Core” appraisals. Barlow and colleagues (2010) identify a common stumbling block that comes up in treatment: sometimes “the patient identifies an appraisal, but there is a

noticeable disconnect between the nature of the appraisal and the intensity of the patient's response in that situation." In these cases, "the disconnect between the patient's behavior and his or her appraisal of the situation is a cue that the patient has not identified his or her core automatic appraisal" (p. 92). The way to get beyond this hurdle, according to Barlow and colleagues, is to use the "downward arrow technique," a technique used in many cognitive-behavioral therapies, to get past the easily accessible "surface level appraisals" to the "core automatic appraisals" that really fuel the intense affect. An example from the UP manual illustrates this idea:

For example, if someone described avoiding a social encounter and the related appraisal was 'I won't have anything to say to people,' this would show a disconnect between the extreme behavior (avoidance) and the relatively mild automatic appraisal. What may be more likely is that the patient interpreted the situation as, 'I won't have anything to say, people will reject me, and I will never have any friends for the rest of my life.' (Barlow et al., 2010, p. 88)

The use of the downward arrow technique in the UP makes clear that "core" phenomena (in this case, cognitions) that are not so easily accessible or apparent can trigger and drive intense affect. The language that Barlow and colleagues (2010) use—the *downward* arrow technique, going *beyond the surface*, getting to the *core*—suggests that this process involves uncovering previously inaccessible material. Thus, one way in which the UP effects change is to uncover inaccessible phenomena that trigger negative affects so that they are accessible and can be talked about and reappraised.

Modifying maladaptive action tendencies/emotion driven behaviors (EDBs).

Modifying maladaptive action tendencies, or emotion driven behaviors (EDBs), is another "core

strategy” in the UP. Maladaptive EDBs are those behavioral reactions to emotional experiences that lead to ineffective rather than effective outcomes. According to Barlow and colleagues (2010), emotion avoidance and maladaptive EDBs are major sources of dysfunction and dysregulation. These authors make a distinction between maladaptive avoidance and EDBs: Whereas EDBs *follow* the activation of an emotion response, emotion avoidance usually *precedes* the activation of the emotion. In preceding the activation of the emotion, avoidance can help people prevent the activation of the emotion altogether. EDBs, on the other hand, are the ways that people respond to already-activated emotions (i.e., EDBs are secondary reactions). Thus, when Barlow and colleagues propose that modifying EDBs is a mechanism by which the UP effects therapeutic change, they propose that helping people change their responses to emotions is one part of the psychotherapeutic/change process.

Barlow and colleagues (2010) suggest that the way to go about modifying EDBs is applied behavior analysis. The first two steps of this process involve identifying maladaptive EDBs and understanding the role(s) that those behaviors play in maintaining dysfunction—both of which require the ability to cognitively reflect on one’s experiences and behaviors. The third step, which is to modify behavioral repertoires, can be achieved through exposure exercises, described below.

Exposure. Exposure is a primary way by which the UP affects behavioral change. The theory behind exposure exercises as a mechanism of change in the UP is the same as that in DBT: when patients are exposed to aversive stimuli in the controlled setting of a therapy session, their undesired behaviors (i.e., maladaptive avoidance or EDBs) are punished and become “extinct” while desired behaviors (i.e., use of emotion regulation skills) are reinforced. The

patients eventually become habituated to the aversive stimuli and learn the desired behaviors, so that the desired behaviors eventually replace the undesired behaviors.

The UP authors distinguish between two types of exposure exercises. One type, *interoceptive exposure*, is designed to expose and help people habituate to feared/avoided physical sensations that trigger or follow the activation of distressing emotions. For example, the UP prescribes interoceptive exposures for those who suffer from panic attacks, which often involve escalating anxiety due to excessively negative appraisals of physiological sensations like shortness of breath. In cases like this, the UP recommends an exposure exercise that requires the patient to breathe through a thin straw to induce hyperventilation (Ellard et al., 2010).

Emotion exercises are designed to expose people to feared/avoided emotions. Unlike the interoceptive exposures that focus exclusively on physical sensations, emotion exercises focus more broadly on the physiological, cognitive, and behavioral factors that make up, precede, and follow the activation of distressing emotions. Exposures in the UP are planned based on an Emotional and Situational Avoidance Hierarchy. The UP Workbook (Barlow et al., 2011) provides a sample hierarchy for a patient the authors call Kevin, who suffers from panic attacks. At the bottom of Kevin's hierarchy are activities that he finds slightly distressing and rarely avoids (going for a walk, doing something physically strenuous). His hierarchy proceeds with progressively more distressing activities (going to a movie, going grocery shopping, taking a bus) and up to the two activities that he finds most distressing and always avoids (flying, driving on the highway). In UP treatment, Kevin would begin his emotion exposures by engaging in the activities at the bottom of the hierarchy (e.g., going for a walk) in order to evoke mild levels of anxiety so that he could 1) observe how his maladaptive thoughts (e.g., automatic appraisals such as "If I exert myself I will have a panic attack and cause a scene") and behaviors (e.g., avoidance

or dysfunctional EDBs like tensing up) contribute to his anxiety, and 2) practice modifying his thoughts and behaviors (replacing maladaptive appraisals and EDBs with adaptive ones) with the goal of reducing the anxiety that he feels when going for a walk. The idea behind using the Emotional and Situational Avoidance Hierarchy is that patients begin their exposures with activities that evoke some anxiety—enough anxiety so that they can practice modifying the maladaptive thoughts and behaviors that exacerbate their distress, but not so much anxiety that they are overwhelmed and unable to control their behavior. In Kevin’s case, once he is able to manage his anxiety during exposure to the activities towards the bottom of his avoidance hierarchy, the next step would be for him to expose himself to the activities higher up on that hierarchy, which should become less distressing as Kevin becomes more adept at managing his EDBs and thus his anxiety.

According to UP theory, replacing maladaptive EDBs with adaptive ones leads directly to improved adaptation and functioning. This process can be very powerful; not only can it help decrease and moderate distress and negative affect, it can also help people increase their positive affect. Citing Izard (1971), the authors of the UP argue that, when an individual has more control over EDBs, it is possible for that individual “to act his way into a new way of feeling” (Barlow et al., 2010, p. 19). The ability to act one’s way into a new feeling is a “core skill” for emotional regulation (i.e., the ability to influence one’s own emotions, when they occur, and how they are experienced and expressed).

EFT: The “Three Principles of Change”

Greenberg (2002) proposes that there are three principles of change that make EFT work effectively: Emotion Awareness, Emotion Regulation,¹⁸ and Changing Emotion with Emotion. These principles are the affective foundations of adaptive functioning.

Emotion awareness. One principle of change in EFT is to develop emotion awareness, which involves both *experiencing* and *processing* emotions.

Experiencing. Experiencing emotions involves overcoming maladaptive emotion avoidance through attending to the physical, cognitive, and affective components of emotions, especially feared emotions. It is a kind of emotion exposure. This exposure to feared affective states is a crucial part of EFT treatment, and Greenberg (2002) argues that it helps people overcome avoidance (i.e., maladaptive emotion regulation strategies) and achieve adaptive affective functioning via three mechanisms: 1) through experiences of empathic attunement between therapist and patient, 2) through the patient’s internalization of an empathically-attuned object (the therapist), and 3) through the process of habituation.

Empathic attunement. The ability of the therapist to be attuned to and empathize with the patient—that is, to *share* emotional experiences with the patient—is key in EFT. Greenberg (2004b) calls the role that the therapist plays in EFT the “emotion coach” and explains that the role entails “following where the client is moment by moment” and attempting to “enter into the highly subjective domain of unformulated personal experience, a place beyond reason and often

¹⁸ Greenberg’s use of the term “emotion regulation” to label one of EFT’s principles of change is confusing and similar to Linehan’s use of the term to label one of the DBT life skills. Emotion Awareness and Changing Emotion with Emotion, EFT’s other two principles of change, are also principles aimed at developing and expanding patients’ capacities for emotion regulation, so it is unclear why only one of the principles is labeled “Emotion Regulation.” Here again is an instance where the inconsistency with which emotion-related terms are used causes some confusion (see Chapters I and III for more on this point).

beyond words” (p. 7). Greenberg (2002) makes a direct connection between the experience of sharing affective experiences with an attuned other and the ability to experience, regulate, and transform emotions. He writes, “sharing dreaded feelings with another breaks the isolation in which these feelings are usually felt” (p. 210). This corrective experience helps alleviate the pain and despair associated with such feelings and provides a safe space in which people can experience their emotions rather than hold up “protective barriers” against them (p. 76). According to Greenberg, this is “an important element of the change process” (p. 79).

Internalization of the empathically-attuned object. Greenberg (2002) argues that effective psychotherapy helps patients develop regulatory capacities in the same way that effective parenting does for children. The therapist’s role parallels that of the attuned, nurturing, and accepting caretaker who can soothe the dysregulated child. The patient’s role parallels that of the child who develops the abilities to experience, tolerate, and regulate a full range of affective experiences, including primary emotions, by internalizing the caretaker’s capacity to soothe and tolerate intense affect so that it need not be avoided. Thus, a guiding principle of EFT is the idea that the way to treat or undo emotion dysregulation is to provide the patient access to an empathic, affectively-attuned other (a therapist) who can serve as a surrogate caretaker and provide the support and soothing that the client missed in earlier development (a “corrective emotional experience”). This formulation is based on the assumption that people at different points throughout the lifespan, even into adulthood, develop regulatory capacities in relational contexts, by internalizing the regulatory capacities of others.

Habituation. Habituation is another mechanism by which experiencing emotions leads to improvements in emotion regulation. Just as in the behavioral models, Greenberg asserts that when people are repeatedly exposed to stimuli that they associate with negative outcomes and

fear (e.g., intense emotions) under safe circumstances, their association between the stimuli and fear fades so that they can respond to the formerly feared stimuli with adaptive emotion regulation skills rather than maladaptive avoidance. Greenberg (2002) puts special emphasis on the importance of attending to the body and habituating to the physiological expressions of emotion. He writes, “processing bodily felt experience and deepening this in therapy in a good therapeutic relationship environment may be a core ingredient of change in psychotherapy, regardless of approach” (p. 7).

Processing. Experiencing and overcoming avoidance are not the only ways in which EFT effects change and helps people more effectively manage affect. Processing affect, or reflecting on affective experiences, is another mechanism of change in EFT. It involves symbolizing bodily felt experience in words, or “assimilating nonverbal emotional meaning into conscious narrative structures” (Greenberg, 2002, p. 67). This integration of language and experience, or “head and heart,” helps people gain some distance from their feelings and recognize, for example: “It is now ‘I’ who feels ‘worthless,’ and ‘worthless’ is not all of what I am [...] I now feel that ‘worthless’ is something I am ‘feeling’ rather than it ‘being’ me” (Greenberg, 2002, p. 90).

Creating new meaning through narrative. According to Greenberg (2002), the process of integrating language and experience and the act of labeling/naming experiences can make people feel more in control of their experiences, more like agents than victims of feelings. Through these processes, people become “authors” of their experiences and can then develop personal narratives that help them understand their experiences and create new meaning in their lives. According to EFT theory, the process of symbolization, reflection, and creation of new meaning through narrative is healing and plays a “central” role in therapeutic change.

Cognitive restructuring. Another part of the work of processing in EFT is challenging peoples' destructive beliefs and replacing them with healthier ones, or cognitive restructuring. Though here Greenberg (2002, 2007) draws from cognitive theories like that of Beck (1976), he also emphasizes the limitations of such "top-down" approaches to psychotherapy that suggest that emotion processes can be changed through deliberate, conscious, cognitive processes of self-control. He argues that verbal mediation of emotions and emotion regulation strategies is insufficient and that "automatic" emotion processes must be changed through implicit, experiential, and relational processes. Thus, he writes that therapists "cannot rationally argue clients into healthier emotional processes," and that the therapist's job is instead to "help clients find their alternative, healthy feelings and use these to transform their unhealthy feelings" (Greenberg, 2002, p. 98). In the EFT model, cognitive restructuring plays a limited role in helping people regulate their emotions while "changing emotion with emotion" (a concept that is explored below) plays a much more significant role.

Emotion regulation. Though emotion regulation is often used to denote a general capacity to tolerate and modulate emotion, Greenberg (2002) uses the term here to refer to a much narrower set of behaviors, or skills, that facilitate adaptive emotional functioning. The emotion regulation skills that are emphasized in EFT focus mostly on those that help people tolerate and cope with distress (e.g., identifying and labeling emotions, reducing vulnerability to negative emotions, self-soothing, breathing, and distraction). Greenberg also includes interpersonal soothing (e.g., experiences of empathic attunement, validation, or acceptance from others) as an important aspect of emotion regulation.

According to Greenberg (2002), emotion regulation skills are useful because they help people gain a "working distance" from their emotions. When one has no distance from one's

emotions, those emotions can feel intense and overwhelming, like “emergency signals,” and they are often associated with dysregulation and maladaptive action tendencies. Emotion regulation skills are thus important facilitators of emotion reflection; they help “turn off the alarm signal” of intense emotions so that one can tolerate and have the psychic space to reflect on the emotions (Greenberg, 2002, p. 62). The two principles of change mentioned so far—emotion awareness and emotion regulation—work together to make intense emotions more tolerable so that emotions can be the source of adaptive rather than maladaptive action tendencies.

Regarding the processes by which people develop the ability to self-soothe, Greenberg (2002) writes that there are some self-soothing techniques that can be “learned” in therapy, particularly those that target the physiological expressions of emotions, such as diaphragmatic breathing and relaxation. He also writes, though, that other self-soothing techniques, like developing self-compassion and self-empathy, cannot be acquired via didactic methods. In order to develop these self-soothing capacities, people must have experiences of being in the presence of an empathically-attuned, soothing, and protective other. In EFT, when these experiences take place between patient and therapist/emotion coach, patients are able to internalize the empathic, soothing, and protective functions that the emotion coach provides. Greenberg (2002) offers an example of how this might work: “Having clients imagine taking the therapist back with them into an abusive scene, as protection against the abuse or threat, combines the client’s learning how to self-soothe with his or her internalization of the soothing function of the therapist” (p. 62).

Changing emotion with emotion. Emotion awareness and regulation are processes, or principles, that help people recognize, identify, and tolerate a wide range of emotions. Greenberg’s third principle of change—Changing Emotion with Emotion—helps people develop

the capacity to actually *transform* maladaptive emotions (those that trigger maladaptive action tendencies and lead to emotional disorder) into adaptive ones (those that trigger adaptive action tendencies and contribute to psychic health and wellbeing). This principle is part of what makes EFT an emotion-focused treatment. Greenberg (2002) writes, for example, “Reason clearly is seldom sufficient to change automatic emergency-based emotional responses; instead, one needs to replace one emotion with another” (p. 62).¹⁹

In order to illustrate how changing emotion with emotion effects change in psychotherapy, Greenberg (2002) offers the example of how changing maladaptive shame or fear with adaptive anger can be helpful. Anger is an adaptive response to being physically violated because it is associated with a protective “thrust forward” and affirmation of one’s self-worth. Shame and fear, however, are common secondary responses to anger, and they cause people to shrink away and often experience loss of self-esteem—a maladaptive response to violation. Transforming the shame/fear into primary anger can help one use the “thrust forward” associated with anger to protect oneself and reaffirm one’s self-worth.

How does EFT help transform those maladaptive emotions into primary, adaptive ones? Greenberg (2002) proposes two ways in which EFT helps people achieve this goal: 1) by arousing the maladaptive emotion and replacing it with a more adaptive one, and 2) by engaging in “expressive enactment,” or physiological changes, that induce adaptive emotions.

Replacing maladaptive emotions with adaptive ones via arousal. Transforming maladaptive emotions through arousing them in a controlled setting (i.e., the therapy session) and replacing them with adaptive emotions is a major emphasis of EFT. Though it may seem that

¹⁹ Greenberg (2002) does not deny that maladaptive cognitions contribute to dysfunction and that cognitive restructuring can facilitate psychological treatment and healing. He makes clear, though, that cognitive restructuring is only a tool used to facilitate emotional change, not the factor that actually drives change or that cures pathology.

this process works in the same way that exposure exercises do, Greenberg (2002) makes a distinction between the two processes, arguing that transforming emotions via arousal “goes beyond ideas of exposure and habituation, in that the maladaptive feeling is not simply attenuated by the person feeling it. Rather, another feeling is used to transform or undo it” (p. 63).

Greenberg (2002) describes a variety of ways in which emotion coaches can help people arouse adaptive emotions and initiate this transformational process. With *shifting attention*, after arousing a maladaptive emotion in the patient, the coach helps the patient shift attention away from that emotion towards more adaptive emotions that are “subdominant” (e.g., following the example above, this may involve helping a frightened and ashamed patient shift attention away from the dominant fear and shame and towards underlying anger). Together, emotion coach and patient work to arouse the adaptive emotion, and then focus on and elaborate it so that it becomes more dominant. With *expressing an emotion on the client’s behalf*, therapists disclose their genuine emotional responses to their patients (e.g., “I feel furious and outraged on your behalf”), which can guide patients towards less dominant emotions and can also give patients “permission” to feel emotions that they may not feel entitled to feel. With *accessing needs and goals*, coaches help patients access healthy emotions by asking them a key question: “What do you need when you feel this?” (here, “this” refers to the healthy feeling). According to Greenberg (2002), becoming aware of needs and goals makes people feel active and in control, which triggers the activation of internal resources as well as healthy emotions along with their associated adaptive action tendencies.

Talking about healthy emotions, remembering times when one felt healthy emotions, humor and expressive arts, and positive imagery are also used to help patients access adaptive

emotions. These exercises show patients that emotions are temporary and do not define a person. Greenberg (2002) writes that he tries to help people see that any given emotional state is “a partial self among many possible selves” (p. 181). In developing the capacity to shift between emotional states, an ability that is at the core of emotion regulation, “Changing Emotion with Emotion” exercises lead directly to improvements emotional functioning.

Changing emotion with emotion via expressive (physiological) enactment of adaptive emotions. We often think of the physiological changes that accompany emotions as the expressions or consequences of the emotions. We smile *because* we are happy. The happiness triggers the smile. Citing the James-Lange theory of emotion and research studies (Berkowitz, 2000; Flack, Laird, and Cavallaro, 1999), Greenberg (2002) proposes that the relationship between the emotion and the physiological change is not necessarily unidirectional. He argues that just as the emotion can trigger the physiological change, the physiological change can trigger the emotion. Thus, he suggests that one way to induce a desired but avoided or suppressed emotion is by engaging in the physiological postures and gestures associated with that emotion. For example, he recommends consciously smiling to induce or intensify happiness.

AEDP: Affective Competence and the Affective Model of Change

Regarding her theory of how AEDP effects therapeutic change, Fosha (2000) emphasizes that “AEDP lives and breathes multiplicity” and that “different mechanisms of change are responsible for healing” (p. 335). What sets AEDP apart from other psychotherapy models, though, is its “affective model of change.” This model of change proposes that experiencing and processing core affect in the context of a dyadic relationship constitutes a “corrective emotional experience.” According to Fosha (2000), this type of experience “contributes to the

metamorphoses of the self” and is “the central agent responsible for therapeutic change” (p. 17). Following this affective model of change, Fosha proposes that AEDP works by helping patients develop “affective competence,” or “the capacity to feel and deal while relating” (p. 6; see Chapter IV for more on this concept). The three elements that make up affective competence—feeling, dealing, and relating—are examined in more detail below.

Feeling. A key component of the affective model of change and affective competence is the experiencing of core affect. Fosha (2000) describes core affect as “all aspects of emotional life experienced directly and viscerally, in the absence of defenses and anxiety” (p. 16). She further asserts that core affects are inherently powerful therapeutic forces with “explosive healing properties”: in experiencing core affect, people gain access to unconscious material, a sense of being in touch with a “true self,” and sources of liveliness that were inaccessible when affect was avoided. In addition, these experiences release adaptive action tendencies that point people in the direction to pursue and fulfill their wants and needs and also function more openly and effectively in relationships.

Fosha (2000) posits that one way that AEDP effects therapeutic change is by helping patients become aware of their affective states and access core affects. Core affects are by their very nature healing, but deepening experiences of core affects also contributes to therapeutic change by “desensitizing” patients to their feared and avoided emotions and increasing their capacity to experience a full range of affect. Citing Alexander and French (1946), Fosha (2000) describes having these experiences in the presence of an empathically-attuned, validating, and affirming other (the therapist) as a “corrective emotional experience” that has the power to “promote mastery” and undo “the pathological mourning that was at the core of the pathology that had made treatment necessary” (p. 135).

Relating. Another key component of the affective model of change is the dyadic relationship. Fosha (2000) explains that the dyadic relationship facilitates the *accessing* of core affect. In her words, the connection between therapist and patient “results in the establishment of safety, a corresponding reduction in anxiety, and in turn a mitigation of the need for defenses, promoting and permitting access to core affects” (p. 5). This relationship also provides the context in which core affect can be fully *experienced*. Consistent with her idea that affective experiences are intrinsically relational, intersubjective phenomena, Fosha argues that communicating core affects to a receptive, empathically-attuned other is an essential step in fully experiencing those affects. Finally, the relationship provides experiences of mutual coordination and dyadic regulation, wherein an open, empathically-attuned therapist joins the patient in connecting with, feeling, and coping with core affect.

AEDP and the affective model of change are based on the idea that people develop and expand their capacities to tolerate and regulate affect in dyads, through these experiences of mutual coordination and dyadic regulation. In a developmental context, children develop regulatory capacities through the internalization of their experiences of dyadic regulation with empathically-attuned caretakers. The psychotherapy situation parallels this process: patients develop regulatory capacities through the internalization of their experiences of dyadic regulation with their empathically-attuned therapists (i.e., they internalize this object relationship). Psychotherapy is effective, according to Fosha (2000), because it makes it possible for patients who have suffered from pathogenic affective avoidance to access, experience, and regulate life-enhancing core affects.

Dealing. Drawing from the mentalization research of Peter Fonagy and colleagues (1991), Fosha (2000) explains that the “dealing” element of affective competence is closely

related to one's "capacity to conceive of the wishes, intentions, and actions of [self and] others in terms of mental states" (p. 44). This capacity, which Fosha (2000) calls the "reflective self function," allows people to take a step back from their experiences and view them with some perspective. From that perspective, they can understand that "any bad state is just that, a bad state, and that other states of mind are available. A given state does not have to carry the weight of completely representing the individual's identity" (p. 262). This "heightened awareness of multiple states" contributes to affect regulation because it helps people become aware of their maladaptive reactions to emotions (e.g., avoidance, shame). More, it helps people recognize that their mental states are temporary and so makes them better able to shift from one state to another (i.e., to regulate their affective states).

According to Fosha (2000), AEDP therapists, whose own reflective self function must be robust, help patients build affective competence and regulatory capacities by appropriately and accurately reflecting patients' mental and affective states back to the patients. Fosha explains that this is "not cool, detached reflection but reflection informed by empathy and caring" (p. 58). This reflection can then "activate and enhance the operation of patients' reflective self functioning" (p. 55).

Working through and making meaning of conflict. Fosha (2000) writes, "Affect is often a royal road to the unconscious. Deep experiencing unlocks deeper experiencing, and through it, entire realms of previously unavailable material [...] can be worked through" (p. 21). That is, "experiencing" ultimately helps to make unconscious conflicts conscious so that they can be "worked through." For Fosha, "working through" conflicts involves "processing" or making meaning of them by translating them into words and narratives. One of the mechanisms by which AEDP effects therapeutic change, then, is by helping patients understand and then use

their own words to describe how their core affects, anxieties, and defenses produce their symptoms. The narratives that come out of this process are based on the triangles of conflict described in Chapter IV (see *Figures 4 and 5*). According to Fosha (2000), the process of developing these narratives is empowering, as it demystifies symptoms and pathology and helps people feel more competent and in control of their lives. When patients internalize this narrativizing process, they internalize “a methodology for handling emotionally stressful situations and experiences,” which represents another mechanism that produces therapeutic change in AEDP (p. 270).

Chapter V: Discussion

The previous chapters of this dissertation have shown that DBT, the UP, EFT, and AEDP are all based on two main ideas regarding the genesis and treatment of psychopathology: 1) maladaptive cycles involving negative arousal, anxiety, and emotion avoidance play a principle role in the genesis and maintenance of emotion dysregulation and psychopathology, and 2) the way to treat that dysregulation is to break those negative cycles by undoing avoidance. This chapter has thus far addressed the question of *how* these treatments purport to undo pathogenic avoidance and how the various authors explain the mechanisms by which their treatments have a therapeutic effect on emotion dysregulation. This discussion will examine to what extent these various treatment models overlap and diverge on this topic.

Four Points of Theoretical Convergence

Four points of convergence regarding how DBT (Linehan, 1993a, 1993b), the UP (Barlow et al., 2010), EFT (Greenberg, 2002), and AEDP (Fosha, 2000) conceive of the mechanisms of therapeutic action stand out from this study and are reviewed here.

1) Mindfulness. First, all four treatment models suggest that a first step towards therapeutic change and improved emotion regulation is developing awareness of both body and mind, or affective and mental states (e.g., mindfulness, emotion awareness, reflective self function). They all emphasize the importance of patients developing the ability to recognize physiological changes and understand that those changes can be signals of emotional responses.

2) Metacognition. Second, all four therapy models propose that developing metacognitive abilities—the capacity to think about thinking—is another factor that drives therapeutic change. They all emphasize the importance of patients developing the ability to step back and gain a “working distance” from their emotions so that they can observe the links between bodily changes, emotional responses and behaviors, and cognitive and affective states. From this distance, patients can make sense of their experiences and recognize that their cognitive and affective states are temporary and that other states are possible. The distance also provides patients the space they need to identify and eventually modify the maladaptive cognitive and affective processes that contribute to dysfunction and dysregulation.

3) Experiencing. All four models also agree that the most effective way to undo pathogenic affective avoidance is through fully experiencing primary emotions, and all place special emphasis on experiencing the physiological aspects of emotions. Furthermore, they all use exposure exercises of one type or another to help patients build tolerance for their adaptive but avoided emotions.

4) Focus on process. The different treatment models studied here focus to varying degrees on how the contents of people’s thoughts and feelings—the *what* of thinking and feeling—can cause and maintain dysfunction, and how changing that content (e.g., through cognitive restructuring) can be curative. It is notable, though, that all also recognize that

emotional and cognitive processes—the *how* of thinking and feeling—can also cause and maintain dysfunction, and that psychotherapy must address those pathogenic processes in addition to the pathogenic content.

The nature of the roles that content, process, insight, and experience, play in therapeutic action have been questioned and debated throughout the history of psychotherapy theory and practice. In the field of psychoanalysis, for example, the debate over the relative contributions of insight and experience in therapeutic action is almost as old as psychoanalysis itself (Stark, 2000).

Behavioral, cognitive, and experiential theories all have different takes on the question of the roles of insight and experience/process in therapy. Behaviorists have traditionally distanced themselves from the idea that “insight” plays a role in change because the concept was associated with psychodynamics and the unconscious. They instead attribute adaptive change to learning *processes*. In contrast, Beck (1976) assigned an important role to understanding the content of both automatic thoughts and core schemas in cognitive therapy. Experiential therapies, as the name suggests, are based on the premise that experiences in therapy can be “corrective,” and when they are, they are the primary agents of therapeutic change.

Experiential and emotion-focused therapies have a broad understanding of the word “experience.” The term can refer to the processes that take place in therapeutic sessions—the interactions between patient and therapist and any therapeutic activities they may engage in (e.g., talking, role playing, guided imagery). The term can also refer, though, to the visceral experiencing of primary emotions. So, when experiential theorists attribute transformative and healing power to “experiencing,” this includes both the interpersonal interactions that take place in therapy but also the full and deep experiencing of emotion, particularly the physiological

aspects of it. The theory behind experiential therapies is that these process-oriented experiences release inner adaptive potential, which is curative.

What is striking about the therapy models studied here is that they all put major emphasis on this last idea—that the visceral experiencing of emotions releases inner adaptive potential and so is therapeutic—an idea that was originally associated only with the experiential school. Given this emphasis on the visceral experiencing of emotions, all of the models share similar goals: to help patients access and experience their primary emotions, and also to help patients change the ways in which they deal with their emotions so that they no longer have to avoid them. In all of the models studied here, the processes of experiencing emotions and practicing dealing with them in different ways are the curative elements of the treatments. Psychological content—the kinds of thoughts and feelings people have—is of secondary importance. This is a meaningful point of convergence among the different therapy models.

Points of Divergence

What distinguishes the various therapy models from each other is that they have different notions about how people manage to access and experience their primary emotions and how people come to deal with feelings in different ways. DBT (Linehan, 1993a, 1993b) and the UP (Barlow et al., 2010) are both based on the idea that patients can access their formerly avoided emotions when they are in safe, controlled spaces and when they have support and validation from therapists—therapists who maintain their otherness throughout the therapeutic process. In this scenario, patient and therapist represent two distinct subjectivities, and therapeutic change (e.g., developing the skills to access, experience, and deal with emotions) takes place within the patient. Learning (i.e., operant conditioning, contingency management) is responsible for the change that takes place. Interpersonal interactions between patient and therapist may serve as

social reinforcement in the learning process, but those interactions are not themselves the agents of change.

EFT (Greenberg, 2002) and AEDP (Fosha, 2000), on the other hand, are both based on the idea that patients can access their formerly avoided emotions when they are in safe, controlled spaces and when they have experiences of empathic attunement with their therapists. Greenberg and Fosha describe empathic attunement as an intersubjective phenomenon wherein the therapist enters into the patient's subjective experiences and joins the patient, feeling and sharing the patient's emotions, so that the patient is not alone with the overwhelming emotions. In this scenario, the curative element has to do with what goes on between patient and therapist, not with what takes place within the patient. Therapeutic change (i.e., developing the capacities to regulate one's own emotions) comes about when patients internalize these empathically-attuned others (in the case of EFT) or when they internalize experiences of attunement and mutual coordination with their therapists (in the case of AEDP). This attachment-based, intersubjective model that attributes change to the internalization of objects/object relationships is very different from the learning/behavioral one described above.

Insight and the Unconscious

Given the emphasis on process in DBT (Linehan, 1993a, 1993b), the UP (Barlow et al., 2010), EFT (Greenberg, 2002), and AEDP (Fosha, 2000), what is the role of insight in these therapies? Does insight in these therapies have anything to do with making the unconscious conscious, as it does in many psychodynamic theories?

For Linehan (1993a), insight is achieved "when a person figures out what is influencing his or her behavior" (p. 300). Therapist "interpretations" can help patients achieve insight, as can other interventions like behavior chain analyses or cognitive modification. In the case of

cognitive modification, insight involves seeing discrepancies between one's perceptions of an event and "the facts" of that event. Linehan (1993a) makes clear that her concepts of insight and interpretation do not involve uncovering "repressed" material that was pushed out of awareness in some motivated way. Rather, insight and interpretation clarify the antecedents and consequences that shape behavior (and only observable behavior) because "most people most of the time have difficulty accurately identifying the factors that control their own behavior" (p. 271). Insight and interpretation contribute to the change process insofar as they help patients identify target behaviors/cognitions and the functions that they serve. Learning, though, is still the factor that drives behavioral change.

Though the word "insight" does not appear in the UP manual, Barlow and colleagues (2010) emphasize how important it is that "patients have a very clear understanding of the difficulties associated with avoiding uncomfortable emotions, and why trying to push away uncomfortable feelings may not be the best solution" (p. 62). These authors argue that one way in which the UP works is to help people understand the short-term benefits and long-term negative consequences of emotion avoidance, as well as how these can be in conflict with each other. If a patient does not recognize the negative consequences of an EDB, for example, the job of the UP therapist is to help the patient identify and understand those consequences. This emphasis on recognizing and understanding is consistent with an insight-oriented approach to therapy. Another element of the UP that is consistent with an insight-oriented approach is the use of cognitive reappraisal and the "downward arrow technique" for going beyond surface level automatic thoughts to reaching and understanding "core" appraisals. While Barlow and colleagues do not suggest that these "core" appraisals are outside of immediate awareness

because they have been “repressed,” the idea of uncovering meaningful psychological conflict is present in the UP.

In EFT, insight plays more than one role. Greenberg (2002) writes that what he calls “insight” is valuable in that, when people understand the pathological ways in which they view themselves, the world, and others, they can then change their views by “accessing alternate experiences to undo them” (p. 95). Understood more broadly, though, insight plays an even greater role in EFT. For Greenberg, integrating language and experience, or symbolizing experience, reflecting on it, and creating new meaning from those experiences, is understood as a kind of insight. That is, the narrative that one develops through this process represents insight, and Greenberg’s stance is that this process is healing and plays a “central” role in therapeutic change. Again, the emphasis here is not on uncovering “repressed” material, but on understanding and contextualizing psychological content.

While Fosha (2000) unequivocally argues for the primacy of visceral experience over insight in therapeutic action, she does attribute some of the power of therapy to the ways in which it helps people develop insight. In describing the role that insight plays in AEDP, Fosha, like Greenberg, argues that making meaning of experiences through narrative represents insight and is part of the healing process; it helps people understand and feel more in control of their experiences. Unlike Greenberg, Fosha (2000) has specific ideas about the structure these narratives should have: they should be based on the patient’s dynamic conflicts and expressed in terms of the triangles of conflict described in Chapter IV (see *Figures 4 and 5*). In order to develop such narratives, patients must understand their dynamic conflicts, including their defenses, the “red signal” emotions that trigger those defenses, and the “core affects” that have

been blocked by the “red signal” emotions. Fosha is unique among the authors studied here in suggesting that insight does involve the unearthing of repressed content.

Conclusions

Through a comparison of how Linehan (1993a), Barlow and colleagues (2010), Greenberg (2002), and Fosha (2000) conceive of the mechanisms of therapeutic action and change in psychotherapy, this chapter aimed to shed light on the primary question posed by this dissertation: to what extent does the focus on affect and affect regulation that DBT, the UP, EFT, and AEDP all share represent theoretical convergence among these psychotherapy models? This chapter found that all of the therapies studied here share an emphasis on viscerally experiencing primary emotions—an element of therapy traditionally associated with experiential theory but not necessarily with cognitive, behavioral, or psychodynamic theories (though this emphasis is characteristic of some psychodynamic theories). This emphasis on “experiencing” is also associated with a focus on psychological and interpersonal processes in therapy, with less focus on the importance and power of psychological content in these processes. While these factors point to meaningful theoretical convergence among the four therapy models, the differences between the behavioral orientation of DBT (Linehan, 1993a, 1993b) and the UP (Barlow et al., 2010) and the attachment/intersubjective orientations of EFT (Greenberg, 2002) and AEDP (Fosha, 2000) are major. The following chapter will explore whether the differences can be reconciled in any way and if theoretical/practical integration among these therapies is possible.

CHAPTER VI: Conclusions, Implications for Practice, and Future Directions

This concluding chapter has three main aims. The first is to summarize and synthesize the information provided in the previous chapters of this dissertation in order to draw conclusions about the extent to which the focus on emotion regulation in the four psychotherapy models studied here—Dialectical Behavior Therapy (DBT; Linehan, 1993a, 1993b), the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (the UP; Barlow et al., 2010), Emotion-Focused Therapy (EFT; Greenberg, 2002), and Accelerated Experiential Dynamic Therapy (AEDP; Fosha, 2000)—represents a unifying factor or point of theoretical convergence among the four models. The second aim of this chapter is to address the following question, which was posed in the introduction to this dissertation:

- *To what extent do the theoretical convergences and divergences between the four models studied here translate into similarities and differences in the application or practice of those models?*

That is, given their shared emphasis on emotion regulation, how much do these four models actually share in practice? Finally, this chapter will conclude with a set of comments and questions regarding how this study can inform future work in both psychotherapy practice and research, and it will address how this study can be understood from the perspective of psychotherapy integration.

Summary and Conclusions

Chapter I of this dissertation introduces the idea that affective science, and particularly the rapidly growing field of “emotion regulation” research, has had an increasingly significant impact on clinical psychology and the theory and practice of psychotherapy over the past few

decades. This impact can be seen in the increasing number of psychotherapy models that have been developed within that period that focus on “emotion dysregulation” as a central target of treatment. Chapter I also comments on the lack of definitional and conceptual clarity regarding emotion-related terms that can make the literature on this subject confusing and imprecise. The terms “emotion,” “emotion regulation,” and “emotion dysregulation,” for example, are not consistently defined or used in either the affective science research/literature or the clinical psychology research/literature. Because these terms refer to a multiplicity of overlapping phenomena that are difficult to distinguish, categorize, and define, it is not clear on the surface whether two authors or psychotherapy models that share “emotion dysregulation” as a treatment target necessarily target the same underlying phenomenon or phenomena. This conclusion leads to the main question that inspired this dissertation: *Does the shared focus on emotion regulation across different schools of thought in psychotherapy represent a unifying concept, or a convergence of theory and practice, among those traditionally distinct (even, at times, polemically oppositional) schools of thought?*

In order to shed light on this question and the role that the concept of “emotion regulation” plays in contemporary psychotherapy literature, this dissertation examines four theoretically diverse psychotherapy models that focus on “emotion regulation” in order to assess the extent to which that shared focus represents a point of theoretical convergence among the different models. The four models include Dialectical Behavior Therapy (DBT; Linehan, 1993a, 1993b), the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (the UP; Barlow et al., 2010), Emotion-Focused Therapy (EFT; Greenberg, 2002), and Accelerated Experiential Dynamic Therapy (AEDP; Fosha, 2000).

While Chapter I provides an introduction to this dissertation's main research questions and goals, Chapter II provides an overview of the four models studied here as well as a review of their main theoretical influences. That chapter finds that, while the four models' common emphasis on emotion theory and the importance of emotions and experience in psychological functioning is certainly notable, their foundations in different theoretical and clinical traditions represent meaningful differences between the various models. Most importantly, the learning theory that shapes DBT and the UP lead those models to focus on skills deficits as the root of psychopathology and on building emotion regulation skills through contingency management as the cure for that pathology. In contrast, EFT and AEDP are at their cores experiential and attachment-based theories and so focus on attachment/relational trauma as the roots of psychopathology and on the relationship and experiences of empathic attunement between patient and therapist as the cure for that pathology. This leads the theories to different ideas about how people operate in the world and in relationships and how they make meaning of their experiences.

The following chapters of this dissertation (Chapters III-V) explore to what extent the differences in the four models' theoretical foundations, identified in Chapter II, lead the various authors studied here to differing ideas about the role that emotion regulation/dysregulation play in human functioning and in dysfunction. To that end, each chapter considers a separate set of questions, which are summarized here.

Chapter III of this dissertation addresses the following question:

- *Do the various authors studied here define, operationalize, and use emotion-related terms in the same ways?*

Chapter III finds that the definitional and conceptual ambiguity regarding emotion-related terms, which has been identified as a problem in the fields of affective science and clinical psychology, is also present in the writing on DBT, the UP, EFT, and AEDP. This chapter determined that a closer study of how these models conceptualize emotion-related phenomena was needed in order to clarify the role that these phenomena play in each treatment model, and so it proceeded by addressing the following questions:

- *What is the impact of the various authors' diverse theoretical and philosophical assumptions on how they conceptualize emotion-related phenomena?*
- *How much overlap/divergence is there between how different authors understand the nature of emotion-related processes (i.e., emotion, emotion regulation/dysregulation)?*

Chapter III concluded that the various authors' diverse theoretical positions do lead them to different conceptualizations of emotion-related phenomena. On the one hand, DBT and the UP define emotions as experiences that take place within an individual as that individual interacts with the environment, a position that is consistent with behavior theory. On the other hand, EFT and AEDP define emotions as intersubjective phenomena that can only be understood in their relational contexts, a position that is consistent with attachment theory. While this marks a meaningful difference between the therapy models (a difference that has implications for their respective theories of therapeutic action), there are also significant similarities between them. All of the models, for example, view the generation and experience of emotion as a dynamic, multicomponential process. All also reject linear models of emotional processing, along with the idea that appraisal *necessarily* mediates emotional responses. This reflects a consensus among the different authors regarding the question of whether cognition or experience/physical

sensations are primary in the generation of emotion responses, a question that has historically polarized the field (see, e.g., Lazarus, 1982, 1984; Zajonc, 1980, 1984).

Given the conclusions reached in Chapter III, Chapter IV proceeded by addressing the following questions:

- *How much overlap/divergence is there between how different authors understand the role that emotion regulation and dysregulation play in the genesis, maintenance, and treatment of psychopathology, and how does this influence the ways in which different authors define the targets of psychotherapy treatment?*

In order to answer these questions, this chapter critically compares and contrasts the developmental accounts offered in the DBT, UP, EFT, and AEDP literature, which all include theories regarding the development and maintenance of “emotion dysregulation.” The most salient point of convergence among the different accounts is that they all consider emotion avoidance (including emotion inhibition, suppression, and denial) to be a central factor in psychopathogenesis. This convergence leads the different models to similar conclusions about *what* to treat in psychotherapy: all models target emotion avoidance for change in treatment. They all also agree that undoing this avoidance is therapeutic and curative and so is a central aim of treatment.

This chapter also identifies several points of divergence between how the different models studied here understand the developmental and psychic factors that lead to and maintain pathogenic emotion avoidance. DBT and the UP, for example, focus on learning, operant conditioning, and environmental contingencies. EFT and AEDP focus on experiences of empathic attunement/misattunement and the quality of an individual’s internalized objects/object relations. AEDP stands apart from the other models in that it also points to unconscious

intrapsychic conflict as a causal and maintaining factor for emotion dysregulation and psychopathology.

Chapter V examines to what extent the models' different ideas about the genesis and maintenance of pathogenic emotion dysregulation lead to different theories of therapeutic action. To that end, Chapter V addresses the following questions:

- *How much overlap/divergence is there between how the different authors understand the mechanisms by which psychotherapy can help transform emotion dysregulation into emotion regulation, and does the shared focus on “emotion regulation” across the different psychotherapy models point to a convergence in their theories of therapeutic action?*

In response to these questions, Chapter V identifies four main points of overlap among the four models with regard to their theories of therapeutic action:

1. *Mindfulness*: All four models suggest that a first step towards improved emotion regulation is developing awareness of both body (including physical sensations) and mind, or affective and mental states (e.g., mindfulness, emotion awareness, reflective self function).
2. *Metacognition*: All models propose that developing metacognitive abilities (e.g., the capacity to think about thinking, gain a “working distance” from emotions, and identify links between physical, affective, and cognitive states) is another factor that drives therapeutic change. Developing the capacity for metacognition is a first step in helping people modify their maladaptive cognitive and affective processes.
3. *Experiencing*: All models agree that the most effective way to undo pathogenic affective avoidance is through fully experiencing all aspects of primary emotions, and all use

emotion exposure (in DBT and the UP, with formal exposure exercises; in EFT and AEDP, through the therapist joining in, empathically attuning to, and mirroring patients' emotional experiences in order to "deepen" those experiences) to help patients build tolerance for their adaptive but avoided emotions.

4. *Focus on process*: All recognize that emotional and cognitive processes—the *how* of thinking and feeling—cause and maintain dysfunction and that one of the ways in which psychotherapy cures pathology is through corrective experiences that help modify dysfunctional emotional and cognitive processes.

These four areas of overlap represent meaningful convergence among the different therapy models studied here. The idea that developing metacognitive capacities plays a role in therapeutic action underlies many, if not most, forms of psychotherapy. In contrast, the ideas that developing mindful awareness of the body and experiencing primary emotions play roles in therapeutic action has not historically been so widely embraced.

The prominent roles that mindfulness and experiencing play in the psychotherapy models studied here reflect the growing influence of experiential, body-oriented theories over the past three decades. This growing influence has been observed within the cognitive-behavioral tradition and has played a big role in launching and shaping the third "wave" or "generation" of CBT (Hayes, Folette, & Linehan, 2004; Herbert & Forman, 2011). As we see from this dissertation, the growing influence of experiential theory can also be seen outside of the cognitive-behavioral tradition (e.g., in Fosha's AEDP). Some authors have observed this "turn to affect" even more broadly in the social sciences and humanities (Athanasiou, Hantzaroula, & Yannakopoulos, 2008; Leys, 2011). This turn has undoubtedly been propelled by advances in neuroscientific research and functional brain imaging, which have led to challenges to Cartesian

dualism (e.g., Damasio, 1994) and the idea that emotions or “passions” represent the opposite of reason and logic (and, therefore, science). The ideas that emotion and reason are not dichotomous and that emotions *promote* adaptive functioning rather than *detract* from it—not new ideas (see, e.g., Darwin, 1872; James, 1902), but ones that are now supported and even touted by some neuroscientists—are the foundational ideas upon which experiential, affect-focused therapies rest. The emphasis on experiencing affect that we see in DBT, the UP, EFT, and AEDP (and in other psychotherapy models not studied here)²⁰ is likely a reflection of this larger shift in Western thought and science; a shift that has the effect of bringing previously disparate theories of psychotherapy closer together.

Chapter V also identifies some areas of divergence that represent meaningful differences between the models. The most important difference is the models’ different notions about how people can be helped to access and experience their primary emotions and deal with feelings in different ways. DBT and the UP are both based on the idea that this can be achieved by providing patients validation that supports them (from an outside perspective) as they *learn* (through operant conditioning and contingency management) the skills that will help them access adaptive emotions and modify maladaptive ones. What matters in these therapies is what happens *within* patients; what changes are induced in them that can help them better adapt to their environments. EFT and AEDP, on the other hand, are both based on the idea that the curative element in therapy is the internalization of experiences of *empathic attunement*, wherein therapists enter into and share patients’ subjective experiences so that patients are not alone with

²⁰ As mentioned in Chapter I, DBT, the UP, EFT, and AEDP are just four examples of the many emotion-focused therapies that have developed over the past few decades, and there are many other examples, including Steven Hayes’ Acceptance and Commitment Therapy (ACT; Hayes et al., 2011) and Leigh McCullough and colleagues’ treatment for “affect phobia” (McCullough et al., 2003).

their overwhelming emotions. These are *dyadic* experiences. What matters in these experiences is the relating that goes on within the dyad, what goes on *between* patient and therapist, and not just what happens within the patient.

See *Figure 6* below for an illustration of the common and distinguishing features among DBT, the UP, EFT, and AEDP.

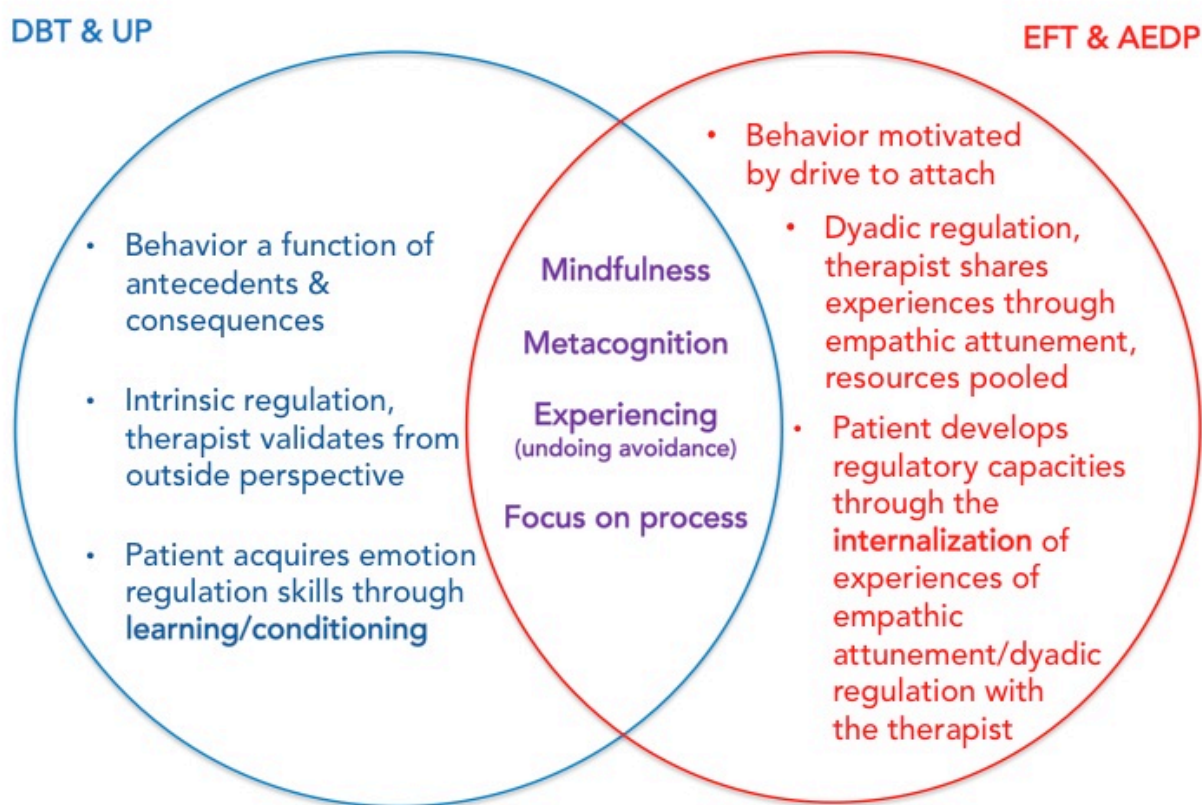


Figure 6: The four models: Common and distinguishing features

From Theory to Practice

One question that was stated in the introduction to this dissertation and remains unanswered thus far is:

- *To what extent do the theoretical convergences and divergences between the four models studied here translate into similarities and differences in the application or practice of those models?*

That is, given all that these models share regarding targets, goals, and mechanisms of change in psychotherapy, how much do these four models actually share in the kinds of interventions they prescribe and in the actual carrying out of those interventions?

Exposure. As mentioned above, the four models' agreement that developing awareness of emotions and fully (viscerally) experiencing them through exposure to them represents a significant similarity among the four models. As such, all of the models include interventions designed to elicit patients' emotions in the here-and-now of the therapeutic session as well as those designed to help patients attend to their bodies and recognize the physical changes involved in emotional responses. The different models, however, go about eliciting those emotions in different ways. DBT and the UP do so through formally planned and scheduled emotion exposure exercises, which have definite boundaries within the session (i.e., a beginning and an end). These exercises involve identifying a hierarchy of feared/avoided stimuli, exposing the patient to those stimuli (in order of least to most feared), and helping patients tolerate their responses by validating their distress and monitoring it using a quantified measure of emotional distress, called subjective units of distress (SUDs). One type of exposure used in the UP, for example, involves exposing patients who struggle with panic to a feared stimulus associated with panic, hyperventilation, by having them breathe through a thin straw to induce the physical sensations associated with hyperventilation. This exercise is designed to help patients tolerate those physical sensations so that they no longer have to be so feared or avoided.

In contrast, the emotion “exposures” in EFT and AEDP are not formally scheduled and do not necessarily have a distinct beginning or end in the session. Instead, they occur as the psychotherapy session unfolds and as therapists validate and *join* patients in their subjective experiences. In these models, therapists help patients “deepen” their emotional experiences through labeling and describing those experiences in words, but also through nonverbal “mirroring” of emotions. Therapists help patients monitor, tolerate, and modulate their distress in the face of feared/avoided emotions, not by quantifying it, but rather by “moment-by-moment” tracking of patients’ verbal—but more importantly, nonverbal—expressions of distress.

Two main differences between the behavioral and experiential exposures described here are: 1) behavioral exposures are scheduled and based on avoidance hierarchies while experiential exposures occur more organically/spontaneously over the course of therapy sessions, and 2) behavior therapists validate emotions and monitor distress using quantified scales and experiential therapists validate *and empathize* with emotions and monitor distress through “moment-by-moment” verbal and nonverbal tracking.

While these two types of exposures seem very different on the surface, and they would likely feel different to both therapists and patients as carried out, one must ask how different they actually are in the ways that they impact patients. The two types of exposures are structurally very similar: in both cases, patients’ feared emotions are elicited in the presence of therapists who validate and monitor their discomfort and distress in response to the feared emotions. Regarding the first difference between the two types of exposures identified above (point 1), though the experiential exposures are not *explicitly* scheduled in the same way that the behavioral ones are, nor are they based on *explicitly* constructed fear/avoidance hierarchies, this

planning and proceeding according to hierarchies is certainly done implicitly. According to Greenberg (2002) and Fosha (2000), EFT and AEDP therapists do not randomly mirror or “deepen” any emotions that come up during the course of a session. Whether they make it explicit or not, they purposefully select which emotions to attend to and deepen based on case formulations and treatment plans. This process is based on something like a hierarchy, as the idea is to first deepen emotions that are less feared/avoided by patients and then proceed gradually with those that are more feared/avoided, depending on how patients tolerate the exposure to those emotions.

The second difference between the two types of exposures identified above (point 2) is related to a major theoretical difference between the behavior therapies (DBT and the UP) on the one hand and the attachment-based therapies (EFT and AEDP) on the other: DBT and the UP conceive of emotion as a process that occurs within an individual as that individual interacts with the environment, while EFT and AEDP conceive of emotion as an intersubjective, dyadic process. This leads Greenberg (2002) and Fosha (2000) to emphasize the importance of therapists *empathizing* with and *joining* patients in mutual coordination (because, according to their theories, emotions can only be fully experienced when they are shared with an other, and the goal of the therapy is for patients to fully experience their emotions), while Linehan (1993a) and Barlow and colleagues (2010) emphasize instead the importance of therapists validating patients’ experiences, which involves reassuring patients that their responses to circumstances make sense from an outsider’s perspective but does not necessarily (at least theoretically) involve empathizing or joining patients in their experiences.

At the level of theory, this is a major difference. In practice, however, both techniques involve therapists closely attuning to and tracking patients’ experiences and helping them

modulate distress so that it does not become overwhelming. Though behavior therapists may not explicitly state that they are joining or sharing experiences with patients, surely their very close engagement with patients in these exercises has an effect similar to that of the experiential therapists. In both cases, patients are assured and reassured that they are not alone in their distress and that they can rely on others to help them tolerate and modulate their distress. The theoretical differences between how DBT, the UP, EFT, and AEDP conceive of emotions lead to theories of therapeutic action that seem incompatible and to clinical interventions (in this case, exposures) that seem very different on the surface. Upon closer study of how these interventions are carried out, though, these different approaches look more alike and certainly less incompatible.

Metacognition, emotional awareness, and insight. Another set of goals that all of the therapy models studied here share is to help patients develop metacognitive skills, emotional awareness, and insight. Here again, however, the different models prescribe interventions that seem quite different in order to achieve those goals. Like with the exposure exercises, DBT and the UP use distinct, structured exercises (with identifiable beginnings and ends) to achieve these aims. To help patients develop metacognitive, emotional awareness, and self-monitoring skills, these therapies prescribe the use of diary cards, which require that patients record the frequency of a range of maladaptive (target) and adaptive behaviors and emotions, along with the intensity of those emotions, each day of the week. To help patients achieve insight, or an understanding of the forces that shape their behavior, these models use behavior chain analyses (BCAs, i.e., exercises in which therapists help patients recreate the causal chains of events, including behaviors, thoughts, and emotions, that lead to maladaptive behaviors).

While the content of these exercises is varied and may center around behavioral or emotional phenomena, the processes required to engage in and benefit from these exercises are based in language, cognition, and cognitive understanding or insight. An underlying assumption involved in using these exercises is that cognitive understanding or insight that is articulated in language plays an important role in shaping emotions and behavior.

In contrast, Greenberg focuses more on the mutative power of experiential and relational processes that are not necessarily verbalized or even symbolized. Through moment-by-moment tracking of patients' verbal and nonverbal communications, EFT "emotion coaches" attempt to "enter into the highly subjective domain of unformulated personal experience, a place beyond reason and often beyond words" (Greenberg, 2004b, p. 7). The therapist in EFT takes on the goal of going *beyond* reason and words, using techniques like empathic reflection and mirroring that steer patients towards felt experiences rather than conceptual problem solving or intellectual insight. Even with this goal of going beyond reason and words, though, EFT ultimately aims to help patients integrate cognition and emotion, symbolize experiences, and make meaning of those experiences through the development of narratives (processes that are also based in cognition and language).

AEDP is similar to EFT in its emphasis on nonverbal expression and communication. AEDP therapists mirror their patients' emotions (both verbally and nonverbally) as they emerge in the here-and-now in order to help them focus on the visceral, physical sensations associated with emotional experiences. Fosha (2000) writes that, in AEDP, "Insight is formally and unequivocally replaced by visceral experience as the sought-for catalytic agent" (p. 328). However, like in EFT, the ultimate goal of AEDP is to put words to nonverbal experiences and

to understand them in terms of narratives that explain and help make sense of how underlying conflicts shape experiences.

As with the differences identified between behavioral and experiential exposures, one must ask how different the behavioral interventions described here are from the experiential ones in practice. Again, they seem very different on the surface. EFT and AEDP therapists do not use diary cards or write out BCAs. How different, though, is the process of going over diary cards to help patients monitor their emotions and shifts in affective states from the process of moment-by-moment tracking of patients' affective states to help them cultivate self-awareness and self-monitoring? How different is the process of creating a BCA (which tracks cognitive, emotional, and behavioral events to explain and make sense of behaviors/experiences) from that of creating a narrative to make meaning of experiences? Again, these interventions derive from theories of pathogenesis and change that seem incompatible, but looking beyond the topography of their respective interventions, the four models studied here share many features when put into practice.

Therapist stance. The fundamental divergences between behavior and attachment *theories*, which have been described in the preceding sections of this dissertation, are very clearly seen in the ways the different models conceive of the therapeutic relationship and the stance that the therapist takes in relation to the patient. In the behavioral models, which are largely didactic or psychoeducational in nature, the therapist takes on a role similar to that of a teacher. Skills training sessions in DBT, for example, are structured like classroom lessons. Therapists lead individuals or groups through sessions that cover the modules and skills that are outlined in the DBT manual (Linehan, 1993b, 2015). Therapists also distribute handouts, which summarize the major teaching points of each session, and assign and review homework in each

session. The UP is similar in that therapists and patients work together using a workbook, and homework is assigned and reviewed. A good deal of UP treatment is based on psychoeducational reading materials, which are provided in the workbook (Barlow et al., 2011).

Greenberg (2002) argues that the didactic, “skills training” model that many behavior therapies use to foster emotion regulation skills is ineffective. He writes,

People don’t learn emotion regulation in the same way they learn, say, math or biology; rather, the skill is absorbed implicitly by being in the presence of a person who has this ability. If, for example, clients see that their therapists are calm in response to their expressions of distress or anger and can contain them, they find this reassuring and are calmed. (p. 73)

Rather than using the teacher-student relationship as a model for the therapist-patient relationship, Greenberg (2002) uses the caretaker-child developmental model. Therapists take on the role of nurturing caregiver, whom patients can internalize and then draw upon for comfort and soothing in times of distress.

Like Greenberg, Fosha (2000) compares the therapist to a caretaker. Fosha writes that, like mothers who attune to and track their children’s affective states as they shift from moment to moment and empathize with them in order to foster secure attachments, AEDP therapists must attune to their patients’ affective states as they shift from moment to moment and empathically join them in those states. In her words,

The process of affective sharing, in which patient and therapist share intense emotions, elicits powerful feelings of closeness and intimacy. Relief, lightness, closeness, melting experiences, and other in-sync states are experiential correlates of affective sharing and are aspects of the core state of openness and relaxation.

Noteworthy is how often affective sharing of intensely painful and negative emotions brings with it relief and lightness for the patient. (Fosha, 2000, p. 150)

In addition to the relief and lightness that affective sharing elicits, this sharing also provides the opportunity for therapists to use their own affect regulation and reflective capacities to help patients “deepen,” “amplify,” and “process” their affective experiences without being overwhelmed by them.

Both Greenberg and Fosha see the bond that develops between therapist and patient as intensely personal. This is in contrast to the UP, in which the importance of therapists validating patients is acknowledged insofar as such validation serves as social reinforcement, but there is little recognition that a *relationship* or bond develops between therapist and patient at all. Barlow and colleagues (2010) write, for example, that when patients become nervous or discouraged near the end of treatment, therapists can tell them:

But, remember, over the course of treatment, you’ve been developing important skills for responding more adaptively to your emotions. I would say that you now have a good understanding of these skills, and if you continue to practice what you’ve learned, I imagine you’ll become even better at applying these skills over time. I guess it’s sort of like any class you may have taken. You don’t simply forget everything you’ve learned just because the class is over. But in order to really retain that information, you may need to continue practicing it, or at least revisit it from time to time. (p. 150)

While statements like these may encourage patients and make them feel more confident in their abilities to manage their own emotions, they include no acknowledgment that the therapeutic

relationship itself may be meaningful to the patient, nor that the end of treatment represents a relational *loss* for the patient.

This view of the therapeutic relationship is not characteristic of all behavior therapies, and Linehan makes clear that the therapeutic relationship in DBT is powerful, and as such, can be used as a tool in treatment. She writes, for example, that DBT therapists should use the connection between therapist and patient as a contingency in behavior management. That is, therapists should reward patients (with warmth, praise, and a positive relationship) in response to desired behaviors and punish patients (with withdrawal of warmth and approval) in response to undesired/target behaviors. Linehan distinguishes DBT from a client-centered model and makes clear that there is no such thing as “unconditional positive regard”; patients should understand that they may act in ways that will cause others (including therapists) to reject them. Linehan admits that, because the therapist uses the relationship in this way, DBT has been called a “black mail therapy.” She defends this stance, though, explaining that it helps patients recognize the effects and consequences of their interpersonal behaviors and helps shape patients’ maladaptive behaviors into more adaptive ones. In her words,

The therapist creates a context of validating rather than blaming the patient, and within that context the therapist blocks or extinguishes bad behaviors, drags good behaviors out of the patient, and figures out a way to make the good behaviors so reinforcing that the patient continues the good ones and stops the bad ones.

(Linehan, 1993a, p. 97)

This section of this dissertation examines the ways in which the different theories of relationships and relating adopted by Linehan (1993a), Barlow and colleagues (2010), Greenberg (2002), and Fosha (2000) shape how these various authors conceive of the therapeutic

relationship and the stance that the therapist should take in relation to the patient. Barlow and colleagues (2010) maintain that validation and a positive therapeutic relationship are useful in that they can provide social reinforcement that can support learning, but these authors do not explicitly consider the attachment that develops between patient and therapist, nor do they consider the impact of relational loss on the patient. Linehan (1993a) also views validation and the therapeutic relationship as important sources of reinforcement that can be used in the service of behavioral management and operant conditioning. She also recognizes, though, that a meaningful relationship develops between patient and therapist and that the possibility of losing that relationship represents a threat to the patient (as can be seen in her idea that withdrawal of therapists' warmth can serve as punishment for patients' maladaptive behaviors).

While her recognition of the attachment that develops between patient and therapist brings her conceptualization of the therapeutic relationship closer to the attachment-based one espoused by Greenberg (2002) and Fosha (2000), Linehan's (1993a) use of relational loss as a tool for shaping behavior is antithetical to the attachment-based therapy models. The attachment-based models prescribe that therapists maintain their attuned connection and "radical empathy" with patients in the service of creating a safe space in which patients can access core affect. According to EFT and AEDP theories, therapy can only become a safe space for patients if they can trust that their relationships with their therapists will survive ruptures and overwhelming experiences. This is what makes it possible for patients to access and fully experience their emotions in the context of therapy when they cannot on their own or with others in their lives.

These differences in how the various therapy models conceptualize the therapeutic relationship and how it can be used to effect change in treatment may hold as a true difference in

practice as well as in theory. EFT and AEDP theories prescribe that therapists adopt a stance involving a level of closeness and unconditional empathy that is quite different from that prescribed by DBT and the UP. However, the degree of difference between the therapies as they are actually carried out in practice likely depends as much on therapist and patient differences as it does on theoretical differences. In the practice of any therapy model, some therapists, patients, and therapist-patient dyads will have greater tolerance and capacity than others to maintain closeness and empathy, regardless of what goes on in the therapy. Levels of tolerance and capacity of this kind also shift within individuals and dyads over time, even over the course of a single therapy session.

These differences and shifts inevitably impact the degree of closeness and empathy achieved and maintained in any treatment. Even in EFT and AEDP, it is understood that therapists should assess the level of patients' tolerance for relating and closeness and adjust therapeutic interventions accordingly, so as not to come across as intrusive with patients who have lower tolerance in this regard or as distant with patients who have higher tolerance. More, even if EFT and AEDP therapists embrace the idea of unconditional empathy in theory, in practice countertransference reactions may interfere with this stance. In all treatments, then, the degree of empathic closeness achieved and maintained is to some degree fluid, shifting from moment to moment or session to session as the relationship and treatment develop and unfold. These ideas raise two points: when assessing how any two or more therapy models differ in practice 1) individual and dyadic differences must be taken into account in addition to theoretical and technical ones, and 2) attention must be paid to the inevitable fluctuations and adjustments to therapeutic stance and the application of therapeutic techniques that must be made in any

ongoing, dynamic interaction between two (or more) people—even when a therapist is following a treatment “manual.”

Conclusions. The previous chapters of this dissertation identify many areas of theoretical divergence between the various psychotherapy models studied here that distinguish one from the other. The most significant difference between them involves their conceptualizations of the forces that shape human development and behavior, which leads them to different ideas about how to effect therapeutic change in psychological treatment. While DBT (Linehan, 1993a) and the UP (Barlow et al., 2010) draw from behavior theory and point to learning and operant conditioning as the primary forces that shape behavior and effect change in psychotherapy, EFT (Greenberg, 2002) and AEDP (Fosha, 2000) draw from attachment and experiential theories and point to relational experiences as the primary motivators and agents of psychic and behavioral change. As a result, the nature of the various models’ interventions appears on the surface to be quite different.

A close examination of those interventions, though, calls into question how different they really are when actually put into practice. Though DBT and the UP on the one hand and EFT and AEDP on the other use different language to describe the interventions they prescribe, as well as different language to describe their theories about how those interventions promote therapeutic change, looking beyond those semantic differences illuminates important underlying similarities among the different models that have been obscured by the different languages and vocabularies used by the different authors studied here. This is not to say that the models do not differ from each other at all; certainly they do. Those differences, however, do not necessarily reflect categorical or irreconcilable differences, and they do not necessarily create problems for our field. Rather than thinking of the different models studied here as opposing or conflicting

accounts of human development and behavioral change, it is more useful to think of them as pointing to complementary or additive accounts. That is, they are different ways of interpreting and translating complex and dynamic developmental, behavioral, and psychic phenomena into language. As a rule, translations never completely capture their referents, and no one translation is entirely comprehensive. Multiple translations can be useful in that they can shed light on different aspects of a complex set of phenomena. Rather than relying on just one, it is most useful to consider different translations in order to construct a fuller picture of those phenomena.

While this conclusion is an argument for appreciating how a collection of diverse translations (i.e., diverse models of psychology and psychotherapy) can enhance our understanding of psychological phenomena and an argument against defending any particular translation at the exclusion of others, it does not suggest that all translations are equal. Indeed, some translations are more complete or nuanced than others. Based on the material studied here, this dissertation argues that the attachment-based models (EFT and AEDP) are more complete and nuanced than the behavioral models. That is not to say that the behavioral models are “wrong” or that they have nothing to offer. On the contrary, the principles of learning and operant conditioning are extremely important and useful in psychotherapy theory and practice. They are so important, in fact, that they underlie (if implicitly) most psychotherapy models, even those that are not classified as “behavioral.” EFT and AEDP may be included among those “non-behavioral” models that are based on, or presuppose, many behavioral principles (e.g., the principles of reinforcement, punishment, and habituation to aversive stimuli). What makes EFT and AEDP more complete and nuanced, though, is their deep appreciation for the importance of interpersonal attachment and relating and the unique influence these factors have on self-development and psychic functioning. That said, the behavioral models studied here also

provide valuable perspectives on how psychotherapists can intervene when presented with different kinds of clinical presentations.

Implications for Practice: An Argument for Integration

These last points speak to the ways in which the present study can be useful and informative for clinicians. Above it was said that when assessing how any two or more therapy models differ in practice, 1) individual and dyadic differences must be taken into account, and 2) attention must be paid to the inevitable fluctuations and adjustments to therapeutic stance and techniques that must be made in any ongoing, dynamic interaction between two (or more) people. These points must also be taken into account in clinical practice. Even when following a “manualized” treatment, clinicians must be flexible and able to adjust for the ongoing shifts described above.

Given the dynamic nature of the psychotherapy process, clinical practice will inevitably draw from and integrate multiple schools of thought, whether or not this is explicitly acknowledged. If not acknowledged (i.e., if clinicians adhere to only one school of thought and neglect or reject others—or, to extend the “translation” metaphor used above, if they read only one “translation”), they limit the potential comprehensiveness of their understandings of human development and functioning and their vocabularies for describing those phenomena. If clinicians *do* acknowledge their integration of multiple theories and clinical models, they have the opportunity to expand their understandings of and vocabularies for the phenomena that they treat. Drawing from both the behavioral and attachment-based models covered here, for example, may help a clinician be better prepared to understand and modify the environmental contingencies that contribute to maintaining a patient’s presenting problems (through, e.g., a behavioral chain analysis and behavioral modification) and may also help the clinician attune to

the subtleties in that patient's interpersonal expectations and patterns of relating (internalized object relationships) that also contribute to maintaining the problems. The attention to the relational factors may also help the clinician be aware of the ways in which the patient perceives and reacts to the therapist (transference), which may inform how the therapist approaches the patient so that the therapist can be more effective with that particular individual. Again, viewing these different ideas as additive rather than opposing can help make clinicians better prepared for and more effective in their work.

This dissertation thus argues for the utility of considering multiple perspectives on any clinical phenomenon, especially on a phenomenon as complex as emotional functioning. This study can also be useful to clinicians because it brings attention to the definitional and conceptual ambiguity that can cloud researching, writing about, and working clinically with emotion-related phenomena. It therefore points to the importance of clarifying (in both research and clinical contexts) how we think about emotion and the roles it plays in adaptive functioning. Even if emotion is an elusive topic that cannot be entirely "pinned down," acknowledging the complexity of the topic and asking or exploring what "emotion regulation" refers to in any given context can help us develop deeper and more nuanced understandings of how we can talk about and work with these multifaceted ideas. With that understanding, we can be more sensitive and attuned to the different kinds of emotion-related phenomena that we encounter in our research and clinical work and thus better equipped to identify and plan appropriate psychotherapeutic interventions for a given clinical presentation, as well as more precise and intentional in carrying them out.

Limitations

The topic of emotion regulation as it is understood and used in contemporary psychotherapy theory and practice is expansive and multifaceted. This study is limited in its scope; it does not provide a comprehensive survey of this topic and thus should be considered an introduction to the topic. Four significant limitations of this introduction are identified here, and recommendations for future research in this area follow.

First, this study would have provided a more complete overview of the current literature on emotion regulation as it is used in psychotherapy if it had examined more psychotherapy models. It would have been especially interesting to study Mentalization-Based Therapy (MBT; Fonagy et al., 2002), a model that is informed by attachment and clinical developmental theories but is not as indebted to the experiential tradition as are the attachment-based models studied here (EFT and AEDP). MBT is more cognitively oriented than either EFT or AEDP and focuses on poor reflective functioning (and less on emotion avoidance) as the source of psychopathology. Another therapy model that would have presented an interesting contrast to the models studied here is Leigh McCullough and colleagues' (2003) *Treating Affect Phobia*. Like Greenberg (2002) and Fosha (2000), McCullough and colleagues point to dynamic conflict, which triggers emotion avoidance (which they describe as "affect phobia"), as the root of psychopathology. Their model integrates behavioral techniques, like systematic desensitization (graduated emotion exposures), into a psychodynamic framework.

Second, it was beyond the limits of this study to examine and evaluate the research cited by Linehan (1993a), Barlow and colleagues (2010), Greenberg (2002), and Fosha (2000), which they used as evidence to support and justify their respective treatment models (e.g., to evaluate the psychotherapy process and outcome research, emotion theory and research, and

neuroscientific research that these authors drew upon to shape their treatment models). This would be a very useful endeavor, especially because it could provide the background and foundation needed to evaluate the different therapy models based on their consistency with the most current psychotherapy and emotion/emotion regulation research. This is related to a third important limitation of this study, which is that it did not thoroughly assess the claims made by the therapy models studied herein. For example, this dissertation points out four major points of convergence among DBT, the UP, EFT, and AEDP (i.e., all emphasize mindfulness, metacognition, experiencing, and process in their theories of therapeutic action), but the dissertation does not evaluate whether these are indeed important factors in therapeutic action. One question that is worth asking is whether the various models' promotion of "experiencing" overlooks the possibility that emotional avoidance may at times be adaptive or in some way contribute to psychological health and/or functioning. This question is elaborated in the "Future Directions" section below.

Fourth, it was beyond the scope of this study to critically evaluate the concept of "emotion regulation" as a measure of psychological health and as a goal of psychotherapy treatment. This is an important task, though, and one that is woefully overlooked and neglected in the contemporary literature. Louis Charland points out that "emotion regulation is ultimately, and invariably, a *normative* enterprise: there must be some *prescribed* normative endpoints to guide and orient regulation." He adds that these normative endpoints cannot be conceived of or understood apart from the social values and culture-specific morals that establish and shape socio-cultural norms and expectations. He writes, "There is a moral undertow that always draws the science of emotion regulation back to values, and ultimately to morals" because "the 'how' and means of emotion regulation always logically presuppose certain ends, which in the final

instance prescribe ‘why’ emotions should be regulated one way rather than another” (Charland, 2011, p. 84).

Charland’s (2011) argument makes us aware that the concept of emotion regulation is culturally and socially constructed. As with any such concept, the assumptions (including the moral values) that shape our understanding of the concept and the implications of those assumptions (e.g., how the values of certain socio-cultural groups are included while others are excluded, neglected, or rejected) should be investigated, examined, and appreciated. This is especially important when the concept in question is used prescriptively as a measure or standard of mental health and functioning, as “emotion regulation” is.

Based on the literature reviewed in this dissertation, this type of investigation, examination, and appreciation of the assumptions and values that underpin conceptualizations of “emotion regulation” is not done enough. As a result, there is very little acknowledgment in the psychotherapy literature that psychotherapy treatments that focus on “emotion regulation” are limited in terms of their applicability and may neglect or even pathologize certain groups or individuals who do not conform to certain socio-cultural/moral norms. Linehan (1993a) briefly touches upon this problem when she writes about how BPD is diagnosed at much higher rates in women than it is in men. She suggests that the higher prevalence of BPD in women may have to do with invalidating and impossible cultural ideals and expectations for women around issues like femininity, dependence, and independence. She raises the point, for example, that the emphasis on independence that typifies so many Western cultures may be at odds with the kinds of interpersonal bonding and relating that tends to be associated with women in those same cultures, thus pathologizing what is seen as a “feminine” need for social support. This is an under-investigated area in the literature, and more work should be done to better understand the

assumptions that underlie our ideas about what constitutes adaptive emotional functioning and how those assumptions influence clinical nosology and diagnosis as well as psychotherapy development, research, and practice.

Future Directions

This dissertation concludes with some comments regarding future directions that can be explored in the study of emotion regulation as it is used in clinical work.

1. Future work could expand upon this study and critically compare more psychotherapy models that focus on “emotion regulation,” such as Fonagy and colleagues’ (2002) *Mentalization-Based Therapy*, McCullough and colleagues’ (2003) *Treating Affect Phobia*, and Hayes and colleagues’ (2011) *Acceptance and Commitment Therapy*. This would further expand our understanding of how the concept of “emotion regulation” is understood and used in contemporary psychotherapy theory and practice.
2. As has been noted throughout this dissertation, inconsistency in how different authors use emotion-related terms leads to conceptual and definitional ambiguity regarding how these terms and concepts (e.g., emotion, affect, emotion regulation, emotion dysregulation) are understood in the clinical literature. This is particularly problematic for research in this area, as treatment targets and goals are sometimes ill defined. It would be helpful for researchers to utilize a consistent vocabulary/set of definitions for these terms (e.g., those outlined by Rottenberg & Gross, 2007). This would help researchers be more precise in identifying and describing the objects of their studies. Standardizing a vocabulary for these terms would also help clinicians be more precise in defining treatment

targets and goals and in planning and carrying out the most effective interventions to meet those goals.

3. As mentioned above, another limitation of this study is that it does not evaluate the research that the authors studied here cite as evidence to support and justify their respective treatment models. Exploring this evidence would be useful in that it would provide the background needed to evaluate the different therapy models based on their consistency with the most current psychotherapy and emotion/emotion regulation research, and to assess whether that research supports some models or claims more than others.
4. Another limitation of this study that was mentioned above is that it did not thoroughly assess the claims made by the therapy models studied herein. One question that is worth asking is whether the various models' promotion of "experiencing" overlooks the possibility that emotional avoidance may at times be adaptive or in some way contribute to psychological health and/or functioning. Is there any research that points to negative consequences of experiencing? Are there any exclusion criteria for these experientially-oriented treatments? Recent writing by Linehan and colleagues promotes DBT as appropriate for a wide range of diagnoses, including schizophrenia and psychotic-spectrum disorders (Neacsiu, Bohus, & Linehan, 2014), and the UP claims to be a transdiagnostic treatment appropriate for bipolar, dissociative, and other disorders (Barlow et al., 2010). While these authors make a case for why "experiencing" and "undoing avoidance" is helpful for anxiety and depressive disorders, they do not explain how these processes could/would affect individuals suffering from illness related

to psychosis, mania, or dissociation. Future research should examine the data available on the impact of mindfulness and experiencing when it is used in the treatment of different diagnostic pictures and clinical presentations.

5. Another area that should be investigated in this field is what the impact of neuroscientific research and literature is on the way that the concept of “emotion regulation” is understood and used in contemporary psychotherapy, and how advances in neuroscience may be changing how the concept is used and understood in clinical contexts. All of the authors studied here cite neuroscientific research in support of their claims about emotion regulation. Is this warranted? Does neuroscientific research support these authors’ ideas, as they claim it does? How can this be evaluated?
6. Following points 2-4, future research should also investigate how “emotion regulation” is assessed, particularly in psychotherapy outcome research. What measures are used, and do different researchers use different measures? If so, how can we synthesize and consolidate the different veins of research that are being pursued in this area?
7. As mentioned above, one limitation of this study is that it does not adequately consider the socio-cultural implications of adopting “emotion regulation” as a marker of psychological health and a goal in psychological treatment. It also does not question the normative prescriptions that using the concept in this way inevitably involves. Who and what might be marginalized or pathologized in using the concept in this way, especially when the socio-cultural assumptions

embedded in that concept are left unexamined? Future research should consider these questions.

8. One of the aims in taking a comparative approach in this study was to challenge the idea that different psychotherapy models and schools of thought are necessarily opposing or conflicting. This study shows that clinicians associated with different schools of thought (cognitive-behavioral, experiential, psychodynamic) are working towards common goals (treating “emotion dysregulation”) and are coming to similar conclusions about how to achieve those goals (helping patients develop mindfulness/awareness and capacities for metacognition and experiencing). Future work in psychotherapy research should continue this comparative work, not just to determine which models are most effective, but also to understand how different therapy models may complement each other. In a similar vein, future research should investigate which nonspecific treatment factors are most effective in treating emotion regulation. These integrative approaches to research will hopefully open up productive conversations in a field that is too often divided by splits between different schools of thought.

References

- Ainsworth, M.D., & Bell, S.M. (1970). Attachment, exploration, and separation: Illustrated by the behavior of one-year-olds in a strange situation. *Child Development*, 41, 49-47.
- Alexander, F., & French, T.M. (1946/1980). *Psychoanalytic therapy: Principles and application, volume 1946*. Lincoln: University of Nebraska Press. (Original work published 1946).
- American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Athanasiou, A., Hantzaroula, P., & Yannakopoulos, K. (2008). Towards a new epistemology: The 'Affective Turn.' *Historein*, 8, 5-16.
- Barlow, D.H. (2010). About treatments that work. In D.H. Barlow, T.J. Fairholme, K.K. Ellard, C.L. Boisseau, L.N. Allen, & J.T. Ehrenreich May, *Unified protocol for transdiagnostic treatment of emotional disorders: Therapist guide* (pp. v-vii). New York: Oxford University Press.
- Barlow, D.H., Allen, L.B., & Choate, M.L. (2004). Toward a unified treatment for emotional disorders. *Behavior Therapy*, 35, 205-230.
- Barlow, D.H., Farchione, T.J., Fairholme, C.P., Ellard, K.K., Boisseau, C.L., Allen, L.B., & Ehrenreich May, J.T. (2010). *Unified protocol for transdiagnostic treatment of emotional disorders: Therapist guide*. New York: Oxford University Press.

- Barlow, D.H., Ellard, K.K., Fairholme, C.P., Farchione, T.J., Boisseau, C.L., Allen, L.B., & Ehrenreich May, J.T. (2011). *Unified protocol for transdiagnostic treatment of emotional disorders: Workbook*. New York: Oxford University Press.
- Barrett, L.F., Ochsner, K.N., & Gross, J.J. (2007). On the automaticity of emotion. In J.A. Bargh (Ed.), *Social psychology and the unconscious: The automaticity of higher mental processes* (pp. 173-217). New York: Psychology Press.
- Bateman, A.W., & Fonagy, P. (2012a). *Handbook of mentalizing in mental health practice*. Arlington, VA: American Psychiatric Association.
- Bateman, A.W., & Fonagy, P. (2012b). Preface. In A.W. Bateman & P. Fonagy (Eds.), *Handbook of mentalizing in mental health practice* (pp. xv-xxi). Arlington, VA: American Psychiatric Association.
- Beck, A.T. (1976). *Cognitive therapies and the emotional disorders*. New York: International Universities Press.
- Beck, A.T., Davis, J.H., Frederick, C.J., Perlin, S., Pokorny, A.D., Schulman, R., Seiden, R.H., & Wittlin, B.J. (1973). Classification and nomenclature. In H.I.P. Resnick & B.C. Hawthorne (Eds.), *Suicide prevention in the 70's* (pp. 7-12). Rockville, MD: Center for Studies of Suicide Prevention, National Institute of Mental Health.
- Beck, A.T., Freeman, A., & Associates. (1990). *Cognitive therapy of personality disorders*. New York: Guilford Press.
- Beck, J.S. (2015). Question: Does Cognitive Behavior Therapy Include Insight? *Huffington Post*. Retrieved from http://www.huffingtonpost.com/judith-s-beck-phd/question-does-cognitive-b_b_7443086.html

- Beebe, B., & Lachmann, F.M. (1994). Representation and internalization in infancy: Three principles of salience. *Psychoanalytic Psychology*, 11(2), 127-165.
- Beebe, B., Lachmann, F.M., & Jaffe, J. (1997). Mother-infant interaction structures and pre-symbolic self and object representations. *Psychoanalytic Dialogues*, 7, 133-182.
- Berkowitz, L. (2000). *Causes and consequences of feelings*. Cambridge, England: Cambridge University Press.
- Bohus, M., Haaf, B., Simms, T., Limberger, M.F., Schmahl, C., Unckel, C., Lieb, K., Linehan, M.M. (2004). Effectiveness of inpatient dialectical behavioral therapy for borderline personality disorder: A controlled trial. *Behaviour Research and Therapy*, 42(5), 487-499.
- Bollas, C. (1989). *Forces of destiny: Psychoanalysis and human idiom*. London: Free Association Books.
- Boisseau, C.L., Farchione, T.J., Fairholme, C.P., Ellard, K.K., & Barlow, D.H. (2010). The development of the unified protocol for the transdiagnostic treatment of emotional disorders: A case study. *Cognitive and Behavioral Practice*, 17, 102-113.
- Bowlby, J. (1982). *Attachment and loss: Vol. I. Attachment* (2nd ed.). New York: Basic Books.
- Bromberg, P.M. (1996). Standing in the spaces: The multiplicity of self and the psychoanalytic relationship. *Contemporary Psychoanalysis*, 32, 509-535.
- Burton, R.A. (2013). *A skeptic's guide to the mind: What neuroscience can and cannot tell us about ourselves*. New York: St. Martin's Press.
- Cappas, N.M., Andres-Hyman, R., & Davidson, L. (2005). What psychotherapists can begin to learn from neuroscience: Seven principles of brain-based psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, 42(3), 374-383.

- Cassidy, J. & Shaver, P.R. (Eds.). (2008). *Handbook of attachment: Theory, research, and clinical applications* (2nd ed.). New York: Guilford Press.
- Cautela, J.R. (1993). Insight in behavior therapy. *Journal of Behavior Therapy and Experimental Psychiatry*, 24(2), 155-159.
- Charland, L.C. (2010). Science and morals in the affective psychopathology of Philippe Pinel. *History of Psychiatry*, 21(1), 38-53.
- Charland, L.C. (2011). Moral undertow and the passions: Two challenges for contemporary emotion regulation. *Emotion Review*, 3(1), 83-91.
- Damasio, A.R. (1994). *Descartes' error: Emotion, reason, and the human brain*. New York: Putnam.
- Damasio, A.R. (1999). *The feeling of what happens: Body and emotion in the making of consciousness*. New York: Harcourt Brace.
- Darwin, C. (1872/1965). *The expression of emotion in man and animals*. Chicago: University of Chicago Press. (Original work published 1872).
- Davanloo, H. (1980). *Short-term dynamic psychotherapy*. New York: Jason Aranson.
- Eagle, M.S. (2011). Classical theory, the Enlightenment Vision, and contemporary psychoanalysis. In M.J. Diamond, C. & Christian, (Eds.), *The second century of psychoanalysis: Evolving perspectives on therapeutic action* (pp. 41-70). London: Karnac Books, Inc.
- Ellard, K.K., Fairholme, C.P., Boisseau, C.L., Farchione, T.J., & Barlow, D.H. (2010). Unified protocol for the transdiagnostic treatment of emotional disorders: Protocol development and initial outcome data. *Cognitive and Behavioral Practice*, 17, 88-101.

- Ehrenreich, J.T., Fairholme, C.P., Buzzella, B.A., Ellard, K.K., and Barlow, D.H. (2007). The role of emotion in psychological therapy. *Clinical Psychology: Science and Practice*, 14(4), 422-428.
- Ekman, P. (1984). Expression and the nature of emotion. In K.R. Scherer & P. Ekman (Eds.), *Approaches to emotion* (pp. 319-343). Hillsdale, NJ: Lawrence Erlbaum Associates, Inc., Publishers.
- Ezriel, H. (1952). Notes on psychoanalytic group therapy: Interpretation and research. *Psychiatry*, 15, 199-126.
- Fairholme, C.P., Boisseau, C.L., Ellard, K.K., Ehrenreich, J.T., & Barlow, D.H. (2010). Emotions, emotion regulation, and psychological treatment: A unified perspective. In A.M. Kring & D.M. Sloan (Eds.), *Emotion regulation and psychopathology: A transdiagnostic approach to etiology and treatment* (pp. 283-309). New York: Guilford Press.
- Farchione, T.J., Fairholme, C.P., Ellard, K.K., Boisseau, C.L., Thompson-Hollands, J., Carl, J.R., Gallagher, M.W., & Barlow, D.H. (2012). Unified protocol for transdiagnostic treatment of emotional disorders: A randomized controlled trial. *Behavior Therapy*, 43, 666-678.
- Flack, W., Laird, J.D., & Cavallaro, J. (1999). Emotional expression and feeling in schizophrenia: Effects of specific behaviors on emotional experiences. *Journal of Clinical Psychology*, 55, 1-20.
- Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. New York: Other Press.

- Fonagy, P., Steele, M., Steele, H., Moran, G.S., & Higgitt, A. (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment. *Infant Mental Health Journal*, 12, 201-218.
- Fonagy, P., & Target, M. (1998). Mentalization and the changing aims of child psychoanalysis. *Psychoanalytic Dialogues*, 8, 87-114.
- Fosha, D. (2000). *The transforming power of affect: A model for accelerated change*. New York: Basic Books.
- Fosha, D. (2001). The dyadic regulation of affect. *Journal of Clinical Psychology/In Session*, 57, 227-242.
- Fosha, D. (2004). 'Nothing that feels bad is ever the last step:' The role of positive emotions in experiential work with difficult emotional experiences. *Clinical Psychology and Psychotherapy*, 11, 30-43.
- Fosha, D. (2005). Emotion, true self, true other, core state: Toward a clinical theory of affective change process. *Psychoanalytic Review*, 92(4), 513-551.
- Freud, S. (1926/1959). Inhibitions, symptoms, and anxiety. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 20, pp. 75-175). London: Hogarth Press. (Original work published 1926).
- Frijda, N.H. (1986). *The emotions*. Cambridge: Cambridge University Press.
- Frijda, N.H. (1988). The laws of emotion. *American Psychologist*, 43, 349-358.
- Gendlin, E. (1991). On emotion in therapy. In J.D. Safran & L.S. Greenberg, (Eds.), *Emotion, psychotherapy & change* (pp. 255-279). New York: Guilford Press.
- Goleman, D. (1995). *Emotional intelligence: Why it can matter more than IQ*. New York: Bantam Books.

- Greenberg, L.S. (2002). *Emotion-focused therapy: Coaching clients to work through their feelings*. Washington, DC: American Psychological Association.
- Greenberg, L.S. (2004a). Introduction: Emotion special issue. *Clinical Psychology and Psychotherapy*, 11, 1-2.
- Greenberg, L.S. (2004b). Emotion-focused therapy. *Clinical Psychology and Psychotherapy*, 11, 3-16.
- Greenberg, L.S. (2007). Emotion coming of age. *Clinical Psychology: Science and Practice*, 14(4), 414-421.
- Gross, J. J. (1999). Emotion regulation: Past, present, future. *Cognition and Emotion*, 13, 551-573.
- Gross, J.J. (Ed.). (2014a). *Handbook of emotion regulation* (2nd ed.). New York: Guilford Press.
- Gross, J.J. (2014b). Emotion regulation: Conceptual and empirical foundations. In J.J. Gross (Ed.), *Handbook of emotion regulation* (2nd ed.) (pp. 3-20). New York: Guilford Press.
- Gross, J.J. & Thompson, R.A. (2007). Emotion regulation: Conceptual foundations. In J.J. Gross (Ed.), *Handbook of emotion regulation* (pp. 3-24). New York: Guilford Press.
- Hayes, S.C., Folette, V.M., & Linehan, M.M. (Eds.). (2004). *Mindfulness and acceptance: Expanding the cognitive-behavioral tradition*. New York: Guilford Press.
- Hayes, S.C., Strosahl, K.D., & Wilson, K.G. (2011). *Acceptance and commitment therapy, second edition: The process and practice of mindful change*. New York: Guildford Press.
- Herbert, J.D. & Forman, E.M. (2011). The evolution of cognitive behavior therapy. In J.D. Herbert & E.M. Forman (Eds.), *Acceptance and mindfulness in cognitive behavior*

- therapy: Understanding and applying the new therapies* (pp. 3-25). Hoboken, NJ: John Wiley & Sons.
- Izard, C.E. (1971). *The face of emotion*. New York: Appleton-Century-Crofts.
- James, W. (1902/2015). *The varieties of religious experience: A study in human nature*. Irvine, CA: Xist Publishing. (Original work published 1902).
- Lachmann, F.M., & Beebe, B. (1992). Reformulations of early development and transference: Implications for psychic structure formation. In J.W. Barron, M.N. Eagle, & D. Wolitzky (Eds.), *Interface of psychoanalysis and psychology* (pp. 133-153). Washington, DC: American Psychological Association.
- Lazarus, R.S. (1982). Thoughts on the relations between emotion and cognition. *American Psychologist*, 37, 1019-1024.
- Lazarus, R.S. (1984). On the primacy of cognition. *American Psychologist*, 39, 124-129.
- Lazarus, R.S. (1991). *Emotion and adaptation*. New York: Oxford University Press.
- Leys, R. (2011). The turn to affect: A critique. *Critical inquiry*, 37, 434-472.
- Linehan, M.M. (1993a). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.
- Linehan, M.M. (1993b). *Skills training manual for treating borderline personality disorder*. New York: Guilford Press.
- Linehan, M.M. (2015). *DBT skills training manual* (2nd ed.). New York: Guilford Press.
- Main, M. (2000). The adult attachment interview: Fear, attention, safety, and discourse processes. *Journal of the American Psychoanalytic Association*, 48, 1055-1096.
- Malan, D.H. (1976a). *The frontier of brief psychotherapy*. New York: Plenum Press.

- Malan, D.H. (1976b). *Toward the validation of dynamic psychotherapy*. New York: Plenum Press.
- Malan, D.H. (1979). *Individual psychotherapy and the science of psychodynamics*. London: Butterworth.
- Malatesta, C.Z., & Haviland, J.M. (1982). Learning display rules: The socialization of emotional expression in infancy. *Child Development*, 53(4), 991-1003.
- Marziali, E.A. (1984). Prediction of outcome of brief psychotherapy from therapist interpretive interventions. *Archives of General Psychiatry*, 41(3), 301-304.
- McCullough, L., Kuhn, N., Andrews, S., Kaplan, A., Wolf, J., & Hurley, C.L. (2003). *Treating affect phobia: A manual for short-term dynamic psychotherapy*. New York: Guilford Press.
- Menninger, K. (1958). *Theory of psychoanalytic technique*. New York: Basic Books.
- Messer, S.B., & Warren, C.S. (1995). *Models of brief psychodynamic psychotherapy: A comparative approach*. New York: Guilford Press.
- Neacsiu, A.D., Bohus, M., & Linehan, M.M. (2014). Dialectical behavior therapy: An intervention for emotion dysregulation. In J. J. Gross (Ed.), *Handbook of emotion regulation* (2nd ed.) (pp. 491-507). New York: Guilford Press.
- Peres, J. & Nasello, A.G. (2008). Psychotherapy and neuroscience: Towards closer integration. *International Journal of Psychology*, 43(6), 943-957.
- Prenn, N. (2011). Mind the gap: AEDP interventions translating attachment theory into clinical practice. *Journal of Psychotherapy Integration*, 21(3), 308-329.
- Rottenberg, J., & Gross, J.J. (2007). Emotion and emotion regulation: A map for psychotherapy researchers. *Clinical Psychology: Science and Practice*, 14(4), 323-328.

- Satel, S., & Lilienfeld, S.O. (2013). *Brainwashed: The seductive appeal of mindless neuroscience*. New York: Basic Books.
- Siemer, M., Mauss, I., & Gross, J.J. (2007). Same situation—different emotions: How appraisals shape our emotions. *Emotion*, 7, 592-600.
- Stark, M. (2000). *Modes of therapeutic action: Enhancement of knowledge, provision of experience, and engagement in relationship*. Northvale, NJ: Jason Aronson.
- Stern, D.N. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. New York: Basic Books.
- Sullivan, H.S. (1953). *The interpersonal theory of psychiatry*. New York: W.W. Norton.
- Sullivan, H.S. (1956). *Clinical studies in psychiatry*. New York: W.W. Norton.
- Swenson, C.R., Sanderson, C., Dulit, R.A., & Linehan, M.M. (2001). The application of dialectical behavior therapy for patients with borderline personality disorder on inpatient units. *Psychiatric Quarterly*, 72(4), 307-324.
- Tamir, M. (2011). The maturing field of emotion regulation. *Emotion Review*, 3(1), 3-7.
- Thompson, R.A. (1994). Emotion regulation: A theme in search of definition. In N.A. Fox (Ed.), *The development of emotion regulation and dysregulation: Biological and behavioral aspects. Monographs of the Society for Research in Child Development*, 59 (2-3), 25-52.
- Wachtel, P.L. (1993). *Therapeutic communication: Principles and practice*. New York: Guilford Press.
- Whelton, W.J. (2004). Emotional processes in psychotherapy: Evidence across therapeutic modalities. *Clinical Psychology and Psychotherapy*, 11, 58-71.

Wittgenstein, L. (1953/2009). *Philosophical investigations* (4th ed.). P.M.S. Hacker & J.

Schulte (Eds.). (G.E.M. Anscombe, P.M.S. Hacker, & J. Schulte, Trans.). Malden, MA:

Blackwell Publishing, Inc.

Zajonc, R.B. (1980). Feeling and thinking: Preferences need no inferences. *American*

Psychology, 35, 151-175.

Zajonc, R.B. (1984). On the primacy of affect. *American Psychology*, 39, 117-123.