The Use of Verbal and Written Emotional Expression for Empowerment and Healing in Clinical Social Work Practice

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Dedication

I dedicate this writing to my husband, John Schmit, who supported me throughout my graduate work with unlimited love and encouragement. If it were not for your strength, wisdom, and perseverance, I may have never had the courage to pursue a higher degree. Thank you for all your gentle, and sometimes not-so-gentle, nudges to complete this project, and for always knowing that I had it within me to accomplish it.
Acknowledgement

I would like to extend my deepest gratitude to the people who have influenced my educational goals and achievements. Thank you to Monique DiCarlo, for giving me the unique opportunity to work with you and learn from you. As busy as you are, you always made time to help me. You demonstrate true social work values in action, and your caring, nonjudgmental attitude was always a pleasure to witness. I admire your limitless tact and diplomacy in addressing issues of oppression.

Sincerest thanks to my early mentors, Linda and Roy Chastain and Kelly Sherwin. You all helped me to learn more about life and healing than any academic program could ever hope to achieve. Your support and confidence have helped me overcome innumerable limitations which I had believed I would never overcome. Thank you for pushing me, with love, to face my fears.

Many thanks also to my thesis committee members, Jerry L. Johnson and Salvador Lopez-Arias of Grand Valley State University, and Lisa K. Walsh, licensed psychologist, for their assistance and guidance in the evolution of this publication. I have appreciated your insights and feedback.
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Abstract

Social work practice often demonstrates ambivalence about emotions and emotional expression. Forced by managed care to keep clinical work short-term, and having removed the depth of psychoanalytic and other psychodynamic approaches, social workers have retreated from attending to the emotional life of clients, and now focus mainly in the realm of thoughts and behaviors. By integrating literature from other disciplines with social work, and incorporating contemporary thought on the topic, this paper addresses the importance, challenges and rewards of utilizing emotional expression in clinical social work practice. We find that, by addressing the emotions of our clients, we begin to shift our approach from one resembling mechanistic parenting, to a practice which embodies holistic social work and addresses the whole person.
Chapter I: Introduction

Background

This thesis integrates literature from other disciplines with social work, and incorporates a range of contemporary thought on the topic of emotions and emotional expression. The purpose of this study is to assist the multitude of clinical social workers in gaining an understanding of the importance and rewards, as well as the challenges, of assisting their clients in exploring their emotional lives beyond the limits of their thoughts and behaviors. This thesis also demonstrates the applicability of the subject of emotional expression for empowerment and healing for our clinical social work clients.

One of the first and most obvious challenges which arises around emotions and emotional expression is the ambivalence felt by our culture. Richards and Gross (2000) explained the nature of this quandary:

Western culture is decidedly ambivalent about emotions. On the one hand, emotions are seen as wanton marauders that supplant good judgment with primitive, immature, and destructive thoughts and impulses (Young, 1943). On the other hand, emotions are seen as indispensable guardians of our well-being that direct our responses to life’s challenges (Leeper, 1948) (p. 410).

Martin (1998) added to the argument by stating “Descartes’ dualist legacy has encouraged scientists and philosophers to neglect the emotions and place undue emphasis on conscious, rational thought” (p. 272). This legacy has been an influence upon the field of social work, as the profession’s ambivalence about emotions is also somewhat reflective of Western culture.
However, cultural ambivalence is not solely to blame for the avoidance of emotional expression, as the field of clinical social work has also been irrevocably influenced by policies and restrictions of third party payers. The provision of mental health services has “undergone massive changes with the evolution of managed care” according to Coleman (2003, p. 36.). Managed care has been found to affect client confidentiality (Davidson & Davidson, 1996), diagnoses (Braun & Cox, 2005; Danzinger & Welfel, 2001), assessment and planning (Gibelman & Mason, 2002), ethical practices and, most notably, treatment decisions (Danzinger & Welfel) in the provision of mental health services.

In their study, Danzinger and Welfel found that “counselors believe that client care is compromised when...treatment decisions are made by third parties” (p. 147). They noted that other research found that managed care often controls how many visits are allowed and what is appropriate treatment for mental health clients, and that “quality mental health care is difficult to realize under managed care due to its monetary incentives to limit services” (Danzinger & Welfel, p. 147). Finally, another study by Kane, Hamlin and Hawkins (2003) found that clinical social workers believed managed care to be more concerned about dollars than clients, and that quality of mental health care has been lowered by managed care.

In these times of restrictive managed care policies (Timberlake, Sabatino & Martin, 1997) and widespread budget shortfalls (Gradet, 2003), the new mantra for clinical social work seems to be “fewer...faster...further.” That is, insurance and cutbacks encourage fewer sessions (Timberlake et al.; Gibelman & Mason, 2002). As well, clients terminate from care faster than they might otherwise choose (Danzinger & Welfel), due to both the burden of cost (U.S. Department of Health and Human Services,
1999; Zuvekas, 2001) and lowered accessibility (National Alliance on Mental Illness, 2006). Also, clinicians may stay further away from deeper therapeutic work dealing with emotions due to session limitations imposed by funding sources (Timberlake et al.; Danzinger & Welfel). Timberlake et al. declared that those funding sources “increasingly emphasize practice accountability and cost containment by specifying preferred intervention modalities for diagnosis-related groups and requiring documentation of intervention effectiveness” (p. 375). They further noted “that clinical social workers are experiencing more than ever the impact of vendorship regulations” (Timberlake et al. p. 375).

As an example of managed care limitations, a survey of 2,640 advanced practice clinical social workers in the public, non-profit, and for-profit settings showed that 71% of respondents used short-term methods (up to 12 appointments) with clients for an average of 11 hours a week and 74% used moderate-term methods (about 20 appointments) for an average of 10 hours a week (Timberlake et al., 1997). That study also found that behavioral or intrapsychic clarification techniques were likely to be used in short-term practice with clients who had “restrictive mental health insurance coverage and evidencing problems associated with interpersonal violence, interpersonal relationships, physiological issues, children, societal or criminal issues, common human needs, and mental illness” (Timberlake et al., p. 381). The moderately time-limited methods more likely to be used with restrictive coverages included models involving “intrapsychic clarification, coercive, confrontational, or threat-reduction techniques” (Timberlake et al., p. 384). Timberlake et al. stated that their “findings suggest that managed care’s involvement in practice decisions influences clinical social work practice” (p. 384).
With a multitude of areas in which managed care impacts the practice of clinical social work, practitioners have had to find ways to work within the confines of the system, at times even breaking ethics codes and laws to do so (Braun & Cox, 2005; Danzinger & Welfel, 2001). Not only are counselors submitting inaccurate diagnoses to receive reimbursement (Braun & Cox; Danzinger & Welfel), but are also “failing to provide complete informed consent” due to client fears about confidentiality (Danzinger & Welfel, p. 146). Another study found that clients who are covered by managed care were much more likely to be diagnosed with a disorder versus those paying out of pocket (Kielbasa, Pomerantz, Krohn & Sullivan, 2004).

Even with the constraints of managed care, there are options that clinical social workers can explore to become a participant in the process, and a publication with helpful suggestions (Getting Paid in Behavioral Healthcare) has been designed to assist with issues of reimbursement. Anderson (2000) offers useful suggestions as well, recommending that the mental health professional “develop a positive working relationship” with each clients’ case manager at managed care organizations and that client-specific treatment plans be submitted (p. 344).

Braun and Cox (2005) also stressed that practitioners should refer to the ethical guidelines for their profession and to inform clients of the limitations of their managed care coverage from the beginning of the therapeutic relationship. Providers should also know the “risks for liability associated with diagnoses of mental disorders in relation to insurance reimbursement” and to seek consultation, supervision, or even legal advice if needed (Braun & Cox, p. 431). Braun and Cox also declared that practitioners should discuss options with clients whose managed care has denied coverage, such as private pay, reduction in fees, pro bono service, and community agency referrals.
Still, many practitioners feel they are forced into committing breaches of ethical practice guidelines, but as Davidson and Davidson (1996) pointed out, "clients’ rights and the social work ethical and legal commitment are worth fighting for" (p. 214). Social workers must participate in social action and lobby for change in managed care policy (Davidson & Davidson) and advocate for insurance reform to reimburse for all diagnostic codes (Braun & Cox). Others are calling for a change of the entire health care system to one of universal coverage (Berger, 2000), and advocating for implementation of such a system to cover those who are un- or underinsured is also a worthwhile social justice agenda for clinical social workers.

Furthermore, Samantrai (1998) stressed that clinicians “have no choice but to become political” (p. 169). If clinical social workers were to “remain detached and distant from the arena of social policy” (p. 168), then we simply reinforce the “notion that people’s difficulties are a result of their own inadequacies and pathologies, that their problems have nothing to do with social structures that restrict access to life-sustaining and life-enhancing resources” (p. 169). This applies both to our clients and to ourselves as helping professionals, and is a decision as to whether we choose empowerment or victimization for ourselves and those we hope to help. Social workers make up a sizeable group and therefore have considerable potential to influence policies and social good.

There is a large number of social workers and by extension, their numerous clients, that the subject of emotional expression for empowerment and healing is applicable to and beneficial for. For instance, the National Association of Social Workers (NASW, 2006) recently found that 37% of licensed social workers reported their practice specialty as mental health, the most commonly reported area. The NASW (2006) also found that child/family welfare and health were both reported at about a third
of the frequency of mental health (13% each), and 9% reported their specialty as aging and 8% as school social work. Of those licensed social workers practicing in mental health, the most commonly reported setting (38%) was in private practice with another 20% in behavioral health clinics (NASW, 2006).

Furthermore, when asked about the activities they engage in, 93% of those licensed social workers who responded do screening/assessment, 91% do information/referral, 89% do crisis intervention, 86% do individual counseling, and 86% do client education (NASW, 2006). An additional item of note is that 29% of licensed social workers replied that they spend more than half their time doing individual counseling and 25% reported more than half their time was spent on psychotherapy (NASW, 2006).

In another report, the NASW (2005) found that 81% of licensed social workers responding to their survey stated that they provided counseling to their clients during visits. Additionally, family relationship problems were by far the highest reported (31%) primary concern of licensed social workers' clients. The next highest reported primary client concerns were parent/child issues (17%), diagnosed mood disorders (16%), diagnosed anxiety disorders (16%), and then couple's relationship problems (15%) (NASW, 2005). Health issues as a primary concern/diagnosis for clients were reported as 13% of clients served, with abuse and neglect (victim focused) reported by 9% as a primary concern (NASW, 2005).

The NASW (2007) proclaimed that “clinical social workers are the largest group of professionally trained mental health providers in the United States, supplying more than half of counseling and therapy services” (para. 3). The NASW (2007) further declared that in the field of clinical social work, the “emphasis is on helping clients help
themselves” and that the “services include aiding a client in understanding the causes of emotional distress, [and] developing and implementing methods to resolve the situation” (para. 4). These principles of helping clients to help themselves as well as to help them understand the causes of their emotional distress are both addressed extensively in this thesis. We can also see from the above statistics, gathered by the association which serves the broad profession of social work, that there are indeed significant numbers of social workers and their clients to whom this topic is applicable and beneficial.

Although clinical social workers are an immense force in the mental health system within the United States, some social work theorists have charged that “social work has lost its way” by participating in clinical practice (McLaughlin, 2002, p. 187). Criticisms applicable to the topic of this paper center around the increasing number of social workers moving to private practice and the use of psychotherapy as a “preferred method of intervention” in social work (McLaughlin, p. 188). Critics have declared that the nature of clinical practice is “one of control and coercion” and that the political influence of “neo-conservative ideology” utilizes these practices to carry out control by the dominant social class (McLaughlin, p. 188). McLaughlin also observed the argument that the embrace of psychotherapy has led to the abandonment of the mission to help those who are poor, disadvantaged and oppressed.

Both McLaughlin and Haynes (1998) declared that such debates have been around since the beginnings of the profession of social work. McLaughlin stated that Mary Richmond believed that social reform would happen through “improving life for individuals, one person at a time” and Jane Addams “emphasized social change within the community and larger society” (p. 189). Both perspectives of these social work leaders have guided the profession over the past century, and “great debate [has]
frequently emerged about which method would result in the greatest good” (McLaughlin, p. 189).

However, Haynes stressed that social workers must “strengthen our commitment both to help individuals clinically as well as to intervene or advocate for more expansive and humane social welfare policies” (p. 509). She argued that the strength of our profession has been in both the breadth of intervention techniques and the commitment to advocacy (Haynes). Haynes added the following assertions to this stance:

As we embrace the notions that to act to right social wrongs, to work to increase diversity and reduce discrimination, to expand choice and opportunity are the goals of social work, then…these goals might equally and legitimately lead us to individual treatment or to social reform strategies, and we as professionals must follow them there (p. 509).

Swenson (1998) synthesized such principles into a perspective termed “clinical social justice practice,” and offered various “ways to understand clients in the contexts of their strengths, social positions, and power relationships” (p. 527). She further asserted that “clinicians can develop techniques to enable clients to understand themselves in these relationships and to be liberated when these relationships are oppressive” (Swenson, p. 527).

We must also remember that part of social justice is making sure that we help to remove barriers to accessibility for mental health care. According to Mojtabai (2005), the number of people “with significant psychological distress who reported that they could not afford mental health care” (p. 2011) has been growing, and “the poor and the uninsured will increasingly face financial barriers” (p. 2014). Reducing the disparities in access to needed care for vulnerable populations, Shi and Stevens (2005) said, will

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“likely require multiple clinical or policy strategies” (p. 153). Galambos (2005) outlined numerous steps social workers can take on the macro, mezzo and micro levels, including volunteering at free clinics and organizing workshops on universal access to needed services.

In addition to participating in advocacy and activism, some techniques and perspectives which Swenson declared as fitting under an umbrella of clinical social justice practice are as follows: strengths perspective (a focus on capacities and abilities); ethnic-sensitive (or culturally competent) practice; narrative approaches (clients learn to externalize or separate their problems from themselves in order to exercise more control over problems); and empowerment practice (reduce internal and external oppression and resulting obstacles to power). These techniques and perspectives are directly applicable to the use of emotional expression with clinical social work clients for healing and empowerment, and are discussed more in depth in this writing.

**Historical Significance**

Part of the motivation to write about this topic came through the incredible story of Bertha Pappenheim, a Jewish social worker in Europe who lived from 1859-1936 and is now one of the persons credited with the very beginnings of modern psychotherapy. Her story has not only helped to support this thesis topic, but also serves as a personal inspiration in embracing the possibility of overcoming multiple barriers in order to provide effective social work. In her biography of Bertha Pappenheim, Guttmann (2001) explained that “in Vienna Bertha discovered the ‘talking cure,’ which gave birth to psychoanalysis and upon which all modern psychotherapies are based” (p. 3). This credit is quite significant in the field of mental health.
Guttmann (2001) went on to explain that the new therapy came about through her work with a personal family friend and doctor, and Sigmund Freud’s mentor, Dr. Josef Breuer, who published Bertha’s case history under the now famous pseudonym, Anna O. In the 1950s, a Freud biographer broke years of confidentiality and disclosed that Anna O. was indeed Bertha Pappenheim, a famous social worker known for her feminist activism until her death from cancer in 1936 (Guttmann).

The details of Bertha’s work with Dr. Breuer in the latter part of the nineteenth century were well documented. Dr. Breuer was called upon to treat Bertha at the age of twenty-one, due to her “severe hysterical symptoms, including paralysis of three limbs, language disturbances, and terrifying hallucinations, all initially appearing as she nursed her beloved father” who was dying of tuberculosis (Guttmann, 2001, p. 5). During nearly two years of intense therapy, Dr. Breuer and Bertha talked almost everyday and often more than once a day, as they together developed what they would call the “cathartic” method, which Freud later stated was the “germinal method of psychoanalysis” (Guttmann, p. 60).

Guttmann (2001) described how Bertha, in her first known experience of catharsis, had developed a peculiar aversion to drinking water, and through her expression of rage over an incident involving her nanny, she became permanently free from this peculiar manifestation. In a single episode of this new therapy with Dr. Breuer, “Bertha demonstrated not only that suppressed rage had enormous power over human behavior, but also that the dysfunction it caused could be permanently ‘talked away’” (Guttmann, p. 60). Addressing the magnitude of this event, Guttmann declared that “Bertha’s symbolic action of following every symptom to its source made Breuer renowned as both a psychological and medical pioneer” (p. 61).
Several years after their work together, Bertha herself became renowned as a social worker in Eastern Europe. Guttmann (2001) highlighted her achievements:

Outraging the sensibilities of her fellow German-Jewish assimilationists, Bertha journeyed alone throughout Eastern Europe, rescuing and researching, and publishing articles on Jewish prostitutes, victims of white slavery, and the plight of abandoned wives and unwed mothers. She fought on all fronts for the political, educational, and economic equality of Jewish women. With the support of kindred spirits, she first envisioned and then cofounded the first national organization of Jewish women...in 1904...[then] in 1907, she built a Home for Wayward Girls...to protect and educate Jewish girls and women at the margins of society (p. 5).

Although unclear as to whether Bertha utilized the cathartic method in her social work with women, it is clear that her therapeutic work with Dr. Breuer enabled her to do such important social activist work. Without the insightful expression of her suppressed rage, grief, and other emotions, she apparently would not have been able to walk, communicate, or even live outside the walls of an asylum (Guttmann, 2001). Bertha’s story renews our faith in the ability of people to overcome their difficulties, past traumas, personality flaws, and somatization of suppressed emotions. Her story also helps one to realize that one can provide effective social service without having to be “perfect,” since in our own way, each one of us is, and perhaps always will be on a basic level, perfectly imperfect.

A central tenet of this thesis is that the understanding and expressing of emotions is a vital endeavor in clinical social work efforts. No matter how ambivalent we may be about emotions (ours or others), the mental health profession has been irrevocably
influenced by the work of Dr. Breuer and his patient Bertha Pappenheim, and the years of Freud's work since that time. Their work contributed to the very beginnings of the field of clinical social work and a focus on clients' emotional lives.

In fact, Mary Richmond wrote *Social Diagnosis* in 1917, the first textbook about social work (Strean, 1993). Much of the activity of social workers had taken place in the client's own environment, although Strean notes that friendly visitors in the 1920s eventually realized that they needed a better understanding of the social forces which contributed to maladjustment. Social workers began to notice psychoanalysis after the founder, Sigmund Freud, an Austrian psychiatrist, visited Massachusetts in 1909, sharing his ideas about self-destructive behavior and other coping mechanisms (Strean).

According to Strean (1993), Freud maintained that the poor had a right to help for their minds as much as for life-saving surgery, and psychoanalytic theory was having a significant impact on social work. Strean remarked that “in the 1930s, Freud's perspective refocused the social worker's lens from poverty to the person who was poor,” (p. 7). Strean further commented that, “psychoanalytic theory helped transform a one-dimensional moralistic approach to human beings in trouble into a non-judgmental psychosocial process” (p. 7). Social workers began taking into account how clients' past experiences and unconscious urges in addition to external pressures contributed to current malfunctioning, which, in turn, humanized much of the field of practice (Strean).

The psychoanalytic movement in social work gained popularity as Freud’s psychoanalytic perspective focused on intrapsychic dynamics instead of on environmental factors (DuBois & Miley, 2002). Elaborating on this trend, Brandell (2004) stated that “caseworkers had begun to recognize the limitations of advice giving, moral suasion, and manipulation of the environment in their work with clients” (p. 4).
fact, Freud’s theories are said to have “stimulated great interest among social workers, a
significant number of whom sought psychoanalytic treatment, thereby initiating a trend
that endured for several generations” (Brandell, p. 5). In a 1940 social work publication,
it was noted that Mary Richmond’s concepts of “social diagnosis and social treatment”
had evolved into “psychosocial diagnosis and psychosocial treatment” (Brandell, p. 5),
thus adding the focus on mental and emotional processes.

With psychoanalysis receiving wide acclaim, the number of teaching institutes
increased and other helping professionals began to incorporate Freud’s concepts into their
work (Strean, 1993). With the onset of the Great Depression, social workers began
assisting clients from all walks of life (Strean). Strean noted that social workers were
helping clients resolve resistance by utilizing psychoanalytic methods such as
confrontation, clarification and interpretation. Unfortunately, there were few outpatient
services until the end of World War II when 37 percent of medically discharged
servicemen were diagnosed as mentally ill, leading the Veterans Administration to
expand facilities and training, as well as Congress to increase psychiatric service
provision through a national health policy (Friedlander & Apte, 1980).

The significance of this movement from a focus on moral superiority and
environmental manipulation, and toward psychosocial diagnosis and treatment is further
described in the following statement:

The incorporation of Freudian ideas into social work practice thus enabled
social workers to individualize the person-in-environment configuration;
each client was regarded as having a unique set of personal experiences,
specific strengths and weaknesses peculiar to him or her, and highly
individualized, idiosyncratic ways of operating in the world (Strean, 1993) 
(Brandell, 2004, p. 5).

Strean (1993) pointed out that "social work theory began to diverge from psychoanalysis" in the 1960s and 1970s, a time when looking outward was the common theme (p. 10). Consequently, family, group and short-term therapy gained prevalence over analysis, and a division began between direct action providers and social action, planning and legislation (Strean).

Though these beginnings of clinical social work were founded on Freud’s theories, certainly not all cathartic methods nor emotionally expressive techniques utilize his specific theoretical orientation (see Beutler, Engle, Oro’-Beutler, Daldrup & Meredith, 1986; Greenberg, 2004; Janov, 1970; Keeling & Bermudez, 2006; Pennebaker, 1991; Pos, Greenberg, Goldman & Korman, 2003; Scarf, 2004). There are social work schools of thought both past and present that disagree with the principles of psychoanalysis as well.

One such theorist from the early part of the twentieth century, Jessie Taft, developed a "functional school of social work" which "rejected the notion that emotional problems were the result of unresolved conflicts and intrapsychic pathology" (Furman & Bender, 2003, p. 124). This view opposed the psychoanalytic perspective, or diagnostic school, at a time when social workers were embracing Freud’s theories (Timms, 1997). Functionalists believed that "significant psychological growth....would be accomplished by the client’s use of a professional social worker whose own training had provided not technical know-how” but an experience which produced growth, versus a set of techniques (Timms). Taft declared that “emotions were to be accepted and experienced, not changed or blunted....the highly functioning individual is able to tolerate a high
degree of emotion without reactivity, without the need to ‘act them out’” (Furman & Bender, pp. 124-125).

Another critique noted by Prochaska and Norcross (2001) is that “a common criticism of classical psychoanalysis [is that] insight alone does not necessarily bring about behavior change” (p. 447). On the other hand, trying to change behavior without self-awareness is likely to initiate only temporary changes (Prochaska & Norcross). Research evidence supports the necessity of an assessment of “client’s readiness for change and to tailor therapy relationships and interventions accordingly” (Prochaska & Norcross, p. 447). These perspectives in relation to the use of emotional expression for healing and empowerment are discussed more in depth in this writing as well.

Other particularly interesting influences on the field of clinical social work include the hard work of social workers during the twentieth century. According to the NASW Foundation (2004), Mary Cromwell Jarrett was a major influence on social work, founding psychiatric social work as well as researching other chronic illness in the early 1900s. She began the organization that later became the American Association of Psychiatric Social Workers in 1920 (which eventually merged into the NASW) and had worked with soldiers who suffered from what would much later be termed as Posttraumatic Stress Disorder (PTSD) (NASW Foundation), thus also contributing to a focus on mental and emotional processes in the field of social work. Jarrett became the Associate Director of the Smith College Training School for Psychiatric Social Work, and she “helped to define the role of the social worker in relation to the treatment of mental illness” (NASW Foundation, para. 1).

In a “classic and influential paper” from the 1919 National Conference of Social Work, “The Psychiatric Thread Running Through All Social Case Work,” Jarrett stated
that “psychiatry not only provided a thread but was the warp of the fabric of all social casework” (NASW Foundation, 2004, para. 2). Jarrett went on to do extensive research, was instrumental in the development of programs under the Social Security Administration Act of 1935, and directed a project demonstrating home care of the chronically ill, “which like her many other projects, was well ahead of their time” (NASW Foundation, para. 4).

However, the field of social work began moving away from the psychoanalytic movement that was begun in Freud’s heyday, and “the definitions of social work in the 1950s began to recapture the dual perspective of the individual and the social environment” (DuBois & Miley, 2002, p. 40). Finally, in 1958 a “Working Definition of Social Work Practice” was developed by the NASW’s Commission on Practice which pointed to “the interactional dimension of the reciprocal relationship between individuals and their environment as a target of change” (DuBois & Miley, p. 41).

Throughout the 20th century, as much as social work definitions had changed, all remained focused “on the problems, issues, and needs that arise in the transactions of people within social systems” (DuBois & Miley, 2002, p. 43-44). Some of this movement away from psychoanalytic approaches may be credited to this “dual perspective” (DuBois & Miley, p. 40) as well as the “quest for professional status” (p. 44) which had been driven by the pursuit of such factors as “legitimate professional authority, membership solidarity, and a sanctioned monopoly in the provision of services” (p. 46). But perhaps this retreat from intrapersonally-focused work with clients is most affected by what many believe is the need to secure “a unique domain of activity…services that can be provided exclusively by professionally prepared social workers” (DuBois & Miley, p. 46).
However, Turner (1995) declared that “the psychological functioning of our clients has been the essence of clinical social work practice since its earliest beginnings” (p. 313). He further stressed the importance of this area of social work by proclaiming the following:

There is probably no area of practice to which social work could make a more critical contribution than the psychosocial aspects of the range of psychological problems that our clients of all cultures manifest. Yet there seems to be no other area of practice in which there is more discomfort about teaching each other and our colleagues in other disciplines what we know to be helpful and effective (Turner, p. 315).

One explanation for this discomfort in sharing clinical experiences is the possibility of social workers’ experiences being devalued. As Weick (2000) stated, “it takes unusual strength to maintain clarity about the effects of one’s own experience, especially when that experience is ignored, dismissed, or actively denigrated” (p. 397). She further declared that “we need to move past the years of silence and speak once again with our own voice” (Weick, p. 401). When social workers do find that strength to speak out, they will be able to “speak with passion and clarity about the trials of people’s daily lives and social workers’ willingness to join them” (Weick, p. 401). Furthermore, Weick insisted that when social workers do find their “own voice,” the words spoken “will be rich with the complexity of human emotion and full of the mystery of people’s struggles to survive and grow” (Weick, 2000, p. 401).

Some pioneer social workers have remained strong advocates for the psychodynamic perspective in clinical social work. For example, Jean Sanville is a clinical social worker who published her research over the entire last half of the 20th
century and was well known for having integrated psychoanalysis in her clinical social work practice (Edward & Rose, 1999). The California Institute for Clinical Social Work honored Sanville by renaming their non-profit institution (which offers doctoral degrees in clinical social work) to “The Sanville Institute” (The Sanville Institute, n.d.).

Sanville helped to found the school in 1974, was the first dean at its inception, and spoke at the renaming inaugural event in 2005 (The Sanville Institute, n.d.). Sanville is credited with the creation of the first psychoanalytic training program to accept nonmedical (i.e. social work) applicants on the West Coast and also happened to be the editor of the Clinical Social Work Journal for many years (Brandell, 2004).

In her own words at the inauguration ceremony of The Sanville Institute, she declared “historically, we social workers may have drawn much more heavily upon psychoanalytic theory. I am sad that in today’s world there would seem to be few schools of social work still embracing the concepts of Freud and his creative followers” (The Sanville Institute, n.d., para. 15). Edward and Rose (1999) declared that Sanville has brought together psychoanalysis and social work by “her emphasis on the importance in all treatments to restoring and strengthening this sense of [self],” also known as self-determination and empowerment (p. 207). Edward and Rose further asserted that many psychoanalysts today, especially those in clinical social work, understand the magnitude of the “reclamation of a sense of self and consider its achievement an important goal of treatment” (p. 207).

In addition to clinical social work researchers, contemporary researchers and authors are writing about the importance of awareness and expression of our emotions (see Harris, 2000; Scarf, 2004; Goleman, 1995; Martin, 1998). Harris (2000) stated the following about the importance of developing insight into our emotions:
We shall not fully understand human emotions unless we take [the] capacity for awareness and reflection seriously. Our ability to report on and anticipate our emotional state critically turns on the extent to which we are aware of, and understand, the way that we feel. Moreover, it is likely that our awareness of emotion, however partial, can change and improve. Indeed, it is part of the Freudian legacy that it is possible to develop such insight into our own emotional lives (p. 281).

Other prominent authors have written about the importance of emotions and emotional expression as well (see Darwin, 1969; Dunbar, 1955). Darwin (1969) declared that “we have also seen that expression in itself, or the language of the emotions, as it has sometimes been called, is certainly of importance for the welfare of [hu]mankind” (p. 366). Darwin deemed many years ago that humankind would benefit from expression of emotions, contrary to the ambivalence exhibited by Western culture and quite often our own profession.

The following pages describe a thorough review of much contemporary thought and applicable literature from various related disciplines. An argument is built for redirecting our attention as clinical social workers to the emotional lives of our clients and the richness that this refocusing can bring to clients’ lives. The hard work and dedication of the above mentioned social workers serves to provide exceptional insight into the practice of clinical social work. The argument is made, and amply supported, that addressing the whole person, emotions and all, in our social work practice is truly beneficial to our clients in numerous ways.

As with any theory or perspective of practice, there are factors which may prevent the effective use of emotionally expressive methods with clinical social work clients.
Issues regarding limitations to the applicability and appropriateness with certain populations as well as possible exceptions to these findings are addressed in this writing. Challenges to the delivery of such services and suggestions for making these services accessible to all who are interested are also discussed.
Chapter II: Literature Review

Holistic Social Work Practice

According to Rothman (1998), the professional ethical standard for social workers stipulates that social workers' "primary responsibility [is] to the well-being of the client. While well-being is not defined, social work's core values would seem to include mental and emotional, as well as physical, well-being within this obligation" (p. 191). On the other hand, social work ethics support "a commitment to respect the primacy of a client's interests through self-determination, and to respect the client's own definition of 'well-being'" (Rothman, p. 191). Self-determination can mean "free choice or self-direction," it is seen as "a basic human right," "an opportunity for learning coping skills," and "basic to human development, dignity, and freedom" (Rothman, p. 128).

There is much talk in social work academia of empowerment of clients, focusing on clients' strengths, and centering social workers' endeavors around clients' needs, desires, and current circumstances. A perspective in social work which encompasses the whole person is an ideal framework within which to address our contact with clients. Enabling clients to gain or regain power should be at the core of our "good works."

The underlying purpose of all social work effort is to release human power in individuals for personal fulfillment and social good, and to release social power for the creation of the kinds of society, social institutions, and social policy which make self-realization most possible for all men [and women] [emphasis added] (Smalley, 1967, p. 1, as cited in Weick, Rapp, Sullivan, & Kisthardt, 1989, p. 352).
What is self-realization and is it truly important? According to the well-known hierarchy of needs developed by Abraham Maslow, self-actualization is the highest need which people strive to meet (DuBois & Miley, 2002). It is defined as “the process of realizing one’s maximal potential, marked by a vision that encompasses the whole of humankind” (DuBois & Miley, pp. 13-14). Rothman (1998) added that “Aristotle saw the goal of human life as the achievement of happiness….and moving always toward self-actualization” (p. 131).

If all endeavors of social work are a means to the end of self-realization, as Smalley declared 40 years ago (Weick et al., 1989), then we must ask ourselves, “Are we as social workers doing what it takes to ‘make self-realization most possible’ (p. 352) for our clients?” Additionally, the need for emotional growth is one of the universal basic needs according to DuBois and Miley (2002), and as social workers we need to go about helping our clients strive for emotional growth and to realize their highest potential, as this is inextricably connected to their sense of well-being.

The abilities to know one’s own emotions, handle one’s emotions, motivate oneself, recognize others’ emotions, and handle relationships successfully have been declared to be essential components of “emotional intelligence” (Goleman, 1995). Bar-On (2001) found positive correlations between levels of emotional intelligence and levels of self-actualization in his study. As well, Mehrabian (2000) found that components of emotional intelligence were also related with various measures of life success relative to self-actualization such as relational, work, physical, and overall success. Thus, assisting our clients to develop such emotional abilities through emotional expression can be steps in the right direction toward making self-realization possible.
Along the line with Smalley’s emphasis on releasing human and social power (Weick et al., 1989), Parsons, Gutiérrez and Cox (1998) stated that “empowerment practice strives to develop within individuals, families, groups, or communities the ability to gain power” (p. 4). Weick et al. also addressed the issue of power and stated that “the principles of knowing what is best and doing what is best places the power of decision where it should be—with the person whose life is being lived” [emphasis added] (p. 353). Additionally, Weick (2000) declared that the “qualities of good practice flow into professional encounters in ways that enliven, give hope, and shed light on the murky and troubling circumstances in which human beings often find themselves” (p. 400).

When social workers remain focused on clients’ problems it becomes challenging to exhibit foundational values of the social work profession (Weick et al., 1989). Thus, “the belief in the dignity and worth of each individual and the corresponding belief in individual and collective strength and potential cannot be realized fully in the midst of concerns about assessing liabilities” (Weick et al., p. 352). When social workers are focused on “assessing liabilities” (or clients’ deficits/shortcomings) this puts them in a “position of authority” and makes it challenging for their clients to trust themselves and their own decisions about their lives (Weick et al., p. 352). Weick et al. emphasized that when this happens, our clients may then “be tied to professional help for extended periods” (p. 352), which in turn is disempowering.

In their review of the literature on empowerment practice, Parsons et al. (1998) stated that four components were found to be necessary for empowerment: attitudes/values/beliefs, validation through collective experience, knowledge/skills for critical thinking/action, and taking action. However, the authors cautioned that there is no linear relationship between the four components and no one component is considered more
important than another, but also asserted that “one must start where the client system is to
define its needs and goals” (Parsons et al., p. 5).

This common theme of power is further supported by the thought that “social
work value recognizes that people have an inner wisdom about what they need and that
ultimately, people make choices based on their own best sense of what will meet that
need” (Weick et al., 1989, p. 353). This line of thinking is commonly referred to as a
strengths perspective in which social workers assume that our clients’ “inner wisdom can
be brought into more conscious use by helping people recognize this capacity and the
positive power it can have in their lives” [emphasis added] (Weick et al., p. 353).

Elaborating on the qualities of a strengths perspective, Saleebey (1996) stated that
it focuses on the “nature of possibility and opportunity and the nature of the individual
beneath the diagnostic label” (p. 302). He further noted that it “involves creating access
to communal resources so that they become the ticket to expanded choices and routes to
change” (p. 302). This access to resources that allow choices and thus change are the
keys to empowerment for our clients. Weick et al. (1989) further stated that “an
assumption is made in the strengths perspective that the quality of growth is enhanced by
attending to the positive abilities already expressed, rather than to their absence” (p. 353).

Developing and allowing expression of power for the advancement of self-
actualization, focusing on clients’ strengths, and encouraging clients to access and act
upon their inner wisdom all together begin to show us a holistic view of social work
practice. As explained by Timberlake, Farber and Sabatino (2002), a holistic perspective
in social work is defined as follows:

Persons and populations are viewed holistically when the focus is on (1) the
total person and the interdependent dimensions of body, spirit, mind, and
feelings; (2) the person nested within and transacting with the environment; and (3) the environment as consisting of social, physical, economic, psychological, and political forces that support and impede individual and collective social functioning and well-being. Thus, the family, culture, physical surroundings, community, and society of the individual are seen as essential parts of a holistic view of person-in-environment (p. 2).

Timberlake et al. make mention first of focusing on the total person including feelings, and social workers must be mindful to include this important interdependent dimension of clients in their clinical practice. This dimension of our clients’ lives is vital to the development of their self-actualization, access to their inner wisdom, and an essential source of strength and power. When clients are assisted in focusing on and accessing their emotional lives, these inner resources are rallied to greatly increase a sense of empowerment.

Another term for a holistic social work perspective is the biopsychosocial model. Saleebey (1992) stressed that the social work profession credits itself for the use of such a perspective in practice as well as theory. He further asserted that “it is social workers’ moral purpose as professionals to respect the regenerative capacity of individuals and the strengths that allow them to accept, overcome, or ameliorate illness or impairment” (Saleebey, p. 112). Ryff and Singer (2000) added that a look into practices utilizing a biopsychosocial model showed that the promotion of social support and emotional expression in group settings were found to result in multiple positive health effects for subjects in numerous studies (Ryff & Singer).
**Emotions**

In a culture which demonstrates ambivalence about emotions (Richards & Gross, 2000), though some people might have a basic understanding of what emotions are, few can actually describe the concept. To effectively examine emotions and emotional expression, one must understand the common perspectives in the field of study. There are varying perspectives about emotions, but a recent and more comprehensive perspective of emotion is as follows:

Emotion is a blanket term, covering multiple physiological experiences, feelings, and expressions. Akin to a quilt, emotions resemble numerous converging patches with varying representations and intensities. Some emotions are strong, pleasing, and reinforcing whereas others haunt, taunt, and erode our well-being. If we fail to manage emotional highs and lows, particularly in the context of our close personal relationships, this may very well contribute to our being ‘torn at the seams,’ to extend the metaphor (Canary, Emmers-Sommer & Faulkner, 1997, pp. 24-25).

We take from these authors’ statements the premise that emotions are a complex phenomena. They can be either a positive or negative experience and require some form of “management” to minimize their destructiveness. Nonetheless, Goleman (1995) added that “all emotions are, in essence, impulses to act, the instant plans for handling life that evolution has instilled in us” (p. 6). He further explained that “the very root of the word *emotion* is *motere*, the Latin verb ‘to move,’ plus the prefix ‘e-’ to connote ‘move away,’ suggesting that a tendency to act is implicit in every emotion” (Goleman, p. 6). However, some complexity is dispelled by adding what other scholars have proposed—theories of which emotions people primarily experience.
MacKinnon and Keating (1989) summarized some leading emotion theory published by prominent sociologists and social psychologists as follows:

Kemper (1987) proposes a theory of four primary emotions (fear, anger, depression, and satisfaction) that are characterized as physiologically grounded and cross-culturally universal. Within the limits set by autonomic constraints, secondary emotions (guilt, shame, pride, and so on) are socially constructed, essentially grafted onto the primary emotions through socialization’ (1987, p. 265). Kemper’s four primary emotions can be seen as corresponding closely to the five prototypical or basic emotions of Shaver et al. [1987]: fear and anger have been identified by both, while depression in Kemper’s set corresponds directly to sadness in Shaver et al.; Kemper’s satisfaction subsumes their basic emotions of love and joy” (p. 82).

We gain an understanding from MacKinnon and Keating’s summary that although emotions are complex, we can appropriately categorize them into four universal emotions which all people experience, and other secondary emotions which are experienced through socially constructed lenses.

A definition of emotional experience and a description of what it entails is also necessary. According to Guerrero, Andersen and Trost (1998), “emotional experience refers to the intrapersonal, internal reaction one has to an emotion-eliciting stimulus. As such it can encompass affect, emotion, and moods” (p. 9). People often describe their feelings in response to stimuli in the dichotomy of pleasure and displeasure, although there are several components of emotional experience (Guerrero et al.). These components include affect or the outward expression of feelings, awareness of the
meaning of a situation and an appraisal of the events, readiness to react by either inhibiting or allowing expression of the feeling, physiological reactions such as increased heart rate, and the perceived significance of the emotion itself (Guerrero et al.).

Goleman (1995) described the physiological details of how each emotion prepares the body for different types of responses. His descriptions have been summarized and formatted into the following table for the reader’s convenience (Table 1). These descriptions lend a further understanding of emotional experience by gaining knowledge of physiological reactions associated with the primary or universal emotions and some of the secondary emotions. This also helps social workers to understand that emotions are an experience of both the mind and the body simultaneously.
Table 1: Goleman's (1995) Physiological details of emotional response

<table>
<thead>
<tr>
<th>Emotion</th>
<th>Typical Physiological Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger</td>
<td>Blood flows to the hands, making it easier to grasp a weapon or strike at a foe; heart rate increases, and a rush of hormones such as adrenaline generates a pulse of energy strong enough for vigorous action.</td>
</tr>
<tr>
<td>Fear</td>
<td>Blood goes to the large skeletal muscles, such as in the legs, making it easier to flee....the body freezes, if only for a moment, perhaps allowing time to gauge whether hiding might be a better reaction....a flood of hormones puts the body on general alert, making it edgy and ready for action, and attention fixates on the threat at hand, the better to evaluate what response to make.</td>
</tr>
<tr>
<td>Happiness</td>
<td>Increased activity in the brain center that inhibits negative feelings and fosters an increase in available energy, and a quieting of those that generate worrisome thought....makes the body recover more quickly from the biological arousal of upsetting emotions....offers the body a general rest, as well as readiness and enthusiasm for whatever task is at hand.</td>
</tr>
<tr>
<td>Love</td>
<td>Physiological opposite of the “fight-or-flight” mobilization shared by fear and anger....a bodywide set of reactions that generates a general state of calm and contentment, facilitating cooperation.</td>
</tr>
</tbody>
</table>
Sadness

Brings a drop in energy and enthusiasm for life’s activities, particularly diversions and pleasures, and, as it deepens and approaches depression, slows the body’s metabolism. The introspective withdrawal creates the opportunity to mourn a loss or plan new beginnings.

Surprise

Lifting of the eyebrows allows the taking in of a larger visual sweep and also permits more light to strike the retina. This offers more information about the unexpected event, making it easier to figure out exactly what is going on and concoct the best plan for action.

(p. 6).

Aside from the physiological responses to emotions which prepare us to take action, there are many other reasons to consider emotions to be important, even vital, to our existence. Coinciding with Darwin’s (1969) line of thinking about the importance of emotions, Cacioppo, Berntson, Larsen, et al. (2000) stated the following about the significance of emotions:

[they] saturate human existence throughout the lifespan. Emotions guide, enrich, and ennoble life; they provide meaning to everyday existence; they render the valuation placed on life and property. Emotions promote behaviors that protect life, form the basis for the continuity in life, and compel the termination of life. They can be essential ingredients for, as well as overwhelming obstacles to, optimizing human potential, and they often serve as
the engines for intellectual development….there is little doubt that emotions are both biologically rooted and culturally molded (p. 173).

Additionally, Greenberg (2004) noted in a summary of emotion literature that “at the most basic level of functioning emotions are an adaptive form of information-processing and action readiness that orients people to their environment and promotes their well-being” (p. 3). She elaborated on this statement, saying that many emotion theories assert that emotion is based on one’s judgment of situations, and results in providing them with the information that “an important need, value, or goal may be advanced or harmed” (p. 3).

Along these lines, Martin (1998) added “modern neuroscientists are only now beginning to realize that the emotions are key ingredients of rationality and vital for normal human functioning” (p. 272). Greenberg (2004) asserted that the field of neuroscience has demonstrated that emotions are foundational to cognitive processes and especially to decision making. Thus, she summarized neuroscientific findings this way: “Dysfunction in the ability to access and process emotional information, both positive and negative, thus disconnects people from one of their most adaptive orientation and meaning production systems” (Greenberg, p. 4). Emotions help people to make rational decisions as well as make sense of their experiences, and are necessary for very basic neurological functioning.

Goleman (1995) declared that “a view of human nature that ignores the power of emotions is sadly shortsighted” (p. 4). Martin (1998) further argued that “the Cartesian notion of a disembodied, rational mind, unencumbered by mere emotion, simply does not correspond with the true nature of the human organism” (pp. 272-273). He went on to claim that “we are no more capable of coping with life solely by rational calculations
than we could through emotions and feelings alone. Both are essential if we are to function in the real world” (Martin, p. 273). Thus, aiming for a balance between the use of emotions and rational thought in our coping with life’s everyday challenges is a worthwhile goal.

Goleman (1995) added that according to sociobiologists, our emotions “guide us in facing predicaments and tasks too important to leave to intellect alone….each emotion offers a distinctive readiness to act” (p. 4). As most people have personally experienced, “when it comes to shaping our decisions and our actions, feeling counts every bit as much—and often more—than thought” (Goleman, p. 4). We gather from the above authors’ assertions that emotions are essential for living, and should not be dismissed or ignored as they help maintain or even improve our quality of life. Emotions call us to action, and help to process information, make decisions, feel oriented, give meaning, and support our basic human functioning.

Diversity and Expression of Emotions

It is important to consider various factors of clients’ backgrounds when addressing emotional expression. For instance, the ability to express the details of one’s life has often been suppressed in those who have experienced oppression. Saleebey (1996) explained the importance of this topic in social work in the following citation:

Many alienated people have been named by others—labeled and diagnosed—in a kind of total discourse. The power to name oneself and one’s situation and condition is the beginning of real empowerment….a strengths-based practice does provide a richness of thought and an array of
actions that go far toward serving well those who seek help from the profession [emphasis added] (p. 303).

Along these lines, Weick (2000) added that “as is true of all expressions of experience not represented in the dominant language, they ride under the surface of conscious thought, always present but carefully disguised under layers of doubt and guilt and misgiving” (p. 400). Essentially, empowerment can be fostered by allowing clients to describe, in their own words and in their own way, the experiences they have had and any emotions connected with these experiences (Saleebey, 1996).

Gender can also affect expression of emotion. Differences between the way men and women experience and express their emotions have been investigated extensively. The myth that women are overly emotional compared to men has been challenged by researchers, and some have found that women do express emotions differently. For example, in their research, Kring and Gordon (1998) found that “compared with men, women were more expressive, did not differ in reports of experienced emotion, and demonstrated different patterns of skin conductance responding” (p. 686). Additionally, Stanton et al. (1994) declared that “specific emotional approach coping strategies, involving efforts to acknowledge, understand, and express emotion, appear adaptive in managing stressful encounters, at least for women” (p. 360).

However, the variation between women’s and men’s emotional expression is not affected by what they reported for their experiences of emotion (Kring & Gordon, 1998). In other words, “women did not report experiencing more emotion than men” (Kring & Gordon, p. 686). Kring and Gordon (1998) stated that their findings were in line with a view of development that suggests that men and women are socialized differently in expressing but not in experiencing emotion. They further explained that “gender role
characteristics and family expressiveness moderated the relationship between sex and expressivity” (Kring & Gordon, p. 686).

In line with this thinking, Canary et al. (1997) reviewed the literature on emotion and gender and concluded that “although sex similarities far outweigh differences in the experience of emotions, women appear to have a wider latitude of emotional expression than do men” (p. 46). They went on to explain these differences in expression more specifically, stating that women are more likely to directly discuss “their fear, anger, and lack of joy; men more frequently rely on indirect means for expressing their emotions—such as avoidance during anger episodes or distraction in times of sadness” (Canary et al., p. 46).

Grossman and Wood (1993) also studied gender differences in emotional experience, and found that their study participants’ reports of their own emotional responses corresponded to their beliefs about stereotypical emotional reactions. For example, the women in their study who believed that women experience more intensity in their emotions “reported heightened emotions themselves” and men who believed that men experience less intensity in their emotions “reported relatively subdued, attenuated emotional response” (Grossman & Wood, p. 1020).

In another study on gender differences and expression, Gray and Heatherington (2003) found that in a small group setting, “men expressed more sadness verbally...when their turn [to speak] followed a person who had expressed sadness than when they followed one who had withheld such expression” (p. 308). A further finding of their study was that social context made a significant impact on men’s display of sadness, and those findings suggested that “it may be more important to young men to have another man model expression of sadness” (Gray & Heatherington, p. 309).
Canary et al. (1997) also addressed socialization and gender roles, noting that “less conventionally defined partners appear to have a wider latitude of emotional expression, probably due to not feeling constrained by traditional gender role expectations” (p. 46). Attending to the issue of socialization, Porter and Samovar (1998) added that “culture affects how we learn to have feelings and express them in manners that are consistent with our culture” (p. 468). This is explained further by noting that “culture determines who may express emotions as well as both the circumstances under which they may be expressed and the degree to which they may be expressed” (Porter & Samovar, p. 468). Cultures may be focused on individuals or on the community as a whole. Kennedy-Moore and Watson (1999) depicted the differences between the two, stating that “members of individualistic cultures may use the strategy of emotional expression to achieve their goal of self-assertion. Members of communal cultures may use nonexpression to achieve social harmony” (p. 98).

As an explanation from established theory on the topic, Matsumoto, Kudoh, Scherer and Wallbott (1988) noted that “related to these cultural differences is the concept called display rules, culture-specific rules that manage or modify emotional behavior in social settings (Ekman, 1972)” (p. 284). An example of such differences was established in a study comparing emotions of American and Japanese subjects. Matsumoto et al. summarized their findings in this way: “American subjects were found to experience emotions for longer durations and with greater intensity than the Japanese subjects, and they reported more physiological, verbal, and nonverbal reactions.… Japanese subjects tended to mute or attenuate their observable emotional reactions” (p. 283).
In another study comparing emotions of male and female subjects from different cultures, MacKinnon and Keating (1989) stated the following about the results of their study involving subjects from the U.S. and Canada:

Our analysis of emotion content suggests that U.S. subjects may be more in touch with their feelings and more emotionally expressive than Canadian subjects, and female subjects more so than male subjects. Within cultures this gender difference is more pronounced for U.S. subjects; alternatively, this cross-cultural difference is more pronounced for women (p. 81).

Older adults may also have different ways of dealing with their emotions and emotional expression, regardless of their capabilities in other areas. Ong and Bergeman (2004) stated that “compared with the declines in cognitive and physiological functioning observed in later life, emotional functioning shows a remarkable degree of resiliency, with positive emotions lingering longer and negative emotions making briefer intrusions” (p. P117). Referring to the research in this area, Ong and Bergeman noted that “improved emotion regulation is associated with greater emotional complexity in later life....[meaning] the capacity to distinguish between pleasant and unpleasant feeling states” (p. P117).

These cultural, gender and age differences impact clinical social work, and it is important to have an awareness and understanding of what these differences mean for practice. Porter and Samovar (1998) asserted that “intercultural communicators must be aware of and understand the cultural dynamics that produce [emotional] behavior” (p. 469). However, a social worker’s job doesn’t end here with awareness and understanding, but also requires a sense of comfort with these differences. Porter and
Samovar asserted that what is required for effective intercultural communication is the ability “not only to interpret the behavior, but also to be (or at least appear to be) comfortable with the ambiguity that can come from emotional expressions that seem out of place or inappropriate to a particular situation” (p. 469).

*Emotional Expression*

One reason why the ability to express emotions is important, according to Salovey, Bedell, Detweiler and Mayer (2000), is that “those who can quickly and accurately appraise and express their emotions are better able to respond to their environment and to others” (p. 506). The authors further declared that evidence from previous studies has demonstrated that people who can effectively communicate their emotions “are more empathic and less depressed than those who are unable to do so” (Salovey et al., p. 506). Thus, abilities in the expression of emotion can help or hinder the quality of relationships with others.

However, there are numerous factors that influence the nature of one’s emotional expression. Guerrero et al. (1998) discussed the intricacies of emotional expression in the following citation:

Although emotions can be experienced and not expressed, the natural condition of emotion is that they are interpersonally expressed. Emotional expression encompasses actions that occur in private (e.g., grimacing and swearing when hitting your hand with a hammer), spontaneous emotional expressions (e.g., automatically smiling back at someone), and strategic communication (e.g., telling someone you love them before criticizing them). Humans may also express (or not express) emotion by...
strategically altering their emotional expression in a manner consistent
with their personal goals or with the rules of social appropriateness....
emotional expression that often involve conscious, strategic
communication processes (p. 9-10).

Additionally, Darwin (1969) believed that the expression of emotions is
important to “the welfare of mankind” (p. 366). He further proclaimed that “most of
our emotions are so closely connected with their expression, that they hardly exist if
the body remains passive” (Darwin, p. 237). The type of expression tends to depend
on the type of actions which one previously has performed in the same states of mind,
i.e. yelling when feeling angry (Darwin). Thus, habitual ways of responding to
emotional stimuli can oftentimes help one trace from an action to a trigger in order to
gain an understanding of emotional influences.

People tend to regulate their emotions in several ways, often strategically deciding
how and when or when not to express them, as Guerrero et al. (1998) described in the
above citation. To give a better idea of what emotion regulation involves, Richards and
Gross (2000) summarized it with the following statement:

Emotion regulation refers to the evocation of thoughts or behaviors that
influence which emotions people have, when people have them, and how
many people experience or express these emotions....emotions may be
regulated in almost limitless ways....emotion regulatory efforts may be
directed at two different points in the emotion generative process.

Antecedent-focused emotion regulation is evoked...very early on in the emotion-generative process, whereas response-focused emotion regulation occurs...after emotion response tendencies have been triggered. Thus,
response-focused regulation mops up one's emotions; antecedent-focused
regulation keeps them from spilling in the first place (p. 411).

Another way of looking at how and why people express or do not express their
emotions is to compare the possible costs and benefits of expression and suppression of
emotions. Kennedy-Moore and Watson (1999) summarized this cost/benefit analysis
with their following published table (Table 2), which may also be useful in educating
clients about emotional expression and helping them to weigh out the costs and benefits
of their expression.
<table>
<thead>
<tr>
<th>Possible benefits of adaptive expression</th>
<th>Possible costs of maladaptive nonexpression</th>
<th>Possible costs of maladaptive expression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arousal regulation</td>
<td>Suppression requires physiological work that may take a cumulative toll on the body.</td>
<td>Extreme or unrelenting expression may intensify or prolong arousal to an unhealthy extent.</td>
</tr>
<tr>
<td>Self-understanding</td>
<td>Lack of awareness of distress hinders initiation of appropriate coping efforts.</td>
<td>Being overwhelmed by emotion interferes with clear thinking and hinders the use of emotional responses as a source of information about the self and the environment.</td>
</tr>
<tr>
<td>Coping/emotional processing</td>
<td>Effortful preoccupation with holding in feelings impedes coping efforts and intensifies distress.</td>
<td>Passive preoccupation with emotion may interfere with ability to implement active coping efforts.</td>
</tr>
<tr>
<td>Adaptive social communication</td>
<td>Inability to communicate feelings may interfere with the development of intimate relationships and the marshaling of social support.</td>
<td>Inappropriate expression may drive away potential or existing social support. Violating social norms or personal values may evoke feelings of shame.</td>
</tr>
</tbody>
</table>

(p. 298).
As is demonstrated by the above table, there are numerous negative interpersonal consequences to the lack of emotional expression that people may experience. Gross and John (2003) stated that people who suppress their emotions seemed to withhold from sharing positive as well as negative feelings with others, avoided close relationships, had the lowest scores in positive relationships, had lower self-esteem, were less satisfied with their life, and had more symptoms of depression. These “suppressors,” as Gross and John termed people who have a tendency to inhibit the expression their emotions, were also found to mask inner feelings, were unclear about what they were feeling, had less success at repairing their moods, had “painful feelings of inauthenticity,” and “ruminat[ed] about events that make them feel bad” (p. 360).

Additionally, in a review of the literature on emotional processes in psychotherapy, Whelton (2004) found that “emotion and emotional processing are now widely perceived to be vital dimensions of therapy in all therapeutic modalities” and that “emotional arousal and expression can lead to constructive change for some clients and problems” (p. 67). He added that successful outcomes in therapy can be predicted when a client is productively engaged and processes information experientially, and that anxiety and other symptoms of trauma can be reduced when clients are exposed to fearful stimuli while their emotions are heightened within a safe and supportive environment (Whelton).

Written Emotional Expression

Many people use or are at least familiar with the idea of keeping a diary or a journal as a method of expressing thoughts and emotions. Writing about one’s feelings is anything but new as a concept for expressing emotion, and many
persons, even cultures have utilized written expression (Pennebaker, 1991).

Along these lines, Parsons et al. (1998) noted that “individuals impart, receive, or affirm meanings largely through telling and retelling stories and recounting narratives” (p. 301).

This practice of utilizing writing such as in a journal, sometimes considered an act of making a confession, is described by Pennebaker (1991) as follows:

The power of confession, written or oral, has been recognized in many cultures over many centuries....Indians of North and South America had elaborate confession rituals at which tribe members disclosed their transgressions to each other. Eastern and Western religions...have used rituals of confession as well (pp. 64, 66).

There are specific advantages to written communication, as shown by research on the topic (Pennebaker, 1991). “The act of writing can be an avenue to that interior place where, free of pain and doubt, we can confront traumas and put them to rest—and heal both body and mind” (Pennebaker, p. 64). Even if written words are never read by another person, they can have healing power, as Pennebaker proclaimed, “using writing as a means of confession, we’ve found, can measurably improve physical and mental health” (p. 64).

Roughly three decades ago, a large research project was begun in order to “determine the extent to which it’s healthy for us to express what’s stored deep inside” (Pennebaker, 1991, p. 66). After a decade of this research project, the data showed “a clear correlation between confessional writing and greater health” (Pennebaker, 1991, p. 66).
Pennebaker (1991) described the nature of his extensive study and summarized the findings in the following citation:

The immediate impact of the study was far more powerful than we had ever imagined....Essay after essay revealed people’s most intimate feelings. Many of the stories depicted profound human tragedies....writing didn’t help these students feel better initially—just the opposite....[however,] four months after the experiment, we found that their moods had improved. Writing about their deepest thoughts had started a process that resulted in a lighter mood and more positive outlook....People who wrote about their deepest thoughts and feelings about a traumatic event became healthier—they visited the health service for treatment much less often than other groups after the study (p. 66).

Pennebaker, Colder and Sharp (1990) asserted that they had established “that a writing intervention can potentially overpower naturally occurring stages of coping....writing about traumas or other stressors has positive physical and long-term psychological benefits” (p. 536). The authors went on to argue that “as a form of preventive psychotherapy, then, the writing technique is simple, inexpensive, and free of potentially negative social feedback” (Pennebaker et al., p. 536).

Another research study utilized a writing and art intervention to help clients express emotions and externalize their problems, and allowed clients to be “the best judges of their own experience” (Keeling & Bermudez, 2006, p. 406). This written emotional expression intervention utilized externalization, a component of narrative therapy, by having subjects create sculptures and write in a journal (Keeling & Bermudez). The intervention helped subjects express their emotions, raise awareness of
personal resources, and develop a sense of empowerment and control over problems (Keeling & Bermudez).

Explaining why the writing technique is important, Pennebaker et al. (1990) stated that it may be related to one of the following two processes:

The first, which has evolved from work on venting or modern-day views of catharsis, assumes that emotional expression serves as a release of pent-up emotional energy. Once the emotional energy is released, then, positive health effects follow (Scheff, 1979). The second and, perhaps, more likely possibility is that emotions are a fundamental part of any upsetting experience. The failure to write about emotions, then, suggests that individuals are excluding a part of the trauma that also required understanding and assimilation. In contrast to catharsis, then, this second view holds that writing about emotions facilitates insight (p. 530).

Although research subjects experienced benefits, Pennebaker, Kiecolt-Glaser and Glaser (1988) cautioned that, according to another comparative study, clients were more depressed following writing therapy sessions than they were after live client-centered therapy sessions. They further warned that although writing is quite cost-effective, it does not, by itself, allow for opinions, support, or coping information from objective outsiders (Pennebaker et al., 1990). Even with this in mind, the writing therapy “may provide an alternative form of preventive therapy that can be valuable for individuals who otherwise would not enter therapy” (Pennebaker et al., 1990, p. 245).
Mind-Body Connection

The idea that the mind and body are two separate entities is being challenged by researchers. Efran and Fauber (1995) declared the following:

[A] mischievous scheme that grips people’s lives is the Aristotelian insistence that experience should be divided into feelings, thoughts, and behaviors....This mythology insists that people dualistically locate talking (and thinking) ‘in the head’ and feelings somewhere down below. It has resulted in no end of trouble in the culture....Ironically, there now seems to be a revival of interest in emotion and techniques for encouraging emotional expression (pp. 281-282).

The connection between the mind and body has been termed in the medical field as psychosomatic medicine. Nearly a half-century ago, Dunbar (1955) wrote a book on the topic, and explained the origins of the term: “Psychosomatic medicine....derives its name from ‘psyche,’ which has been translated as mind or spirit or soul, but which actually includes all of them, and ‘soma,’ which means body” (p. xi). According to Dunbar, a French physician in the mid-nineteenth century named Claude Bernard is said to be one of the first in his field to understand the mind-body connection, to see his patients as a whole, and to use this information in his treatments.

Taylor (1995) added “it is now known that physical health is inextricably interwoven with the psychological and social environment: All conditions of health and illness...are influenced by psychological and social factors” (p. 6). Another author, Scarf (2004), stated that “while we usually think of our emotional lives as being immaterial in nature, they are in fact deeply rooted in our bodily experiences of emotionally charged events that are currently happening or that have happened in the past” (p. xxxi).
Explaining how emotions are more than simply a biological process, Efran and Fauber (1995) emphasized the following:

Emotions are not separate neural or hormonal processes that kick in only on special occasions. Emotional states, including shifts and adjustments in hormonal levels, are continuous support factors that affect all human performance. Thus, rational deliberation and serious contemplation have specific emotional requirements just as attacking, escaping, and affiliating do (p. 282).

Additionally, there is significant research about the effects of trauma on states of health. For example, Jankowsi (n.d.) stated that “a considerable amount of research has found that trauma has negative effects on physical health” (para. 3), and added that “a growing body of literature has found a link between PTSD [a diagnosis of Posttraumatic Stress Disorder] and physical health” (para. 4). Jankowsi further explained that “PTSD may promote poor health through a complex interaction between biological and psychological mechanisms....the experience of trauma brings about neurochemical changes in the brain” (para. 6). Such neurochemical changes may have behavioral, psychological and biological changes affecting health, and may cause vulnerabilities to hypertension and heart disease, abnormalities in hormonal functions (such as thyroid), and increased risks of infection and immunologic disorders (Jankowsi, para. 6).

Fava and Sonino (2000) published a thorough review of the psychosomatic medicine literature with their following published summary table (Table 3), demonstrating research findings that support an association between stressful events and medical conditions.
One can see from this summary of the available research on the topic that there is a significant and well-established connection between the mind and the body which can affect states of health.
Saleebey (1996) further asserted that “the ample literature exploring the relationship between body, mind, and the environment and health and wellness suggests that this interaction is complex” (p. 300). He added that this connection is “always implicated in keeping people well, assisting individuals in regenerating after trauma, and helping individuals and communities survive the impact and aftermath of calamity and ordeal” (Saleebey, p. 300). The impact these principles have on the field of social work, is that “in a sense, the strengths perspective itself begins with appreciating the body and its tremendous restorative powers” (Saleebey, p. 300).

Trauma and Emotional Expression

In the citation below, Scarf (2004) described how the body reacts specifically to emotional trauma and the possible results of such trauma:

It is now widely recognized that the body stores memories of intensely stressful experiences, particularly in certain regions at the core of the brain (the limbic system, which is the seat of our emotions). We may not care to speak of these events to anyone, but memories of them—whether vividly recalled or lost to awareness—color many aspects of our daily existence, often without our conscious realization (p. xix).

Scarf (2004) added to her description of the phenomena of traumatic experiences that there are mainly two ways that the body will respond to events that feel overwhelming: hypervigilance (or hyperarousal) and its opposite, shutting down (emotionally distancing). Scarf further noted that although these two reactions have different appearances, similar things happen in the body.
The body becomes physiologically ready to meet a threat, by either fighting, fleeing, or freezing (Scarfy, 2004). Though this physiological reaction is meant to help keep us alive, Scarf noted that “a complex, highly developed memory network enables us to keep certain experiences alive within us....remaining in a state of high arousal and preparedness to meet a threat long after the danger itself is in the past” (p. xx). Essentially, this phenomenon means that for humans “the body ‘remembers’ what once happened—and at times neutral, even benign, occurrences can trigger similar kinds of biologically based, internal alarms” (Scarfy, p. xx).

In line with these claims, McCauley et al. (1997) stated that their research “suggests that the ‘wounds’ of childhood abuse may go unhealed” (McCauley et al., p. 1366). Speaking of this phenomenon of trauma experienced long ago, Dunbar (1955) stated that “flashbacks to the past often appear to be singularly impressive, and as they should, for they and the memories which are buried beyond willful recall have left traces which are the foundations of health and of illness” (p. 3).

However, these old wounds are believed to be “repairable,” and Dunbar asserted that “patience and skill will often dredge to the surface some of the buried memories, and...the dredging process is invaluable. This has been recognized ever since Freud noted that the neurotic suffers from reminiscences” (p. 3). The author further declared that “a real understanding of the reminiscence is essential to treatment, no matter how far back it must be traced. The creation of a sound mind begins at the same time as the creation of a sound body” (Dunbar, p. 3).

Adding to this line of thinking, Greenberg, Wortman, and Stone (1996) stated that “previously inhibited thoughts and feelings are presumed to rebound as intrusive ruminations, resulting in chronic stress and renewed inhibition” (p. 588). Such inhibited
feelings and thoughts can cause even more serious problems, accordingly “the work of inhibition serves as a cumulative stressor in the body that, over time, increases the probability of disease processes (Selye, 1976)” (Pennebaker et al., 1990, p. 530).

This process has been explained as follows: “the failure to talk about or, in some way, translate the experiences into language impedes the natural cognition assimilation process” (Pennebaker et al., 1990, p. 530). According to Wegner (1989) this means that “events that are not assimilated, then, will more likely remain in consciousness as unwanted thoughts” (as cited in Pennebaker et al., p. 530). However, Pennebaker et al. asserted that “when upsetting experiences are confronted...they are more likely to be understood and assimilated and the work of inhibition is reduced” (p. 530).

Further describing the solution to these problems, Greenberg et al. (1996) stated that “actively confronting feelings about past traumas should undo the cumulative physiological stress of inhibition and strengthen resistance to disease” (p. 588). Additionally, the confrontation of past traumas possibly has a therapeutic effect by the means of “a decrease in the intensity of physiological arousal following prolonged exposure to a threatening stimulus,” a process also known as “habituation” (Greenberg et al., p. 588). The benefits of confronting feelings “may extend beyond revision of specific past events to include more general perceptions of control and mastery over one’s emotional reactions, regardless of how these are triggered” (Greenberg et al., p. 589).

Nightingale and Williams (2000) suggested that “it is perhaps by the expression of emotion and construction of a coherent understanding of the experience that emotional processing occurs” (p. 252). Further description of this type of research is offered by Stanton, Danoff-Burg, Cameron and Ellis (1994), who added the following conclusions from their study:
Our findings add to the growing body of theory regarding the benefits of emotional expression in managing traumatic experiences. Rather than being dysfunctional, coping through emotional processing and expression appeared adaptive for the women in this study. The potential value of emotional expression and the examination of the conditions under which such emotional approach coping facilitates or hinders adjustment in stressful encounters require a place in current stress and coping theory (p. 361).

Stanton et al. (1994) further declared that the potential usefulness of emotional processing and expression in coping with stressful events has been empirically demonstrated.

*Emotional Expression and Health*

Addressing the connection between past experiences and health, Pennebaker et al. (1990) stated that "major life events can affect all aspects of one's functioning, including moods, eating habits, physical health, motivation levels, social behaviors, and even views about oneself" (p. 528). As described by Taylor (1995), one's state of health is interdependent with matters of the mind as well as social factors.

Taylor (1995) stressed that, in order to be well, one must be aware of his or her own mental state, which is detailed further in the following citation:

The mind and the body cannot be meaningfully separated in matters of health and illness. An adequate understanding of what keeps people
healthy or makes them get well is impossible without knowledge of the psychological and social context within which health and illness are experienced (p. 6).

Additionally, Taylor (1995) declared that disease is caused by various factors, which, among other causes, can include “early learning experiences and conflicts, current ongoing learning and conflicts, and individual cognitions and coping efforts” (p. 5). Along these lines, McCauley, Kern, Kolodner, et al. (1997) stated that “childhood physical or sexual abuse is associated with adult health problems including physical symptoms, psychological problems, and substance abuse; for many variables, this association is as strong for patients experiencing current abuse” (p. 1362).

Researcher’s findings stressed that 1 in 5 female primary care patients were found to have experienced childhood abuse, either sexual or physical (McCauley, et al., 1997). This means that potentially 20% of female clients have experienced abuse in their childhoods, thus clinical social workers have to be prepared to work with clients who have experienced abuse and trauma as children.

The authors also found no difference in “physical symptoms, emotional distress, substance abuse, or suicide attempts” between women who had reported either childhood or adult abuse, but those who reported both had “higher levels of psychological problems and physical symptoms than those who reported childhood or adult abuse alone” (McCauley et al., 1997, p. 1362). In summary, experiencing current and past conflicts and abuse tends to negatively affect one’s health.

When analyzing what may have a positive influence upon health, researchers have found that dealing with emotions does have an impact on states of wellness. In his review of related studies, Spiegel (1999) stated that “several researchers have provided
evidence that medical treatment is more effective when standard pharmacological intervention is combined with the management of emotional distress” (p. 1329). He further noted that “ventilation of negative emotion…seems to have helped these patients acknowledge, bear, and put into perspective their distress…[in] a growing number of studies, it is not simply mind over matter, but it is clear that mind matters” (Spiegel, 1999, p. 1329).

In a review of research on cancer and emotions, Ornstein and Sobel (1987) further supported this argument by declaring that “while ‘venting’ emotions may still cause difficulty in social situations, keeping feelings to yourself may be injurious to your health” (p. 158). Thus, expression of any emotion, negative or positive, can have an impact upon health.

As Taylor and Bagby (2004) found in their thorough review of emotion studies, “researchers have examined the content of written language as a possible predictor of longevity….positive emotional content showed a reduced risk of mortality in later life” (p. 75). Summarizing cancer research, Gross (1989) stated that “it may not be simple nonexpression of emotion that is critical….researchers found that both extreme emotional suppression and extreme emotional expression were associated with cancer” (p. 1245). Striking a balance with emotional expression is thus critical.

Fawzy, Fawzy, Hyun, et al. (1993) found in their study that their subjects who received a structured psychiatric intervention had better survival rates and lower recurrence at several years’ follow-up than control subjects did. In a more recent study also involving cancer and emotional expression, Stanton, Danoff-Burg, Cameron, et al. (2000) found the following in their research:
Women’s use of coping through emotional expression following primary treatment for breast cancer is associated with decreased distress, increased vigor, improved self-perceived health status, and fewer medical appointments for morbidities related to cancer and its treatment.

Expressive coping also predicted improved quality of life (p. 879).

In their review of the literature, King and Emmons (1990) found that styles of emotional expression were found to be related to physical illnesses, including cancer, coronary heart disease, and several other diseases. They noted that one study in particular (Cox & McCay, 1982) concluded that an antiemotional attitude, including suppression of negative emotions, was the “strongest psychosocial predictor of cancer” (King & Emmons, p. 864). They also found in their own research study that “ambivalence [over emotional expression] was positively correlated with several indices of psychological distress” (King & Emmons, p. 864).

Janov (1970) added his thoughts about the nature of consciousness, saying it “is the result of feeling; simply making needs known solves nothing” (p. 388). He also refers to the idea that feelings and needs are not separated out somewhere in the body or encapsulated in the brain. Janov further declared that one’s feelings/needs “must be felt organismically, because needs permeate the entire body. If this were not the case, then there would be no psychosomatic symptoms” (p. 388).

Fava and Sonino (2000) also thoroughly reviewed the psychosomatic medicine literature (186 articles) and constructed the following published summary table (Table 4), regarding the effects of psychotherapy on medical conditions:
Table 4: Fava and Sonino's (2000) Medical conditions in which short-term psychotherapies have been found to be effective in randomized controlled trials

<table>
<thead>
<tr>
<th>Chronic pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic fatigue syndrome</td>
</tr>
<tr>
<td>Coronary heart disease</td>
</tr>
<tr>
<td>Hypertension</td>
</tr>
<tr>
<td>Tension headaches</td>
</tr>
<tr>
<td>Diabetes</td>
</tr>
<tr>
<td>Cancer</td>
</tr>
<tr>
<td>Asthma</td>
</tr>
<tr>
<td>Epilepsy</td>
</tr>
<tr>
<td>Obesity</td>
</tr>
<tr>
<td>Peptic ulcer</td>
</tr>
<tr>
<td>Irritable bowel syndrome</td>
</tr>
<tr>
<td>Inflammatory bowel disease</td>
</tr>
<tr>
<td>HIV infection and AIDS</td>
</tr>
<tr>
<td>Arthritis</td>
</tr>
<tr>
<td>Preparation to medical procedures</td>
</tr>
</tbody>
</table>

(p. 191)

To understand why the expression of emotions seems to help in processing trauma and conflict, Pennebaker et al. (1990), offered the following explanation:
Upsetting events such as traumas are difficult to understand and assimilate because of their complex nature and, in many cases, their unexpected onset. A particularly efficient way to organize and ultimately understand events is to translate the experiences into language (p. 529).

**Principles of Working With Emotions**

There are some basic principles regarding emotional work of which social workers need to be aware. Specifically addressing the strengths perspective in social work, Saleebey (1996) declared that this work “honors two things: the power of the self to heal and right itself with the help of the environment, and the need for an alliance with the hope that life might really be otherwise” (p. 303). This alliance between the client and social worker may be central to the development of effective work. Saleebey further noted that “the goal may not be the heroic cure but rather the constancy of caring and connection and collaborative work toward improving the quality of day-to-day living” (p. 303).

To help build this therapeutic alliance, Becvar (1999) stated that a therapist filling the role of a “non-expert” is important and that he or she “attempts, by moving out of the expert role, to reduce the hierarchical nature of the therapy process and to unhook from a position of power and control” (p. 75). We must keep in mind this position of power we have as social workers, and remember, as Becvar observed, that “we have it in our power to either normalize or pathologize events” for our clients (p. 76). Saleebey (1996) added that it is critical how social workers manage our encounters and he asserted that we “must engage individuals as equals….must be willing to meet them eye to eye and to engage in
dialogue and a mutual sharing of knowledge, tools, concerns, aspirations, and respect” (p. 303).

In their research study, Murray and Segal (1994) found that “both written and vocal expression without a therapist result in an upsurge in negative mood and a corresponding decrease in positive mood after each session” (p. 403). The authors found that psychotherapy was associated with a difference in subjects’ mood after such expressive sessions, and thus concluded that this finding “is most likely due to something about the function of the therapist” (Murray & Segal, p. 403). Social workers should not underestimate the power their presence may have in helping their clients to feel more safe and secure when expressing and dealing with emotions.

Shulman (1993) declared that his review of the literature found that “a social worker’s skill contributed to the development of a positive working relationship that in turn was a precondition for helpfulness” (p. 92). He further noted that the social worker’s skill fosters a helpful working relationship which is how the social worker impacts the outcome (Shulman). The two dimensions of this relationship involve how much the client feels he or she can trust the social worker and how much the client feels the social worker cares about him or her (Shulman). Shulman further asserted that social workers’ necessary practice skills fall into two categories: the skill to help with management of feelings and the skill to help with management of problems.

Additionally, Maguire (2002) reviewed the literature regarding psychosocial practice and concluded that there are six central procedures for clinical social work. One of these central procedures is “exploration, description, and ventilation...[to] help the client become more aware of facts relevant to the situation or bring out feelings. ‘Please tell me more about that incident...’ or ‘How did you feel when that happened?’ may be
appropriate” (Maguire, p. 286). This connects back to Saleebey’s (1996) assertions about engaging in dialogue with clinical clients as well as Murray and Segal’s (1994) conclusion that the presence of a therapist makes a difference in how clients feel after expressing their emotions.

In their thorough summary of the literature, Fava and Sonino (2000) concluded that psychotherapy research shows that there are some basic components common to most psychotherapeutic techniques. According to Fava and Sonino, these components, listed below in their published table (Table 5) can be utilized “with specific effects and do not require highly specialized training” (p. 192).
<table>
<thead>
<tr>
<th>Ingredients</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Attention</td>
<td>the therapist’s full availability for specific times</td>
</tr>
<tr>
<td>2. Disclosure</td>
<td>the patient’s opportunity to ventilate thoughts and feelings</td>
</tr>
<tr>
<td>3. High arousal</td>
<td>an emotionally charged, confiding relationship with a helping person</td>
</tr>
<tr>
<td>4. Interpretation</td>
<td>a plausible explanation of the symptoms</td>
</tr>
<tr>
<td>5. Rituals</td>
<td>a ritual procedure that requires the active participation of both patient and therapist and that is believed by both to be the means of restoring the patient’s health</td>
</tr>
</tbody>
</table>

(p. 192)

The above authors make the point clear that clinical social workers do not require specialized training to build effective relationships with and to encourage emotional expression in their clients.

Another principle of working with emotions is described by Greenberg et al. (1996), who stated that “Scheff [1979] proposed that healing emotional discharge involves ‘optimum distance’ (p. 60) from the distressing emotions expressed” (p. 589). In this state of ideal distance, clients can experience emotions “while in a context of ‘present safety’ (Scheff, 1979, p. 60); [and] can terminate the emotional episode before it becomes overwhelming” (Greenberg et al., p. 589). As the client perceives control and mastery over distressing feelings instead of simply being immersed in the feelings, the

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healing catharsis unfolds (Greenberg et al.). Greenberg et al. added to these principles, stating that “how the emotional reaction is triggered may be a less important component of change than what the emotional reaction is and how much control is perceived and exerted over its progression as the encounter unfolds” (p. 589).

Kosmicki and Glickauf-Hughes (1997) declared that essential components of effective cathartic method in therapy are the active emotional expression which needs to be mediated by cognitive processes and “providing a balance between affective experience and optimal distancing from that experience” (p. 159). This is similar to what Greenberg et al. (1996) had stated above regarding the client’s perception of distance.

Along these lines, Murray, Lamnin and Carver (1989) stated that “therapeutic resolution can be viewed as involving three processes: the expression of negative feelings, cognitive reappraisal, and a shift to positive feelings” (p. 415). Kennedy-Moore and Watson (1999) agreed with these required components, as did Kosmicki and Glickauf-Hughes (1997) and Segal and Murray (1994), who added that “there is general agreement that catharsis, in the sense of a simple affective discharge, is not sufficient for therapeutic change” (p. 189). Murray et al. further declared that “as far back as Breuer and Freud (1895/1937), who used abreaction to eliminate ‘strangulated affect,’ there was a recognition that the expression of feelings had to be accompanied by an ‘associative correction’ to be effective” (p. 414).

One experienced practitioner offered a note of caution regarding client emotional expression when it is not followed through with cognitive appraisal and the development of insight. He elaborated on this warning in the following citation:

...there are pitfalls to the process as well. One can easily get caught in an endless cycle of expressing feeling without learning
from the process itself; believing that the expression is the means AND the end. One can become a ‘drama junkie’ and get hooked on the process of ‘expressing’ without gaining awareness of the deeper issues and patterns one is living out that cause pain, anger and fear (R. Israel, personal communication, September 24, 2004).

Another note of caution was offered by Lipchik (2002), who stated that “sometimes clients come in so emotionally overwrought that they cannot describe what they are feeling. We may need to help them clarify before they can establish goals and find solutions” (p. 65). Lipchik elaborated on this warning, stressing that the pace should be slow and we should be sensitive to nonverbal as well as verbal responses during emotional processing. An interesting perspective is also offered up: “Clients’ inability to know what they feel may have served a positive function for a long time, a way of protecting themselves from feelings they cannot bear. A sudden lifting of the veil can be more disturbing than helpful” (Lipchik, p. 65).

This is one important reason to assess what “stage of change” (Prochaska & Norcross, 2001, p. 443) the client may be in. Prochaska and Norcross stated that “tailoring the therapy relationship to stage of change can enhance outcome, specifically in the percentage of patients completing therapy and in the ultimate success of treatment” (p. 443). If a client is in the precontemplation stage, there is “no intention to change behavior in the foreseeable future” and may have presented for therapy because of pressures from others (Prochaska & Norcross, p. 443). Clients who are in the contemplation stage are aware of a problem and are thinking about dealing with it but may not have made any commitments to take action (Prochaska & Norcross).
In the *preparation* stage, clients typically intend to “take action in the next month and have unsuccessfully taken action in the past year” and may report some “baby steps” toward change (Prochaska & Norcross, 2001, p. 444). The *action* stage is when clients do change in order to take visibly recognizable control of problems, requiring a commitment of energy and time, and successfully modify behaviors, experiences, and their environment for at least one day and up to six months (Prochaska & Norcross). Following the *action* stage is the *maintenance* stage where relapse prevention is the goal, and being free of identified problem behaviors is the hallmark of this stage (Prochaska & Norcross). When the change process is finally complete and relapse is of no concern, then the *termination* stage is achieved (Prochaska & Norcross). Prochaska and Norcross recommended that clinicians assess the stage of change, assume clients are not all in the *action* stage, and set realistic goals to move through the stages one at a time. They also advised practitioners to offer “therapeutic relationships of choice” and “treatments of choice” to match the client’s stage of change, noting that “action-oriented therapies may be quite effective with individuals who are in the preparation or action stages” (Prochaska & Norcross, p. 447).

Nonetheless, Fosha (2004) added that positive emotions should always be present in the place of completion with the processing of difficult emotional experiences. She noted that the “moment-to-moment tracking and processing of emotion to completion”—in an emotionally-engaged patient-therapist dyad where the individual feels safe and known—constitutes a powerful mechanism of therapeutic transformation...positive emotions are sensitive markers of that transformational process” (Fosha, p. 30). Fosha further delineated seven distinct positive experiences which can mark these transformations: 1) experiences of being in sync or a resonating between client and
therapist; 2) being in touch with personal resilience or vitality; 3) adaptive actions or
"clarity, relief and self-validation—'I did the right thing’” (p. 39); 4) receiving another’s’
empathy, and feeling known, seen, and/or understood; 5) relaxation, expansiveness and
positive somatic experiences; 6) healing affects or a sense of changing for the better; and
7) a core state of calm and “subjective feeling of truth and the aesthetic experience of
things being ‘right,’ regardless of whether they are happy or painful” (p. 40).

Practice Models Utilizing Emotional Expression

Though the research has established that trauma and abuse and other upsetting
events have an impact on our health, clinical social workers need an understanding of
what methods to use to counteract those harmful effects. Scarf (2004) posed the question
as to what can be done about these memories, and especially the early memories that can
be strongly encoded in the brain, which clients may be unaware of, but still affect areas of
their lives. She noted that “thus far the best answer to this question—has been the
emergence of a group of relatively new therapeutic methods and procedures that rely
heavily upon ‘somatic memory’—that is, upon what the body knows” (Scarf, p. xxxii).

Though the various body-oriented approaches may look different from each other,
they have a common feature which is crucial (Scarf, 2004). That critical feature is that
“they are all geared toward targeting and then integrating scattered bits of data stored
within the patient’s physical as well as psychological self” (Scarf, p. xxxii). All of these
body-oriented approaches aim to heighten bodily awareness for clients by accessing not
only their emotions but also sensations (sight, touch, smell, sound, etc.) during traumatic
times or specific events (Scarf). The memory of the entire body “is thus put into play as
a way of gaining access to regions deep within the brain where hugely oversensitized
networks of reacting have been established” (Scarf, p. xxxii).

In addition to these body-oriented therapies, there are experiential therapy
perspectives that assist clients in expressing their emotions. Beutler, Engle, Oro’-Beutler,
Daldrup and Meredith (1986) proposed a process for effective experiential therapy that
involves five basic steps. First, an interpersonal focus needs to be established for the
therapeutic work, and second, a commitment to working on interpersonal conflict is
arrived at (Beutler et al.). The third step involves active experimentation such as two-
chair dialogues, resulting in emotional intensity and the ensuing emotional decline
(Beutler et al.). In step number four, the client assesses his or her experience, and in step
five, the client develops plans for the future and may decide whether or not to have a
direct exchange with the target of his or her interpersonal conflict (Beutler et al.).

Beutler et al. (1986) further summarized their process and outcomes in the
following citation:

By defining an appropriate target for the expression of interpersonal anger,
assessing the patient’s expectations about the expression of the suppressed
emotion, directing the patient in an imagined dialogue with the feared
interpersonal target, and intensifying the activity of the interchange until a
resolution is recognized, the patient seems to gain a sense of completion
and control that may be conducive to reducing stress, alleviating
depression, and releasing debilitating or obsessive attachments to
interpersonal relationships (p. 757).

A mental health practitioner with extensive contact with clients who’ve
experienced abuse, asserted that this practice of experiencing, expressing and releasing

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deep-seated emotions changes clients' lives dramatically (Kelly Sherwin, personal communication, September 22, 2004). In her own words, she described the principles she utilizes in working with her clients as follows:

When we fully feel our emotions, they dissipate, leaving us feeling connected, alive, balanced and free. We are then more able to maintain meaningful, respectful and loving relationships. Our energy is freed up to create a more meaningful life....my practice with clients includes a focus on learning to recognize and identify emotions. We practice being conscious of emotional states and learn to express and integrate feelings in a responsible and healthy way. Clients are encouraged to practice journaling and emotional expression at home. In my experience, allowing an emotional life naturally creates a more peaceful, integrated, mature person....When we welcome our emotions back into our lives we become more informed and empowered because our feelings connect us to our life in a very real way (Kelly Sherwin, personal communication, September 22, 2004).

Citing the literature on emotional processing, Pos, Greenberg, Goldman and Korman (2003) noted that the processing of emotions, which involves experiencing and understanding the significance of emotions, has been assumed to be important for change in several practice models. These include psychoanalytic, experiential, and cognitive-behavioral models, but experiential approaches to treatment also view emotions “as a source of adaptive information” (Pos et al., p. 1007).

Pos et al. (2003) summarized the components necessary for optimal emotional processing, which include approaching, allowing and tolerating emotional experience;
integrating cognition and affect; exploring, reflecting upon and making sense of the
cognitive information and beliefs related to the experienced emotion; voicing their
emotional experience; and identifying any needs which may transform personal meaning
and beliefs. Pos et al. further declared that when these essential components are present,
"new emotional reactions and new meanings potentially emerge that subsequently may
be integrated into and change existing cognitive-affective meaning structures" for clients
(p. 1008).

Pos et al. (2003) also stressed that positive outcomes in experiential therapy may
be the result of clients’ capacities for emotional experiencing versus a result of the
therapeutic process creating or establishing skills in processing. They base this on
research findings that "clients who are internally focused or are more willing to deal with
their feelings early in therapy have better outcomes" (Pos et al., p. 1008).

Additionally, their investigation found that the "depth of emotional processing at
the end of therapy was coincident with psychotherapeutic improvement" (Pos et al.,
2003, p. 1014). Nearly 20 years before Pos et al. declared this finding, Beutler et al.
(1986) asserted that the research had indeed confirmed that experiential therapies were
"more effective at alleviating depression among emotionally overcontrolled patients than
are more traditional, insight-oriented therapies" (p. 757).

In addition to encouraging verbal emotional expression, our clients can benefit
from written emotional expression. Pennebaker (1991) recommended that anyone who
finds themselves dwelling on events or experiences too often or if there is something that
they would like to share with others but are afraid of being embarrassed or punished, they
can be encouraged to write down their thoughts. Pennebaker offered the following
guidelines, formatted into the following table for the reader’s convenience (Table 6).
Table 6: Pennebaker's (1991) Guidelines for expressive writing

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1.</td>
<td>Explore both the objective experience and your feelings about it.</td>
</tr>
<tr>
<td>2.</td>
<td>Let go and express your deepest emotions: what you feel about it and why you feel that way.</td>
</tr>
<tr>
<td>3.</td>
<td>Write continuously; don’t worry about grammar, spelling or sentence structure.</td>
</tr>
<tr>
<td>4.</td>
<td>If you run out of things to say or reach a mental block, just repeat what you have already written.</td>
</tr>
<tr>
<td>5.</td>
<td>Try to write for 15 minutes a day in a setting where you will not be interrupted.</td>
</tr>
<tr>
<td>6.</td>
<td>Find a unique, comfortable, isolated room where you will not be interrupted or bothered by unwanted sounds, sights or smells.</td>
</tr>
<tr>
<td>7.</td>
<td>From a health perspective, you will be better off making yourself the only audience.</td>
</tr>
<tr>
<td>8.</td>
<td>You may feel sad or depressed immediately afterward. These feelings usually dissipate within an hour; in rare cases they may last a day or two. If you’re coping with death, divorce, or some other major trauma, you won’t feel better instantly after writing.</td>
</tr>
</tbody>
</table>

(p. 67).

In his research on writing interventions using the above guidelines, Pennebaker (1991) reported that “the vast majority of our volunteers [study subjects] report feeling a heightened sense of relief, happiness and contentment that lasts up to six months after the writing studies are concluded” (p. 67). Pennebaker (1991) further asserted that
expressive writing should give clients a clearer understanding of their feelings and their situation, allowing for some distance and additional perspective on their lives, which can lead to positive changes in their physical and mental health. Other benefits of the writing intervention include the fact that clients can confront traumas when they are ready and at their own pace, and this, in turn, can encourage clients to formulate individual meanings and solutions to their own conflicts (Pennebaker et al., 1988).

**Barriers to Integrating Emotional Expression in Holistic Practice**

One of the toughest barriers to integrating emotional expression in holistic social work practice is a willingness on the part of clients to talk about their experiences of trauma and abuse. Pennebaker et al. (1990) noted that “a large percentage of people do not discuss major personal upheavals with others” (p. 529). They explained this statement further, asserting that “people are either unable or unwilling to talk to others about upsetting experiences for fear of embarrassment, disapproval, or punishment…. [and] actively inhibit their desire to talk about the significant events” (Pennebaker et al., p. 529).

In addition to the fear of being embarrassed or punished, people also tend to not think of themselves or others “as having emerged from scarring events with something useful and redemptive” (Parsons et al., 1998, p. 302). Many people believe they can simply leave the past behind because there is nothing useful about bringing it up again. This connects back to the statement by Richards and Gross (2000) about Western culture as a whole being ambivalent about emotions: on some level, people know their emotions are important to their well-being, while also believing emotions to be destructive. King and Emmons (1990) agreed with this construct of ambivalence, declaring that
"expression is viewed as uncivilized and yet beneficial" (p. 864). These conflicting beliefs make it challenging to embrace emotional experience and expression.

Additionally, clients who have a negative attitude about emotional expression "are likely to be less open, extraverted and agreeable" (Nightingale & Williams, 2000, p. 252). An attitude of keeping a "stiff upper lip" about expressing emotions could be problematic "when faced with high levels of symptoms often present following traumatic experiences" (Nightingale & Williams, p. 252). A negative stance about emotional expression may also affect therapist-client rapport, what type of treatment is found to be acceptable by the client, choices for interventions, and the direction of therapy (Nightingale & Williams).

However, such clients may be the ones who most need assistance in handling their emotions after traumatic events. Consistent with other researcher's findings, Nightingale and Williams (2000) found that "negative attitudes to emotional expression are related to more intrusive symptoms and predict the diagnosis of acute PTSD at 6 weeks following road accidents" (p. 252). Techniques such as cognitive therapy could modify or reduce the level of negativity about emotional expression (Nightingale & Williams). Slowly working with clients to challenge their negative thinking about emotional expression, and helping them understand the many benefits of expressing their emotions could be a worthwhile endeavor.

As with any other type of treatment, social workers must not force the processing of emotions upon their clients. As Kennedy-Moore and Watson (1999) stated, "a conviction concerning the importance of nonexpression may be part of a client's highly valued cultural or personal belief system" (p. 16). In addition to considering a client's valued belief system, social workers need to take into consideration the possibility that a
client has difficulty experiencing all emotions, since “the suppression of negative emotion tends to reduce a person’s ability to experience any emotion, positive or negative” (Spiegel, 1999, p. 1328). In some clients, this inability to experience emotion may be extreme, and this tendency has been termed as *alexithymia*.

Nearly 35 years ago, the concept of “alexithymia” was introduced as a construct which “reflect[s] a deficit in the cognitive processing of emotion” (Taylor & Bagby, 2004, p. 69). This concept has been linked “with classic psychosomatic diseases and failure to respond to dynamic psychotherapy” and is strongly associated with depression (Taylor & Bagby, p. 68). However, some researchers have found “significant reductions in alexithymia scores especially when levels of depression decrease” (Taylor & Bagby, p. 73).

Some researchers have suggested that alexithymia is a consequence of either extreme childhood or adult trauma, or both, and one study found that it was associated with PTSD symptom severity but not the severity of trauma (Taylor & Bagby, 2004). Additionally, various studies regarding written emotional expression have suggested that individuals who had high alexithymia scores did not experience the benefits from expressive writing that other research participants did (Taylor & Bagby).

Furthermore, persons with clinical diagnoses of schizophrenia, bipolar disorder, or other major psychiatric disorders have been found to be negatively affected by high levels of emotional expression (Bradley, 2000). This issue “has been seen as an important factor in relapse” although this was examined as the effects of expression from a “significant adult toward the patient” involving such negative expression as “critical comments, hostility, and emotional overinvolvement” (Bradley, p. 76). However, Bradley noted that this “appears to indicate that vulnerable individuals have more
difficulty responding to or dealing with negative interactions than do the less vulnerable” (p. 245). It may be possible to extrapolate these findings to apply to the utilization of emotional expression by clients within the therapeutic context, and caution should be exercised with the application of expressive techniques with especially vulnerable persons.

In addition to personal beliefs, cultural values, and challenges with the cognitive processing of emotions, there are stereotypes about the way men and women should show their emotions. Regarding emotional expression, Shields (1987) stated that “the stereotype suggests the existence of an essential and inevitable difference between the sexes” (p. 229). Not only are men and women both affected by societal “display rules” about emotional expression, but also by “individual expectations of gender-appropriate experience” (Shields, p. 233). Women are also expected to have more difficulty expressing anger, and to direct it inward in a self-destructive manner (Shields). These enduring stereotypes can impact both clients and social workers, just as it impacts our society as a whole.

Unfortunately, the research shows that diagnosis and treatment rates for mental illness are much higher for women than men, though the majority of patients in mental health treatment facilities were men in the first half of the twentieth century (Doyle & Paludi, 1998). A possible explanation for the reversal in the trend is that women are “more likely to exhibit behaviors that others are apt to label as mental illness,” because men have been taught to suppress emotional expression and women have been taught to be emotionally expressive (Doyle & Paludi, p. 228). People who are expressive with their emotions are likely to “be perceived as disturbed or troubled” (Doyle & Paludi, p. 228), and thus these stereotypes and the possible threat of involuntary commitment to
mental health facilities are compounding factors which may cause people to be fearful of expressing their emotions.

Furthermore, Doyle and Paludi (1998) noted that differences in the rates of diagnosed mental illness between women and men could also be that while women tend to freely discuss their emotional problems, men tend to disguise or not admit their troubles. An alternate explanation offered by Doyle and Paludi for this difference “concerns women’s unequal social position and greater discrimination” (p. 229), including the higher likelihood of being victims of violence and other traumatic events, which may then lead to women’s emotional problems.

In addition to gender differences in mental health status, Alegria, Perez and Williams (2003) noted that “minorities have more symptoms of distress than their white counterparts have” (p. 52). They further asserted that “the consequences of psychiatric disorders are greater for minorities, with increased odds of incarceration for minorities who are substance abusers than for whites with the same disorder” (Alegria et al., pp. 52-53). There are also differences between whites and minorities in the treatment received and quality of treatment, and African Americans receive mental health services at half the rate of whites, and Latinos receive services much less often (Alegria et al.).

Hines-Martin, Malone, Kim and Brown-Piper (2003) examined obstacles to access of mental health care service in a low-income African American population, and found barriers at individual, environmental and institutional levels. Hines-Martin et al. noted that their study participants faced lack of insurance, support, encouragement and information; stigma; biases of gatekeepers to needed services; and “difficulties understanding the magnitude and source of their problems” (p. 252). Another important factor deserving of consideration is that their study “participants expressed a lengthy
process involved in gathering sufficient knowledge to act successfully,” and thus preventive approaches for such at-risk populations should also be a priority in social action of clinical social workers (Hines-Martin et al., p. 253).

Common policies which address such service disparities at a national level only help people with mental health coverage, and unfortunately African Americans are twice as likely and Latinos are three times as likely as whites to be uninsured (Alegria et al.). Any health policy must account for inequities in income to lead to equities in health in the population, and Alegria et al. found that the Earned Income Tax Credit and Section 8 housing vouchers are two programs which are effective in reducing those inequities between minorities and whites. Making our clients aware of and assisting them in utilizing these programs should be part of our “clinical social justice practice” (Swenson, 1998), but of course such policies are not “a substitute for service interventions” (Alegria et al., p. 60).

Other barriers that keep clients from receiving the help they need in the first place relate to systems that are in place which may be disempowering. Shi and Stevens (2005) stated that in order to ensure that racial or ethnic minorities can obtain needed care, “language difficulties, cultural beliefs, and practices” may need to be addressed to “ensure that all adults feel empowered to obtain care” (p. 153). Socioeconomic status, including occupation and education level (which can affect insurance availability and limit flexibility in time, location, behaviors/ability in seeking help) needs to be addressed to reduce disparities in access to needed care (Shi & Stevens). Addressing these issues will take multiple strategies in both the clinical and policy arenas (Shi & Stevens).

Yet another barrier to clients’ emotional expression is the willingness of social workers to delve into abuse experiences with their clients. Studies have shown that
professionals in the mental health services field may have experienced abuse in their lives as much or more as the general public (Pope & Feldman-Summers, 1992). In their study of 296 psychologists, Pope and Feldman-Summers found that approximately 33% of their respondents reported sexual or physical abuse as a child or adolescent, and nearly 37% reported abuse during adulthood. Their study also found that about 33% of male and 70% of female respondents from the mental health field reported at least one instance of abuse during their lifetime, consistent with general findings in other surveys (Pope & Feldman-Summers). Abuse experiences of mental health workers can potentially make them less than willing to encourage their clients to express emotions about abuse if they have not done that themselves.

As an extension of this line of thinking, there is also the need for others within the therapeutic setting to accept that there will be noise associated with emotional expression by clients. One experienced social worker who ran a successful women’s group for 5 years where she utilized emotional expression, working with anger, encouraging clients to yell and hit pillows, had stopped doing such work with her clients (C. Mullen, personal communication, November 19, 2003). She explains why in the following excerpt from our personal communication:

You’d have to have a whole practice here that’s ok with it. When I was at [name deleted] when we were in that era that people could do anger work in a room...you’re going to hear it in another room, and then when a client that you’re working with gets frightened because they hear pounding, then you help them with that. So it has to be a ‘group mind’ that we are all going to agree that this is what goes on here. Because most people haven’t done anger work in America, somehow emoting isn’t ok—this [office]
ought to be a place where people can sob loudly or talk loudly, you don’t necessarily have to be screaming but [express it] and let it go (C. Mullen, personal communication, November 19, 2003).

There are obviously numerous barriers to integrating emotional expression in holistic social work practice, as outlined here. The challenges faced by our clients range from stretching their comfort level in taking a leap of faith to try emotional expression, to the downright inability to know, express, or even manage what they are feeling. Professional social workers must understand the variety of challenges this technique may pose and proceed cautiously. However, armed with the above knowledge, personal and professional experience, supportive supervision, and a judicious approach to treatment choices, the utilization of emotionally expressive techniques in clinical social work practice can be empowering and healing for our clients.
Chapter III: Methodology

This study utilized secondary data analysis of both quantitative and qualitative research regarding emotions and emotional expression and applied it to the topic of empowerment and healing in clinical social work. A sampling of classic and more recent peer-reviewed articles regarding emotion, expression of emotion and outcomes, as well as various applications of such theory, was reviewed. A cross-section of contemporary literature from various disciplines that addressed the healing aspects of expression as well as cultural and ethical practice concerns have been examined. Applicable literature was found by searching EBSCOhost, OCLC FirstSearch, ProQuest, Wilson Select, and other electronic journal databases from the social and behavioral sciences and medical disciplines on the Grand Valley State University e-databases collection, as well as by reviewing the reference section listings of such relevant literature.
Chapter IV: Findings

Importance of Encouraging Emotional Expression

With the findings that 86% of social workers reporting that they provide individual counseling (NASW, 2006) and clinical social workers making up the “largest group of professionally trained mental health providers” in the U.S. (NASW, 2007, para. 3), there is a significant number of professionals to whom this research is applicable. If we combine the reported percentage of couple/family, parent/child, health, and abuse issues found to be reported as primary concerns (versus diagnosed mental illness) by clients of licensed social workers, then as many as 85% (NASW, 2005) of clients seen could potentially utilize and benefit from focusing on emotional expression in therapeutic encounters. The sheer number of persons that this research can potentially affect deems this topic as greatly important.

Professional social work has evolved from “advice giving, moral suasion, and manipulation of the environment” (Brandell, 2004, p. 4) to psychosocial diagnosis and treatment (Turner, 1995), thus focusing on mental and emotional processes. We found that since the beginnings of the clinical social work profession, attending to clients’ psychological functioning has been at its core (Turner, 1995), including assisting clients to understand causes of emotional suffering and to develop and then implement methods for resolving the cause or situation (NASW, 2007). Holistic social work perspective now includes a focus on the interdependence of body, mind, spirit and emotions (Timberlake et al., 2002). Culturally competent social work practice empowers clients to describe their experiences, especially “those not represented in the dominant language” (Weick,
2000, p. 400), and any related emotions in their own words and in their own way (Saleebey, 1996).

Through this review of the literature, we found that for numerous reasons many authors have declared the profound importance of human emotions and emotional expression. For instance, in 1948 Leeper declared that emotions were "indispensable guardians of our well-being" (Richards & Gross, 2000, p. 410), and many years prior, Charles Darwin wrote that the expression of emotions was important to "the welfare of [hu]mankind" (Darwin, 1969, p. 366). Additionally, Greenberg (2004) reiterated that emotions promote ones well-being. It is certainly no stretch of the imagination to say that social workers can and should partake in assisting their clients to utilize such a valuable asset—their emotions.

The professional ethical standards for social workers stipulate that social workers’ "primary responsibility [is] to the well-being of the client" (Rothman, 1998, p. 191). Thus, the encouragement of emotional expression in clinical social work client interactions can be an important means of living up to the ethical standards for our profession and encouraging wellness in our clients. Social workers often are busy helping our clients meet their basic needs, but we should remember that emotional growth has been declared by social work authors to be a universal basic human need (DuBois & Miley, 2002), and doing all we can to "make self-realization most possible" is the fundamental purpose of social work practice (Weick et al., 1989, p. 352).

We found that emotions are profoundly important to our lives for a multitude of other reasons. Not only are emotions physiological responses that prepare us to take action which can help save our lives (Goleman, 1995; Greenberg, 2004; Scarf, 2004; Cacioppo et al., 2000), but they also "guide, enrich, and ennoble life" and "provide
meaning to everyday existence" (Cacioppo et al., p. 173). Emotions are key to
"optimizing human potential" as well as promote intellectual development (Cacioppo et
al., p. 173), they "affect all human performance" (Efran & Fauber, 1995, p. 282), and are
foundational to cognitive processes and decision making (Greenberg, 2004).

The importance of encouraging emotional expression in clinical social work
practice has been examined and supported in the review of the literature. For instance,
Salovey et al. (2000) stated that "those who can quickly and accurately appraise and
express their emotions are better able to respond to their environment and to others" (p.
506). Awareness and understanding of feelings affects one’s ability to speak about and
even anticipate emotional states (Harris, 2000). Knowing how important our emotions
are, Darwin’s (1969) statement, “most of our emotions are so closely connected with
their expression, that they hardly exist if the body remains passive” (p. 237), thus further
supports the importance of encouraging awareness and expression.

However, we found that the non-expression of emotion, especially relative to
trauma and abuse, can cause a variety of problems and makes these endeavors
tremendously important. Ornstein and Sobel (1987) declared that “keeping feelings to
yourself may be injurious to your health” (p. 158), and Spiegel (1999) noted that many
researchers have shown that when emotional distress is managed, medical treatments are
more effective. Spiegel also asserted that suppressing negative emotions will likely
reduce the ability to experience positive emotions as well. The severe inability to
experience emotion, termed alexithymia, is also linked with psychosomatic diseases and
depression (Taylor & Bagby, 2004).

Unexpressed feelings are also found to keep one from assimilating events
cognitively and may remain as unwanted thoughts (Pennebaker et al., 1990), or put
another way, to "rebound as intrusive ruminations" (Greenberg et al., 1996, p. 588). Scarf (2004) stated that the body "remembers" and is able to physiologically keep alive our memories, as well as to be ready to handle a threat, long after a disturbing event. Dunbar's (1955) assertions about psychosomatic medicine and the effects of "buried memories" (p. 3) also support this idea. Non-expression, or the inhibition of thoughts and feelings, causes chronic stress (Greenberg et al.) and this cumulative stress in the body increases the likelihood of the development of disease (Pennebaker et al., 1990).

Major events in one's life have been found to affect numerous aspects of functioning, from moods to eating to health and other behaviors (Pennebaker et al., 1990). A multitude of research shows that experiencing trauma and abuse can have negative results for one's health status (Jankowsi, n.d.; McCauley et al., 1997; Dunbar, 1955). Taylor (1995) declared that "all conditions of health and illness...are influenced by psychological and social factors" (p. 6) and an extensive review of the psychosomatic medicine literature turned up a long list of medical conditions which researchers have found to be "associated with stressful life events" (Fava & Sonino, 2000, p. 186).

**Challenges of Encouraging Emotional Expression**

One of the main challenges of encouraging emotional expression with our clients is the fact that the culture in which we live and practice clinical social work, "Western" culture, is "decidedly ambivalent about emotions" (Richards & Gross, 2000, p. 410). Additionally, our world has been unduly influenced by "Descartes' dualist legacy" which tells us to keep our emotions separate, focusing on rational thought (Martin, 1998, p. 272), as well as Aristotelian beliefs which separate out feelings from thoughts and behaviors that are associated with our experiences (Efran & Fauber, 1995).
This review of the research found that emotion researchers including neuroscientists now understand emotions to be "an adaptive form of information processing," (Greenberg, 2004, p. 3) as well as "key ingredients of rationality and vital for normal human functioning" (Martin, 1998, p. 272). However, there remains the stereotypes noted by Young in 1943 that emotions are primitive and immature, carrying destructive impulses and as such surpass good judgment (Richards & Gross, 2000).

Such beliefs have undoubtedly influenced funding sources for mental health providers whose decision-makers watch bottom lines carefully and prefer specific interventions for certain diagnoses or require documentation of effectiveness for interventions (Timberlake et al., 1997). Behavioral techniques and short-term interventions are likely to be used with clients when they have restrictive insurance coverage (Timberlake et al.). Social workers may also feel discomfort about sharing with other professionals which techniques and perspectives have been found to be effective or helpful with clients (Turner, 1995), which could possibly be the result of a lack of clarity from years of others ignoring or denigrating social workers' experiences (Weick, 2000).

This challenge in sharing among social workers could also be related to protection of the profession's legacy of casework focused on manipulation of the client's environment, foundational techniques such as Mary Richmond's social diagnosis and treatment (Brandell, 2004), or the quest for a separate and unique identity from other professions (DuBois & Miley, 2002). Perhaps in the particular case of emotionally expressive techniques, this difficulty could be that schools of social work generally do not still embrace Freudian perspectives (The Sanville Institute, n.d.).

Social workers need to remember that in order to embrace true empowerment practice, they should forgo focusing on clients' deficits. This type of focus conveys
authority and in turn discourages independence and encourages long-term dependence upon professional help, and should place the power to make decisions back on the client (Weick et al., 1989). We also found that when utilizing any therapeutic technique with clients, normalizing events for clients (Becvar, 1999), beginning where the client is at (Parsons et al., 1998), and engaging clients as equals (Saleebey, 1996) all help place power back in our clients' hands. As well, recognizing that clients have inner wisdom which can help them make choices and thus gain power, and concentrating on their positive abilities (Weick et al., 1989) all contribute to empowerment of our clients in any setting and regarding any issue.

The complexity of emotions and emotional reactions can also be an intimidating hurdle when convincing social workers of the value of encouraging emotional expression with their clients. We found that emotions involve "multiple physiological experiences, feelings, and expressions" (Canary et al., 1997, p. 24). Traumatic experiences are remembered through a complex memory network (Scarf, 2004) and negatively affect health "through a complex interaction between biological and psychological mechanisms" (Jankowski, n.d., para. 6). As well, the multitude of literature on the mind-body connection, including environmental influences and health/wellness, denotes that these interactions are complex (Saleebey, 1996). Even though emotions can be key to accessing capabilities, they also may be an overwhelming obstacle for our clients to realize their potential (Cacioppo et al., 2000).

And then there's just the "plain ol' messiness" of dealing with emotional expression for social workers to navigate. Noise generated by yelling or sobbing loudly can potentially disturb other clients, and the therapeutic environment needs to be supportive of emotional expression (C. Mullen, personal communication, November 19,
We also found that mental health professionals are as likely as the general public to have experienced abuse (Pope & Feldman-Summers, 1992), which could make them less likely to delve into that "messiness" alongside their clients. Additionally, people also tend to feel afraid of being embarrassed, disapproved of, or even punished for expressing feelings or talking about major upsets (Pennebaker et al., 1990), and may feel that there was nothing useful to remember about scarring events (Parsons et al., 1998).

Negative attitudes about emotional expression can affect clients' openness, the client-therapist rapport, and which approaches to therapy are seen as acceptable, but can also predict the development of acute PTSD after some traumatic incidents (Nightingale & Williams, 2000). As well, we found that clients may experience more depression immediately following writing therapy sessions (Pennebaker et al., 1988; Pennebaker, 1991). Stereotypes about how women and men should display their emotions differently (Shields, 1987) and the real threat of involuntary commitment to mental institutions (Doyle & Paludi, 1998) also affect willingness to express emotions.

Socialization, gender roles, and family expressiveness affect how women and men feel about and demonstrate their emotional expression (Kring & Gordon, 1998), and men often rely on indirect ways of expressing their emotions including avoidance or distraction (Canary et al., 1997). We also found that culture has a significant effect on how people learn about feelings—how to have them and how to show them (Porter & Samovar, 1998; Kennedy-Moore & Watson, 1999; Matsumoto et al., 1988; MacKinnon & Keating, 1989). We must respect our clients with highly valued beliefs regarding non-expression (Kennedy-Moore & Watson, 1999) and not force expression on them as a treatment modality. Social workers need to convey comfort with intercultural differences in emotional expressivity (Porter & Samovar, 1998) to their clients.
Other important findings include that positive experiential therapy outcomes may depend upon the client's capacity to experience emotions instead of processing skills being created or developed during the therapeutic process (Pos et al., 2003). As well, clients with deficits in their mental processing of emotions (alexithymia) have a strong likelihood of having severe PTSD symptoms and depression, are unlikely to respond to or benefit from psychodynamic therapy or expressive writing exercises, but can significantly reduce their alexithymia symptom levels when their depression levels are decreased (Taylor & Bagby, 2004).

**Rewards of Encouraging Emotional Expression**

This review of the literature found a plethora of positive outcomes for encouraging emotional expression with clients. As a case study, we can look at the circumstances of Bertha Pappenheim and how she was permanently freed from peculiar aversions and limitations by expressing her emotions and following her symptoms to the original source, with the help of a supportive professional (Guttmann, 2001). Such ideas helped pique the interest of early social workers and contributed to the psychoanalytic movement in the 1920s (DuBois & Miley, 2002), and enabled a more individualized approach to the well-known person-in-environment perspective of social work practice (Brandell, 2004).

Indeed, thanks to Freud's legacy, we find that we are able to develop insight into emotions, changing and improving our awareness (Harris, 2000). The purpose of social work is to help release human and social power, place the power of decision making with the client, and make self-realization possible for our clients (Weick et al., 1989), and a focus on emotional expression with clients furthers that purpose in many ways.
In addition to being more readily able to respond to the environment and other people, we found that those who can effectively express their emotions experience less depression and are more empathic than those who cannot effectively express emotions (Salovey et al., 2000). By recounting events, individuals can convey, gather, or establish meanings (Parsons et al., 1998), and written emotional expression has been shown to improve mental and physical health (Pennebaker, 1991), even making long-term improvements (Pennebaker et al., 1990). Expressing one's deepest thoughts can result in lighter moods and improved outlooks, happiness and contentment (Pennebaker, 1991), potentially overtaking the usual stages of coping with trauma and other stressors (Pennebaker et al., 1990).

We also found that confronting traumas and other upsetting events can help “put them to rest” (Pennebaker, 1991, p. 64), release pent-up emotional energy, or facilitate insight through understanding and assimilation (Pennebaker et al., 1990). This process has been declared to be invaluable (Dunbar, 1955). This can enable the accumulated physiological stress to be undone, even facilitating a perception of mastery and control over emotional reactions (Greenberg et al., 1996), especially when clients confront traumas at their own pace when they are ready to (Pennebaker at al., 1988).

Once the resolution of an emotional expression episode is reached, clients may have more clarity, perspective, and solutions (Pennebaker at al., 1988), and clients may feel complete with the issue and have more sense of control, thus reducing their stress, depression, and unhealthy attachments (Beutler et al. 1986). Researchers found that the content of written expression was a predictor of mortality or longevity (Taylor & Bagby, 2004). Additionally, structured psychiatric interventions resulted in better survival rates and less recurrence long-term for cancer patients (Fawzy et al., 1993).
Coping with cancer through emotional expression was found to be adaptive for women (Stanton et al., 1994), and improved their vigor, their quality of life, and their perceptions of their health status, and decreased their distress and number of medical appointments (Stanton et al., 2000). However, in another review of related literature, extreme suppression and expression were both found to be associated with cancer (Gross, 1989). A review of the literature found that venting negative emotions seemed to have helped medical patients to recognize, accept, and gain perspective on their distress (Spiegel, 1999). Thus, we can see from these findings that there are numerous reasons to consider emotional expression important to the empowerment and healing of our clients.
Chapter V: Conclusion

Implications for Social Work Practice

In this writing, the question has been asked “Does work with emotional expression matter enough to integrate into clinical social work practice?” and answered affirmatively with ample support. Weick (2000) declared that “the real test is whether meaningful work gets done, not just once but over and over again” (p. 401). Elaborating on this statement, she observed that “years spent refining the values of social justice, human strengths, essential human dignity, and the reaches of human potential must be used as the moral barometers for determining what ideas and theories can credibly advance our work” (Weick, p. 401).

Using Weick’s barometer for what can credibly advance the field of clinical social work, we have taken a look at the evolution of psychodynamic treatment in our profession as well as the broad field of mental health and psychosomatic medicine. The abundant research around the connections between mind and body, emotional expression and health, and expression and healing from trauma give social workers a solid base of convincing support for the utilization of emotionally expressive techniques to help clients improve their well-being.

Foundations of the profession established by the dedicated efforts of pioneer social workers such as Bertha Pappenheim in the late 1800s (Guttmann, 2001), Mary Cromwell Jarrett in the early 1900s (NASW Foundation, 2004) and Jean Sanville in the later 1900s (Brandell, 2004; The Sanville Institute, n.d.; Edward & Rose, 1999), speak volumes about the necessity and especially the value of psychodynamic work in clinical social work practice. Their hard work and dedication serve as inspiration for current and
future social workers as well as provide exceptional insights into the practice of clinical social work. Addressing the topic of such accumulated wisdom in clinical practice, Weick (2000) defined it in the following way:

*practice wisdom* [is] the accumulation of knowledge that is flavored with the richness and intricacies of years of collective practice experience. It includes finely honed intuition, penetrating powers of observation, flashes of insight, and the warm waters in which human connections are forged (p. 400).

The years of collective experience of these social workers, incorporated with the work of the multitude of authors, theorists, and researchers included here within contribute a solid foundation to the practice wisdom about emotional expression for empowerment and healing.

The existing ambivalence in our culture is a force that is present in social work practice and as mental health professionals, we must decide whether or not we will acquiesce to this cultural norm. We can decide that emotions are vital to our clients’ well-being, as implicated by the literature reviewed here within, and proceed from this stance in our encounters with clients. When we do, we can rest assured that our judicious promotion of an emotionally expressive therapeutic encounter which enriches, provides meaning and insight, moves to action, enables wise decision-making, or otherwise heals our clients, is backed by a foundational ethical standard for our profession.

However, third party payers and managed care organizations present another challenge to the ethical standards of our profession. When making decisions about diagnosis, informed consent, and especially treatment we need to keep our ethical standards in mind and utilize professional supervision or peer consultation when
uncertainties arise in order to continue to ethically provide quality mental health care. As well, when we adopt the perspective of “clinical social justice practice” (Swenson, 1998, p. 527) to reduce disparities to access for mental health care, we find ourselves advocating for our clients, lobbying for change, offering reduced fees or pro bono work, and educating the public about needed changes in the current health system. Embracing a breadth of intervention techniques and committing to advocacy for underserved and oppressed populations are strengths of our profession dating back to the beginnings of social work (Haynes, 1998) and enable us to bridge micro, mezzo, and macro levels of involvement for social good.

DuBois and Miley (2002) delineated 12 tenets of the social work profession that “reflect the essence of the social work purpose and the core of the common base of practice....[they] guide generalist practitioners in carrying out the purpose of social work” (p. 54). The first tenet which DuBois and Miley described is to “empower people, individually and collectively, to utilize their own problem-solving and coping capabilities more effectively” (p. 55). Working with clients to express their emotions is one very specific method to utilize their abilities to solve problems and to cope with life’s challenges by tapping into the knowledge and experience they carry within them.

This social work tenet of empowerment involves the social worker and client working in partnership, as equals, to utilize client strengths in order to develop solutions for the client’s life challenges. Empowerment is also a releasing of clients’ potential and their strengths (DuBois & Miley). The internal strength that develops through the survival of abuse, trauma, and stressful life events is usually much more robust than many people may have assumed, and by working with emotional expression our clients
can tap into these strengths, discover internal resources, gain personal power, resolve problems/issues, and begin to meet their own previously unmet needs.

One technique to help clients become aware of these assets within is to guide them to recall previous difficulties from which they have triumphed and gained strength, i.e., a difficult marriage/divorce, a painful bodily injury, a challenging work situation, or family conflicts. Allowing the client to name their own situation and related positive outcome is essential, for they each will see a different value resulting from similar situations, and this empowers them to give voice to their own experience. This also means that we meet the client where he or she is at currently, focus on his or her strengths, and recognize that he or she has valuable inner wisdom.

Alternatively, we can share (or encourage clients to read) inspiring stories such as that of Bertha Pappenheim or a current figure that can serve to encourage and inspire our clients to begin developing the faith that their trials and tribulations can and will somehow result in positive outcomes. A different approach of recitation of the abundance of literature on the topic, though included in this writing, may have served to increase awareness for some clients, but probably has “convinced” few clients of taking action to recover such benefits, and should be used cautiously as this may also put the social worker in the position of authority.

The research findings in the field of emotional expression discussed here (such as Greenberg et al., 1996, Stanton et al., 1994, Pennebaker et al., 1990, and Beutler et al., 1986) have shown us that the benefits of confronting feelings and expressing emotions are adaptive, giving clients a sense of control and mastery of their emotions, enabling them to understand and assimilate events, and to release previously distressing attachments. It is highly likely that gaining a sense of understanding and control over
previously “out of control” emotions can result as well in a greater sense of control and thus empowerment for clients in numerous other areas of their lives.

Framing emotional expression work in terms of “gaining control over emotions” can help clients to reach a level of willingness to try such techniques. Whether clients feel deadened to emotion or controlled by their out-of-control emotions, techniques such as working a two chair dialogue or writing their deepest thoughts about these emotional challenges can be the gateway to emotionally expressive work. One method is to have clients “converse” with their emotions, expressing how they feel about them, and telling them what they want to do with them (i.e., get rid of them, embrace them, control them, etc.) and how they would like to do this (i.e., hide them under a rock, shut out the rest of the world to be alone with them, chain them up, etc.).

As professional social workers, we need to keep in touch with our own sense of fear of loss of control while in emotionally charged encounters with our clients. Especially when we have unresolved traumas, abuse, or stressful life events, we must seek out supportive supervision and/or peer consultation in which to process these challenges. The issues and emotions that “trigger” feeling reactions in social workers should be used as therapeutic “grist for the mill” in our own personal therapy. As Pope and Tabachnick (1994) explained “the therapist’s personal problems may, if unidentified, unexamined, and unaddressed, interfere with the ability to conduct effective therapy” (p. 247). As well, in his review of the research, Clark (1986) found that 44-83% of mental health practitioners reported experiencing personal therapy. The evidence shows that mental health practitioners do indeed utilize personal therapy, so there certainly is “no shame” in participating ourselves.
We also need to keep in check the stereotypes and cultural assumptions we hold about others as to whether they “should” or “should not” feel how they feel and express how they express. We must convey comfort with cultural, gender, and age differences in our counseling sessions, and be aware if we are resisting the use of emotionally expressive techniques simply because our client is male or elderly or from a “less expressive” culture. These assumptions we make may be true, partially true, or entirely false. In a therapeutic group setting, I have witnessed people of many cultures and women and men of all ages yelling into pillows, beating cushions with fists, and sobbing loudly while working with emotionally expressive techniques.

We cannot and must not make assumptions as to which of our clients are or are not open to expressive techniques, and we may have to find a way of being comfortable with the unknown for a time. We can potentially use as a compass that our clients who are more “internally focused” (Pos et al., 2003, p. 1008) are more likely to benefit from experiential therapy involving emotional expression. Social work values include the right to self-determination, and as Kennedy-Moore and Watson (1999) stated, “clinically, we believe it is very important to respect clients’ individual values” (p. 16). As well as demonstrating respect for an individual’s right to choose his or her treatment methods, this is also a part of culturally competent practice and as clinicians we must not force our ideas of how to best approach therapy onto our clients.

Kennedy-Moore and Watson (1999) elaborated on this thought, stating the following about individual and cultural differences:

Clients’ negative attitudes toward emotion may be deeply rooted in their sense of identity and based on powerful experiences or highly meaningful family or cultural values. Simply dismissing these beliefs or forcing
clients to act in a way that is contrary to their values may impede the
development of a good working alliance and is unlikely to lead to a
positive outcome in therapy (p. 208).

As clinicians, we must understand and respect our clients’ individual values as
well as cultural values in regards to emotional expression. Kennedy-Moore and Watson
(1999) added that “forcing clients who value stoicism to burst into tears is unlikely to be
helpful. They are likely to experience this expression as coerced, alien, and shameful.
These clients may prefer more subtle or symbolic forms of expression” (p. 302). On the
other hand, if clients have a negative attitude about expression which they are willing to
challenge, then cognitive techniques such as reframing can be used.

One caution from the literature, which may help clinicians decide when and
whom to use expressive techniques with, relates to the immediate effects of such
methods. Murray and Segal (1994) stated that “although vocal or written expression
seems to have a therapeutic effect, the negative mood produced after each session might
very well lead people to drop out of such treatment before a significant therapeutic effect
occurs” (p. 404). Clients should be cautioned about this effect and directed to report any
thoughts of suicide or harm to self or others to the social worker immediately.

Additionally, clinicians need to assess the client’s “stage of change” (Prochaska &
Norcross, 2001, p. 443) and develop the therapeutic relationship and interventions around
the client’s current stage. Again, we can follow Prochaska and Norcross’
recommendations that we set realistic goals for movement through the stages, keep
assumptions in check that all clients presenting for treatment are in the action stage, and
reserve experiential techniques (or action-oriented therapies) for clients who are in the
preparation or action stages.
If the clinician has a sense, or knows from their experiences of working with a particular client, that the client is unlikely to be tolerant of the resulting displeasure following emotional expression, then this may not be the preferred method to use with said client. This may also be achieved through use of asking some basic questions such as “what do you do when you feel down?” Alternatively, if the clinician is able to find a way to end sessions on a positive note, this may be enough to encourage the client to continue to return for further treatment. This can be accomplished by means such as genuine encouragement from the therapist (“you’re very strong and courageous”), inquiries about upcoming events that the client is anticipating (“what’s something fun you’re looking forward to in the next few days?”), or requesting that the client name one positive thing they got out of the day’s session (“what was the best part of our session today?”).

Though the complexity of emotions and emotional reactions may be intimidating to social workers, it does not have to be complicated to assist our clients in exploring emotional expression. There are basic components for successful therapeutic encounters (see Table 5) which do not require specialized training, and we should keep in mind that simply being present with the client helps them to feel safe. We can also revisit what Beutler et al. (1986) offered up for guidelines so that we feel better prepared when working with experiential techniques. The client should be able to readily agree that the therapeutic encounter will be interpersonally-focused and be committed to work on his or her interpersonal conflicts (Beutler et al.). Then active experimentation, emotional intensification and ensuing emotional decline follow, along with client assessment of the experience, and setting any plans for the future, if action needs to be taken (Beutler et al.).
Along these lines, Pos et al. (2003) had also summarized components for the most beneficial emotional processing which can be helpful guidelines for social workers to follow. Directing clients in how to approach their feelings, supporting them while they allow and (to some extent) tolerate their emotions, and encouraging integration of cognition and affect are all useful strategies social workers can utilize to foster clients’ emotional processing (Pos et al.).

Proceeding from there, we can help clients to explore, reflect upon, and make sense of the information and beliefs they find related to the emotion they have experienced, thus gaining insight through the emotional processing (Pos et al., 2003). Clients should be encouraged to talk about the experience and support can be offered to help them identify what needs they have (and how to meet them) in order to transform the insight they acquired from their experience (Pos et al.). Potentially, new reactions and meanings can be established through this process (Pos et al.).

Additionally, we can use tools with our clients such as a chart of feeling words (see Appendix A) which delineates intensity levels to empower our clients with the language of emotions and allows them to choose the words themselves. This reduces guess work on the part of the social worker and makes it much more likely that both client and therapist are “on the same page” regarding the nature and intensity of clients’ emotions.

Such a tool may even be a tremendous help to emotionally overcontrolled individuals or those with alexithymia, however clients should be reminded that the chart does not contain all possible feeling words and they should be encouraged to add their own descriptions to it. The chart can also serve as reinforcement of the importance of emotions, validation of feelings that a client feels but hadn’t been able to verbalize, and
empowerment for a client to see that there are numerous words for them to choose from to label their various emotions.

Even if the tool is not given directly to the client, it can help educate the social worker about emotion words to offer up when reflecting back to the client, i.e., "it sounds like you are feeling more than annoyed...maybe even outraged about that incident?"

Because of the subjective meaning of language, caution should be exercised to ensure that both the client and social worker are clear about specific connotations when this tool is used in therapeutic work.

Pennebaker's (1991) table, guidelines for expressive writing (see Table 6), outlines some standard instructions for clients to keep in mind when doing therapeutic expressive writing. Social workers can use this table with clients to assist them in getting started with writing, answering any questions clients have, and offering to explain concepts such as the difference between objective experience and feelings about an experience. Remembering to caution clients about the likelihood of increases in depression after writing is crucial, and coming up with a plan of action for the client to institute, even a no harm agreement when needed, is encouraged.

Another approach is to ask clients to write immediately before therapy sessions, even bringing the writing with them if they desire to read it to the social worker in a setting of "present safety" (Greenberg et al., 1996, p. 589). Murray and Segal (1994) advised that a means to motivate clients to stay with treatment is important and "one way of motivating [clients] would be to intersperse psychotherapy hours and make real use of written materials" (p. 404). They further suggested that clients could tape assignments for written or vocal expression to use in the psychotherapy sessions (Murray & Segal).
This may encourage clients to do the “homework” first and then do the “emotion work” in the presence of the supportive social worker. This may give clients a sense of “optimum distance” and the ability to terminate the episode at will (Greenberg et al., 1996, p. 589) so they feel safe delving into their emotions. The social worker can allow the client the time needed for them to read through the assignment, pausing on parts which are difficult to read/express, and even utilizing the writing to generate other assignments or conversations for therapeutic expression. When a client reads their writing without emotion, this can be explored as well, which may lead to a discovery that the client does not feel safe, and strategies can be explored to increase their sense of security.

With emotionally expressive techniques, social workers must find a balance between offering guidance, being directive, and allowing the client to exercise self-determination. Greenberg’s (2004) steps for emotion coaching (see Appendix B) offers some very explicit guidelines which enable social workers to find this balance in their work with clients. By taking on a role of a coach versus a mental health expert, helpers can support, guide, educate, and make proposals regarding accessing, expressing, understanding, and either acting upon or transforming emotions (Greenberg).

With the power differential inherent in the therapist/client relationship, clinicians must take a responsible position in the treatments they utilize with clients. Becvar (1999) stated that “the responsible position is one that offers suggestions and ideas tentatively.... one that recognizes that because what we did with one client ‘worked,’ does not mean that it will be appropriate or even useful with another client” (p. 76). Further developing this line of thought, Becvar added “indeed, the reality is that none of us knows the right way and all of us have something meaningful to offer” (p. 77). Becvar offered an
additional note of support, stating that "as quantum physicists have been telling us for some time, there is no one accurate model of reality, no one correct way to solve problems" (p. 78). If clinical social workers can keep this attitude of cautious optimism and openness about the use of emotionally expressive techniques, then they may find they utilize the "right" approach with the "right" clients at just the "right" time.

As Shulman (1993) stated about the development and testing of a practice theory, "theory building is an ongoing cyclical process in which the results of empirical research verify some existing propositions while generating new ones" (p. 96). He further declared that "if propositions are consistently supported in other studies, social workers can begin to accept them and think of them as 'theoretical generalizations' (Zetterberg, 1965)" (p. 96). Additionally, Shulman referred to a "false dichotomy" between art and science, and asserted that we do indeed have the necessary tools to cultivate "a science that can help guide the artistry of each social worker's practice" (p. 96).

This review of the literature is an attempt to demonstrate the science available that can help guide the artistry of holistic social work practice. The current study is also a limited effort to further develop a theory of social work practice incorporating the use of written and verbal emotional expression in the context of clinical work with clients, in order to foster empowerment and healing in their lives. Obviously, additional research, including controlled studies in the field of clinical social work, would be greatly beneficial as a next step to further cultivate this developing theory.

**Limitations of Research on Emotional Expression**

Despite the fact that much research is supportive of the use of emotional expression, this may not be enough to convince social workers or especially their clients
to utilize these methods. Much of the research found regarding the use of emotional expression is focused on written emotional expression. Often the research is limited to case studies or small pools of subjects, and few have utilized randomized, controlled trials.

**Limitations of This Research Paper**

This publication does not include an exhaustive review of the research, although it has utilized articles which contain extensive reviews in several areas of related fields. As well, a minimal sampling of emotionally expressive techniques have been included in this paper. It is not feasible to explore all emotionally expressive methods and theories as there is a profusion of thought in this area.

**Limitations of Emotionally Expressive Techniques**

As outlined in the Findings Section, there are numerous challenges and several reasons for caution when working with clients to encourage their expression of emotions. Clients who have a low capacity for emotional experiencing, are emotionally overcontrolled, have alexithymia, have a diagnosed mental disorder, or hold valued personal or cultural beliefs about stoicism or nonexpression would likely not be good candidates for emotionally expressive techniques. As well, caution should be exercised with use of these techniques when the client has shown a low tolerance for negative moods or is otherwise especially vulnerable, and “no harm agreements” should be in place, including strategies the client is to take to ensure they won’t harm themselves or others. The social worker and the therapeutic setting must also be supportive of
emotional expression. With the limitations which third-party-payers put on mental health providers, these techniques may not be covered as reimbursable treatment.

In their review of the literature on the use of cathartic techniques in psychotherapy, Kosmicki and Glickauf-Hughes (1997) declared the following:

The debate over catharsis, however, is still unresolved. A review of the recent literature reveals widely divergent definitions of catharsis with corresponding judgments regarding its efficacy. Due to these inconsistencies and the merging of elements from various schools of therapy, the role of catharsis in therapy has become increasingly ambiguous (p. 155).

The authors further noted that some theorists who are opposed to cathartic methods do indeed acknowledge the "importance of emotional expression within a particular context" (Kosmicki & Glickauf-Hughes, p. 155). They cite a prior review of the literature which concluded that catharsis was unnecessary and could even be detrimental when involving the expression of anger, making subjects more hostile instead of more calm (Kosmicki & Glickauf-Hughes).

Limitations of the expressive writing methods were discussed above, including heightened depression or negative feelings immediately after writing, as well as the inability to access outside objective viewpoints, support, or coping assistance unless used in conjunction with psychotherapy. Clients may be hesitant to utilize expressive writing without this objective observer or a sense of otherwise present safety.
## Appendix A: Feeling Words Chart

### Table 7: Turock’s (1978) Feeling Words Vocabulary List

<table>
<thead>
<tr>
<th>Intensity Levels</th>
<th>Happy</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Strong</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excited</td>
<td>Ecstatic</td>
<td>Energized</td>
<td>Thrilled</td>
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<tr>
<td>Elated</td>
<td>Terrific</td>
<td>Enthusiastic</td>
<td>Uplifted</td>
</tr>
<tr>
<td>Exuberant</td>
<td>Jubilant</td>
<td>Loved</td>
<td></td>
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<tr>
<td>Marvelous</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Justified</td>
<td>Joyful</td>
<td>Grateful</td>
<td>Accepted</td>
</tr>
<tr>
<td>Resolved</td>
<td>Proud</td>
<td>Appreciated</td>
<td>Amused</td>
</tr>
<tr>
<td>Valued</td>
<td>Cheerful</td>
<td>Confident</td>
<td>Delighted</td>
</tr>
<tr>
<td>Gratified</td>
<td>Relieved</td>
<td>Respected</td>
<td>Alive</td>
</tr>
<tr>
<td>Encouraged</td>
<td>Assured</td>
<td>Admired</td>
<td>Fulfilled</td>
</tr>
<tr>
<td>Optimistic</td>
<td>Determined</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weak</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Tranquil</td>
<td>Glad</td>
<td>Peaceful</td>
<td>Pleased</td>
</tr>
<tr>
<td>Content</td>
<td>Good</td>
<td>Hopeful</td>
<td>Flattered</td>
</tr>
<tr>
<td>Relaxed</td>
<td>Satisfied</td>
<td>Fortunate</td>
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### Feeling Word Vocabulary List (Continued)

<table>
<thead>
<tr>
<th>Intensity Levels</th>
<th>Scared</th>
<th>Confused</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strong</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fearful</td>
<td>Overwhelmed</td>
<td>Bewildered</td>
</tr>
<tr>
<td>Panicky</td>
<td>Intimidated</td>
<td>Trapped</td>
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<tr>
<td>Afraid</td>
<td>Desperate</td>
<td>Immobilized</td>
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<tr>
<td>Shocked</td>
<td>Frantic</td>
<td>Stagnant</td>
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<tr>
<td></td>
<td>Terrified</td>
<td>Directionless</td>
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<tr>
<td></td>
<td>Vulnerable</td>
<td>Flustered</td>
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<td>Horrified</td>
<td>Confused</td>
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<tr>
<td></td>
<td>Petrified</td>
<td>Baffled</td>
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<tr>
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<td>Appalled</td>
<td>Constricted</td>
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<tr>
<td></td>
<td>Dread</td>
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<tr>
<td></td>
<td>Tormented</td>
<td></td>
</tr>
<tr>
<td><strong>Mild</strong></td>
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<td></td>
</tr>
<tr>
<td>Tense</td>
<td>Insecure</td>
<td>Foggy</td>
</tr>
<tr>
<td>Threatened</td>
<td>Skeptical</td>
<td>Perplexed</td>
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<td>Apprehensive</td>
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<td>Defensive</td>
<td>Suspicious</td>
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<td></td>
<td>Shaken</td>
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<td></td>
<td>Swamped</td>
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<td></td>
<td>Startled</td>
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<td></td>
<td>Guarded</td>
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<td></td>
<td>Stunned</td>
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<td></td>
<td>Awed</td>
<td></td>
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<tr>
<td><strong>Weak</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reluctant</td>
<td>Shy</td>
<td>Surprised</td>
</tr>
<tr>
<td>Anxious</td>
<td>Nervous</td>
<td>Unsettled</td>
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<td>Unsure</td>
<td>Unsure</td>
</tr>
<tr>
<td></td>
<td>Timid</td>
<td>Bothered</td>
</tr>
<tr>
<td></td>
<td>Concerned</td>
<td>Undecided</td>
</tr>
<tr>
<td></td>
<td>Perplexed</td>
<td>Uncomfortable</td>
</tr>
</tbody>
</table>

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### Feeling Word Vocabulary List (Continued)

<table>
<thead>
<tr>
<th>Intensity Levels</th>
<th>Sad</th>
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### Feeling Word Vocabulary List (Continued)

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Appendix B: Greenberg’s Steps for Emotional Coaching

Emotion coaching is aimed at enhancing emotion-focused coping by helping people become aware of, accept and make sense of their emotional experience. Both client (trainee) and therapist (coach) collaborate actively in the creation of an educational experience for the client who is an active participant in the process. The goals of emotional coaching are acceptance, utilization and transformation of emotional experience. In emotion coaching a safe, empathic and validating relationship is offered throughout to promote acceptance of emotional experience. Emotion coaching is a collaborative effort to help clients use their emotions intelligently to solve problems in living by accepting emotion rather than avoiding it, utilizing both the information and response tendency information provided by it, and transforming it when it is maladaptive.

In addition to following where the client is moment by moment the therapist also coaches the client in new ways of processing experiential information. Although difficult, it is possible to enter into the highly subjective domain of unformulated personal experience, a place beyond reason and often beyond words, and have a positive influence. The steps involved in coaching people to experience their emotions skillfully are elaborated below.

Emotion coaching in therapy is based on two phases: Arriving and Leaving. A major premise is that one cannot leave a place until one has arrived at it. The first phase of arriving at one’s emotions, involves the following four steps. These are focused on awareness and acceptance of emotion.

1. It is important to help people become aware of their emotions.
2. People need to be coached to welcome their emotional experience and allow it (this does not necessarily mean they must express everything they feel to other people but
rather acknowledge it themselves). People also need to be coached in skills of regulation if needed to help them tolerate their emotions.

3. People need to be helped to describe their feelings in words in order to aid them in solving problems.

4. They need to be helped to become aware of whether their emotional reactions are their primary feelings in this situation. If not, they need help in discovering what their primary feelings are.

The second phase focuses on emotion utilization or transformation to promote leaving the place arrived at. This stage involves moving on or transforming core feelings. It is here that the coaching aspect is more central.

5. Once the person has been helped to experience a primary emotion, the coach and person together need to evaluate if the emotion is a healthy or unhealthy response to the current situation. If it is healthy it should be used as a guide to action. If it is unhealthy it needs to be changed.

6. When the person’s accessed primary emotions are unhealthy, the person has to be helped to identify the negative voice associated with these emotions.

7. The person is helped to find and rely on alternate healthy emotional responses and needs.

8. People need to be coached to challenge the destructive thoughts, in their unhealthy emotions, from a new inner voice based on their healthy primary emotions and needs, and to learn to regulate when necessary.

The dialectic of acceptance and change, is embodied in a style of following and leading. Following provides acceptance and leading introduces novelty and the possibility of change. This provides direction for the exploration not by suggesting what
content clients should focus on, nor by interpreting the meaning of their experience, but rather by guiding the type of processing in which they engage. Each therapist response is viewed as a processing proposal that guides the type of emotion in which the client engages. The types of proposals used in emotion coaching are those that help people symbolize their internal experience and make sense of them.

Coaching in the emotional domain involves helping verbally label emotions being felt, helping people accept the emotion, talking with the client about what it is like to experience the emotion, facilitating new ways of processing the emotion, and teaching ways of soothing or regulating the emotion. It is important to note that people often cannot simply be explicitly taught new strategies for dealing with difficult emotion but often have to be facilitated experientially to engage in the new process.

For example, accessing a need or goal may be very helpful in overcoming a sense of passivity or defeat or to help move out of a painful feeling. However, explicitly teaching people that this is what they should feel is not nearly as helpful as interpersonally facilitating this by asking them at the right time, in the right way, when they are feeling hopeless and have processed the feeling, what it is they need. It is for example, by experiencing a process of shifting states by accessing needs that the experiential links between states are best forged. This then is consolidated only later by explicit knowledge of the process.


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