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Emotion-focused therapy for symptoms of generalised anxiety in a student population: An exploratory study

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Abstract

Anxiety issues continue to retain the highest prevalence rates within student counselling services (SCS) with generalised anxiety a prominent concern. These issues are associated with poor academic achievement, attrition and self-injurious behaviours. Cognitive behavioural therapy (CBT) is moderately effective in treating generalised anxiety in students. Initial studies of emotion-focused therapy (EFT) for GAD are indicating successful outcomes for clients though research investigating a brief format within SCS populations is needed.

Aim: The present exploratory study represents an early effort to examine the effectiveness of brief EFT for generalised anxiety symptoms within a university SCS and the clients' experiences of this type of therapy.

Method: Participants ($n = 15$) presenting to a SCS with worry and generalised anxiety symptoms received an individual EFT for GAD intervention. Outcomes were assessed using two outcome measures pre- and post-therapy and a semi-structured post-therapy interview examined the clients' experiences of therapy and its outcomes.

Results: Quantitative pre–postdata indicated large effect sizes. Qualitative data described experiences of decreased anxiety, increased self-understanding, resilience, self-compassion and assertiveness. Experiential work and the therapeutic relationship were experienced as helpful aspects of therapy though experiential work was difficult. Personal difficulty engaging in therapy and some remaining symptoms were unhelpful aspects.

Conclusion: Findings suggest that brief EFT for generalised anxiety symptoms in students may be an effective SCS intervention and warrants further investigation.

KEYWORDS

emotion-focused therapy, generalised anxiety, student counselling, worry

1 | BACKGROUND

A global survey from the World Health Organization finds that approximately one-third of screened third-level students meet criteria for a mental disorder in the past twelve months, with major depressive disorder having the highest prevalence followed by generalised anxiety disorder (GAD; Auerbach et al., 2018). Likewise, within student counselling services (SCS), there is a growing concern globally

(Storrie, Ahern, & Tuckett, 2010) that presentations are becoming increasingly severe and complex. Aside from increasing the risk of attrition from third-level education (Auerbach et al., 2016), the presence of a mental disorder between ages 18 and 25 is suggested to impact significantly on an individual's employment, income and living standards by age 30 (Gibb, Fergusson, & Horwood, 2010). The presence of anxiety disorders among university students significantly increases the likelihood of engaging in various self-injurious behaviours (Gollust, Eisenberg, & Golberstein, 2008), binge drinking (Cranford, Eisenberg, & Serras, 2009) and poor academic achievement or dropout (Eisenberg, Golberstein, & Hunt, 2009). The long-term impact of GAD on youth and university students has been demonstrated as being associated with a significantly higher risk of suicidal ideation and attempts after controlling for comorbid disorders over a 25-year period (Boden, Fergusson, & John Horwood, 2007).

In the context of psychotherapy, there is a prolific amount of data concerning the use of CBT for GAD, albeit primarily in comparison with wait-list controls rather than other psychological therapies (Cuijpers et al., 2014). As many individuals receiving CBT do not respond or fully recover from GAD, Hunot, Churchill, Teixeira, and Silva de Lima (2007) suggest that more research is needed exploring the efficacies of therapies other than CBT. This is also in order to foster treatment choice among the providers and service users. The evidence base for the treatment of GAD within SCS mirrors issues within the broader context of GAD treatment. A meta-analysis (Huang, Nigatu, Smail-Crevier, Zhang, & Wang, 2018) of 51 randomised controlled trials (RCTs) investigating interventions within SCS concluded that the effect sizes of CBT for GAD were moderate.

Emotion-focused therapy (EFT; Greenberg, 2017; Greenberg, Rice, & Elliott, 1993) is among the therapies that were recently tested as an alternative to CBT for GAD (Timulak et al., 2017). EFT is a humanistic form of therapy that is trying to facilitate the client to access the underlying core emotional vulnerability, typically characterised by experiences of chronic shame, loneliness and fear, and then transform this underlying vulnerability by generating adaptive emotional experiences such as compassion and protective anger (Timulak, 2015). This is usually achieved through the use of imaginary dialogues (Elliott, Watson, Goldman, & Greenberg, 2004) that allow for the activation of the underlying emotional vulnerability (core emotional pain) and for the enactment of either compassion towards that pain or boundary setting anger which addresses pain-triggering mistreatment.

Emotion-focused therapy was recently adapted as a treatment of GAD (Timulak & McElvaney, 2016; 2018; Watson & Greenberg, 2017). EFT for GAD aims to not only transform the underlying emotional vulnerability, but also to alleviate the symptom-level distress that is characterised by excessive worry. The worry is seen as a protective self-treatment process in which the client is trying to avoid triggering of the emotional vulnerability (e.g. *I do not want to feel ashamed of failing my parents by failing at university and therefore I worry about the exam which leads me to overprepare for it or avoid it*). The worry is addressed by highlighting its function but also its emotional toll (anxiety and exhaustion) and is then balanced by the client either letting go of the worry or standing up to the worry and setting a boundary to it (Murphy et al., 2017). Other symptom-level interventions are used in EFT for GAD (e.g. imaginary dialogue for self-interruption or emotion regulation experiential tasks such as *Clearing a Space*), as well as the dialogues addressing the client's self-criticism (e.g. I worry that I will be found out as a stupid person) and interpersonal injuries (e.g. others will blame me for not succeeding). The interventions are well described in the generic EFT books (Elliott et al., 2004; Greenberg et al., 1993) and specific EFT for GAD books (Timulak & McElvaney, 2018; Watson & Greenberg, 2017).

An early open trial examining the efficacy of EFT for GAD showed promising results (Timulak et al., 2017). This early study was conducted in the context of public health primary care and had a format of up to 20 sessions. The current study sought to look at a shorter format as SCSs often operate in a format of around 6–8 sessions (this was the case for the study's host service). SCSs also typically serve student populations for whom worry and anxiety are very common due to the numerous high demands of university (e.g. academic performance and evaluation). Thus, the overall aim of the current study was (a) to look at initial effectiveness of EFT for symptoms of generalised anxiety in a student population and (b) to supplement this with the interview-based data of clients' experiences of any potential changes due to therapy, of clients' experiences of helpful aspects of therapy and of both difficult-but-helpful aspects and unhelpful aspects of therapy.

2 | METHOD

2.1 | Design

The study was a mixed-methods one group pre–post-design supplemented by the interview-based data of clients' experiences.

2.2 | Participants

Participants (N = 20) were university students attending a SCS between the years 2017 and 2020. From a recruitment of 20 participants, there was an attrition of five participants with ≤3 sessions. The final sample (n = 15) which had at least a minimal dose of therapy, that is, at least 4 sessions (this was determined as being minimally meaningful as it is normally recommended that the chair work—the main feature of EFT—is introduced in session 4, although in this study, due to the brief format of therapy, therapists were encouraged to start with the chair work as soon as clinically feasible) consisted of three males and 12 females with ages ranging from 19 to 30 (M = 22.73; SD = 2.94).

2.3 | Therapy

Emotion-focused therapy developed for the treatment of GAD (Timulak & McElvaney, 2018) was the therapy used in this study.

The treatment focuses on apprehensive anxiety and its corresponding emotional and behavioural avoidance, global or secondary distress, problematic triggers and problematic self-treatment (including worry) and on underlying maladaptive emotions of loneliness/sadness, shame and fear/terror and their transformation by generating compassion and healthy anger (Timulak & McElvaney, 2018). Due to the brief nature of this SCS's therapy provision (typically 8 sessions maximum, fortnightly), EFT experiential tasks such as imaginary chair dialogues for self-critical process, interpersonal injury and worry were enacted as early as session 2 in some cases. This diverges from the more typical practice of engaging in such tasks from session 4 onwards. As worry and GAD type symptoms were the focus of treatment, imaginary dialogues to address self-worry were used in all cases. This experiential task involves the use of chairs, in which the client is asked to enact the worry process to thus experience the impact of worry (i.e. anxiety, fatigue), articulate their needs regarding the worry (e.g. for it to stop) and to generate adaptive emotions of either self-compassion or protective anger to diminish the worry (Timulak & McElvaney, 2018). In keeping with the SCS policies, the therapy length was planned to be from 4 to 8 sessions. For three participants, this was extended to 12 sessions and for one participant to 14 sessions for clinical reasons, therefore extending the therapy range to be from 4 to 14 sessions ($M = 8$; $SD = 4.32$).

2.4 | Therapists

Five therapists provided therapy, and all therapists were employees of the university's SCS. Four therapists were counselling psychologists, and one therapist was a clinical psychologist. Years of practice experience was available for four of five therapists which ranged from 7 to 17 years. All therapists underwent training in EFT with an EFT therapist, supervisor and trainer recognised by the International Society for Emotion-Focused Therapy. Training involved eight days of experiential workshops and a period of supervised EFT client work evaluated for adherence by the trainer with the use of audio recordings. Once adherence to EFT was established, therapists were then individually granted approval to see participants. Therapists continued to receive biweekly supervision (towards the end of the study reduced to a monthly supervision) from the trainer throughout the study. Supervision that was based on reviewing of audio recordings of the sessions was also used to monitor the treatment adherence.

2.5 | Measures

2.5.1 | Generalized Anxiety Disorder-7

The Generalized Anxiety Disorder-7 (GAD-7) was used as the primary outcome measure. It is a seven-item self-report measure which assesses the presence and severity of GAD symptoms over the past two weeks (Spitzer, Kroenke, Williams, & Löwe, 2006). Research has demonstrated the reliability and validity of the GAD-7 in both primary care settings and the general population (Löwe et al., 2008).

2.5.2 | Penn State Worry Questionnaire—Past Week

The Penn State Worry Questionnaire—Past Week (PSWQ-PW) is an adapted version of the Penn State Worry Questionnaire and consists of a 15-item self-report measure which aims to be a highly change-sensitive assessment of pathological worry when monitoring treatment effects; a clinical cut-off is not established (Stöber & Bittencourt, 1998).

2.5.3 | Client Change Interview Schedule: Version 5

The Client Change Interview Schedule: Version 5 (CCISv5) is a semi-structured interview which aims to capture clients' perspectives of change in therapy (Elliott, 2008). Essentially, clients are asked whether they changed since therapy started and about their perceptions of what was helpful, difficult but helpful and unhelpful about the therapy.

2.6 | Procedure

This study was approved by an institutional ethics board. Participants' suitability for the study was based on their initial intake which involved an interview with a SCS staff member trained in assessment. All incoming students to the SCS complete a computerised version of the Counseling Centre Assessment of Psychological Symptoms-34 (Locke et al., 2012); a 34-item self-report questionnaire assessing depression, generalised anxiety, social anxiety, academic distress, eating concerns, hostility and substance use over the preceding two weeks. This was used to aid in establishing anxiety as a primary concern and screen for risk issues. Clients appropriate for further screening for suitability fulfilled the following criteria: (a) a primary presenting issue was anxiety, worry or some similar complaint, (b) no current risk of suicide, (c) no current alcohol or drug dependence and (d) no other contraindication at the discretion of the interviewer. Clients who fulfilled the criteria were introduced to the study verbally. Clients were also provided with written information about the study, in the form of an information sheet. Participants then completed the primary outcome measure, the GAD-7, with the interviewer. A GAD-7 score of ≥5 (i.e. a minimum of mild anxiety as defined by the GAD-7) was used as the cut-off for being invited to participate in the study. For the purpose of this study, no formal diagnostic assessment was made. The GAD-7 and PSWQ-PW were administered at the beginning of each session until completion of therapy. To obtain qualitative data, clients were invited to attend a semi-structured interview based upon the CCISv5, following completion of therapy with the researcher which was audio-recorded.

TABLE 1 Summary of paired samples *t* test

	Mean (*SD*)				
	Pre-therapy (*n* = 15)	Final session (*n* = 15)	*t*	*p*	Cohen's d (95% CI) Pre–post
GAD-7	13.13 (4.06)	6.93 (4.30)	6.254	.000*,a	1.39 (0.67–2.08)
PSWQ-PW	66.47 (13.59)	47.07 (19.78)	5.091	.000*,a	1.20 (0.52–1.86)

Note: $N = 15$.

Abbreviations: CI, confidence interval; GAD-7, Generalized Anxiety Disorder – 7; PSWQ-PW, Penn State Worry Questionnaire—Past Week; *SD*, standard deviation.

*$p < .001$.

Of the 15 clients who attended a minimum of three sessions, 13 attended the qualitative interview post-therapy and two did not respond to the invitation.

2.7 | Data analysis

2.7.1 | Quantitative analysis

Data were analysed using the IBM SPSS version 25.0 software. As the data were normally distributed, a paired samples *t* test was conducted comparing the GAD-7 and PSWQ-PW pre- and post-scores. Last Observations Carried Forward (LOCF) was applied to take into consideration the participants' varying therapy doses. Effect sizes (Cohen's *d*) were calculated for dependent samples, and corresponding confidence intervals were calculated (Cumming & Calin-Jageman, 2016). The rate of improvement on the primary outcome measure (GAD-7) was calculated using Jacobson and Truax's (1991) criteria; a pre- and post-therapy change of ≥4 points (reliable change) constituted reliable improvement.

2.7.2 | Qualitative analysis

The descriptive and interpretive method described in Elliott and Timulak (2005; Timulak & Elliott, 2019) was applied to data from the CCISv5. Audio recordings were first transcribed verbatim. Transcripts were then delineated into meaning units while removing obviously repetitive, redundant or irrelevant data. The meaning units were then assigned to the respective domains of investigation: Experience of Change, Helpful Aspects of Therapy, Difficult-but-Helpful Aspects of Therapy and Unhelpful Aspects of Therapy. These domains corresponded to the CCISv5 interview structure. Within the domains, that data were then categorised (clustered) according to similarities. The names were then given to the categories. The first author analysed all the data and then, independently, also the second author, who also reconciled any differences. All steps of the analysis were audited by the last author.

3 | RESULTS

3.1 | Quantitative pre–post-outcomes

See Table 1 below for a summary of results of a paired samples *t* test comparing our primary outcome measure, the GAD-7, at pre- and post-therapy and the PSWQ-PW at pre- and post-therapy. On both measures, a statistically significant decrease in scores was observed between pre-therapy and post-therapy using the final session, LOCF data. The results for GAD-7 were as follows: the pre-test ($M = 13.13$, $SD = 4.06$), the post-test ($M = 6.93$, $SD = 4.30$) and $t(14) = 6.25$, $p < .001$. The results for PSWQ-PW were as follows: the pre-test ($M = 66.47$, $SD = 13.59$), the post-test ($M = 47.07$, $SD = 19.78$) and $t(14) = 5.09$, $p < .001$. Calculations indicate large effect sizes pre- and post-therapy on both the GAD-7 and PSWQ-PW (Cohen's $d = 1.39$ and 1.20, respectively, at 95% CI). With regard to pre- and post-therapy improvement on the GAD-7, 12 participants improved and three participants experienced no change.

3.2 | Qualitative analyses

3.2.1 | Experience of change

Nearly all participants discussed explicitly their experience of *Decreased anxiety* (categories of experience are indicated using italics) symptoms (e.g. "I definitely have less anxiety" [Ann]; "I think I panic a lot less just generally. Em, I do suffer from panic attacks and they kind of subsided after the therapy." [Susan]), their sense of *Better self-understanding/awareness* (e.g. "…the biggest change has to be that I've learned a lot more about myself" [Stacy]). Nine clients described *Increased resilience* (e.g. "if something goes wrong… I don't feel like I'd be like, floored by it. Feel like I can take it in my stride now." [Harry]), five *Increased confidence* ("I'm getting my confidence back") and eight participants described having a *More self-compassionate stance/self-care* (e.g. "[I am] genuinely being kinder to myself" [Tania]). Six participants described *Increased self-acceptance*, as can be seen from Harry's quote:

> …I'm a more sensitive person than other people may be… but I'm ok with that and I'm proud with that… and I don't think there's anything wrong with that so… em but yeah just to own that to be ok with that.

Five participants attributed their changes to the *Change in external (life) circumstances* with academic matters often contributing towards well-being over the course of therapy:

> I did start the counselling when I had probably more worries than I do now in terms of like, circumstances and stuff. Just like final year and everything like that. Em, I'm passed that obviously now.
>
> [Ellen].

Four participants described feeling *More self-assertive* (e.g. "I've been kind of able to kind of, step up for myself to kind of hold my ground against myself and I guess other people.") and having *Improved relationships with others* (e.g. "…we're in a much better place now… my personal life, I find things are a little bit lighter [laughing]… which is- which is nice yeah." [Ruby]). Two reported that *Therapy promoted retention in university* (e.g. "Well like,.. I would be fairly confident that I wouldn't have made it through the year and finished my degree…" [Niamh]). Two participants reported more generally an *Improved mood* (e.g. "…from the very first session to the last session I've felt like a completely different person really. I feel like it was a really drastic change… on a kind of general basis, like my mood." [Ellen]). See Table 2 below for a complete overview of reported categories of experiences of change.

TABLE 2 Domain: Experience of change

Categories	Number of participants
Decreased anxiety	12/13[*,a]
Better self-understanding/awareness	12/13
Increased resilience	11/13
More self-compassionate stance/self-care	8/13
Increased self-acceptance	6/13
Increased confidence	5/13
Change in external (life) circumstances	5/13
More self-assertive	4/13
Improved relationships with others	4/13
Therapy promoted retention at university	2/13
Improved mood	2/13

[a]12/13 means 12 out of 13 participants contributed to this category.

3.2.2 | Helpful aspects of therapy

It was a near-universal response that *Chair/Experiential work* was a helpful aspect of therapy (e.g. "…the two chairs…I found that really, really beneficial.") and that individually the *Experiential skill of the therapist* was appreciated throughout therapy (e.g. "…him helping me to switch focus was really, really helpful" [Alice]). Ten participants felt there was a *Caring relationship with the therapist*, as Ellen put it:

> Em, and then, in terms of my actual therapist, em I felt that she, I felt that she actually did kind of care about my progress and she seemed really happy for me if there was stuff going well and like that made a big, big difference because eh, it felt like she wasn't just like a job for her if you know what I mean? It kind of- and that made me much more comfortable.

Four clients also discussed how they found it helpful that they *Felt understood by the therapist* ("she was very understanding… she was kind of the first person who I felt like really understood what I was going through" [Niamh]). Six participants discussed how their *Own determination to participate in therapy* helped them (e.g. "…it helps that I was quite open minded about it and I really gave it a go… I made a decision in my head and was like 'okay, I'm going to do this'." [Joyce]). Five reported that it was helpful to have a *Space to talk about difficulties* (e.g. "it was good because I knew that I was looking forward to the session in terms of I was able to let out whatever I wanted at that time so the space to speak was good." [Thomas]). Five appreciated feeling that the therapist respected a *Client-led agenda* (e.g. "…he was always very open to whatever I wanted to talk about…." [Thomas]). Four reported that *Having a positive support network* outside therapy was helpful (e.g. "…talking to family and friends yeah, definitely helped… they were understanding of what I was going through. We were able to kind of, talk about therapy and stuff like that." [Susan]). Five participants also commented on the *Session pacing feeling right* (e.g. "…the time period between each session… that's when our brain starts to process everything and you're living your life, you know, with your eyes… a bit more open… gives you a bit of life to put it into practice." [Tania]).

Four participants appreciated the therapists' "Hot teaching" *(psychoeducation)*, which refers to 'near' experience psychoeducation mainly around their anxiety difficulties which was considered useful (e.g. "In a way he almost kind of simplified it down… So that was good." [Evelyn]). Three participants appreciated the *Focus on anxiety*, mostly around worry (e.g. "…it was better in a way that it was targeted towards one issue specifically which was worry… trying to talk and trying to make sense of what you're feeling, it made more sense to contextualise it always kind of more in terms of worry…" [Thomas]). Three felt an *immediate sense of unburdening* after each session (e.g. "I always felt as though I was lighter when I left…." [Tania]). See Table 3 below for a complete overview of helpful aspects of therapy categories.

3.2.3 | Difficult-but-helpful aspects of therapy

Twelve of thirteen participants described *Chair work* specifically as difficult but helpful, as the quote from Niamh illustrates:

TABLE 3 Domain: Helpful aspects of therapy

Categories	Number of participants
Experiential skill of the therapist	13/13[a]
Chair/experiential work	11/13
Caring relationship with therapist	10/13
Feeling understood	6/13
Own determination to engage in therapy	6/13
Space to talk about difficulties	6/13
Client-led agenda	6/13
Having a positive support network	5/13
Hot teaching/psychoeducation	5/13
Session pacing felt right	5/13
Focus on anxiety	3/13
Immediate sense of unburdening	3/13

[a]13/13 means 13 out of 13 participants contributed to this category.

TABLE 4 Domain: Difficult-but-helpful aspects of therapy

Categories	Number of participants
Chair work	12/13[a]
Depth of painful emotion	4/13
Discussing family or significant relationships	2/13

[a]12/13 means 12 out of 13 participants contributed to this category.

TABLE 5 Domain: Unhelpful aspects of therapy

Categories	Number of participants
Own difficulty engaging	7/13[a]
Some symptoms remaining	6/13
Wanted more sessions to explore issues	4/13
Feeling stigma of being in therapy	2/13
Chair/experiential work	2/13
Not being open with loved ones	2/13

[a]7/13 means 7 out of 13 participants contributed to this category.

> [laughs] Despite my best efforts, it did help me separate- the chairs is what I'm talking about now, so uncomfortable, I fought against that a lot. Em, but it did help, I think it did fulfil its purpose.

Four participants felt that it was difficult but helpful experiencing *The depth of painful emotion* (e.g. "…I was crying in there and I had to feel all the things I really didn't want to feel. But I was feeling those things because I wanted to feel better… it was a good sadness. Or a productive one at least." [Tania]) or *Discussing family or significant relationships* in therapy (e.g. "…delving deep into like… personal details involving like family and relationships… I found it difficult to kind of take ownership for a lot of the things that were probably my responsibility…" [Ellen]). See Table 4 below for a complete overview of difficult-but-helpful aspects of therapy categories.

3.2.4 | Unhelpful aspects of therapy

Seven out of thirteen participants described their *Own difficulty engaging* in therapy as unhelpful (e.g. "There's been a lot of times when I've had to fight the urge to cancel appointments… when I most need therapy is when I find most difficult to go" [Alice]) and six participants reported that there were *Some symptoms remaining* after therapy (e.g. "Yeah, so I wanted to stop worrying completely… or even like get it under control but I think like it's more or less the same" [Evelyn]). Four participants express *Wanting more sessions to explore issues* after therapy had ended (e.g. "I definitely wanted to improve my self-esteem… It's not like– I wouldn't see it as we tried this and we failed as more we didn't try because we didn't have enough time." [Pauline]). Two participants described *Feeling stigma of being in therapy* which either made it difficult to participate in therapy or to be open with others about therapy (e.g. "…So going to appointments, it was all kind of like. It felt weird because it felt secretive (I: Mm) as in going in and out of the building.." [Joyce]). For two participants, certain *Chair/Experiential work* was reported to be unhelpful (e.g. "there were times when I just really couldn't do – like I was trying to do the chair thing and I just couldn't". [Alice]). Two clients reported *Not Being Open with Loved Ones* about attending therapy to be an aspect which was unhelpful to them ("I wasn't able to really open up to her about it and talk to her about it…. that actually would have helped a lot more, for her to know what I'm going through. Like I don't think she really understands."). See Table 5 below for a complete overview of difficult-but-helpful aspects of therapy categories.

4 | DISCUSSION

Quantitative findings from pre- and post-therapy tentatively indicate that EFT for generalised anxiety symptoms in the student population may be an effective treatment with a large pre- and post-therapy effect size observed on both our primary outcome measure, the GAD-7, and on the PSWQ-PW, albeit somewhat smaller than the ones reported in Timulak et al. (2017), who studied a longer version of EFT for GAD (the average number of sessions was 19) in the context of a primary care service. Furthermore, in the current study, clients were screened for having generalised anxiety symptoms; however, they were not formally assessed for GAD as in Timulak et al.'s study. Nevertheless, these results show promise and are a suggestion that further study of EFT as an alternative to the dominant CBT for GAD (in order to foster clients' choice of treatment) is warranted. This is specifically the case in the context of the student population, where the format of therapy, in terms of the number of sessions (typically up to 8 sessions), is often similar to the current study (Broglia, Millings, & Barkham, 2018).

In terms of qualitative outcomes, consistent with Timulak et al. (2017), less anxiety and an increased sense of self-understanding and awareness were quite general responses. The increased awareness included reflecting upon their experience of enacting worry and self-critical dialogues in chair work; participants often discussed vehemently their increased awareness of the detrimental emotional impact of these processes. Consequently, participants spoke of experiencing an increased understanding of their needs and thus feeling empowered to move away from these processes towards more healthy ways of being consistent with the emotion transformation model for GAD (Timulak & McElvaney, 2018). This was permeated with a sense of confidence and resilience to cope with future difficulties, conceptually coherent with emotional resilience in EFT literature (Pascual-Leone, 2009). Additionally, participants' self-understanding was not limited to an increased understanding of idiosyncratic anxiety narratives but also encompassed reports of positive experiences of developing a new understanding of their own personal history and life events. This can be considered an anticipated outcome, as EFT is a narrative constructivist approach in which meaning-making and integration of life stories in therapy are central to adaptive identity development, which establishes a coherent view of oneself (Greenberg, 2017).

As would be expected, relational aspects were reported by many clients as helpful. This included experiences of the therapist being caring, offering a reassuring presence and experiences of feeling understood by the therapist. This type of experience is typical of many therapies (Timulak & Keogh, 2017), particularly humanistic, and EFT is no exception (Timulak, Iwakabe, & Elliott, 2019). Similarly, consistently with central aspects of EFT, participants reported that they saw the engagement in chair/experiential work as helpful. However, almost all participants, while describing the merits of the chair work, noted that it was also a difficult aspect of therapy. Again, this is something that is reported in the research on clients' experiences of EFT more broadly (Timulak et al., 2019). On a similar note, some clients reported the depth of the painful emotions they experienced in therapy, often during experiential tasks, to be a difficult-but-helpful aspect of the therapy. This finding makes sense in the context of EFT's theory: in sessions, core painful emotions are evoked and felt in order to be transformed (Greenberg, 2017; Timulak, 2015). This may be a painful process, while clients may still recognise its helpfulness.

There were some extratherapeutic factors that were seen as helpful. For a few participants, helpful aspects were attributed to the end of examinations, the end of term or dissertation submission with a marked decrease in anxiety, which is not that atypical of therapy in the context of SCSs (Center for Collegiate Mental Health, 2018). Support networks (friends, partners and/or family) were also found to be an important helpful aspect. On the other hand, some clients described having to conceal their anxiety and/or therapy attendance from loved ones, which made therapy more difficult.

Participants held few opinions on what was unhelpful about the therapy, but when they did identify unhelpful aspects, there was a large trend in locating personal responsibility for experiences of difficulty engaging with either therapy tasks or therapy as a whole. Opinions on this were diverse, ranging from having a personal difficulty connecting with emotion, feeling resistant to participation in experiential work, wilful avoidance of difficult topics and difficulty in maintaining motivation to attend. For a minority of clients, the use of chair/experiential work was experienced as unhelpful, although in their case experiential work was reported as unhelpful not globally but rather specifically during certain tasks, i.e., understanding emotion via attention towards bodily experience (experiential focusing) and chair work. In terms of implications for therapy, this stresses the importance of checking-in with the client about how they are in therapy. Symptoms that remained were also seen as negative, mainly the tendency to engage with worry, consistent with quantitative findings. GAD is often chronic in nature, and it could perhaps be argued that the treatment length in this study has its own limits (as visible in the effect size compared to the study of Timulak et al., 2017, that offered much longer therapy), albeit some clients seemed to be OK with the length of therapy and spaced sessions.

There are a number of limitations to this study. The current study lacked a control or comparison treatment group, meaning that the effect of the therapy studied could not be compared to either no treatment or another type of treatment (e.g. cognitive behavioural therapy, treatment-as-usual protocols). Although the current study observed changes in outcomes over time, without non-treatment or alternative treatment groups to compare to, the degree to which the current results are due to placebo, treatment-specific factors and other factors cannot be determined. There was also no long-term follow-up of participant outcomes which, in combination with the above, reduces the robustness of the inferences that can be drawn from the outcomes.

Small sample size is another limitation. Consideration should also be given to the rate of attrition in the current study. Participants with early attrition did not participate in post-therapy client interviews. This means that the data available for analysis is biased towards those who engaged in a greater number of sessions. Those who continued to attend may have found therapy more helpful and so disproportionately underrepresent clients who experience difficulty continuing therapy. Participants were also not formally assessed for GAD diagnosis and their comorbid conditions were not examined. The potential use of antidepressant medication was also not an exclusion to participating in this study and as such presents an unknown variable to treatment outcome, though in general, the use of antidepressant medication by clients receiving EFT with GAD difficulties is not necessarily considered an interfering issue (Timulak & McElvaney, 2018). The therapists' adherence was also not formally assessed, although supervision was intensive and based on session recordings. The therapists were also well trained (meeting criteria to be certified EFT therapists) and only released to the study once they competently adhered to EFT delivery as per the criteria of the International Society for Emotion-Focused Therapy.

5 | CONCLUSION

Overall, these initial findings indicate that EFT for generalised anxiety symptoms in the student population may be an effective treatment that deserves further investigation. The therapy was well accepted by clients in general and they saw its benefits in their lives. They also appreciated many aspects of this therapy, while some caution was expressed in terms of its evocative nature. It would therefore be important to evaluate this form of therapy in a larger randomised controlled trial that would compare its efficacy and effectiveness with a more established treatment such as one of the variants of cognitive behavioural therapy for GAD (Behar, DiMarco, Hekler, Mohlman, & Staples, 2009). If proven as comparably efficacious, EFT could be a viable alternative to CBT, thus increasing the treatment choice for the student population battling with anxiety.

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