

**THE RELATIONSHIPS AMONG ALLIANCE GROWTH, EMOTION SCHEMATIC CHANGE AND LONG-
TERM OUTCOMES AFTER EXPERIENTIAL TREATMENT FOR DEPRESSION**

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Abstract

This study empirically examined whether clients with strong alliance growth (SAG) versus weak alliance growth (WAG) trajectories, and good versus poor long-term outcomes engage in differential emotional change processes during experiential therapy for depression. Using Classification of Affective Meaning States (CAMS), emotional processing was coded during all emotion episodes that occurred in 2 working and 2 termination phase sessions for 14 clients from the York I and York II depression projects who had provided 18-month follow-up outcomes (7 SAG and 7 WAG clients). Cross-sectional analysis (independent and repeated measure t-tests) examined emotional processing differences between the groups across and within therapy phases. Sequences or patterns of CAMS rated emotion episodes were also explored using THEME time sequential analysis. Results found that compared to clients with a WAG trajectory, the SAG trajectory clients expressed: 1) significantly greater proportions of primary adaptive emotions states within both phases of therapy (specifically acceptance and agency, assertive anger, and relief), 2) greater proportions of need expression in the working phase, and 3) significantly less proportions of secondary and maladaptive emotions across both therapy phases (specifically global distress and rejecting anger). Also from the working to the termination phase of therapy, SAG clients expressed 4) significant increases in acceptance and agency, and decreases in expression of fear/shame, need expression, and overall primary adaptive emotion. Alternatively, WAG clients showed 5) significance increases in global distress and relief from their working to termination therapy sessions. THEME results showed that SAG

clients had significantly more instances of need expression linked with the expression of hurt/grief, and repeated expression of relief, while WAG clients showed significantly more repeated expressions of global distress, rejecting anger leading to global distress, and global distress leading to fear/shame. Future directions of this research are discussed.

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The relationships among alliance growth, emotion schematic change and long-term outcomes after experiential treatment for depression

Introduction

This study is an investigation of predicting resilient resolution (18-month outcomes post therapy) of major depression (MDD) after short-term experiential therapy treatment, specifically the relationship between patterns in the therapeutic working alliance that have already been related to resilient outcomes in experiential treatment of depression (Pos & Thompson, 2010) and the emotional processing during the working and termination phases (second and third last sessions) of therapy to which these alliance patterns are related. Most importantly, this study tests a transtheoretical assumption that change in depressogenic emotion (DE) schemes across the working and termination phases of therapy is a core mechanism through which resilient long-term resolution of major depression (MDD) will occur.

Major depressive disorder (MDD) is a leading cause of disability worldwide that burdens global economies (WHO, 2012). By 2020 MDD is expected to carry the second highest global disease burden (Murray & Lopez, 1996). Already the highest economic mental health burden in western economies, in 2001 alone treatment for depression in Canada cost an estimated 10 billion dollars (Public Health Canada, 2010). Moreover even though interpersonal, cognitive-behavioural and experiential psychotherapies have all been demonstrated to be equally effective short term treatments for moderately depressed adults (Elkin, et al., 1989; Shea &

Elkin, 1996; Shea, Elkin, Imber, & Sotsky, 1992; Greenberg & Watson, 1998; Goldman, Greenberg, & Angus 2006; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003), their effects are often not long lasting. This is because more than 50% of those who recover from a first depressive episode will experience additional depressive episodes (American Psychiatric Association, 2000; Kupfer, Frank, & Wamhoff, 1996; Post, 1992). Depressive relapse appears, therefore, to be the rule, not the exception.

It follows that to address both frequent depressive recurrence and the continuous financial burden of treating depression worldwide, treatments for depression must continue to improve. To achieve this, we must better understand predictors of lasting resolution of MDD. One concern with current treatments is their short-term nature (16-20 sessions) because the rate of depressive recurrence has prompted the concern that current short-term therapy treatments may only alleviate superficial depressive symptoms, while failing to treat the underlying causes of depression. This leaves clients vulnerable to relapse (Luyten, Blatt, & Coveleyn, 2005; Teasdale, 1999; Westen & Morrison, 2001). While discussing these concerns Teasdale (1999) proposed that long-term resolution of MDD requires that the causes of depression be addressed in therapy, which he admitted would likely be the client's underlying depressogenic emotion processes, which, he wrote must be the target of therapeutic treatment. Further, he suggested that if depressogenic emotion change *is* the mechanism through which resilient resolution of depression occurs, then changes in DE throughout treatment should predict clients' *long-term* improvements (Teasdale, 1999; Wampold, 2001).

This is especially important to demonstrate given that when outcomes are measured at termination it is difficult to untangle from those outcome reports the very recent effect of the therapeutic working alliance. This is because, at the end of treatment the working relationship is also just terminating. Further, when one considers that the alliance is considered to be partly constituted by agreement on therapy tasks and goals, and that processing emotion is a core task in experiential treatment, understanding how the alliance and emotional processing both contribute to resilient outcomes will be important to our understanding of MDD treatment. As such, the core aim of this study was to identify how depressogenic emotion change across the middle and late phases of experiential based therapies relates to established patterns in the working alliance that predict long-term resolution of depression.

Emotional Processing and Experiential Therapy for Depression

Experiential therapies such as client centred therapy (CCT) and emotion focused therapy (EFT) have strong empirical support as effective treatments for depression (Goldman, Greenberg, & Angus, 2006; Greenberg & Watson, 1998; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003; Watson & Pos, 2017). In experiential therapies, emotional processing is considered a central agent of (positive) change (Pascual-Leone & Greenberg, 2007; Pos, Greenberg, Goldman, & Korman, 2003; Pos, Greenberg & Warwar, 2009). Rachman (1980), a behaviorist, initially described emotional processing as decreases in problematic and subjectively experienced fear states that occur after repeated exposure to those states. Foa and Kozak (1986), two CBT clinicians, later broadened the construct, describing it as an increase or

decrease in emotional responding due to exposure to a fear state as well as the information consistent with an activated cognitive-affective fear structure (Pos, 2006). In experiential therapy, emotional processing is defined more broadly as including emotional awareness, expression, regulation, reflection, and transformation (Greenberg, 2011; Pos et al., 2009). In experiential treatments, emotional processing is promoted by helping clients more fully experience their internal worlds by enabling clients to access potentially meaningful information implicit in emotional experience. It is theorised that when clients engage with meaningful information in emotional experience, they are poised to make new meaning from such experiences, which leads to new adaptive emotional reactions and experiences of the self (Greenberg & Watson, 2006; Pos, 2006).

Operationalizing Emotional Processing in Experiential Therapies

Experiencing during emotion episodes

To-date, the Experiencing Scale (EXP; Klein, Mathieu-Coughlan & Kiesler, 1986) is the most widely used research measure of emotional processing in experiential therapies and has also been one of the most robust predictors of outcomes in psychotherapy process research (Orlinsky & Howard, 1978; Pascual-Leone & Yeryomenko, 2016; also see Hendricks, 2001 for a review). EXP measures the extent to which clients use their internal experience (which includes feelings) as a dynamic referent of information they can use in problem solving (Pos, Greenberg, Goldman & Korman, 2003).

Measuring EXP during clients' emotion episodes (EXP-EEs; Pos et al., 2003; Korman, 1991) in therapy has allowed emotional processing to be operationalised more specifically and has been shown to be a strong predictor of outcomes (Pascual-Leone & Yeryomenko, 2016). Pos et al., (2003) found that depth of experiencing during emotion episodes in the second and third last sessions of therapy better predicted client termination outcomes than clients' capacity to experience at the onset at therapy. Further, in a later study average EXP-EE in working phase sessions (on average between sessions 8 and 12) has been shown to be the most robust predictor of all outcome measures at termination, even more so than the early alliance (Pos et al., 2009). When examining particular levels of EXP during emotion episodes, Pos (1999) found that the proportion of time spent at level 5 EXP (within which clients exhibit the capacity to reflect on experience) and level 6 EXP (within which clients report new shifts in their experience) directly predicted outcome at termination. Pos (2006) then later found evidence that these two Levels of EXP contribute to maintenance of gains at 18-months. Wong (2016) then examined this as well, further finding that for clients who enter therapy with some capacity for internal experience, Level 6 EE-EXP during the working phase predicts better long-term outcomes at 18-months.

While EXP-EE has shown itself to be a robust predictor of outcomes, as an operational measure of emotional processing EXP-EE does have limitations. Primarily, using EXP as a measure of emotional processing provides a global indication of emotional processing depth but does not measure the specific emotion states being processed. Given that experiential

theory suggests that some emotional experiences are more productive than others (Greenberg, Rice, & Elliott, 1993; Greenberg & Paivio, 1997; Sicoli, 2006), a measure of emotional processing that captures specific emotional states may tell us more about what specific emotion states best relate to outcome. In other words, a measure of emotional processing capturing emotion states may better allow an examination of *how* emotional processing contributes to outcomes.

Classification of Affective-Meaning States (CAMS) during emotion episodes

The Classification of Affective-Meaning States (CAMS; Pascual-Leone & Greenberg, 2005) is a measure that does identify specific emotion states or events. The CAMS measure was initially developed to examine emotional schematic change assumptions proposed in emotion-focused theory (Watson & Greenberg, 2006). A core assumption in emotion theory is that optimal emotional processing results in optimal emotion schematic change only if a client's deep adaptive emotional resources are tapped and accessed. This relates to a useful measurable emotion scheme typology suggested by experiential theory (Greenberg & Safran, 1987). Primary (*adaptive or maladaptive*) *emotion* schemes are immediate responses to situations while *secondary emotions* are emotion processes thought to occur in response to previously triggered primary emotions or thought processes. *Primary adaptive* emotions are considered universally sensible emotional reactions occurring in situations relevant to important survival needs. *Primary maladaptive* emotion schemes, on the other hand, are viewed as learned and difficult to regulate over-reactions to current situations that distort thinking and do not support adaptive coping in the present. In emotion-focused theory,

depression is assumed to emerge through the chronic activation of these secondary and maladaptive emotion schemes. Emotion-focused theory further assumes that clients who resolve their depressions will reduce experiences of secondary emotion schemes and increase experiences of primary adaptive emotion schemes (Greenberg, 1993; Greenberg & Watson, 2006). In addition, it is assumed that if clients access and express their core needs, this will lead clients to accessing and expressing important primary adaptive emotion schemes related to those needs (Greenberg & Watson, 2006).

Using the CAMS measure during emotion episodes, Choi, Pos, & Magnussen (2015) found that for 9 highly self-critical depressed clients, increased access to primary adaptive emotions across therapy better predicted improved self-esteem at termination while increased proportions of secondary emotions across therapy predicted poorer outcomes. Research also indicates that for clients who do not enter therapy with strong experiential capacity, accessing primary adaptive emotion in the working phase of therapy predicts good long-term outcomes at 18-months (Wong, 2016), and when looking at specific emotion states within emotion schemes, Wong (2016) showed that working phase primary adaptive assertive anger predicted lower depression scores at 18-months. When examining secondary emotion, Wong (2016) found that higher proportions of working phase global distress and rejecting anger both *uniquely* predicted significant poorer depression outcomes.

Depressogenic Emotion

Depressogenic emotion schemes (or cognitive affective structures) are those thought to relate to maintenance of depression across treatment modalities (see Pos, 2006, for a review). In experiential therapy, there is increasing literature to support that specific emotion schemes experienced by clients during treatment predict good or poor outcome cases (Choi et al., 2016; Wong, 2016). Specifically, evidence has tended to support emotion-focused theory in that the expression of primary adaptive emotions in the working phase of therapy positively relates to treatment outcomes, while expression of secondary emotions in the working phase of therapy has been shown to predict poorer outcomes (Wong, 2016). A full examination of specific emotions, and schematic typologies in the termination phase of therapy as they relate to maintenance of gains at 18-months post-termination has not yet occurred. This may be important because some cases who manage to still have good long-term outcomes may not reach adaptive emotion or reduce secondary emotion until the termination phase of therapy (i.e. they may take longer to get there). Further, sequences of emotions states across all phases of therapy have yet to be examined in relation to long-term outcomes. One important aim of this study was to 'fill in' these current gaps in the emotional processing literature for experiential therapy by analysing the specific emotion states (as well as emotion scheme typology) from the mid-to-late phase of therapy that best differentiate long-term outcomes, including sequences of emotion schemes during those phases. Again according to experiential theory depressogenic emotion is defined here as the preponderance of secondary emotions (global distress and rejecting anger) as well as primary maladaptive emotions (fear/shame,

negative self-evaluation). These depressogenic emotions are those that if maintained throughout therapy are likely to result in maintained, or not resolved, depression.

The Working Alliance and Long-Term Resilience of Therapy Gains

The working alliance is a construct used to describe the degree to which clients agree with their therapist on the goals and tasks of therapy, combined with the level of bond clients feel with their therapist (Bordin, 1979). The working alliance has been shown to robustly predict outcomes at termination across therapeutic treatment modalities for depression (Arnow et al., 2013). For experiential based therapies, the therapeutic relationship has been considered a necessary but not sufficient condition (Rogers, 1967) through which change occurs. The core assumption is that when a client feels a strong alliance with their therapist they will feel safe enough to reduce their vigilance concerning the interpersonal space, and instead feel free to focus inwardly to process their experience. Pos et al., (2009) partly validated this theory by showing that the working and termination phase alliances (rated by clients using the Working Alliance Inventory (WAI; Horvath & Greenberg, 1986) contribute to outcome by supporting client's level of experiencing during emotion episodes within therapy phases. Malin & Pos (2014) also showed that the first session alliance directly predicts EXP and indirectly predicts outcome at termination during experiential therapy.

Pos & Thompson, (2010) explored alliance growth patterns across therapy showing they can predict resilient gains measured 18-months after experiential treatment for depression. They used a longitudinal growth curve analysis of all post session client-rated WAI alliance

measures across therapy for 74 clients who had received experiential treatment for their depressions, and found two distinct alliance growth trajectories, one strong alliance growth (SAG) group and one weaker alliance growth (WAG) group. These alliance growth trajectories differentially related to outcomes at both termination and 18-month follow-up. The SAG clients who exhibited WAI rated alliance patterns that reached ratings of '5' ("I often feel") by mid-therapy (strong alliance group) had significantly better 18-month outcomes than clients in the WAG group who did not reach a WAI of '5' in alliance ratings by mid-therapy (weak alliance group).

A strong alliance during the termination phase of therapy has also been shown to directly predict maintenance of gains at 18-month follow-up (Pos, 2006) for some outcomes. One problem with some of these investigations is that the alliance was related to termination outcomes. An alliance measured so close to termination may be a pseudo measure of treatment success, as opposed to a real measure of the working relationship. For this reason, in order to examine process to outcome relationships measuring outcome at follow-up, 18-months after the therapy relationship has terminated, is preferred to using outcome at the time of termination. The rationale for choosing strong versus weak alliance growth subgroups (SAG versus WAG) in the current study is as follows. Firstly, Pos & Thompson (2010) have shown that alliance trajectories predict 18-month outcomes. Secondly, Wong (2016) has shown that CAMS rated emotional processing in the working phase of therapy also predicts 18-month outcomes. Finally, in the present study I sought to test the connection between these previous

results. If SAG and WAG clients differ in 18-month outcomes, they should also differ in their emotional processing throughout therapy. Also no one had examined emotional processing in SAG and WAG clients in the termination phase of therapy.

If depressogenic emotion scheme change (measured as change in secondary, primary maladaptive and adaptive emotion within the working and termination phases of therapy) is important to long term resilient outcome in treatment of MDD, then clients from the strong alliance growth group should demonstrate significantly better DE change during treatment and by the termination phase than clients with a weaker alliance growth pattern.

The Current Study

The primary objective of the current study was therefore to explore differences in emotional processing across the working and termination phases of experiential therapy between clients with strong and weak alliance growth patterns already shown (Pos & Thompson, 2010) to predict long-term resilient outcomes after experiential therapy for depression. Specifically, this was to explore whether clients who did and did not have strong alliance growth during therapy express different trajectories of depressogenic emotion change in the working and termination phases of experiential therapy for depression.

Hypotheses

Given that previous research has found strong alliances to significantly predict maintenance of gains at 18-months post-therapy, it was hypothesized that this would be replicated in the current study. As such, **Hypothesis 1 was:** SAG clients would have significantly better outcomes at 18-months termination than WAG clients.

Using CAMS and THEME, it was further hypothesized that: **Hypothesis 2:** SAG clients will express (i) significantly more primary adaptive emotion (PAE), and (ii) significantly less secondary emotion (SE) and primary maladaptive emotion (PME) within and across the working and termination phases than clients in the WAG group. Clients in the SAG group will express (i) significantly more primary adaptive emotion, and (ii) significantly less secondary and primary maladaptive emotion within and across the working and termination phases of therapy than clients in the WAG group.

Method

Participants

The current sample consisted of 14 out of the 55 clients who provided 18-month follow-up data after having participated in either York 1 or York 2 randomized control trials (RCTs) that offered short-term experiential therapy for major depressive disorder (Goldman, Greenberg, & Angus, 2006; Greenberg & Watson, 1998). Pos & Thompson (2010) had previously established two alliance growth groups by a latent class analysis of all York 1 and York 2 client-rated working alliance inventory short-form scores (WAI; Horvath & Greenberg,

1986, 1989) obtained post session for every session and every client ($N = 74$). Of the current study's 14 clients, half ($n = 7$) were all the clients with available 18 month data who had been identified as belonging to Pos & Thompson's (2010) weak alliance growth (WAG) group. As well, a matched sample of clients ($n = 7$) were identified from clients with 18 month follow-up data who Pos & Thomson (2010) had identified as having strong alliance growth (SAG). To give some further background, 55 out of the 74 original RCT clients provided 18-month outcome data. Of these 55 clients, 9 clients were weak alliance growth group clients (WAGs) as established by Pos & Thompson's (2010). Due to some insufficient session data, 2 of these clients with weak alliance growth trajectories were omitted, leaving a sample of 7 clients in the weak alliance growth group that were included in this study. Alternatively, 46 clients who gave 18-month outcomes had been in Pos & Thompson's (2010) strong alliance growth group. From these 46 SAG clients 7 clients matching the $n = 7$ WAG clients were identified.

Matched good alliance growth sample selection. To provide a balanced sample, 7 clients out of the 46 strong alliance growth (SAG) clients were selected. To minimize differences between the two groups the clients were matched on pre-treatment distress (using the Beck Depression Inventory of depressive symptoms (Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961); the Rosenberg Self-Esteem Scale measuring self-esteem (Rosenberg, 1965); the Inventory of Interpersonal Problems (Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988), and the Global Symptom Checklist (Derogatis, 1983) to measure general symptomology. Clients were also matched for age, gender, marital status, education, and the presence of any

DSM-4 axis II disorders (APA, 2000). To test the adequacy of this matching, the two groups were compared using independent t-tests. No significant differences on any of the matched variables were found (p s all $> .08$). Thus, alliance growth groups also did not differ on the potential confounding factors of pre-treatment distress, gender, age marital status, education nor presence of axis II disorders. This minimized some potential individual pre-treatment differences in the two groups.

Client demographics. Of the 14 participants selected from the larger sample, the SAG group ranged in age from 27 to 48 ($M=37.57$, $SD=8.62$) and the WAG group range in age from 29 to 60 ($M=43.29$, $SD=11.3$). Clients in both groups were 86% ($n=6$) female and 14% ($n=1$) male.

Inclusion criteria in the original RCTs

Inclusion criteria in York 1 and II studies were:

- a) Meeting the DSM-III-R criteria for clinical depression
- b) A Beck Depression Inventory (BDI; Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961) score of 16 or higher
- c) Being between the ages of 18 and 65 at the time of assessment
- d) Agreement to complete data collection requirements relating to study, including acceptance of sessions being videotaped and audiotaped for such purposes
- e) A Global Assessment score of greater than 50 on the DSM-III-R Structured Clinical Interview (SCID; Spitzer, Williams, Gibbon & First, 1990)

Exclusion criteria in the original RCTs

Exclusion criteria in York 1 and II studies were:

- a) Current drug or alcohol abuse; bipolar or psychotic disorder, current eating disorder, antisocial or borderline personality disorder.
- b) Recent suicide attempts
- c) A past history of incest; the loss of a significant other in the past year; or involvement in an ongoing violent relationship

The presence of these criteria was assessed by the SCID (Spitzer et al., 1990) and a clinical interview. Those with a DSM-III-R Global Assessment and Functioning Scale score lower than 50 were also excluded. These criteria assured that severely depressed, functionally impaired subjects best treated by pharmacological intervention were excluded (Elkin, et al., 1989).

Treatment from the original RCTs

The York I and York II depression studies compared the effectiveness of two brief (16-20 sessions) hierarchically related experiential treatments for MDD: Client-centred therapy (CCT; Rogers, 1957, 1975; Rice, Greenberg, & Watson, 1994) and Emotion-focused therapy (EFT; Greenberg, Rice, & Elliott, 1993; Greenberg & Watson, 2006). Clients were randomly assigned to one of the two treatment approaches and therapists saw an equal number of clients in each treatment condition, thereby acting as their own controls for therapist effects. Of the 14 clients selected for the present study, 5 clients received EFT and 9 clients had received CCT. Adherence to both treatments was achieved in the original study (see Goldman, Greenberg, & Angus, 2006

and Greenberg and Watson, 1998). Both treatments point to the importance of emotional processing in promoting change. Both treatments focus on processing emotion albeit the EFT treatment is considered more directive or structured in its tasks (Elliott, Greenberg, Watson, Timulak & Freire, 2013). Differences between these two experiential treatments that may have made a difference will be discussed later. As for targeting the same process of change, emotional processing, the treatments can be considered equal.

Client-centred therapy (CCT). In the York depression studies, therapists followed a manualized client-centred therapy based on Rogers (1957, 1975; Rice, Greenberg, & Watson, 1994). In this treatment, the therapist provides the necessary relationship conditions: unconditional positive regard, empathy, and congruence. A genuinely empathic and validating environment is assumed to promote self-exploration (Bohart, Elliott, Greenberg, & Watson, 2002). The therapist's consistent validation and acceptance of the client, allows the client increased access to previously-denied or blocked experience, encourages client's self-acceptance, and decreases negative self-evaluation.

Therapists continually follow clients' internal tracks, communicate empathic understanding and encourage ongoing exploration. Therapists respond selectively to clients' messages that seem alive and poignant, communicating understanding of core meaning, or exploring what is not yet stated but is at the edge of clients' awareness (Rice, 1974; Gendlin, 1962, 1997). Therapists encourage the symbolization of emotion and core meaning.

Emotion-focused therapy (EFT). This manualized form of experiential treatment (Greenberg, Rice & Elliott, 1996) integrates client-centred and gestalt therapy (Perls, Hefferline, & Goodman, 1951). While the first three sessions are strictly client-centred with therapists providing client-centred relationship conditions, in later sessions therapist use marker-guided, process directive interventions (i.e. chair work, focusing; Goldman & Greenberg, 1997) to help clients work through specific emotional processing difficulties they are exhibiting in session. The therapy objective is to access and restructure habitual maladaptive emotion schemes that are seen as the source of depression (Greenberg, Watson, & Goldman, 1998). It is assumed that activating sub-dominant, or alternative adaptive emotion schemes, including the experience of related needs, helps the client access resilient innate resources and needs that better organize the individual for adaptive emotional responses (Greenberg & Paivio, 1997).

Process Measures

The alliance groups were originally parsed into classes using MPLUS latent growth curve class analysis by Pos & Thomson (2010) using the WAI scores measured post session for every session and client. As such, archival data from clients' MPLUS alliance-growth group membership from Pos & Thompson was used to establish SAG versus WAG groups.

Working Alliance Inventory (WAI; Horvath & Greenberg, 1986, 1989). The original WAI is a 36-item self-report inventory that measures the quality of the therapeutic alliance in psychotherapy based on Bordin's (1979) conceptualization of the client-therapist relationship. A short form 12-item version used in this study has equal validity and reliability to the original

WAI (Tracey & Kokotovic, 1989). The WAI is composed of three subscales that assess the client-therapist bond, as well as client-therapist agreement on the tasks and goals of therapy. The internal reliability of the entire scale is high (.87 to .93) as well as for the individual subscales (.92 for Bond, .90 for Task, and .89 for Goal; Horvath & Greenberg, 1989). This measure was completed by clients after every session. For the current study all long form WAI scores were transformed into short form WAI scores to maintain consistency.

Categorization of Affective Meaning States (CAMS; Pascual-Leone & Greenberg, 2005).

The CAMS is an observer-rated measure used to categorize the presence of ten discrete emotion types or events. Ratings are based on aroused emotion expressed both verbally and non-verbally and distinguish productive vs. unproductive clinically significant emotional processing states that occur in the resolving of global distress. Ten discrete emotional states are captured (in an assumed order of ascending productivity and depth of emotional processing): (1) Global Distress (GD), which describes instances of overwhelming and undifferentiated distress; (2) Rejecting Anger (RA), which captures distancing and destructive anger; (3) Fear/Shame (FS), which captures core maladaptive pain related to inadequacy, worthlessness, or insecurity; (4) Negative Self-Evaluation (NSE), which describes the expression of a specific self-criticism; (5) Need, which captures the articulation of unmet essential needs for healthy functioning; (6) Relief, which captures client expressions of feeling better, lighter, or more hopeful; (7) Assertive Anger (AA), which captures adaptive boundary setting or healthy entitlement to existential needs; (8) Self-Soothing (SS), which describes clients' self-directed

compassion or nurturance; (9) Hurt/Grief (HG), which captures client acknowledgement of core pain, sadness, or loss; and (10) Acceptance and Agency (ACAG), which describes client expressions of coming to terms with their circumstances or the development of a new, agentic perspective.

Transformation of CAMS categories into Emotion Scheme (ES) types. Based on EFT theory and discussions with the CAMS developer Dr. Pascual Leone, each CAMS emotion category has been further classified as contributing to a type of emotional processing scheme identified as important in EFT theory (secondary, primary maladaptive, or primary adaptive). This allows an examination of changes in emotion schemes. Summed proportions of CAMS categories have been grouped into emotion schemes as follows: secondary emotion is the sum of rejecting anger and global distress categories, primary adaptive emotion is the sum of relief hurt/grief, assertive anger, self-soothing, and acceptance and agency, and primary maladaptive emotion is the sum of fear/shame, negative self-evaluation (see Choi, et al., 2016 for a further description of this method).

Pre-and Post-treatment (Outcome) Measures

The following measures are a standard suite of outcome measures used to evaluate most treatments for major depression.

The Symptom Checklist–Revised (SCL-90-R, Derogatis, 1983). The SCL-90-R was used both to select clients and as an outcome measure. Although this measure taps into nine separate primary psychiatric symptoms (i.e., depression, anxiety, hypochondriasis) as well as

provides a Global Severity Index (GSI). Reported test-retest reliability for the SCL-90 over a one week period range from .80 to .90 and the internal consistency estimates for the nine subscales range from .77 to .90 (Derogatis, 1983). Each of the dimensions has also been found to correlate significantly with the MMPI scale dimension considered to measure a corresponding symptom construct.

The Beck Depression Inventory (BDI: Beck, Ward, Mendelson, Mock, & Erbaugh, 1961).

The BDI is a well-known 21-item, self-report inventory designed to measure severity of depression. Respondents choose one of five alternatives that best describes them at present. Responses are totaled and higher scores reflect greater severity of depression. In a review of 10 years of research using the BDI, Beck, Steer & Garbin (1988) report validity coefficients ranging from .66 to .86, and internal consistency coefficients ranging from .73 to .93.

The Rosenberg Self-Esteem Scale (RSE) (Rosenberg, 1965). The RSE is a 10 item self-report inventory that samples respondents' self-esteem. Respondents rate on a 4-point Likert scale from "strongly disagree" to "strongly agree" on certain attitudes about themselves. High Internal consistency, test-retest reliability, and construct validity has been demonstrated in the RSE (Bagley, Bolitho, & Bertrand, 1997; Rosenberg, 1965)

The Inventory of Interpersonal Problems (IPP; Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988). The IPP was developed to relate interpersonal difficulties to psychiatric complaints. The IPP consists of 126 items describing interpersonal situations. Using a 5-point Likert scale, respondents rate the degree to which they find each situation problematic. Test-

retest reliability for overall interpersonal dysfunction has been reported to range from .82 to .94 (Horowitz et al., 1988).

Procedure

Emotion episode sampling. The core sampling context within which emotional processing was examined was emotion episodes (EEs; Greenberg & Korman, 1993; Korman, 1991). An EE is a segment of psychotherapy narrative or turn taking in which a client expresses a current or past experienced emotion in response to a real or imagined situation. A complete EE contains five components: the situation, an emotional response, an action tendency associated with the emotion, an appraisal of self or situation, and a related concern or need. For an EE to be identified, only the emotional response or action tendency and a reported situation are required (Pos et al., 2003). Archival EE data in the current study was obtained from a previously collected data set from Pos (2006) for all 74 clients in the York outcome studies. In that study, all EEs for all clients were sampled within 5 sessions across therapy. These sessions were: session 2, two working phase sessions that clients identified as the most helpful to them on session outcome measures (normally between session 8 and 11 depending on the client; see Pos 2006 for more detail), and two termination or late phase sessions which were the clients' second and third last sessions. Reliability for identifying EEs was excellent (Pos, 2006, average 92 % hit rate), based on two independent raters reliably identifying the EE components. The current study examined emotional processing within EEs that occurred in the two working phase and two termination phase sessions of therapy.

Emotion process coding. For the current study CAMS codes were obtained for working phase and termination phase EEs of therapy. CAMS data for working phase sessions was archival, obtained from Wong (2016) who had coded EE-CAMS for the two working phase sessions for all clients providing 18-month follow-up data.

Archival CAMS reliability. The three raters used in Wong (2016) were two senior PhD students and a professor, all of whom were members of the Clinical Psychology program at York University and who had received extensive training in CAMS coding from the measure's developer, Dr. Antonio Pascual-Leone. CAMS training was completed over three separate sessions, culminating in 25 hours of training in total.

Out of the 110 sessions included in Wong (2016), 100 sessions were coded by two raters (~91%); 10 sessions (5 sessions each) were coded by one rater after reliability was established. Disagreements in codes were resolved consensually with consensual code being used in analyses, and original codes used to establish reliability. All coding was conducted independently, and all EEs coded by the two raters were included in the reliability calculations.

Current CAMS coding of termination phase EEs. Additional CAMS coding was conducted for all EEs occurring in the two termination phase therapy sessions (2nd and 3rd last sessions) for the 14 currently examined clients (i.e. for a total of 28 late phase sessions). Two independent raters were trained over 12 training sessions (30 hours) to reliability by established CAMS raters. These two raters independently provided CAMS ratings for all EEs for all termination phase sessions (28 sessions). Rating disagreements were consensually resolved

and consensual ratings were used in analyses, while independent ratings were used to establish reliability.

Statistical Analyses

Statistical analyses examined emotional processing in a number of complementary ways. Differences between the SAG group and the WAG group within phases of therapy used independent t- tests; changes within the SAG group and the WAG group in emotional processes over therapy phases were examined with repeated measures t-tests or equivalent ANOVAS; differences in sequences in CAMS coded emotion episodes between the groups were examined using THEME time sequential analyses software (Magnussen, 1993, 2000).

Results

Inter-Rater Reliability of CAMS

Given that the CAMS measure utilises a nominal scale, Cohens's (1960) kappa (k) was the coefficient used to assess the level of agreement between raters.

Archival reliability of CAMS codes. Pervious reliability of some CAMS ratings of EEs was established in Choi & et al., (2016) and Wong (2016). In these two studies, one rater (Choi) participated as a CAMS rater in both studies, while two other independent CAMS raters were shown to be reliable with Choi in these studies. In Wong (2016) CAMS reliability with Choi was shown to be excellent (Cohen's kappa= .77; Fleiss, 1971) for 1264 CAMS ratings. One rater in the current study had achieved excellent reliability with Choi as well, and had demonstrated

excellent reliability with Choi over 970 CAMs rated EEs. Cohen's kappa in that study was reported as .80, excellent reliability beyond chance.

Current CAMS coding reliability. The current reliability sample included CAMS ratings of EEs *not* previously coded by Wong (2016) or Choi et al. (2016). There were 324 CAMS ratings of EEs provided by 2 raters in the current reliability sample. Cohen's *k* for the current CAMS ratings (between an expert reliable with Choi and a currently trained rater) was 0.82.

Impact of Treatment Type on Outcome Groups

Of the strong alliance growth (SAG) clients, five received EFT while two received CCT. In the weak alliance growth (WAG) group, all 7 WAG clients received CCT. A Chi square tested whether outcome was independent of the type of treatment received (CCT or EFT). A significant relationship was found between treatment type and alliance groups ($\chi^2 = 7.78$, $df = 1$, $p = .005$). Clients were therefore more likely to be in a strong alliance group if they received EFT than if they received CCT. The impact of treatment type on alliance groups and emotional processing will be discussed later.

Differences in EE Dimensions between the Strong Alliance Growth and Weak Alliance Growth Groups

T-tests analysed whether the alliance growth groups differed on the following emotion episode dimensions that could confound differences in emotional processing between groups. These were: (1) mean number of EEs per session, (2) mean duration of an EE, (3) the mean

proportion of total session time in EEs. Results are reported in Table 1 and showed that there were no significant differences between the SAG and WAG groups in any of these dimensions ($p = .05$). Clients in the WAG group did however show a trend toward EEs of a longer duration in the termination phase of treatment.

Alliance Growth Groups Differences in Proportion of EE Rated CAMS Categories

T test results for differences in mean proportions of emotion episodes within the working and termination phases of therapy for CAMS ratings are reported in Table 2, and for CAMS ratings calculated as emotion scheme types in Table 3. In all tables effect sizes measured as Cohen's d for both independent and dependent tests. These are provided as reference points given the small sample sizes involved in these comparisons which would likely reduce power to detect effects. Cohen (1988) hesitantly defined effect sizes as "small, $d = .2$," "medium, $d = .5$," and "large, $d = .8$ ", stating that "there is a certain risk in inherent in offering conventional operational definitions for those terms for use in power analysis in as diverse a field of inquiry as behavioral science" (p. 25). You may note that some results that are not significant still exhibit substantial effect sizes.

Differences in working phase proportions of CAMS rated EEs

Independent t-tests found that in the working phase of therapy, the SAG group expressed significantly higher proportions of relief, assertive anger, and expression of needs than clients in the WAG group ($p = .028$, $p = .023$, $p = .001$). There was also a trend in the SAG

group expressing a greater proportion of acceptance and agency in the working phase of treatment ($p = .094$). Alternatively, WAG clients expressed significantly greater proportions of global distress as well as showed a trend to express greater amounts of rejecting anger than SAG client did in the working phase ($p = .08$).

Differences in working phase EE proportions using summed CAMS categories to represent emotion scheme types

Expression of secondary emotion was significantly greater in the WAG group than in the SAG group in the working phase of therapy ($p = .011$). The weak alliance growth group also showed significantly less expression of primary adaptive emotions ($p = .002$) compared to the strong alliance growth group in the working phase of treatment.

Differences in termination phase proportions of CAMS rated EEs

In the termination phase of therapy clients in the SAG group expressed significantly greater proportions of relief and assertive anger than those in the WAG group ($p=.030$, $p=.037$). The proportion of EEs rated as expressing needs, however, was not significantly different between alliance growth groups in the termination phase of therapy. Significantly more termination phase EEs expressing acceptance and agency occurred in SAG clients than in WAG clients ($p = .032$). In the termination phase, the WAG group continued to express significantly more global distress than the SAG group ($p = .010$). WAG clients now also expressed significantly more rejecting anger than SAG clients in the termination phase ($p = .003$).

Differences in termination phase EE proportions using summed CAMS categories to represent Emotion Scheme Types.

Clients in the WAG group continued to express significantly more secondary emotions ($p = .003$) and significantly less primary adaptive emotion ($p = .003$) in the termination phase.

Alliance growth group CAMS rated EE change differences from the working phase to termination phase of therapy

Changes from the working to the termination phase in the mean proportion of EE-rated CAMS categories are reported in Table 4, and for emotion scheme types in Table 5. The SAG group expressed significantly fewer needs from the working to termination phase of therapy ($p = .036$). The SAG clients further showed a trend toward marked decreases in the amount of fear/shame expressed ($p = .104$) and increase in acceptance and agency (.077) as therapy progressed. The WAG group expressed significant increases in the amount of both global distress ($p = .008$) and relief ($p = .042$) from the working phase to the termination phase of therapy.

Exploring differences in change from the working phase to termination phase of therapy in EE proportions using summed CAMS categories to represent emotion scheme types, SAG clients' significant decreased expression of needs from the working to the termination phase. Clients in the WAG group showed a significant increase in expressions of secondary emotions from the working phase to the termination phase of therapy.

THEME Temporal Pattern Analysis

THEME statistical analysis software (Magnusson, 1993; 2000) was used to detect patterns of EE-CAMS ratings that occurred significantly less or more often in the SAG group versus the WAG group. THEME software utilises an algorithm that detects patterns in sequences of behaviours, in this case, emotion state ratings that occur significantly more often than one would expect by chance alone.

A number of THEME analyses were performed. Two THEME analyses detected significant differences between the alliance growth groups. First, differences between alliance growth groups' CAMS rated EE sequences occurring within the working phase were analysed. Second, differences between alliance growth groups' CAMS rated EE sequences occurring within termination phase of treatment were explored. THEME was set to find patterns that occurred in each group in each phase that would not be expected to occur by chance at a significance level of 0.5%. THEME analyses also were set to only detect patterns that occurred at least 7 times in the data set. This allowed us to detect patterns that could occur only in all members of either the SAG or WAG group. That is, THEME allowed us to discover if any significantly detected pattern occurred exclusively in one group only or occurred across both groups.

Preliminary THEME analyses. To determine that patterns found by THEME in the real data are not due to chance, THEME compares obtained patterns with patterns THEME

extracts from data obtained from each of two bootstrapped procedures (shuffling and rotation). Shuffling, randomizes the real data's time signatures while rotation shifts the data's real-time signatures by a random number of degrees in relation to other event series. Following either of these randomization procedures the probability of detecting sequences of a certain mean length in the real data is calculated and compared to the probability of detecting the same length of pattern in the 100 shuffled and rotated versions of the real data. This analysis successfully showed that the patterns detected by THEME could not occur by chance, thereby establishing the validity of the detected patterns. As such, the THEME obtained valid patterns. Further, THEME used a binomial statistical test to detect patterns that appeared more frequently in the SAG group versus the WAG group. The significance level for this binomial test was set to 5.0% meaning that only patterns which 95% of the time would occur more frequently in only one group were detected.

THEME detected differences in CAMS patterns between alliance growth groups in the working phase

Twelve patterns occurred with significantly greater frequency in the SAG group versus the WAG group within the working phase sessions. These 12 patterns ranged in length from 2 to 4 events. All twelve patterns exhibited a link(s) between the expression of hurt/grief and the expression of a need. Examples of these 12 found patterns linking hurt/grief and expression of a

need can be viewed in Appendix A which contains THEME output figures. Patterns exhibiting links between expressing of hurt grief and need expression are Figures 1 to 12.

In the WAG group, THEME found only one pattern to be expressed with greater frequency than in the SAG group in the working phase. This pattern started and ended with the expression of global distress. This pattern can be seen in Appendix A Figure 13.

THEME detected differences in CAMS patterns between alliance growth groups in the termination phase

In the termination phase, THEME detected 2 patterns that occurred with greater frequency in SAG clients versus WAG clients. One of these patterns primarily contained a CAMS rating of an uncodable EE. The other pattern found began and ended with the expression of relief. Both detected THEME patterns are depicted in Appendix A Figures 14 and 15.

For the WAG group 13 patterns were detected by THEME as more frequently occurring in than in the SAG group during the termination phase of therapy. These 13 patterns ranging in length from 2 to 4 events and frequently shared the theme of containing expressions of global distress. The second most frequent pattern theme contained expressions of global distress followed by expressions of rejecting anger, as well as the reverse (expressions of rejecting anger followed by expressions of global distress). A third common pattern theme within these 13 patterns contained expressions of global distress followed by expressions of fear/shame. These 13 patterns can be viewed in Appendix A Figures 16 to 28.

THEME Analysed Emotion Scheme Sequences

THEME detected differences in emotion scheme type expression between alliance growth groups in the working phase. For SAG clients, 3 patterns of emotion scheme types ranging from 2 to 5 events in length were found by THEME as occurring with significantly greater frequency in the SAG group than the WAG group. The expression of primary adaptive emotion in these found patterns was noted. These patterns can be viewed in Appendix A THEME Figures 29 to 31.

Four patterns in emotion scheme types were found more frequently in the WAG group, ranging from 2 to 4 events in length, all containing the expression of secondary emotions. These THEME patterns can be viewed in Appendix A Figures 32 to 35.

THEME detected differences in Emotion Scheme type expression between alliance growth groups in the Termination Phase. THEME detected 3 emotion scheme patterns occurring with significantly greater frequency in SAG versus WAG clients. Ranging from 2 to 5 events in length, these 3 patterns were characterized by one major theme, recurring primary adaptive emotion (PAE) See Appendix A Figures 36 to 38 for a visual representation of these 3 patterns found.

In the termination phase, THEME detected 5 emotion scheme type patterns occurring with significantly greater frequency in WAG clients than SAG clients. Ranging from 2 to 3 events

in length, these 5 patterns all expressed one global emotion type theme, recurrent expression of secondary emotion (SE). The 5 patterns found can be viewed in Appendix A Figures 39 to 43.

Discussion

This study examined differences in emotional processing between client subgroups identified in an earlier study (Pos & Thomson, 2010) as having either strong alliance growth (SAG) or weak alliance growth (WAG) trajectories over the course of their short-term experiential therapy for depression (16-20 sessions). These alliance growth trajectories were established via MPLUS growth curve analysis of every clients WAI scores (post session-short form) from all sessions, session one to termination (Pos & Thomson, 2010). Given that emotional processing during therapy predicts outcome at both termination (Choi et al., 2016; Pos et al., 2009) and 18-months (Wong, 2016), this study also related differences in alliance trajectory groups to differences in long-term outcomes on four outcome measures. In the current sample of 7 SAG and 7 WAG clients, it was hypothesized that the WAG clients would exhibit significantly poorer long term outcomes than SAG clients on all outcome measures. This hypothesis was supported. It was also hypothesized that that the SAG group versus the WAG group would engage in significantly different emotional processing during experiential treatment for depression. Specifically, proportions of emotion episodes rated with CAMS emotion states, as well as summed proportions of CAMS rated EE states representing emotion schemes types, were expected to differ between alliance growth groups. Changes in CAMS rated EEs across the working and termination phases of therapy as well as sequences in CAMS

rated EEs were examined and compared for the two alliance growth trajectory groups. Independent and repeated measure t-tests and THEME analyses found support for the hypothesis that WAG and SAG clients engage in differential emotional processes during both the working and termination phases of therapy. Findings also showed that clients in the SAG group demonstrated changes in emotional expression from the working to the termination phase that distinctly differed from that of the WAG clients. For example, clients in the SAG group expressed significantly more primary adaptive emotion and significantly less secondary emotion than clients in the WAG group within each phase of therapy. Clients in the SAG group also expressed significant increases in acceptance and agency across working and termination phases of therapy while the WAG group expressed significant increases in global distress. Using THEME sequential analysis of CAMS rated EEs it was also shown that clients in each sub-group had differential patterns of emotional processing in and across working and termination phases of therapy. Clients with SAG expressed sequences of need experiences linked to hurt grief while clients with WAG expressed sequences of secondary emotions (global distress and rejecting anger). Overall differences in emotional processing between these two groups were striking and consistent with experiential theory of depression (Greenberg & Watson, 2006).

Differences in Emotion Episode Dimensions

Differences between alliance growth groups in EE dimensions were first examined to make sure that these dimensions were not confounds of the results. The specific EE dimensions assessed were: mean number of EEs per session, mean EE duration, and mean proportion of

sessions in EEs. No significant differences in these dimensions were found between the SAG and WAG groups. There was a trend toward the WAG group having longer EEs later in therapy and this may indicate that WAG clients take longer to explore their emotions. Given that the WAG group also had significantly poorer long-term outcomes, suggesting that the amount of time a client spends in an emotion episode is not as important (to therapy gains) as is the actual emotional processing that occurs within that duration. Based on the EE processing at termination (THEME analysis indicating more secondary emotion in these clients), this also suggests that WAG clients spend more time 'stuck' in unproductive emotional processing (global distress for example).

Differences in Treatment Type

In assessing for potential confounds, it was discovered that significantly more clients in the SAG group had EFT treatment and that all clients in the WAG group had received CCT treatment. Given that clients in the WAG group had poorer outcomes related to differences in emotional processing, it follows that clients who received EFT processed emotions differently than clients who received CCT. Why this was so will be difficult to sort out and explain. This is partly due to some clients in the SAG group (28% or 2/7) also having received CC.

That SAG clients receiving EFT were more likely to have better 18-month outcomes than WAG clients receiving mostly CCT does converge with previous evidence, however. Goldman et al., (2006) found that clients in EFT therapy had greater improvements at termination in interpersonal problems, self-esteem, and general distress, than clients who received CCT. If one

reinterprets the current findings of differential emotional processing within alliance groups to allow for the possibility that alliance growth group differences are potentially the result of treatment differences, it could be argued that clients in EFT demonstrate different emotional processing compared to clients in CCT. Why? It may be that the specific structured interventions in EFT, such as chair-work, engage clients in emotional processing that is more productive, in a way that may differentially predict maintenance of therapy gains long-term. Ellison, Greenberg, Goldman & Angus (2009) also support this idea that maintenance of treatment gains at 18-month follow-up is enhanced by EFT interventions when compared to CCT. They found that less relapse occurred in clients who had received EFT versus CCT after York 1 and 2 depression studies. Future research should explore the differential emotional processing that occurs within these two treatments, as even though they both promote emotional processing, they may be doing so with differences that make a difference (Bateson, 1972, 1979) to long term outcomes.

Also interesting about the fact that all but two clients in the good alliance growth group received EFT while all the weak alliance growth group clients with poorer long-term outcomes received CCT, is that the chi square that tested for a significant relationship between alliance growth group/outcome group and type of therapy received was significant. Therefore being in the good alliance growth group and having better 18-month outcomes was significantly dependent on receiving EFT. While both EFT and CCT work towards helping clients process experience, EFT uses more focal and structured intervention, and, as such, EFT can be

considered to be a more structured treatment. Elliott, Greenberg, Watson, Timulak & Freire (2013) have reported that treatments that are more structured and directive (such as EFT and CBT) may be better treatments for MDD. So the fact that none of the weak alliance growth group who had worse outcomes had EFT is consistent with their analysis concerning structured treatments being more effective (Elliott et al., 2013).

Whether clients in EFT versus CCT necessarily have better alliances with their therapist is another empirical question. While clients in the overall York RCTs who had good and poor outcomes did not significantly differ in early distress, they did differ in their session one alliances, as did clients in the SAG and WAG groups in the current sample. Wong & Pos (2014) found that some client pre-treatment interpersonal problems such as pre-therapy social inhibition, or pre-treatment tendencies to be overly accommodating, predicted a slow starting alliance. These pre-therapy interpersonal problems may negatively interact with the more agency promoting style offered in a purely CCT relationship. Future research should explore whether these potential client differences at the onset of therapy predict degree of fit to a particular model of experiential treatment. Malin (2016) for example has shown that therapists working with clients with pre-therapy problems of being overly accommodating also tend to have therapists who express less empathy to those clients in first sessions and that empathy in first sessions predict client's later emotional processing. Whether these pre-treatment interpersonal problems interact with the relationship style or alliance offered within different experiential therapies, such as EFT versus CCT, will be important to explore.

Hypothesis 1: Clients in SAG group would have significantly better outcomes at 18-months post termination than WAGs.

Pos & Thompson (2010) found SAG and WAG alliance groups to differ in 18-month outcomes in a larger sample of 55 clients. Therefore it was hypothesized that Pos & Thompson's results (2010) would replicate in this smaller study with the seven SAG clients showing significantly better 18-month post therapy outcomes than the seven WAG clients. This was the case. Interestingly, however the alliance growth groups in this study also showed significant outcome differences at therapy termination. This was not found in Pos & Thompson (2010). We know that clients in the overall outcome studies (Greenberg & Watson, 1998; Goldman et al., 2006), who did or did not report 18-month outcomes did not significantly differ in their termination outcomes (Wong 2016). However, for some reason the clients with weak alliance growth trajectories in this study (all of whom provided 18-month outcomes), were also clients who had not reported good outcomes at termination when compared to the SAG clients in this study. Differences found in this study could therefore be relevant for both termination AND long-term outcome. However, since my focus was emotional processes that predict lasting change evident at 18-months, my results will be speaking to these longer-term outcomes.

Alliance, emotional processing, and outcome

Since this small sample of strong and weak alliance growth clients (who reported 18-month outcomes) may reflect the best and worst outcomes at therapy termination, the

potential importance of the alliance to emotional processing in experiential treatment is further highlighted. It could be argued that because the alliance across treatment has been shown to facilitate emotional processing across treatment (Pos et al., 2009), the current results are coherent with Pos et al., (2009). This is because strong and weak alliance trajectory groups showed strong and weak emotional processing trends (as suggested by experiential theory). As such, the alliance strength expressed within each group may have facilitated or supported the emotional processing differences detected in this study within each group. Also remember that these client subgroups differed in their alliance scores in all phases of therapy (alliance trajectory differences that were at the heart of the group selection). This included differences in their alliances in first sessions. We already know from Pos, Greenberg & Warwar (2009) that first session alliances directly predict outcomes in experiential therapy for major depression, and that working and termination phase alliances predict emotional processing within those phases of therapy. However, emotional processing is the strongest predictor of final outcome (Pos et al., 2009). Therefore, while difficulty with the early alliance may be an important early indicator of potential problems to come in later emotional processing (Malin & Pos, 2015), and while these alliance trajectory problems may also sometimes foreshadow termination outcomes, we now also know that these alliance trajectory differences may point to *long term* positive or negative resilient outcomes as well.

Furthermore, while we know that emotional processing measured by EE-Experiencing is the strongest and best direct predictor of termination outcomes (Pos et al., 2009), and that

working phase CAMS coded EEs are the best predictors of long term outcomes (Wong, 2016), now we also know that in a small sample of clients with different alliance trajectories and strong versus weak long-term outcomes, that these same emotional processes are important distinguishers of longer term resilience in those same outcomes. Future research must explore why clients in the WAG group had poorer first session alliances and poorer alliance growth trajectories. It might be that these clients share interpersonal themes that may interfere with the alliance not only in the beginning of therapy but across therapy and that these themes may predict specific problems with emotional processing that will occur throughout therapy as well. This is important because we must know which clients tell us right away in first sessions whether they will do well in this therapy long-term.

Hypothesis 2: SAG clients will express (i) significantly more primary adaptive emotion (PAE), and (ii) significantly less secondary emotion (SE) and primary maladaptive emotion (PME) within and across the working and termination phases than clients in the WAG group.

This hypothesis was partially supported by independent t-tests, repeated measures analyses and THEME analyses.

Primary Adaptive Emotion

Independent t-tests found that the SAG group did express significantly greater proportions of EEs in adaptive emotions states than the WAG group within both therapy phases. THEME analyses also supported PAE as distinguishing SAG and WAG clients. While

results showed that some primary adaptive emotion states significantly increased for the SAG group from the working to termination phase, at the omnibus emotion schematic level, the SAG group did not significantly increase in PAE over the working to termination phases of therapy. Next follows a discussion of results concerning CAMS states that contribute to the global PAE category.

Assertive Anger. In experiential therapy, assertive anger appears to be an important emotion state for clients to experience in alleviating depressive symptoms long-term. In a larger sample of 55 long term outcomes, Wong (2016) found that assertive anger predicted both termination outcomes and 18-month outcomes. The specific importance of anger in resolution of depressive symptoms is provided by many theories of depression (see Choi et al., 2016 for a review). What I have added to this result is that expressing assertive anger in the working as well as in the termination phase of therapy is more likely if there is a strong alliance supporting that expression.

Assertive anger might have been more frequently expressed in the good outcome strong alliance growth clients for a number of reasons. Firstly, depression is a disorder characterised by feelings of isolation, hopelessness and helplessness (Beck, Steer, Beck & Newman, 1993) with their associated action tendencies of withdrawal and physical isolation. If a strong alliance meets a depressed clients' need for support and connection, that depressed client may then be better able to set boundaries and assert against difficult others. Also assertive anger is often associated with feelings of personal control, strength, and entitlement

to personal needs, all of which are experiences which can contribute to lower helpless feelings and lower depression. This is because pushing forward and exercising authority of needs and boundaries are the action tendencies associated with assertive anger (Carver & Harmon-Jones, 2009) and which are opposite to the collapsed hopelessness associated with depressed mood. Feelings of agency may also ensure a sense that one has some control over one's life. This could contribute to a more internal locus of control being experienced, also an antidote to depressed feelings (Haley & Strickland, 1977; Hui & Ming, 2004). When taken together, the feelings and action tendencies associated with assertive anger likely provide a powerful and self-affirming counterbalance to the hopelessness, helplessness and isolation of depression (Timulak, 2015) which works to transform depressogenic emotion.

Hurt Grief. Independent t-tests indicated no significant differences between the SAG and WAG groups in the sheer amount of hurt/grief expression, yet THEME analyses suggested hurt grief is still an important emotion state for clients to experience in the long-term reduction of depressive symptoms. The expression of hurt/grief, marked by sadness over loss and recognition of one's 'woundedness', was a frequently expressed emotion state more likely to occur in the SAG versus the WAG group. This points to the value that EFT case formulation puts on helping clients access their core pain by the therapist using their 'pain compass' to 'zero in' on clients' core pain (Goldman & Greenberg, 2006). For the therapy sessions observed in this study, THEME also indicated that important expressions of a need often precede or follow the expression of hurt/grief in SAG clients. As such, future research may want to explore this link

between experiences of hurt/grief and expression of needs for clients in the long-term resolution of their depression.

That the sheer amount of hurt/grief expressed did not differentiate the SAG and WAG groups, i.e. was present in both, could point to an important discrepancy in what each group does with their hurt/grief experiences in therapy. THEME analyses indicated that for SAG clients hurt/grief expression is followed by expression of a need while the poor outcome clients (WAG group) do not show this pattern. Further, it may be that there are also qualitative differences in the themes expressed by clients in their hurt/grief episodes that might differentiate types of hurt/grief in these two alliance trajectory subgroups. CAMS cannot capture these qualitative differences.

No significant differences within therapy phases of hurt/grief were noted in cross sectional or repeated measures analyses, however THEME analyses did detect many patterns that occurred more frequently in SAG clients that linked expressions of hurt/grief experiences with the expressions of needs. It may be important to again turn to the alliance as a potential additional explanation of these results. Perhaps the alliance supports a client being able to express more vulnerable adaptive emotion and that may be why my results point so strongly to hurt/grief being important to resilient outcome for clients who had stronger alliance growth. Further, my results validate the importance of the experience of needs to expressions of hurt/grief communicated in experiential theory (Greenberg & Watson, 2006). The link between expression of needs and experiences of adaptive emotion in experiential theory has been long

discussed. Future research should parse these events more qualitatively in order to experience not only what the client is doing but what the therapist's role is in supporting these states.

Relief. Relief was the primary adaptive emotion state with the greatest proportion of expression for the SAG group. Clients in the SAG group on average over the working and termination phases demonstrated relief in 15.5% of their EEs. In comparison, those clients with a weak alliance trajectory, expressed relief in only 3.5% of EEs over the working and termination phases. Pascual-Leone & Greenberg (2005) describe relief as feelings of betterment, hope, positivity, accomplishment and a release of tension. That relief is more frequent in the strong alliance growth group may have resulted as a consequence of positive interactions with their therapist. It should be noted, however, that clients in the SAG group appeared more often to experience relief not in a direct relationship moment with their therapist (i.e. by a shared laugh or smile), but rather more often in conjunction with client meaning-making and 'change-talk'. Clients' expressions of relief often appeared to be tied to their narratives concerning needs being met. For example, relief was present when a client with an unmet need for connection with her partner shared a story of positive connection with her partner. Another example was a client who had a need for acceptance from her mother, and came to understand and accept that her mother was not able to meet that need (given her mother's own limitations). As such this client's relief appeared to follow an experience of acceptance and agency. These particular or unique within-client sequences may also be worth exploring in future research. Overall, however, clients in agreement on the goals and tasks of

therapy, may also experience being “on the right path” and/or feelings of accomplishment in therapy, that would also be described/coded by CAMS as relief experiences. THEME analyses also suggest that relief sequences were experienced more frequently in SAG clients.

Relief appears to also be experienced by clients after expressing ‘active’ emotional transformation states such as assertive anger and hurt/grief- perhaps states that had previously been warded off in clients. In this regard, relief could be viewed as an important within session emotional marker of adaptive processing having occurred, or good small ‘o’ session outcome (Greenberg, 1986) that communicates good session process - that is, it may be more than an important emotional expression that can by itself combat depression, but also be an emotion state that also marks experiences of progress in therapy. Moreover, one could also argue that important processing can occur after experiencing a state of relief and that this processing may consolidate as a relief experience of having made therapy gains. This again points to the potential importance of future research exploring emotional precursors and consequences of relief expression in therapy.

Repeated measures analyses results also found that significantly more relief was experienced by clients in the WAG group in the termination phase versus in the working phase of therapy. One way of explaining this is that It is possible that WAG clients were on a path to reaching more productive amounts of PAE (such as relief) but that therapy terminated before these clients could experience adequate amounts of PAEs. Given that treatment for currently sampled clients was a short-term therapy that consisted of 16-20 sessions of therapy, perhaps

WAG clients can achieve productive amounts of PAE (such as relief) if given a longer treatment protocol. Current findings therefore also suggest that it is possible that clients in the WAG group were on a 'slower' trajectory of adaptive emotional processing. This underscores the importance of future research establishing whether some clients require longer treatment protocols.

Acceptance and Agency. As one would expect, SAG clients expressed more acceptance and agency. SAG clients were significantly more accepting and agentic than WAG clients in the termination phase of therapy and trended toward such in the working phase of therapy. Clients in the WAG group, in fact, expressed zero proportions of acceptance and agency in either phase. Acceptance and agency is defined by a sense of 'letting go' or 'moving on', recognizing both positive and negative aspects involved in change, feeling stronger when coping with original stressor, and feeling comfort, calm or good. Since having an external locus of control is thought to be present in depression, experiencing one's agency and an internal locus of control is likely to relate to reductions in depressive symptoms (Haley & Strickland, 1977).

Of the five emotion states that comprise PAE, the expression of acceptance and agency was the only PAE state to show significant increases for the SAG group as treatment progressed. For this group, the expression of acceptance and agency increased by 10% from the working to termination phases. This may indicate that this emotion state has a unique and important trajectory as a PAE. Like relief, it was again noticed that acceptance and agency appeared to occur most often *after* other 'active' emotional transformation first took place (i.e.

experiencing of assertive anger and hurt/grief). As such it acceptance and agency may also impact outcome not only as an emotional state that diffuses depressed feelings but also as a marker of in session or small 'o' process outcome (Greenberg, 1986). As such it could be a marker of an adaptive emotional process that has a double treatment effect on outcomes. Future research many want to examine acceptance and agency as a process marker of good long-term outcomes, perhaps a necessary one. Also when one remembers how important a sense of self-agency or internal locus of control may have in resolution of depression, this may be pointing to the importance of this particular PAE emotional experience in resolving depression long-term. This again points to the potential importance of future research exploring emotional precursors and consequences of acceptance and agency expression in therapy.

Further, these results also speak to how a structured treatment such as EFT may actually lead to a greater sense of agency when compared to a CCT treatment. This is very interesting given that proponents of CCT very strongly assert the importance of supporting client agency. One wonders how the more structured directive treatment somehow promoted clients' greater self-agency experiences and whether this was a treatment or client effect. This will be important for future investigation.

Also it should be underlined that since clients in the WAG group experienced virtually zero EEs containing acceptance and agency, it may be that just reaching (any level of) this emotion state can be viewed as a marker for better outcomes. How a good alliance supports

this is again an empirical question for future research to answer. Future research may want to explore this and also explore the presence of acceptance and agency early in therapy. I would anticipate that this emotion state would be minimally present for both good and poor outcome groups early in treatment. However, some early agency expression in the client may indicate client resilience (Whelton, 2004).

Self-Soothing. Although the primary adaptive emotion state of self-soothing was more frequently expressed in the SAG group than in the WAG group, the differences were not significant. The proportion of total EEs over the working and termination phases of therapy expressing self-soothing appears nominal (average of 5% between the working and termination phases for SAG group and 2.5% for the WAG group). It does not appear that self-soothing was an important emotional process differentiating alliance growth and outcome groups for the currently sampled clients. Further, it appears that this state may occur less frequently in experiential treatment of depression than other PAEs. It may be more important to clients with trauma or PDs, who may have been ruled out of treatment in the present studies.

Expression of Needs

Clients in the SAG group expressed significantly more needs than the WAG group but only in the working phase of treatment. In the termination phase of treatment no significant differences between the two groups on expression of needs remained. In fact, there was a significant decrease in expression of needs from the working to termination phase for the SAG

group suggesting a unique trajectory for this therapy process. It appears that getting to need expression earlier in therapy was good for long-term resilient outcomes.

While expressing needs in therapy has been considered to be linked with better treatment outcomes (especially within task analytic studies) (Greenberg, 1983, 1984a, 1984b; Sicoli, 2006), it has been shown previously that the sheer proportion of CAMS- rated expression of needs in the working phase of experiential treatment does *not* independently predict outcomes (Choi et al., 2016; Pascual-Leone & Greenberg, 2007; Wong, 2016). While in other studies it appears that accessing needs is necessary but insufficient in the emotional change process, THEME analyses in the current study indicated that expression of needs did distinguish SAG clients with good long-term outcomes versus WAG clients with poorer long-term outcomes, especially when linked with hurt-grief expression. Therefore the current results are consistent with core EFT theory. However it does appear that expression of needs in these clients was particularly important to long-term outcomes when accompanied by the expression of primary adaptive hurt/grief.

Future research might identify the conditions under which expression of needs leads to better long-term outcomes. Also given the results of this study, it may be that a strong alliance growth trajectory facilitates clients' productive processing of needs.

Secondary Emotion

As hypothesized, clients in the WAG group expressed significantly more secondary emotion than SAG clients within both therapy phases. Both global distress and rejecting anger were expressed significantly more by the WAG group in the working and termination phases. Further, across therapy phases, there was a significant increase in the amount of global distress expressed by the WAG group as shown by repeated measure t-tests and THEME analyses.

Global Distress. Global distress in the working phase of therapy has been shown to independently predict poorer termination and long-term outcomes in experiential therapy for depression with a much larger sample of clients (Wong, 2016). Those results are consistent with the present results with the addition of demonstrations of emotional processing within the termination phase of therapy being added here. In addition, the current study found that the expression of global distress significantly increased for the WAG group as treatment progressed indicating that these clients progressively express superficial emotion states that may communicate aversion to deep feeling. Further, the WAG group clearly were not engaging in the same adaptive emotional processing that SAGS were expressing and that could reduce core depressogenic emotion in either phase of therapy. Again, a weak alliance may interfere with clients' deeper emotional processing. Future research should explore the expression of global distress in relation to specific alliance promoting therapist behavior. It would also be interesting to examine differences in the expression of global distress occurring within the client group with a poor alliance. This is because the CAMS global distress category captures a diverse 'basket' of problematic emotions. It will be important to discover if some of these, i.e.

hopelessness or anxiety, differentially occur within these poorer outcome clients. Perhaps it is more difficult to build a productive alliance in therapy depending on the preponderance of some emotion states within this GD category. Exploring these connections will be important for future more tailored case formulation.

Rejecting Anger. Rejecting anger also differentiated SAG and WAG groups with the WAG clients expressing significantly greater proportions of this emotion state in the termination phase and trending toward such in the working phase. Pascual-Leone, Gilles, Singh & Andreescu (2013) posit that rejecting anger reflects ‘self’ and ‘other’ critical judgements. Self-criticism has long been recognised as a characteristic of depression (Blatt, Quinlan, Chevron, McDonald, & Zuroff, 1982; Greenberg & Watson, 2006), so it may be that clients in the WAG group are a more self-critical group. This may cause them to be more stuck in rejecting anger. This is another task for

future investigation.

Primary Maladaptive Emotion

Repeated measures and THEME analysis supported the hypothesis that clients in the SAG group express less proportions of fear/shame and negative self-evaluations (which comprise maladaptive emotion) in the working or termination phase of therapy.

Fear/Shame. Although fear/shame proportions did not differentiate the two groups within phases of therapy, the high prevalence of this emotion state indicates that it is an

important process. For the WAG group clients, fear/shame was the most expressed emotion state by this group, expressed on average in 13.5% of EEs over the working and termination phases. It was the second most prevalent emotion state (after global distress) present for this group. This result is consistent with previous research which found not only that fear/shame was the emotion state most often engaged in by clients, but curiously also did not directly predict outcomes (Choi et al., 2016; Pascual-Leone & Greenberg, 2007; Wong, 2016). This again suggests that accessing fear/shame may be necessary but insufficient in the emotional change process. Perhaps fear/shame differs across clients, with some experiences of fear shame resolving while others maintaining depression. Perhaps the WAG clients find being in fear/shame states intolerable and this causes these client to 'back-off' such experiences by going into secondary feelings once more. Parsing types of fear shame may therefore be important for future research.

Fear/shame was the maladaptive emotion state that showed the greatest decrease for SAG clients. This appears to be occurring in tandem with increases in PAE in the termination phase for SAG clients. Moreover THEME analyses indirectly did support this hypothesis as THEME found WAGs expressed more sequences containing both global distress and fear shame in the termination phase of therapy. As such WAG clients appear to be stuck in cycles of PME and SE.

Limitations and Future Directions

All studies have limitations, and this study had limitations as well. First, statistical power was limited by the small sample size of 14 clients. Analyses that found trends in the data (e.g., the difference between alliance growth groups on EE proportion of acceptance and agency in the working phase, and fear/shame decreasing as therapy progressed for the SAG group) may have been significant or disappear in a larger sample. Therefore using larger samples of clients that include termination phase emotional processing will continue to be important. This may also highlight important markers of client readiness for therapy termination that predict long-term outcomes and that can inform more effective treatment protocols.

Secondly, this study examined emotional processing for alliance groups in the working and termination phases of therapy. Although groups were matched on numerous pre-treatment dimensions, it is difficult to know if the emotional processing that did occur was an effect of treatment or better explained by individual client differences entering therapy. Further examination of early phase levels of emotion states for different types of clients will be needed to clarify whether clients enter therapy with important emotional processing differences that will impact their capacity to reach adaptive emotion states.

Third, CAMS as a measure is not without limitations. Even with the added emotion schematic information that CAMS provides it does not as yet parse within CAMS codes variability that may be present within each category that may be important to outcomes. For example, the importance of need expression in the working phase of therapy was underscored in the results of this study. Need expression is considered a necessary but insufficient therapy

process and future research may want to further explore the role of need expression in facilitating emotional processing that is considered necessary in long-term resolution of MDD. As such CAMS, itself, as a measure may require further specification or supplementation as an emotional processing measure.

Lastly, this study distinguished important differences in emotional processing between alliance growth groups, however the apparent interaction between alliance trajectories and emotional processing was not explored. In order to better understand the therapy conditions under which resilient change is produced, it would be prudent to explore the relationship between alliance growth and emotional processing further. Exploring individual trajectories in emotional processing in even smaller samples of clients, perhaps even within single clients, such as occurs within case studies may also be fruitful. Perhaps alliance growth and emotional processing will be found to be linked within clients who share certain pre-therapy interpersonal problems. This too requires future research.

Conclusion

This study was the first to explore and test whether emotional change processes known to relate to long-term resolution of depression differentially occur between clients with strong versus weak alliance trajectories. Further this study was the first to examine differences in emotional processing within and across therapy phases for these two alliance trajectory groups.

Convergent evidence from two analytic procedures suggests that clients with strong alliance growth trajectories process emotions and express needs differently in both the working and termination phases as well as show differential emotion processing trajectories across these phases (from clients with a weak alliance growth trajectory). Not only were reductions of secondary emotions and increases in adaptive emotions found to differ between strong and weak alliance growth groups, particular adaptive emotions (hurt/grief, acceptance and agency, relief, and assertive anger) were identified as important to long-term resolution of depression. Patterns linking need expression and hurt/grief were also shown to be important to long-term outcomes. These results may continue to validate emotion theory and further refine experiential treatment for depression that results in greater resilience in maintenance of therapy gains.

Tables

Table 1.

Differences in Emotion Episode Dimensions between the SAG and WAG groups

EE Dimension	<u>Strong Alliance</u>		<u>Weak Alliance</u>		t	df	p
	M	SE	M	SE			
EE-MEAN	17.64	2.68	14.61	1.097	1.047	12	.147
EE-DUR	130.79	19.71	162.92	8.51	-1.496	12	.160
EE-PROP	.6231	0.041	.6296	.039	-.108	12	.916

Note. $tr = p \leq .10$, $* = p \leq .05$, $** = p \leq .01$, $*** = p \leq .001$; EE-MEAN = mean number of emotion episodes per session; EE-DUR = mean duration of an emotion episode (measured in seconds); EE-PROP = mean proportion of total session time in emotion episodes. No significant differences were found. The EE-DUR difference approached significance in the termination phase.

Table 2.

Mean SAG versus WAG Differences in Proportions of CAMS Categories in Emotion Episodes within Phases of Treatment

CAMS CATEGORY	<u>Working Phase</u>				<u>Termination Phase</u>			
	SAG	WAG	<i>p</i>	<i>ES</i>	SAG	WAG	<i>p</i>	<i>ES</i>
GD	0.09	0.23	.007**	3.21	0.15	0.37	.010 **	1.64
RA	0.04	0.17	.075tr	1.12	0.05	0.17	.003**	2.02
FS	0.25	0.20	ns	-.45	0.10	0.17	ns	.60
ND	0.20	0.04	.001***	-2.33	0.10	0.06	ns	-.61
RE	0.14	0.01	.028*	-1.33	0.17	0.06	.030*	-1.37
HG	0.13	0.08	ns	-0.38	0.08	0.05	ns	-0.39
AA	0.10	0.01	.023*	-1.60	0.07	0.01	.04*	-1.25
SS	0.03	0.02	ns	-.10	0.07	0.03	ns	-.75
ACAG	0.03	0.00	.094tr	-1.06	0.13	0.00	.03*	-1.50

Note. tr = $p \leq .10$, * = $p \leq .05$, ** = $p \leq .01$, *** = $p \leq .001$; GD = global distress; RA = rejecting anger; FS = fear/shame; NSE = negative self evaluation; ND = need; RE = relief; HG = hurt/grief; AA = assertive anger; SS = self-soothing; ACAG = acceptance and agency; SAG = strong alliance growth group (N = 7); WAG= weak alliance growth group (N = 7); ES = Cohen's d calculated using Dr. Lee Becker Effect size calculator at : <https://www.uccs.edu/~lbecker/>.

Table 3.

Mean SAG versus WAG Differences in Proportions of CAMS Emotion Scheme Categories within Phases of Treatment

ES Category	<u>Working Phase</u>			<u>Termination Phase</u>				
	<i>SAG</i>	<i>WAG</i>	<i>p</i>	<i>ES</i>	<i>SAG</i>	<i>WAG</i>	<i>p</i>	<i>ES</i>
SE	0.14	0.43	.011*	1.78	0.21	0.53	.003**	2.03
PME	0.26	0.20	ns	-.33	0.10	0.17	ns	0.59
ND	0.20	0.04	.001***	-2.33	0.10	0.06	tr	-.61
PAE	0.45	0.12	.002**	-2.13	0.51	0.15	.003**	-1.98

Note. tr = $p \leq .10$, * = $p \leq .05$, ** = $p \leq .01$, *** = $p \leq .001$; SE = secondary emotion; PME = primary maladaptive emotion; ND = need; PAE = primary adaptive emotion; SAG = strong alliance growth group (N = 7); WAG= weak alliance growth group (N = 7); ES = Cohen's d calculated using Dr. Lee Becker Effect size calculator at : <https://www.uccs.edu/~lbecker/>; positive ES are interpreted as a higher proportion of that code within phases for the WAG versus SAG group

Table 4.

Mean SAG versus WAG Differences in EE Proportional Change of CAMS Categories between Working Phase and Termination Phase

CAMS Category	<u>Working Phase to Termination Phase</u>					
	<i>SAG</i>	<i>p</i>	<i>ES</i>	<i>WAG</i>	<i>p</i>	<i>ES</i>
GD	.063	ns	1.84	.125	.008**	.36
RA	.101	ns	.03	-.003	ns	-.15
FS	-.149	.104 tr	-1.22	.018	ns	.07
NSE	-.002	ns	-1.13	-.003	ns	-.18
ND	-.110	.036*	-.37	.179	ns	1.23
RE	.029	ns	.65	.043	.042 *	.32
HG	-.043	ns	-.18	-.027	ns	-.70
AA	-.035	ns	-.15	.004	ns	.61
SS	.043	ns	.62	.008	ns	.25
ACAG	0.10	.077 tr	.96	0.00	ns	0

Note. tr = $p \leq .10$, * = $p \leq .05$, ** = $p \leq .01$, *** = $p \leq .001$; positive changes from Working to Termination Phase can be interpreted as increases across therapy; GD = global distress; RA = rejecting anger; FS = fear/shame; NSE = negative self evaluation; ND = need; RE = relief; HG = hurt/grief; AA = assertive anger; SS = self-soothing; ACAG = acceptance and agency; SAG = strong alliance growth group (N = 7); WAG= weak alliance growth group (N = 7); ES calculated as a dependent Cohen's d at https://www.psychometrica.de/effect_size.html#dep

Table 5.

Mean SAG versus WAG Differences in Proportional change of CAMS Emotion Schemes between Working Phase and Termination Phase

ES Category	<u>Change from Working to Termination Phase</u>					
	<i>SAG</i>	<i>p</i>	<i>ES</i>	<i>WAG</i>	<i>p</i>	<i>ES</i>
SE	.072	ns	1.12	.121	.040*	.25
PME	-.160	.067 tr	-1.34	-.030	ns	-.25
ND	-.110	.036 *	-.37	.179	ns	1.23
PAE	.087	ns	.16	.028	ns	.61

Note. tr = $p \leq .10$, * = $p \leq .05$, ** = $p \leq .01$, *** = $p \leq .001$; positive changes from Working to Termination Phase can be interpreted as increases across therapy; SE = secondary emotion; PME = primary maladaptive emotion; ND = need; PAE = primary adaptive emotion; SAG = strong alliance growth group (N = 7); WAG= weak alliance growth group (N = 7); ES calculated as a dependent Cohen's d at https://www.psychometrica.de/effect_size.html#dep

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Appendix A: THEME Generated Patterns

Figure 1. This pattern occurred with significantly greater frequency in the strong alliance group in the working phase. It is marked by

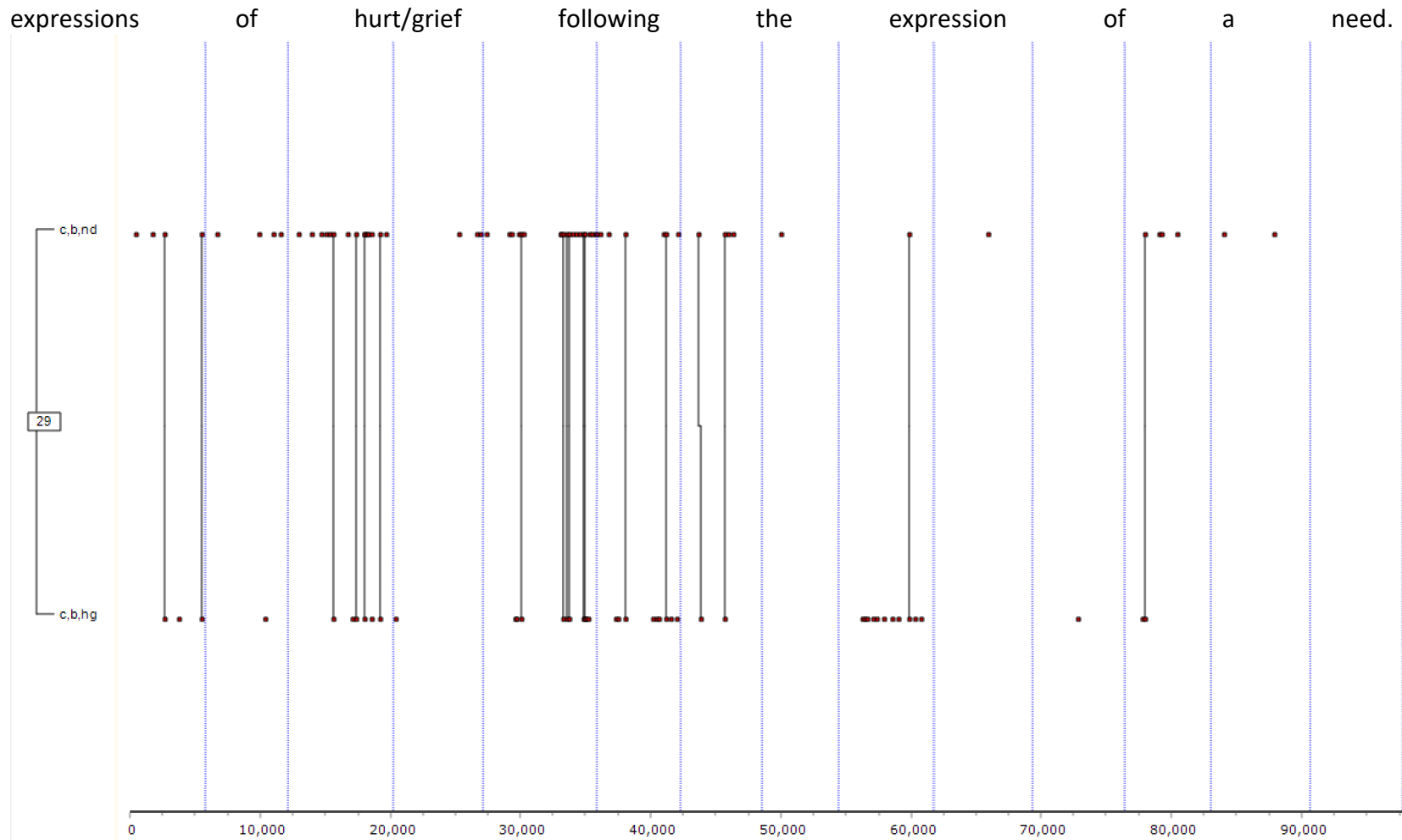


Figure 2. This pattern occurred with significantly greater frequency in the strong alliance group in the working phase. It is marked by expressions of a need following hurt/grief.

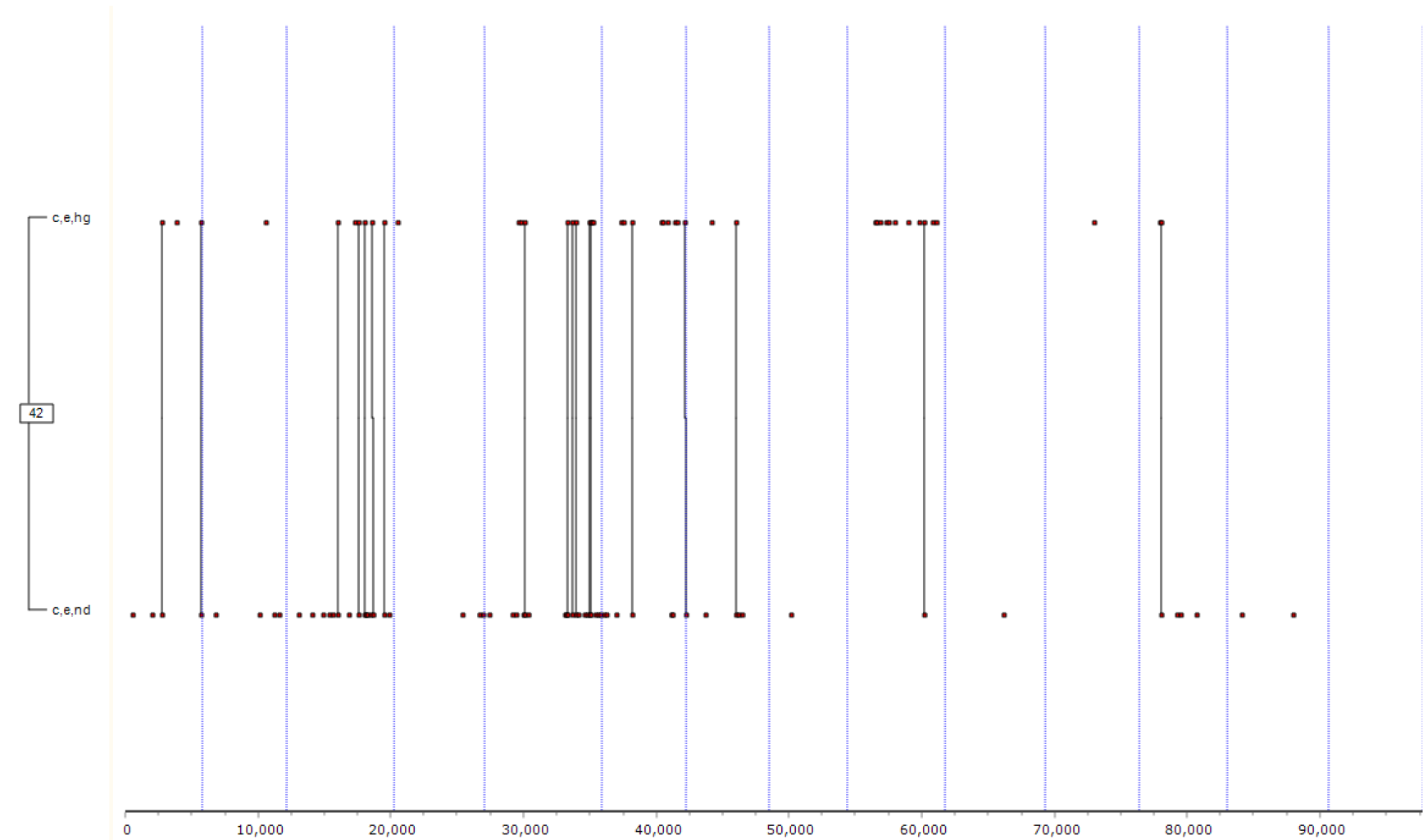


Figure 3. This pattern occurred with significantly greater frequency in the strong alliance group in the working phase. It is marked by expressions of a need following expression of hurt/grief.

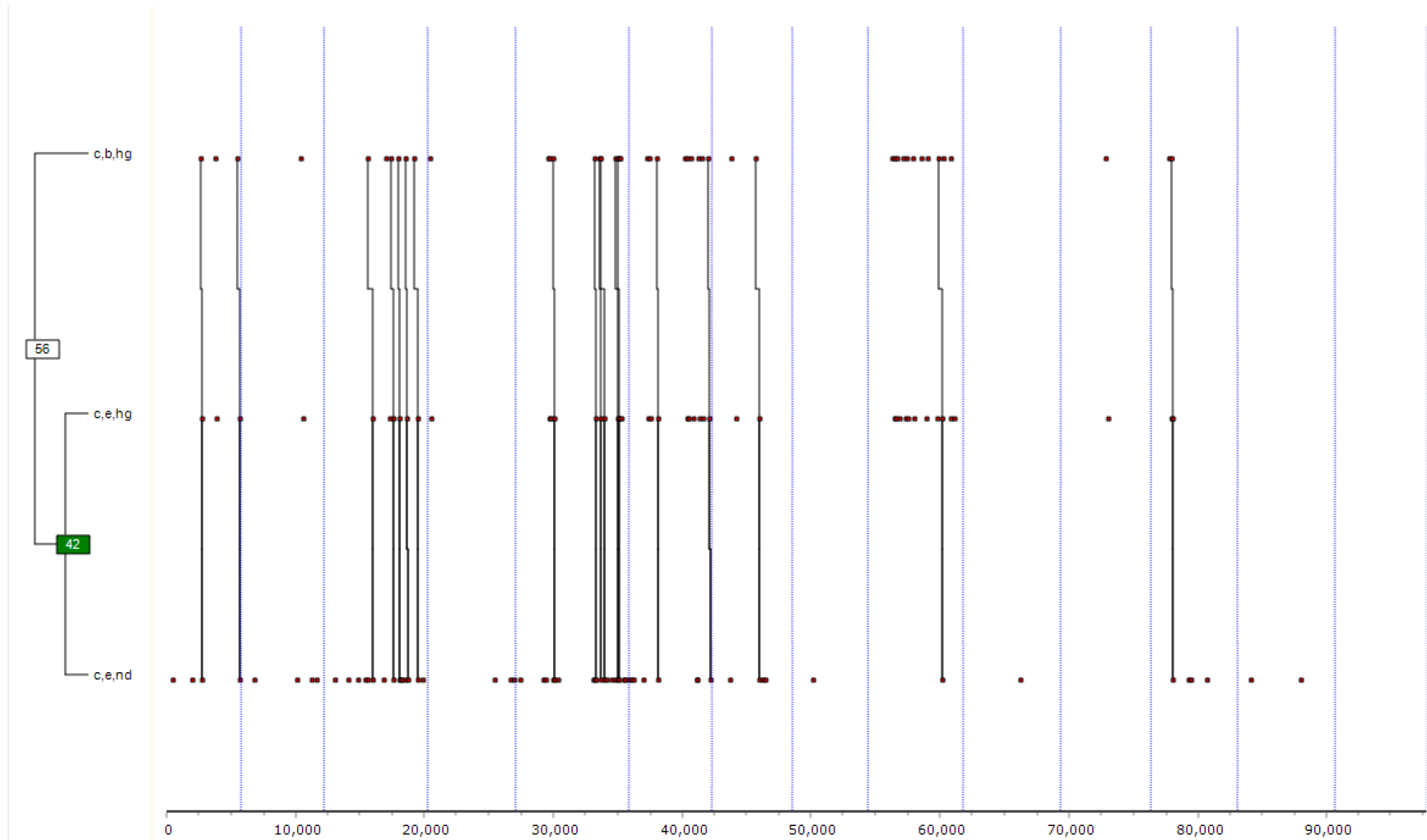


Figure 4. This pattern occurred with significantly greater frequency in the strong alliance group in the working phase. It is marked by expressions of hurt/grief following a expression of a need.

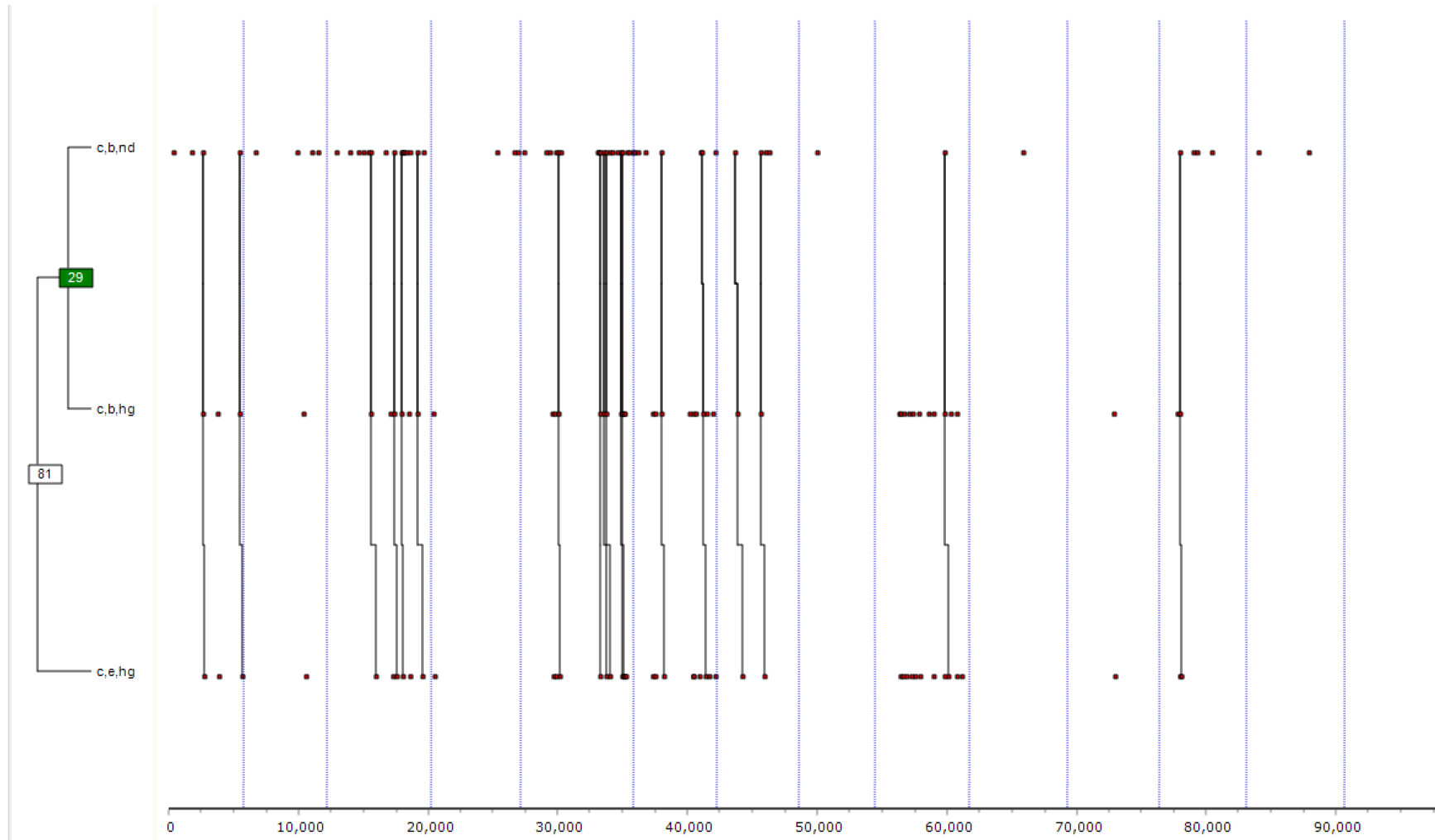


Figure 5. This pattern occurred with significantly greater frequency in the strong alliance group in the working phase. It is marked by expressions of hurt/grief following the expression of a need.

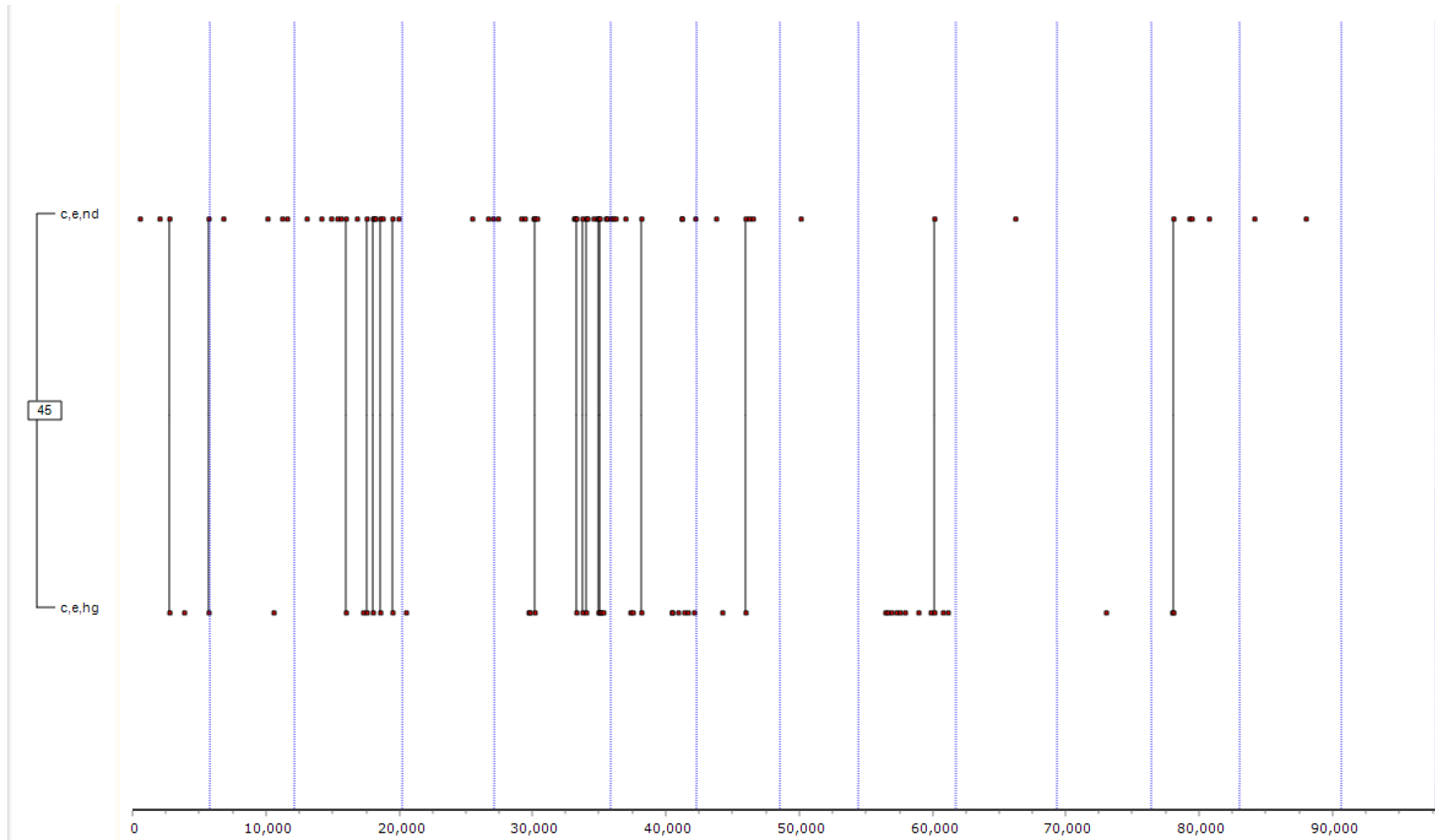


Figure 6. This pattern occurred with significantly greater frequency in the strong alliance group in the working phase. It is marked by expressions of a need followed by expressions of hurt/grief, followed by expression of a need.

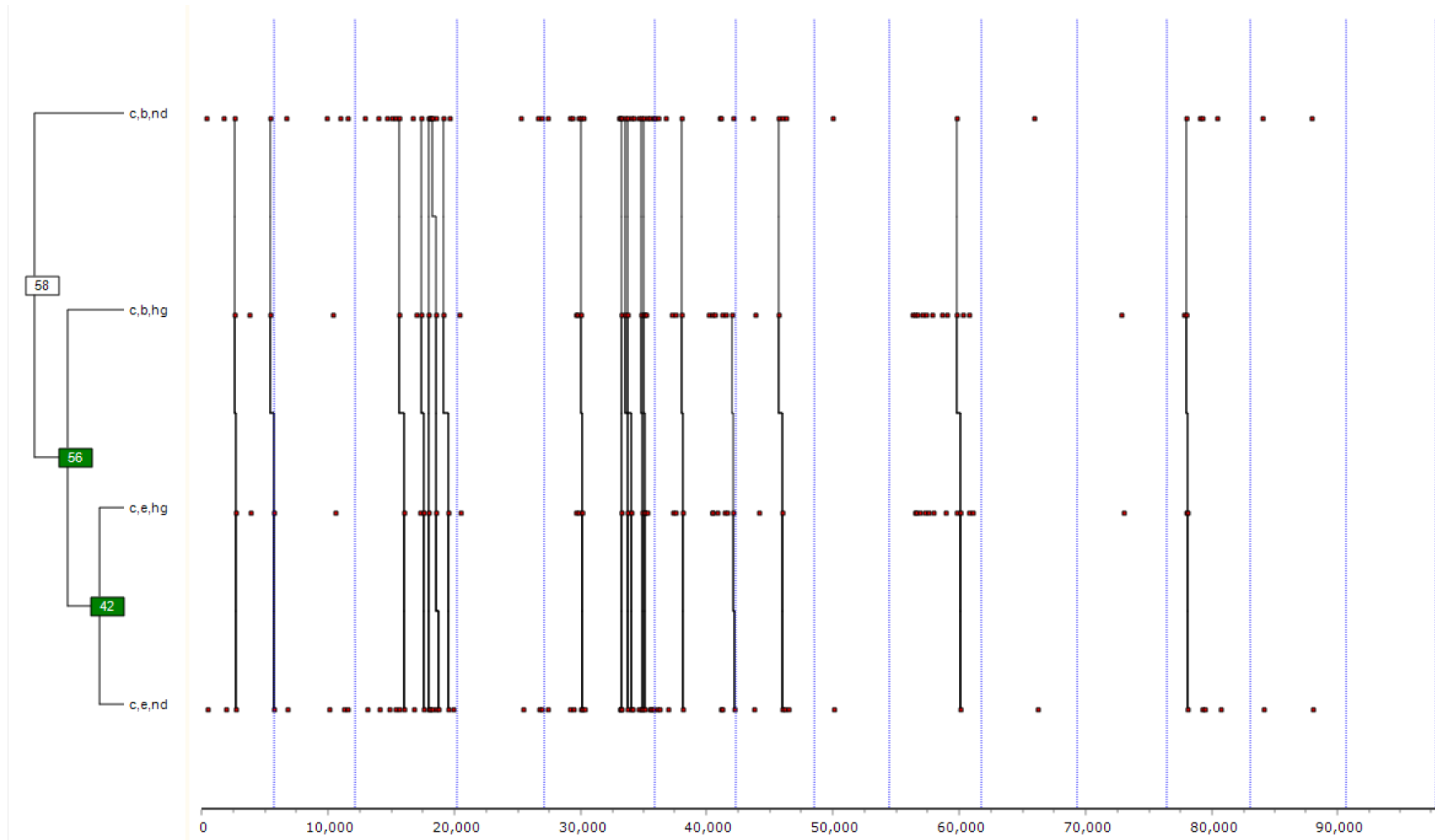


Figure 7. This pattern occurred with significantly greater frequency in the strong alliance group in the working phase. It is marked by expressions of hurt/grief following expression of a need.

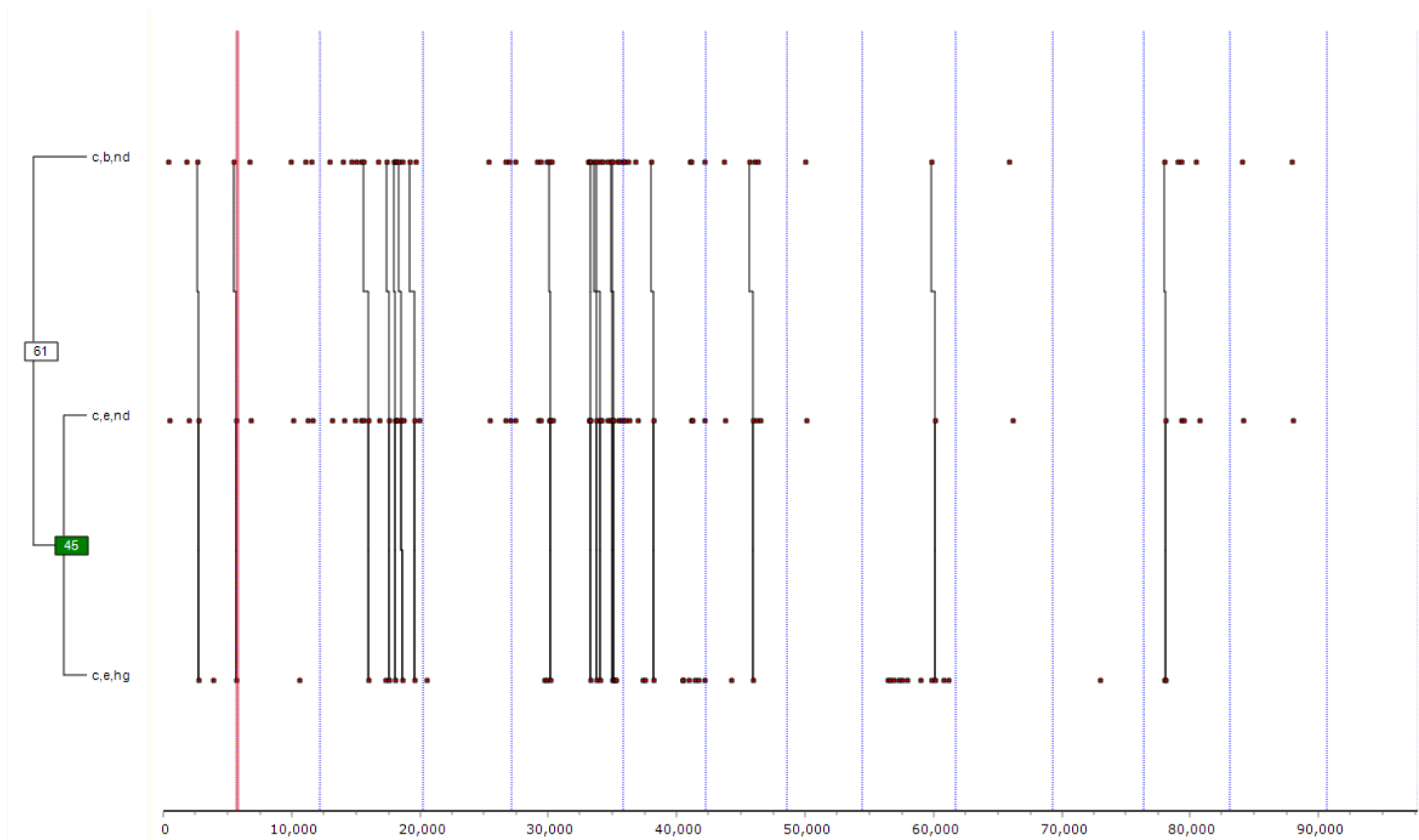


Figure 8. This pattern occurred with significantly greater frequency in the strong alliance group in the working phase. It is marked by expressions of a need, followed by expressions of hurt/grief, followed by expression of a need.

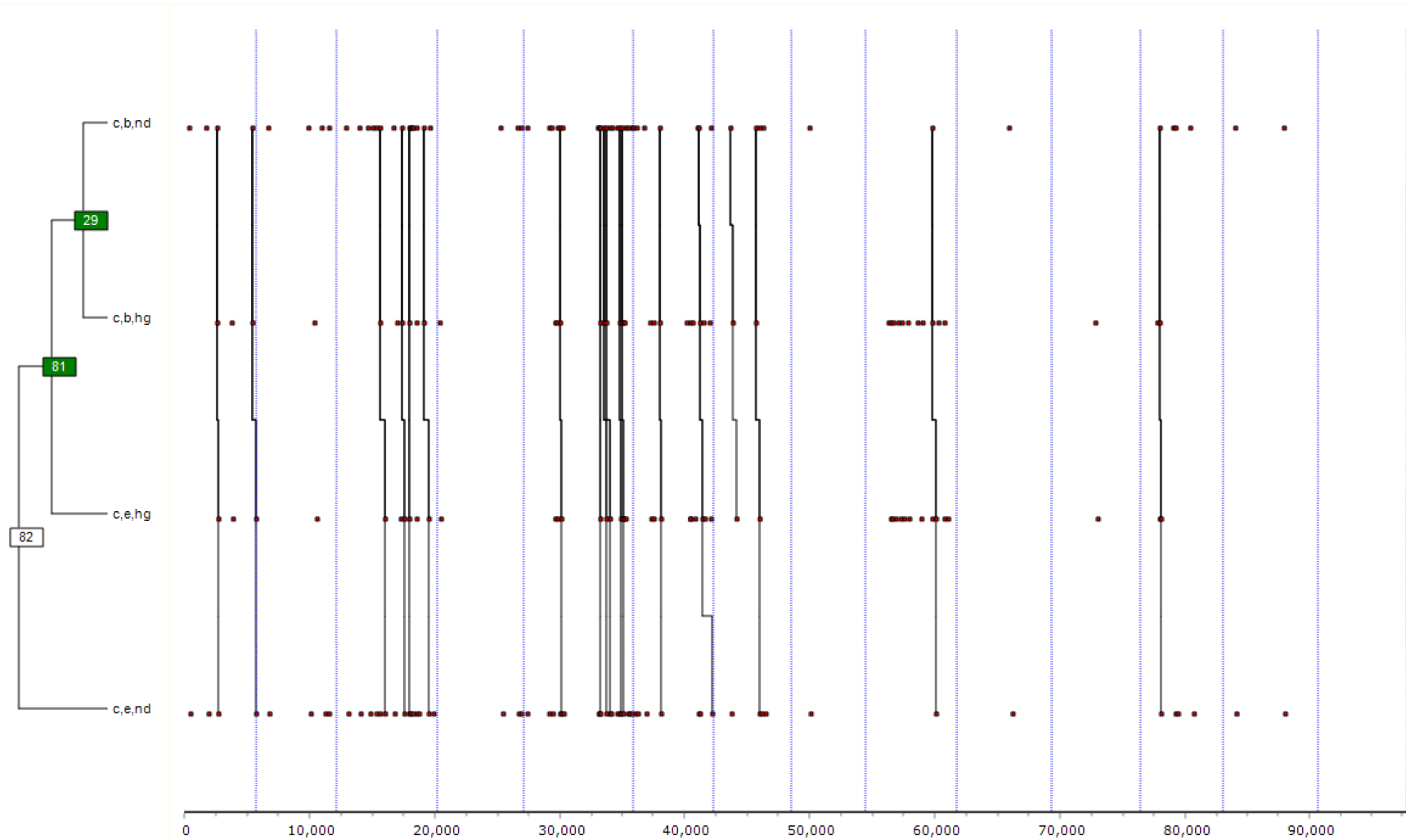


Figure 9. This pattern occurred with significantly greater frequency in the strong alliance group in the working phase. It is marked by expressions of hurt/grief, followed by expression of hurt/grief, followed expression of a need.

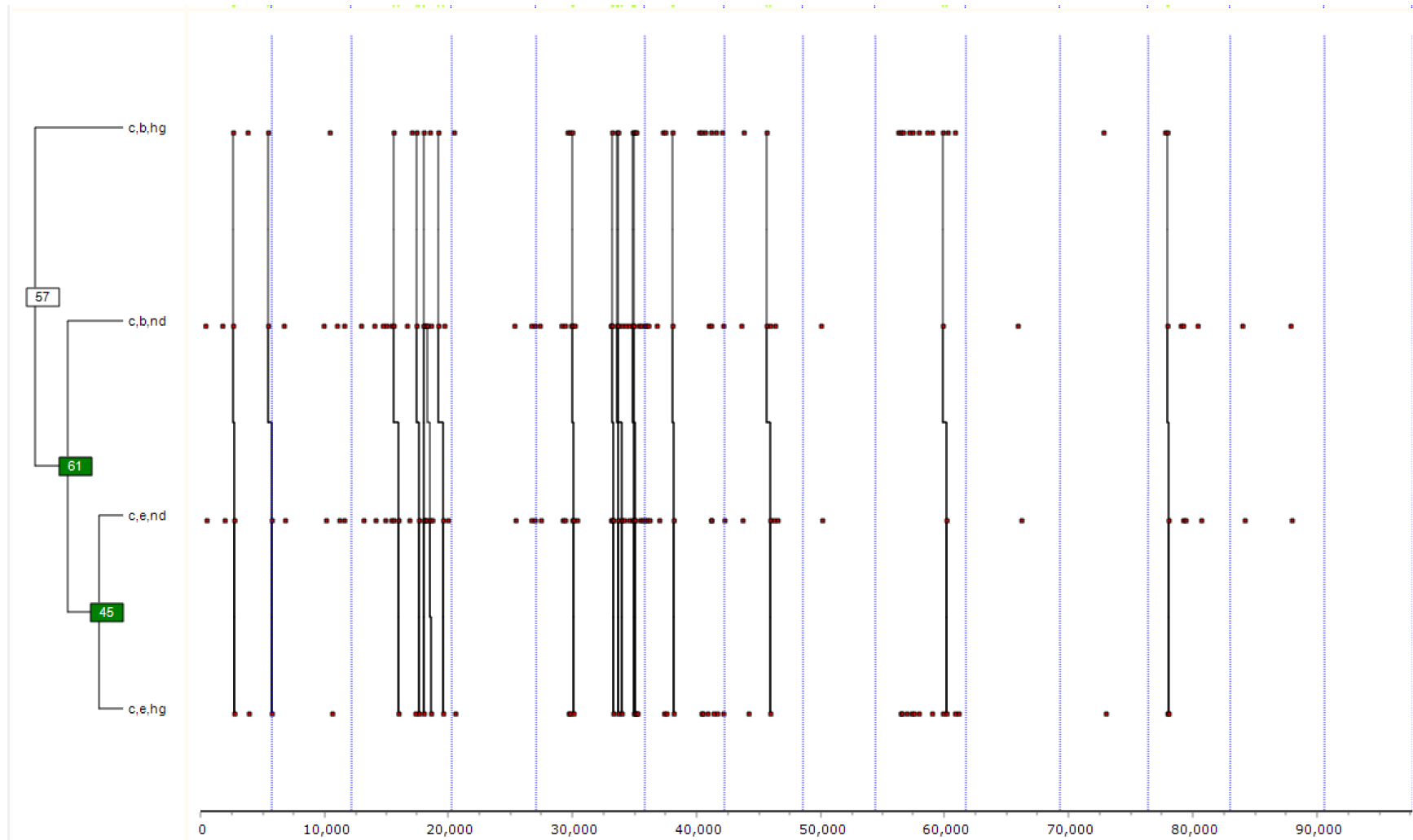


Figure 10. This pattern occurred with significantly greater frequency in the strong alliance group in the working phase. It is marked by expressions of hurt/grief, followed by expression of hurt/grief, followed expression of a need.

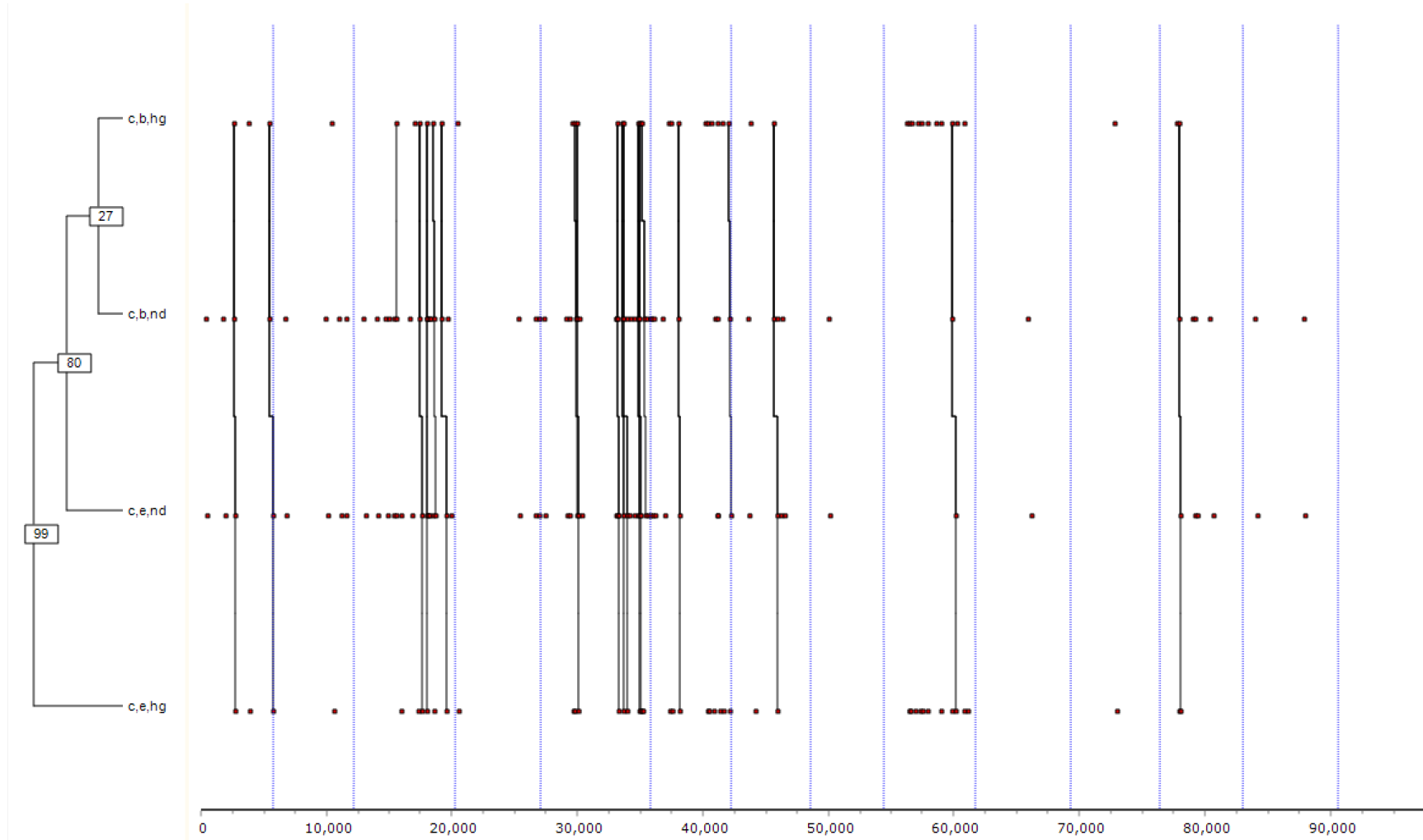


Figure 11. This pattern occurred with significantly greater frequency in the strong alliance group in the working phase. It is marked by expressions of a need.

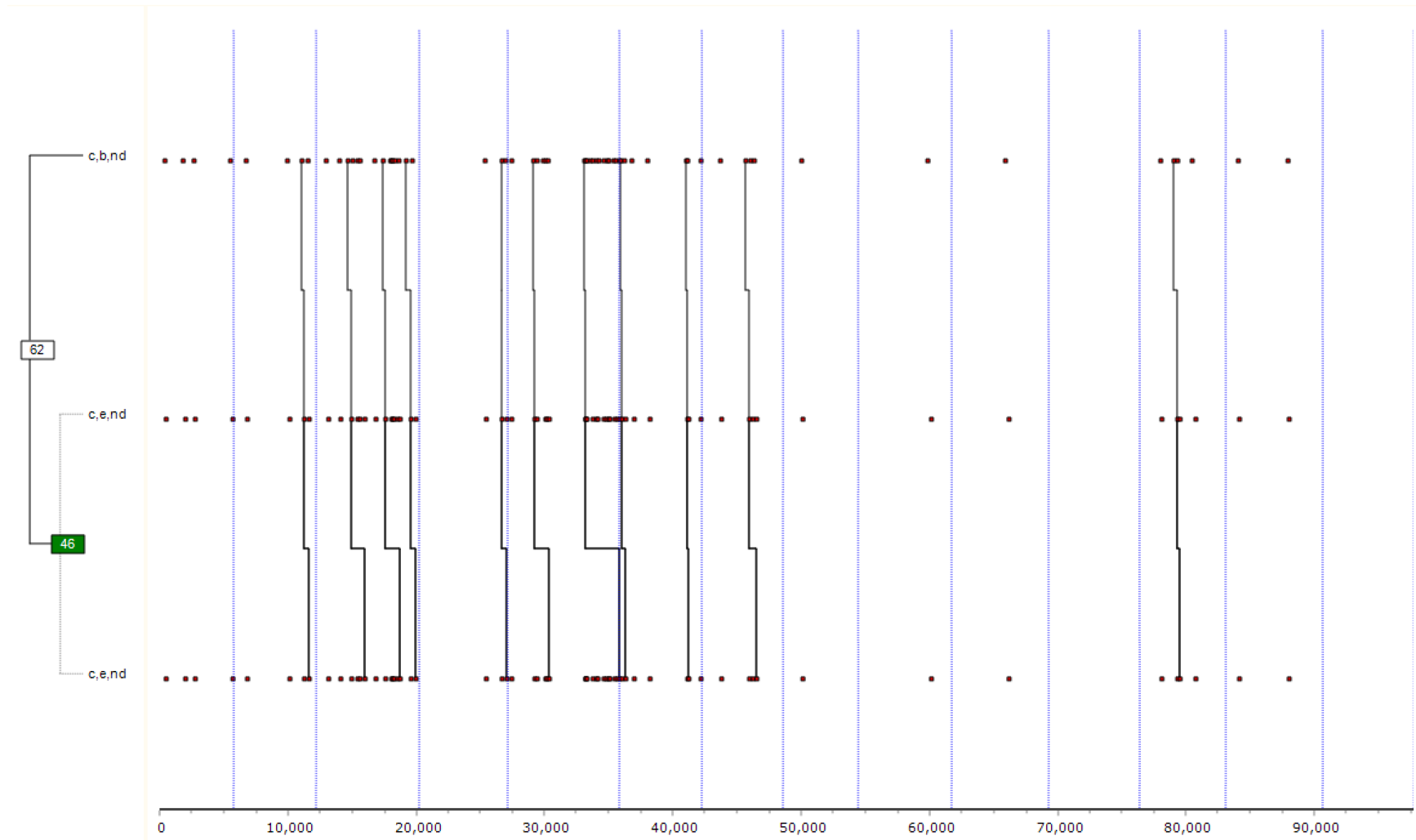


Figure 12. This pattern occurred with significantly greater frequency in the strong alliance group in the working phase. It is marked by expressions of a need.

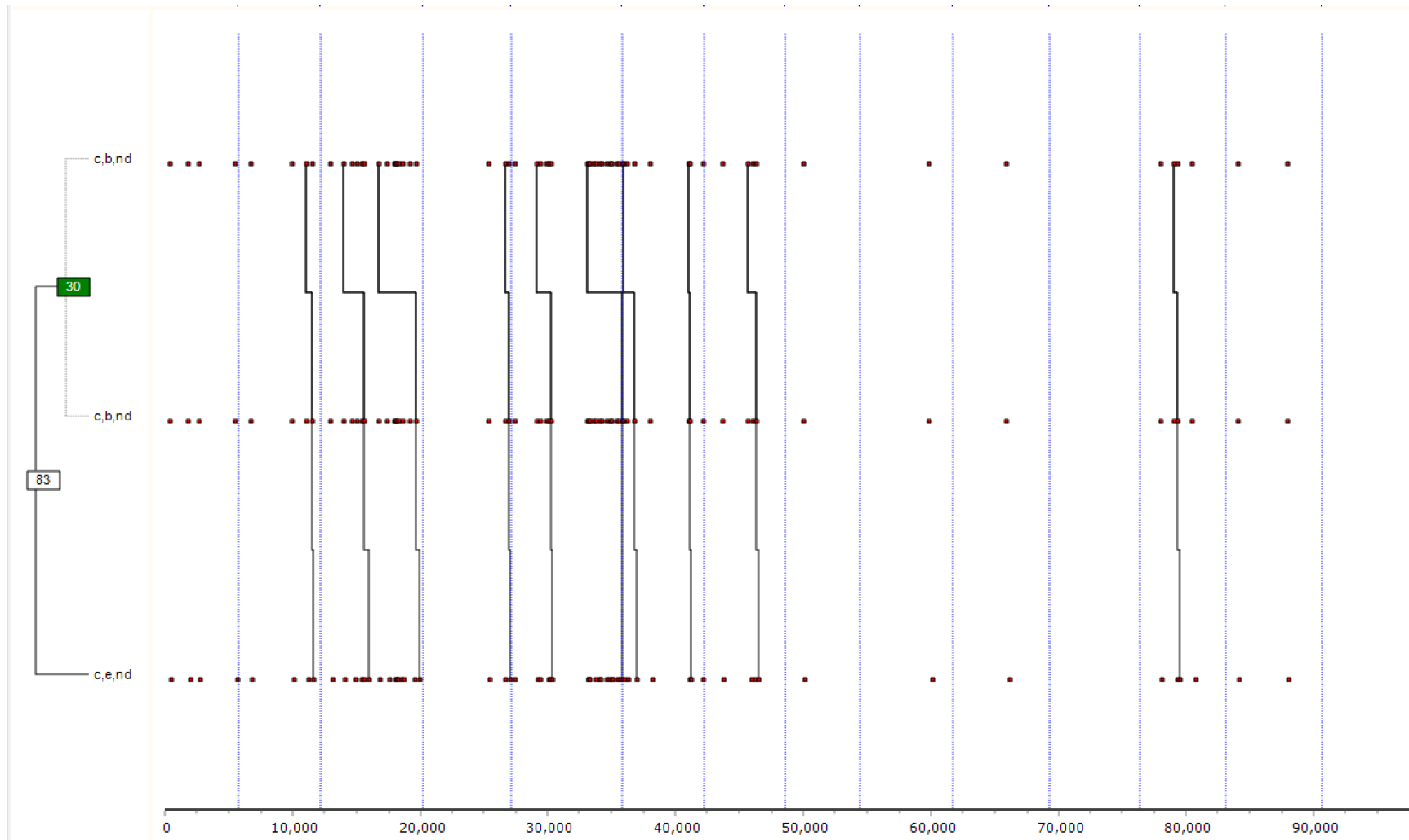


Figure 13. This pattern occurred with significantly greater frequency in the weak alliance group in the working phase. It is marked by expressions of global distress followed by more global distress.

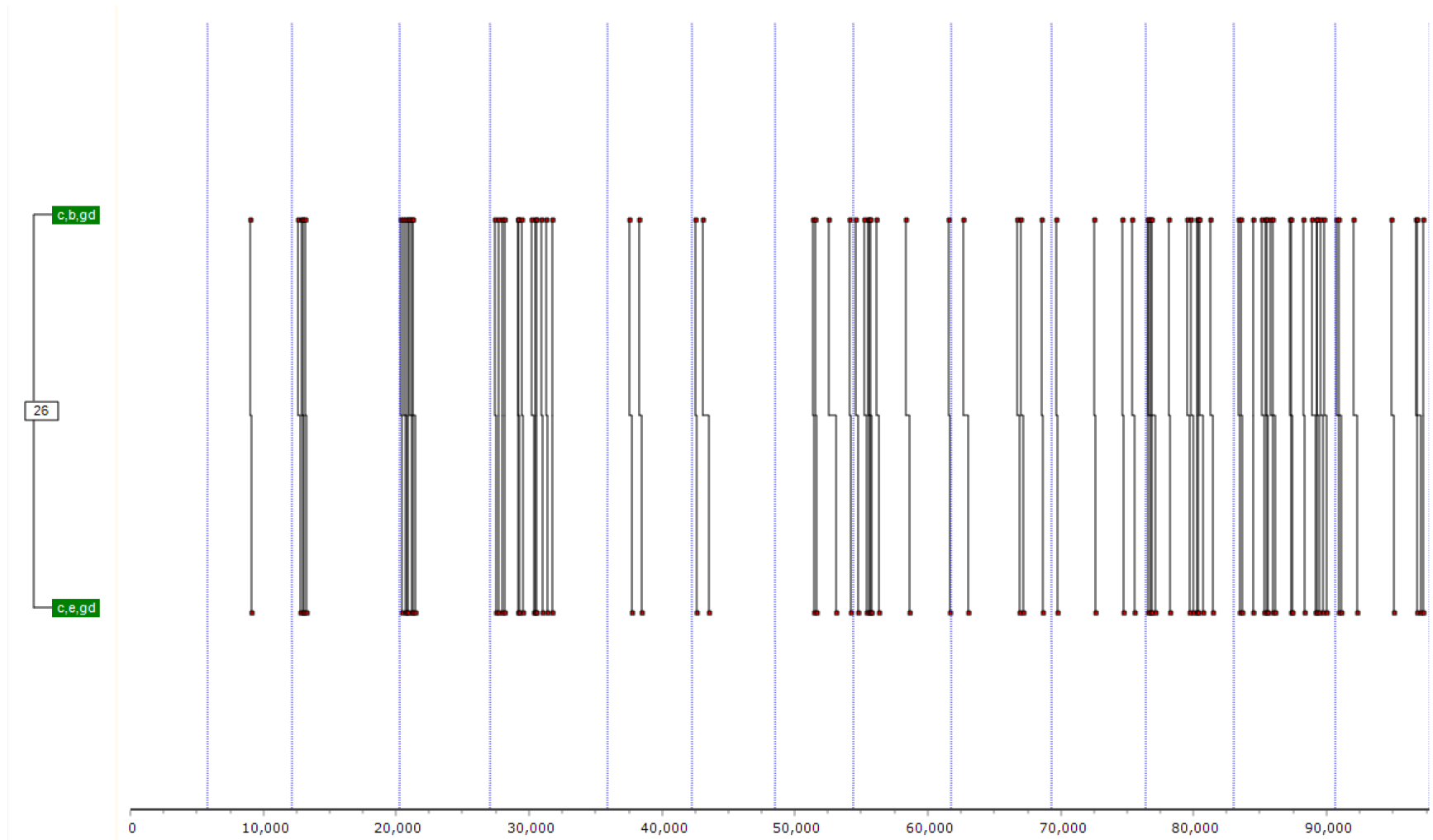


Figure 14. This pattern occurred with significantly greater frequency in the strong alliance group in the termination phase. It is marked by expressions of relief followed by more relief.

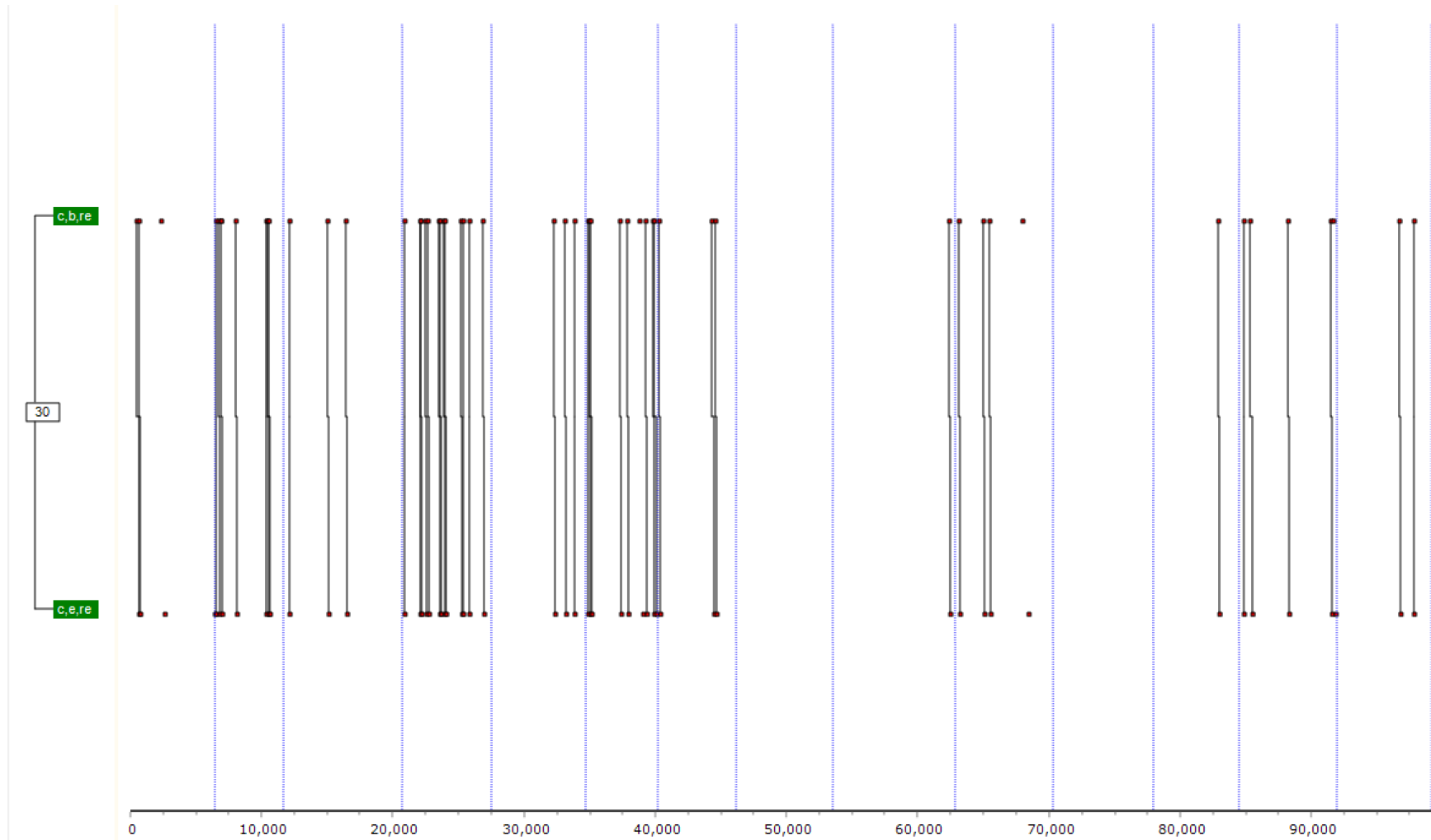


Figure 15. This pattern occurred with significantly greater frequency in the strong alliance group in the termination phase. It is marked by expressions of uncodable followed by more uncodable.

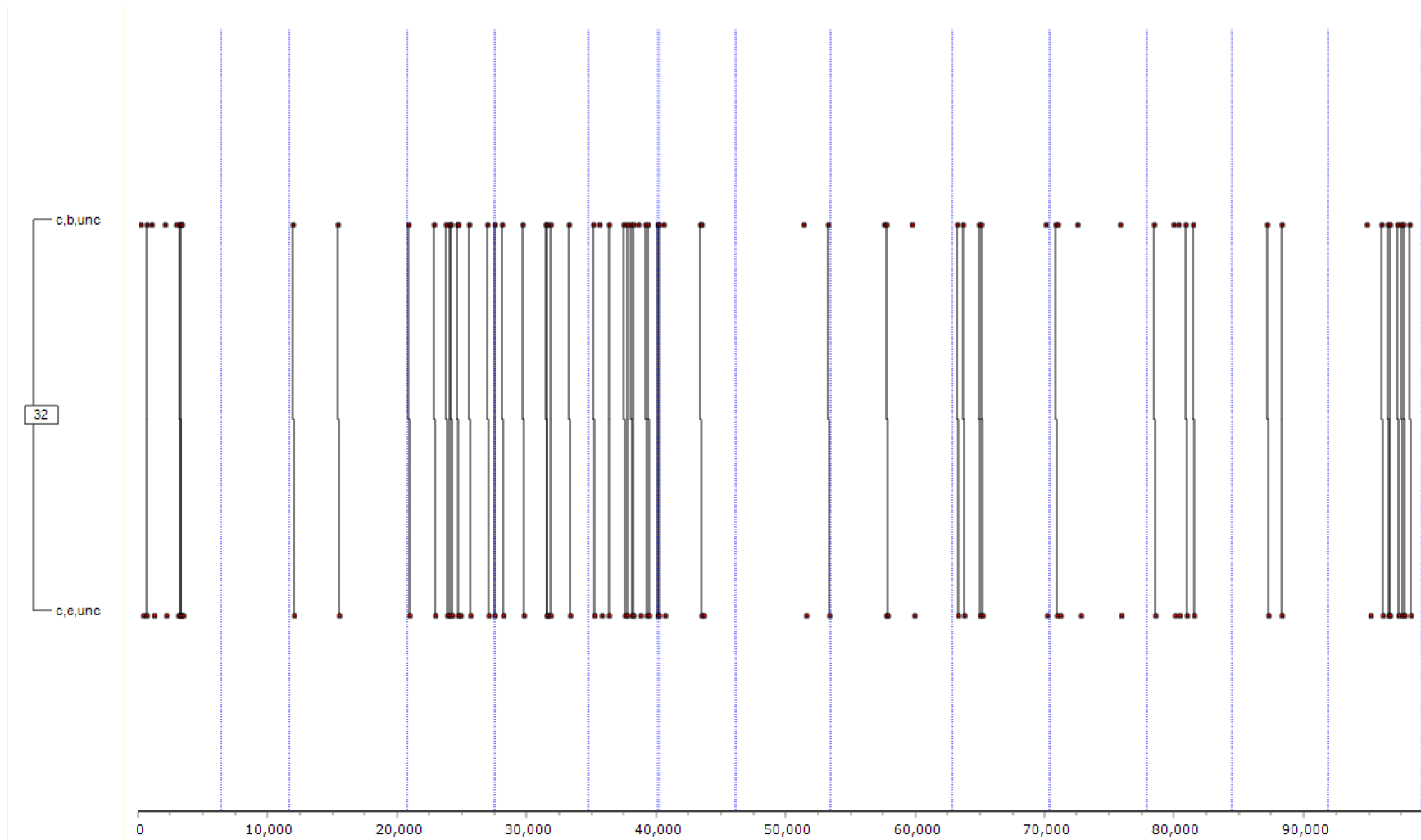


Figure 16. This pattern occurred with significantly greater frequency in the weak alliance group in the termination phase. It is marked by expressions of global distress followed by more global distress.

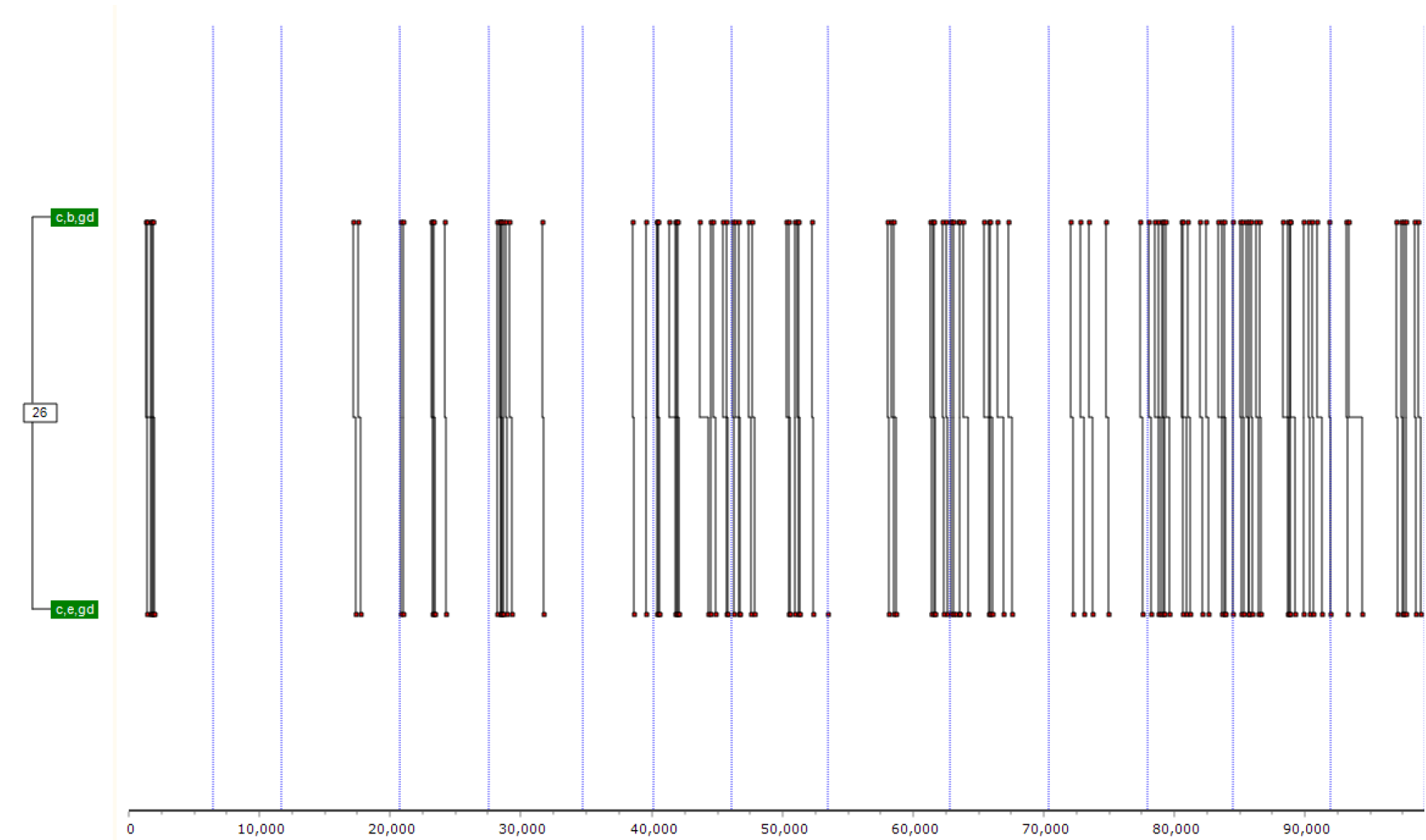


Figure 17. This pattern occurred with significantly greater frequency in the weak alliance group in the termination phase. It is marked by expressions of global distress followed by two more expressions of global distress.

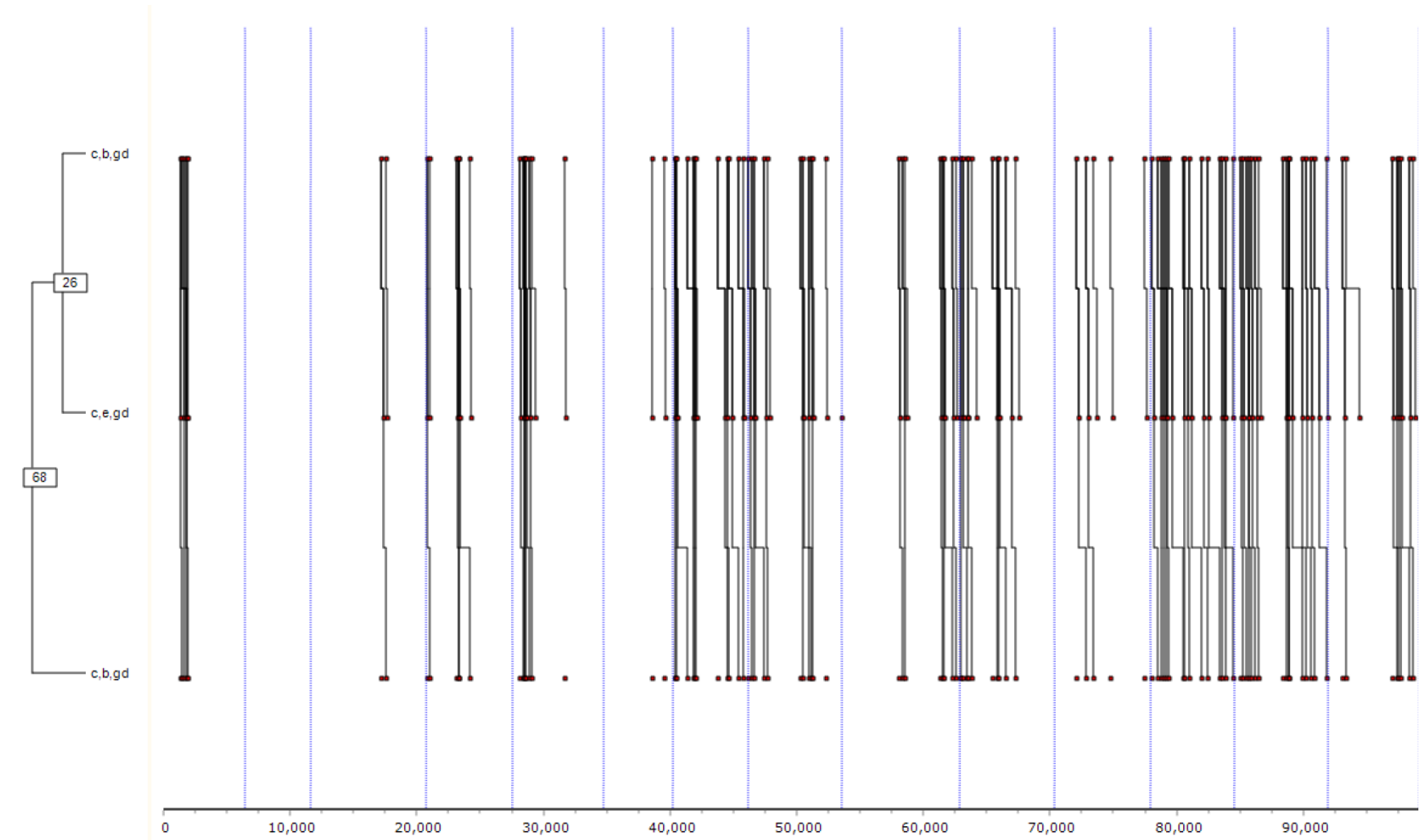


Figure 18. This pattern occurred with significantly greater frequency in the weak alliance group in the termination phase. It is marked by expressions of global distress followed by more global distress.

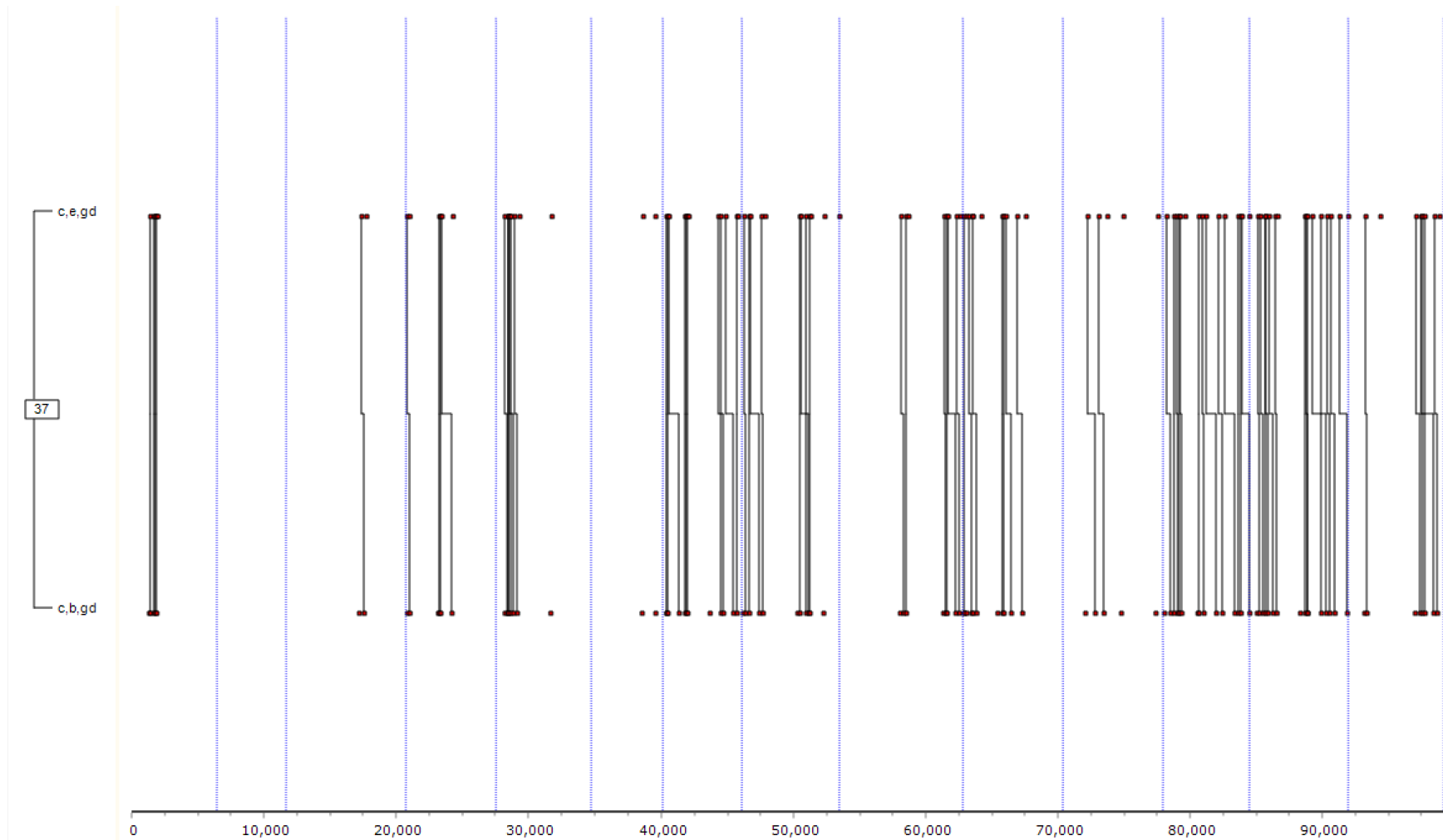


Figure 19. This pattern occurred with significantly greater frequency in the weak alliance group in the termination phase. It is marked by expressions of global distress followed by more global distress.

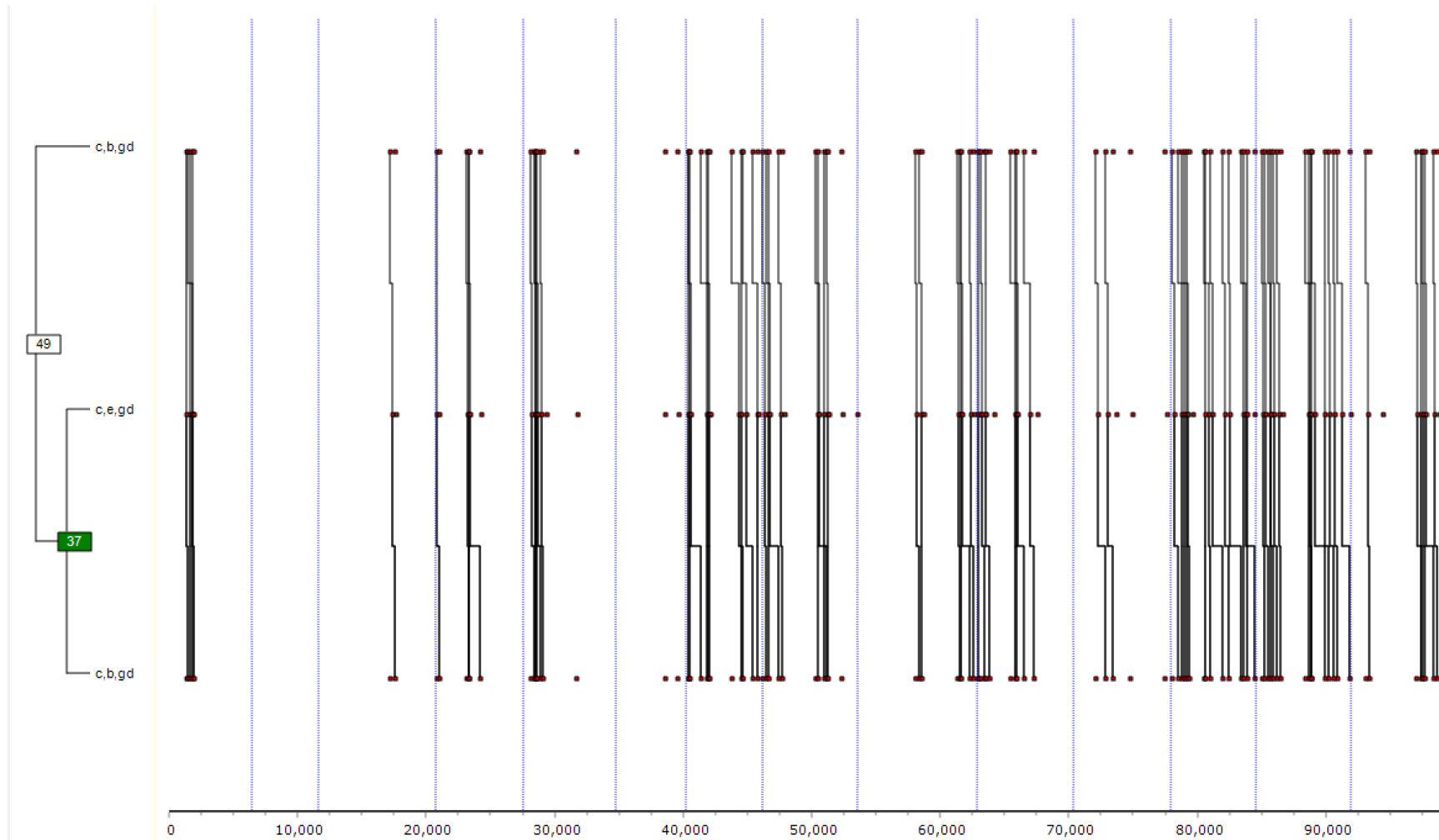


Figure 20. This pattern occurred with significantly greater frequency in the weak alliance group in the termination phase. It is marked by expressions of global distress followed by more global distress.

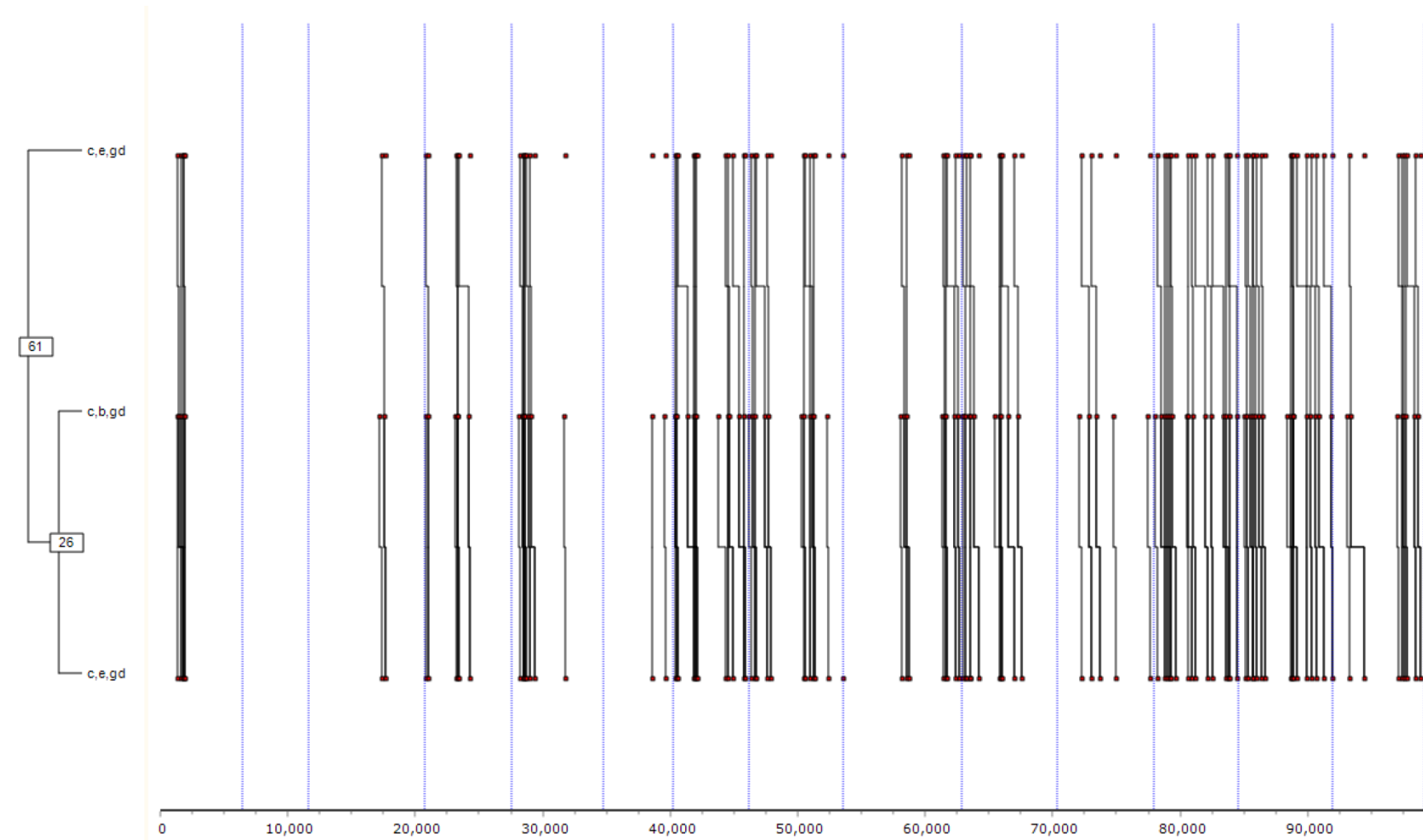


Figure 21. This pattern occurred with significantly greater frequency in the weak alliance group in the termination phase. It is marked by expressions of rejecting anger, followed by more rejecting anger and then repeated global distress.

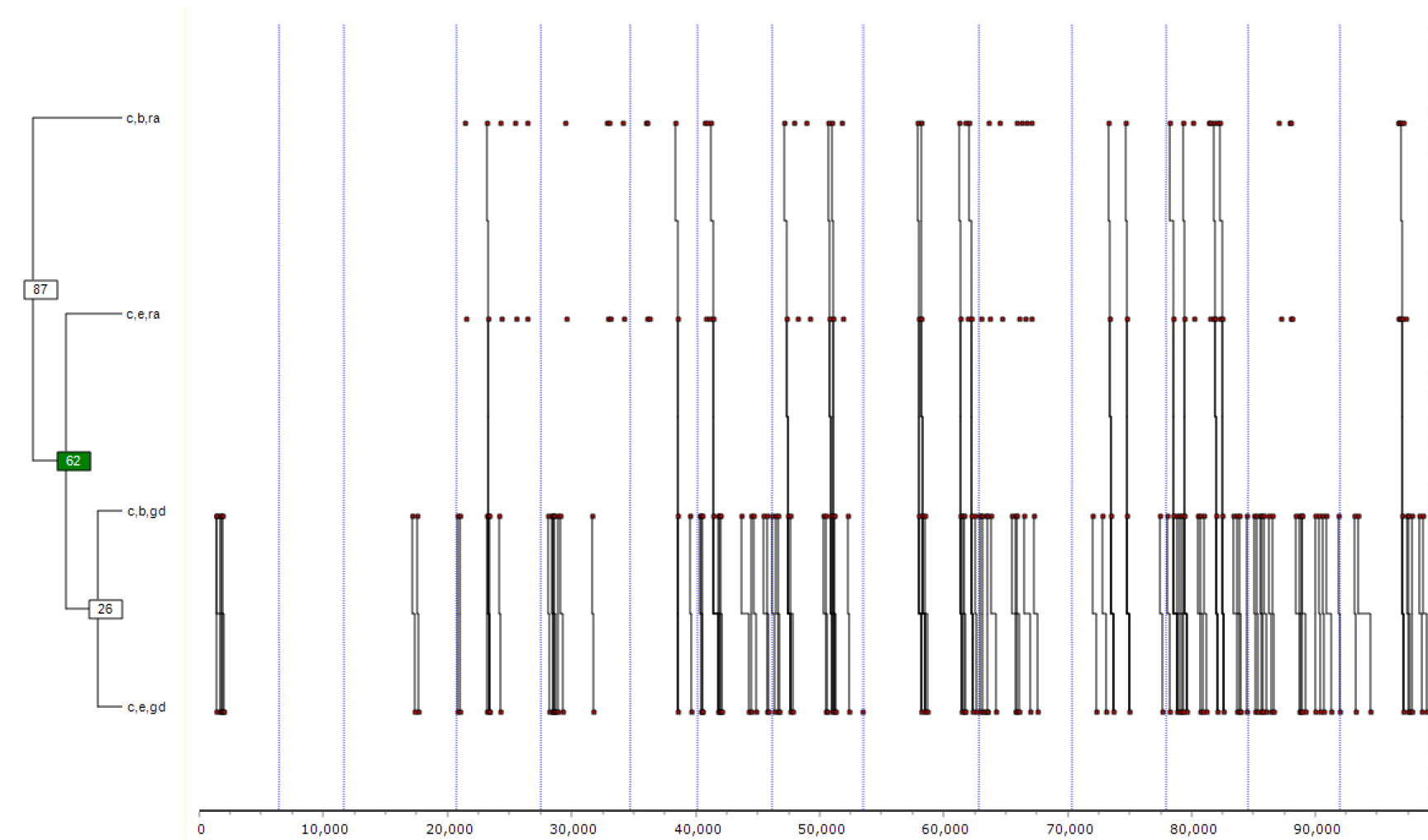


Figure 22. This pattern occurred with significantly greater frequency in the weak alliance group in the termination phase. It is marked by expressions of global distress, followed by repeated fear/shame.

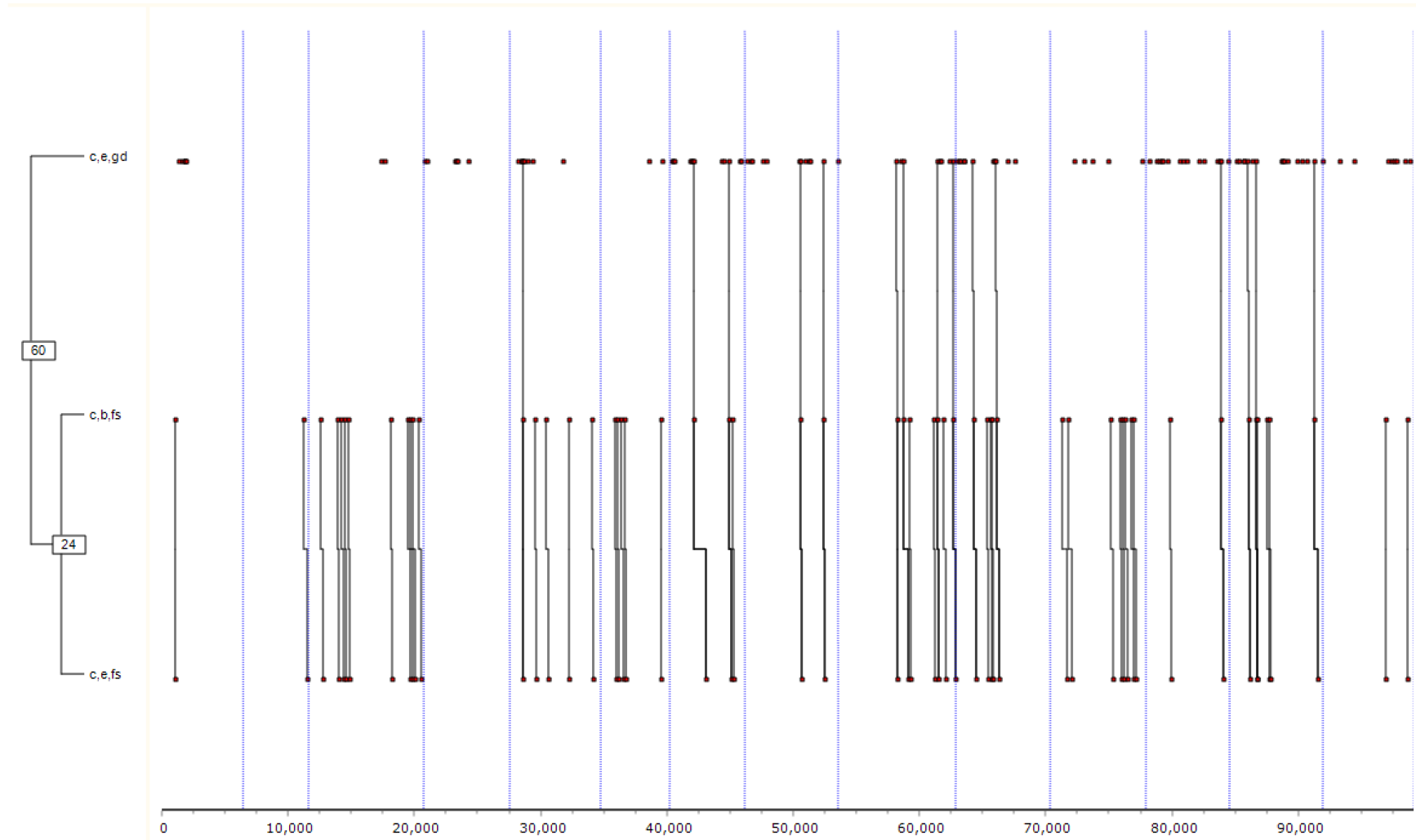


Figure 23. This pattern occurred with significantly greater frequency in the weak alliance group in the termination phase. It is marked by expressions of repeated global distress, followed by more global distress.

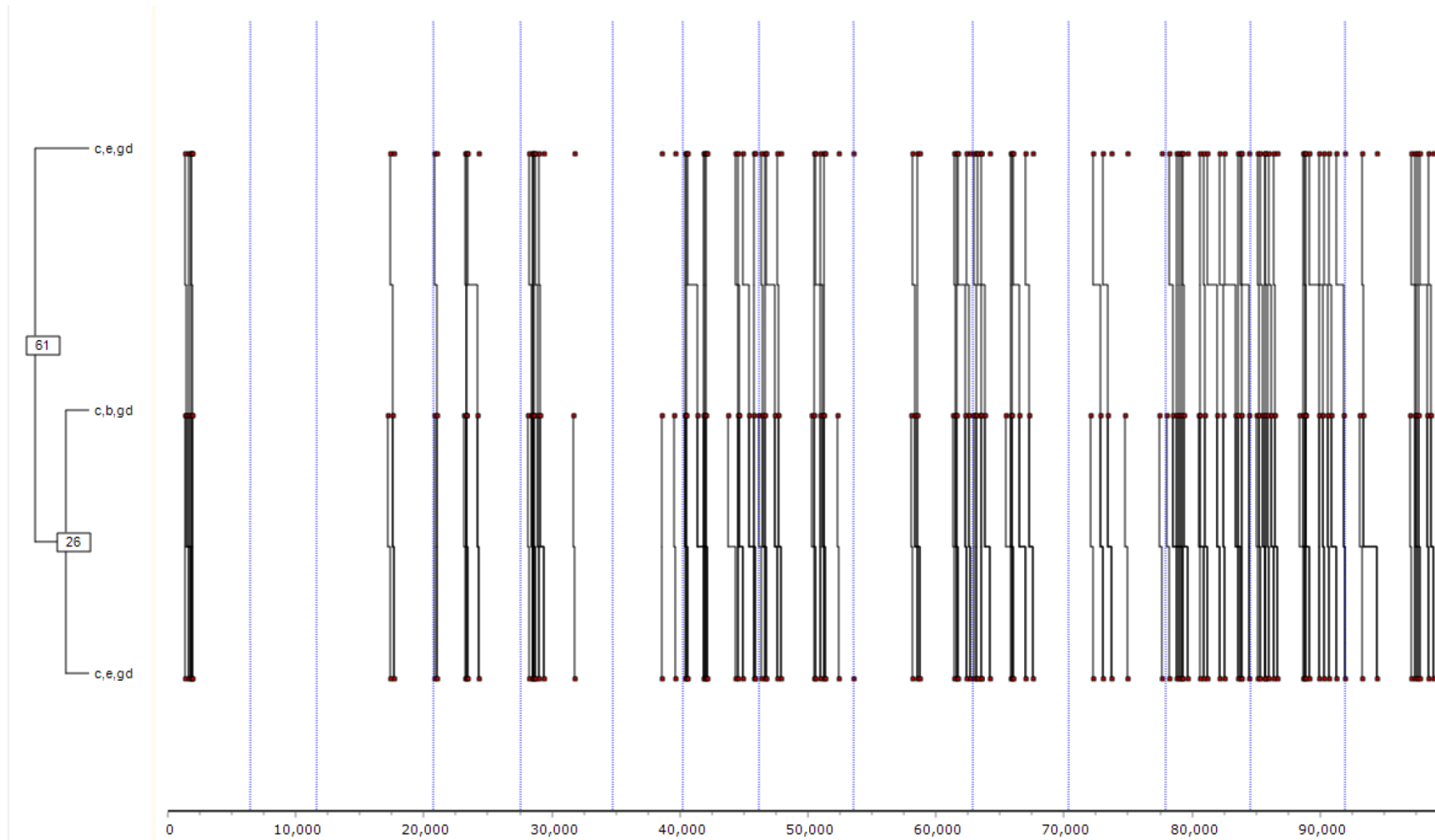


Figure 24. This pattern occurred with significantly greater frequency in the weak alliance group in the termination phase. It is marked by expressions of repeated global distress, followed by fear/shame.

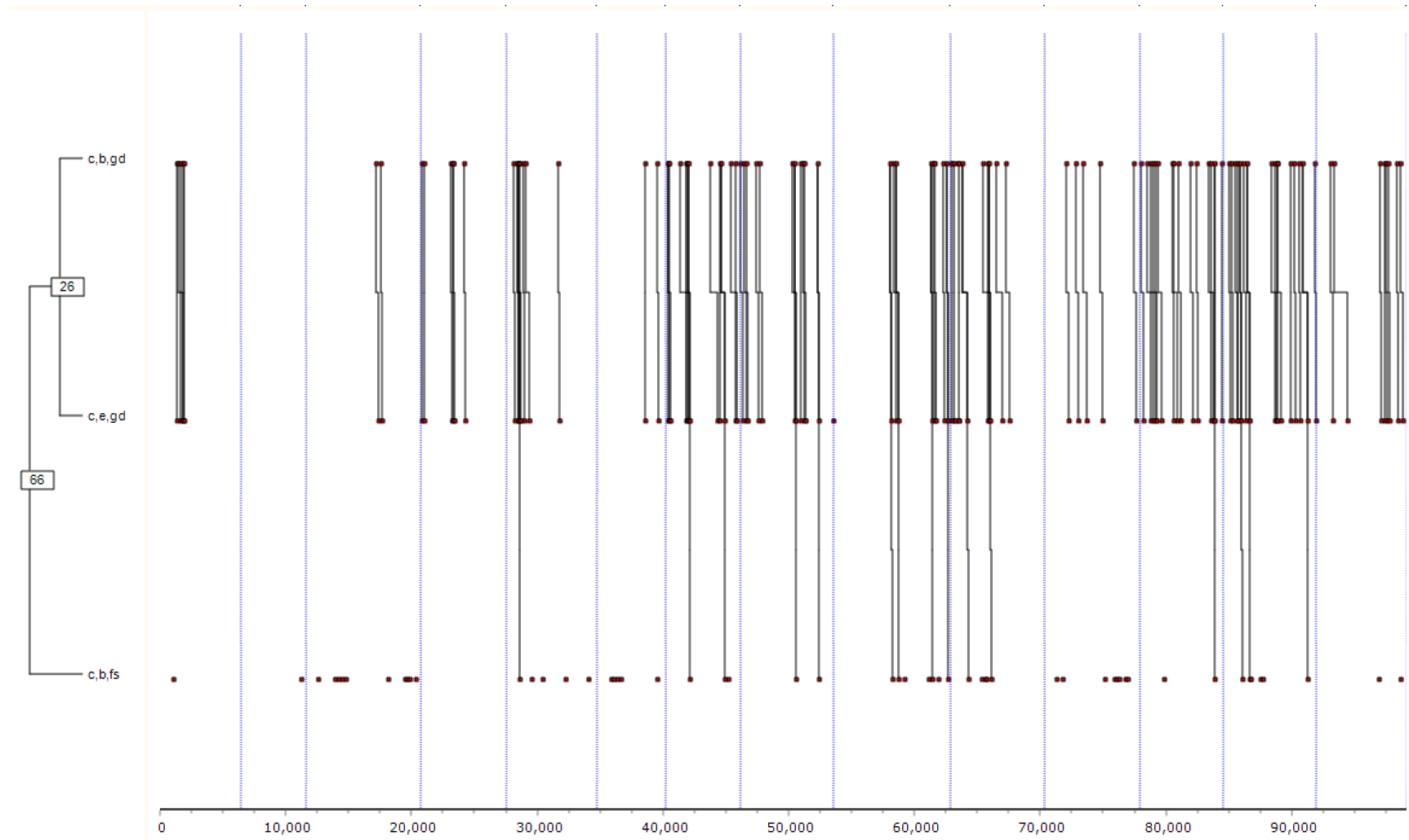


Figure 25. This pattern occurred with significantly greater frequency in the weak alliance group in the termination phase. It is marked by expressions of repeated global distress.

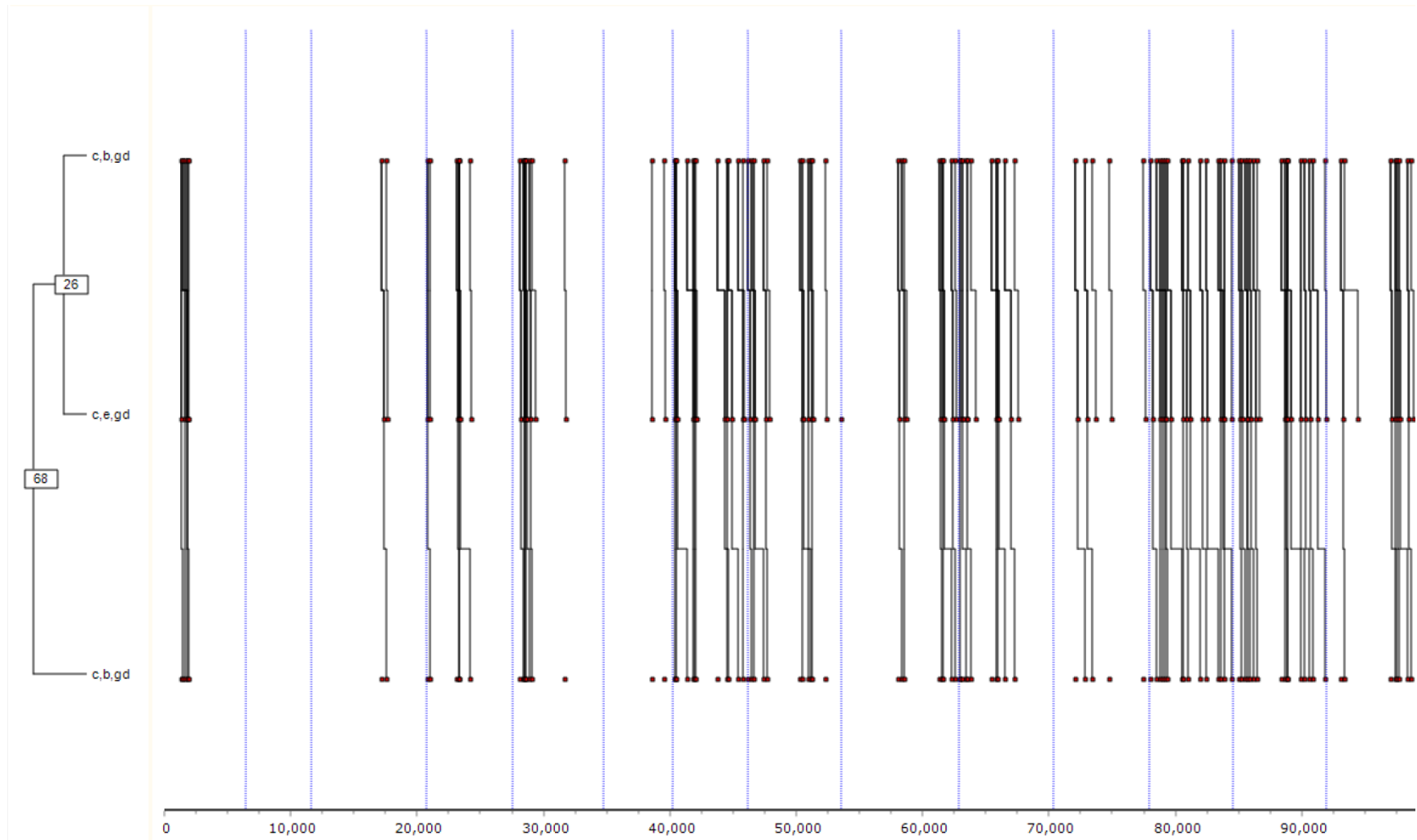


Figure 26. This pattern occurred with significantly greater frequency in the weak alliance group in the termination phase. It is marked by expressions of repeated global distress, followed by fear/shame.

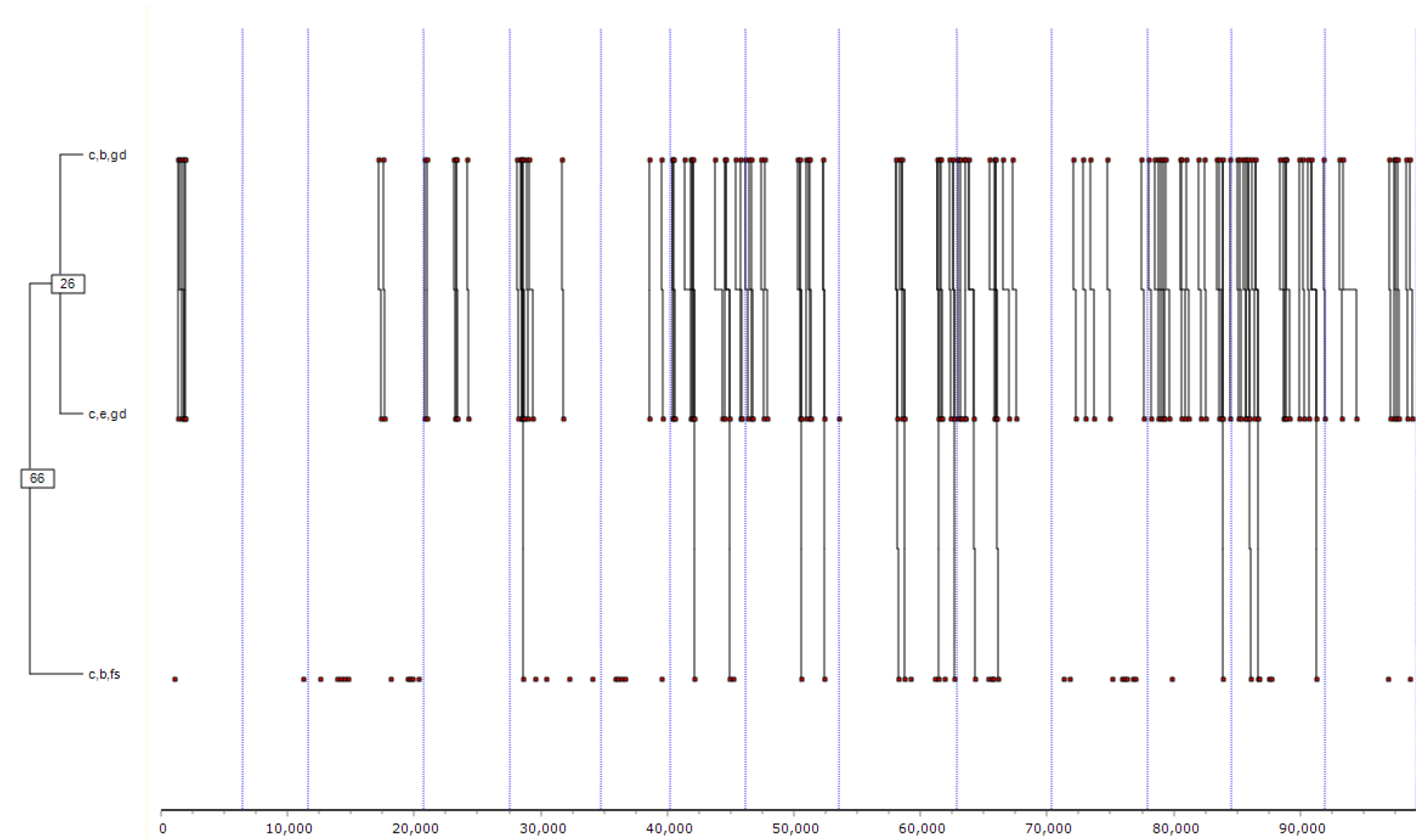


Figure 27. This pattern occurred with significantly greater frequency in the weak alliance group in the termination phase. It is marked by expressions of repeated global distress, followed by repeated fear/shame.

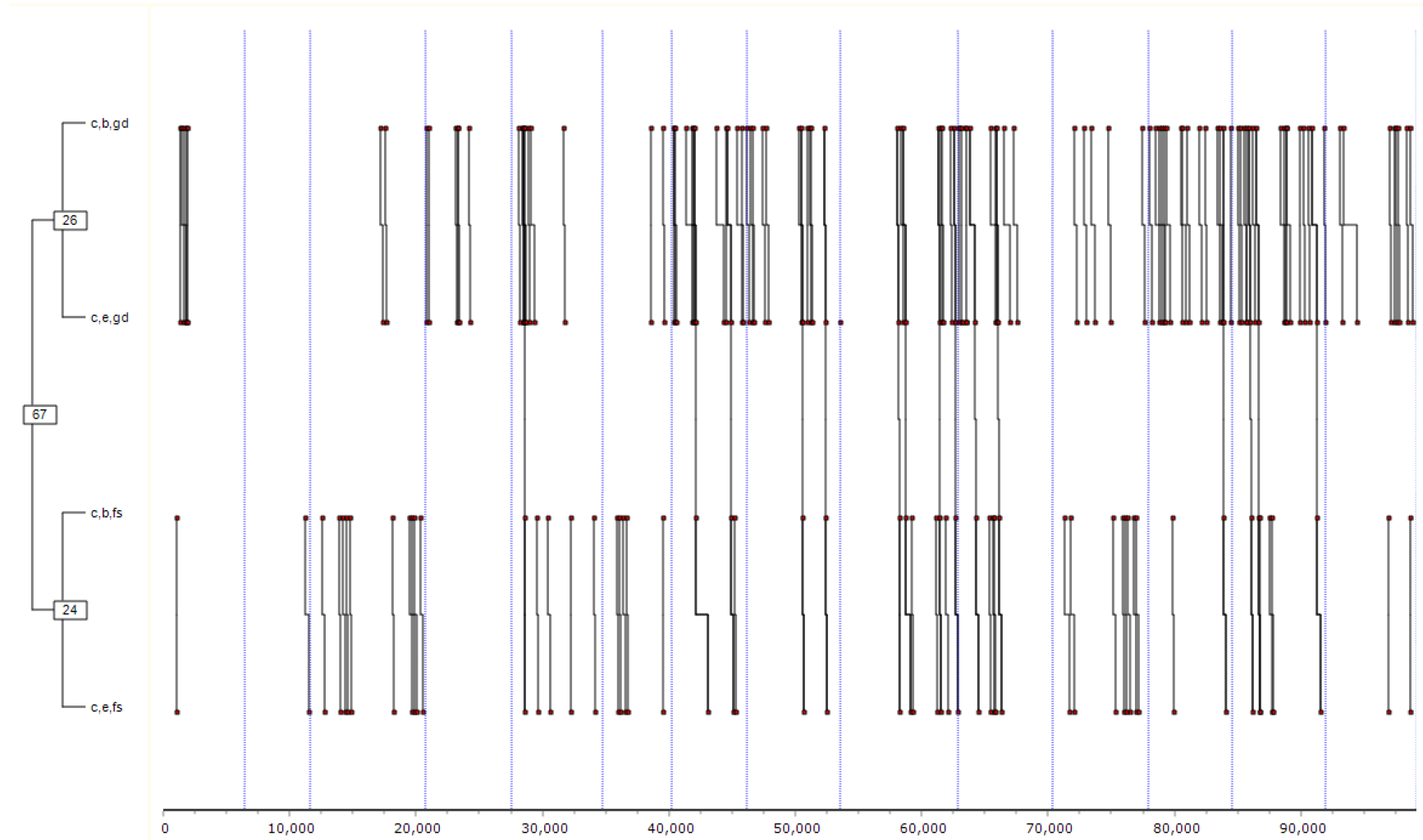


Figure 28. This pattern occurred with significantly greater frequency in the weak alliance group in the termination phase. It is marked by expressions of repeated rejecting anger, followed by repeated global distress.

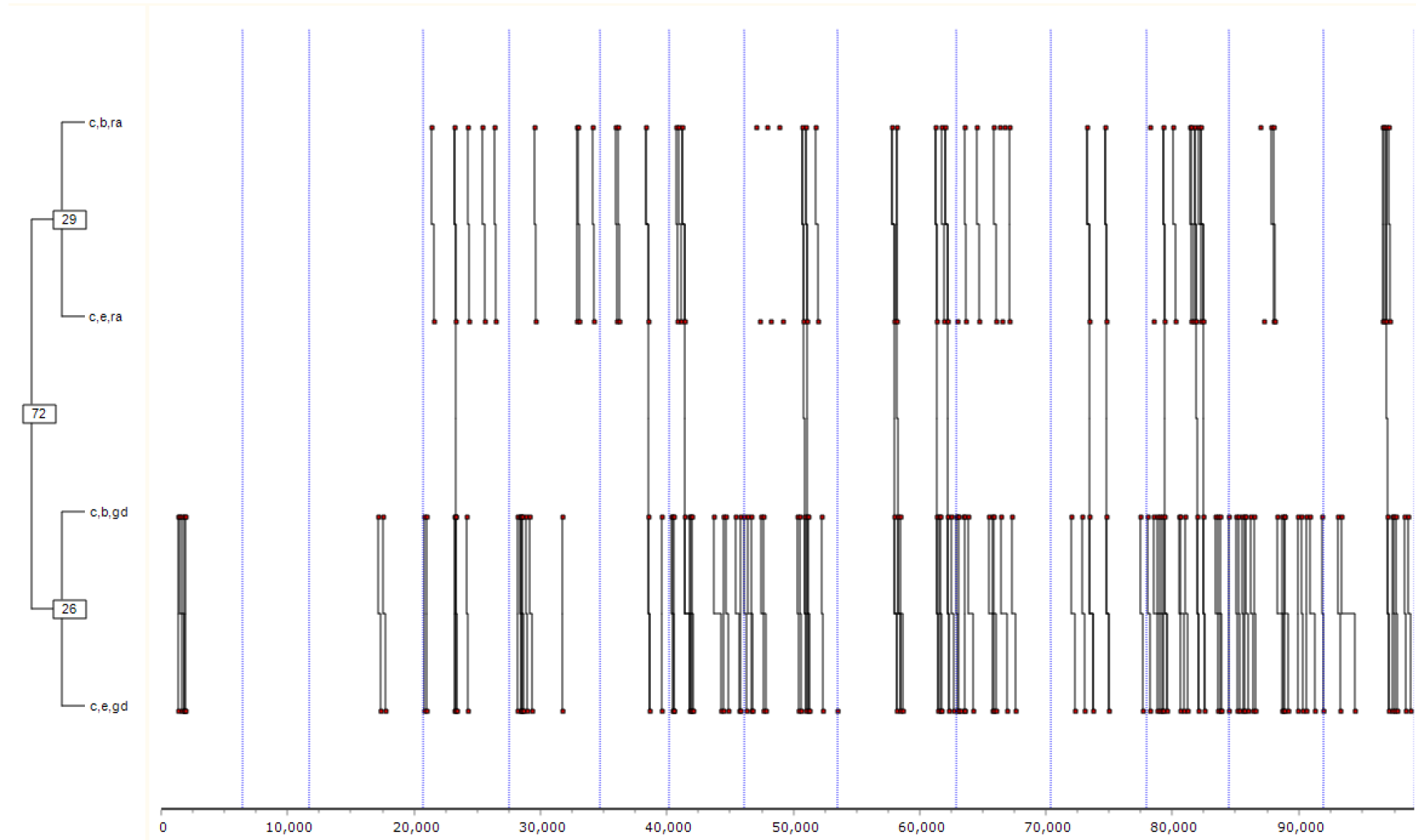


Figure 29. This emotion scheme pattern occurred with significantly greater frequency in the strong alliance group in the working phase. It is marked by expressions of primary adaptive emotion followed by more primary adaptive emotion.

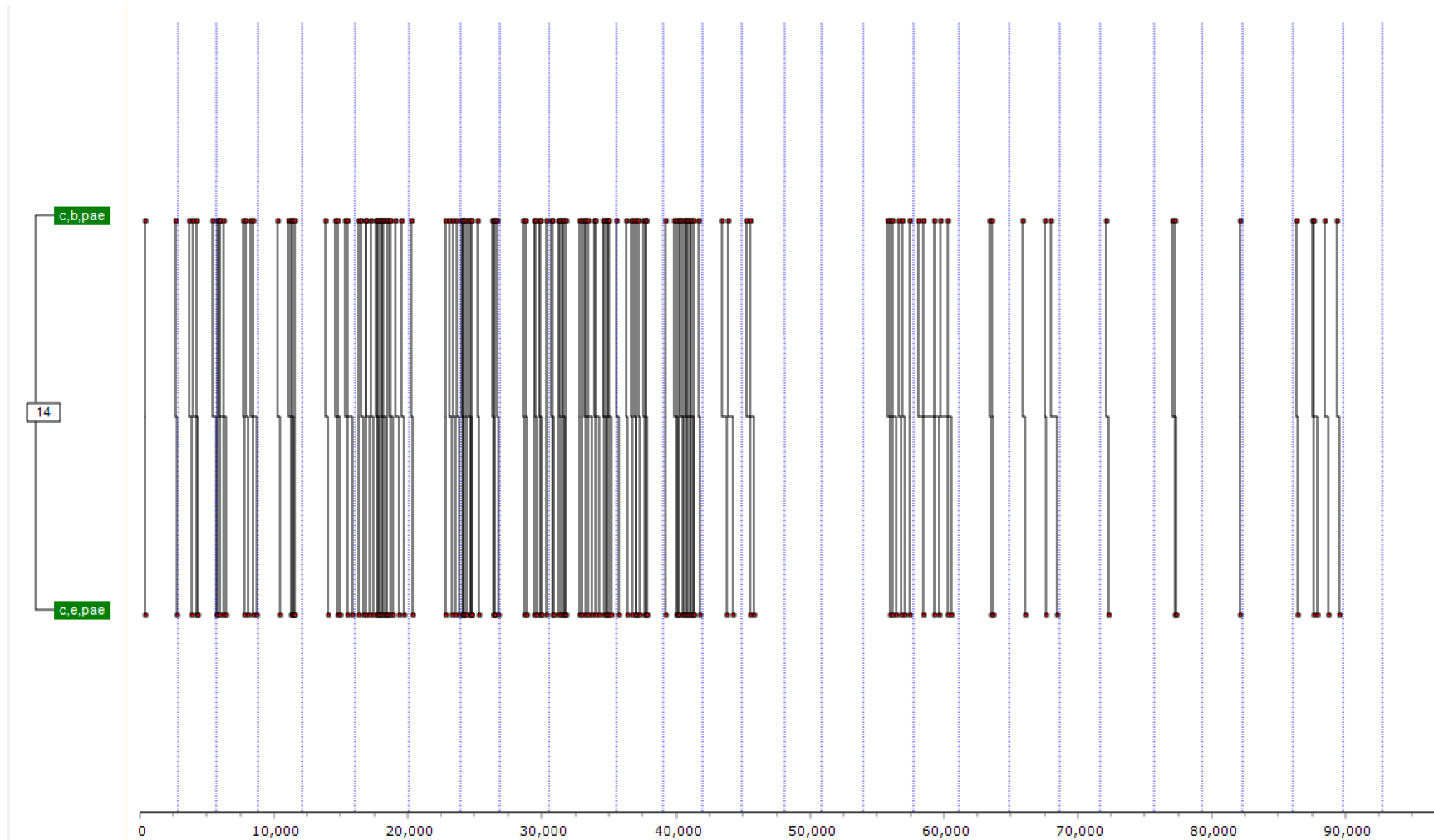


Figure 30. This emotion scheme pattern occurred with significantly greater frequency in the strong alliance group in the working phase. It is marked by expressions of primary adaptive emotion followed by more primary adaptive emotion.

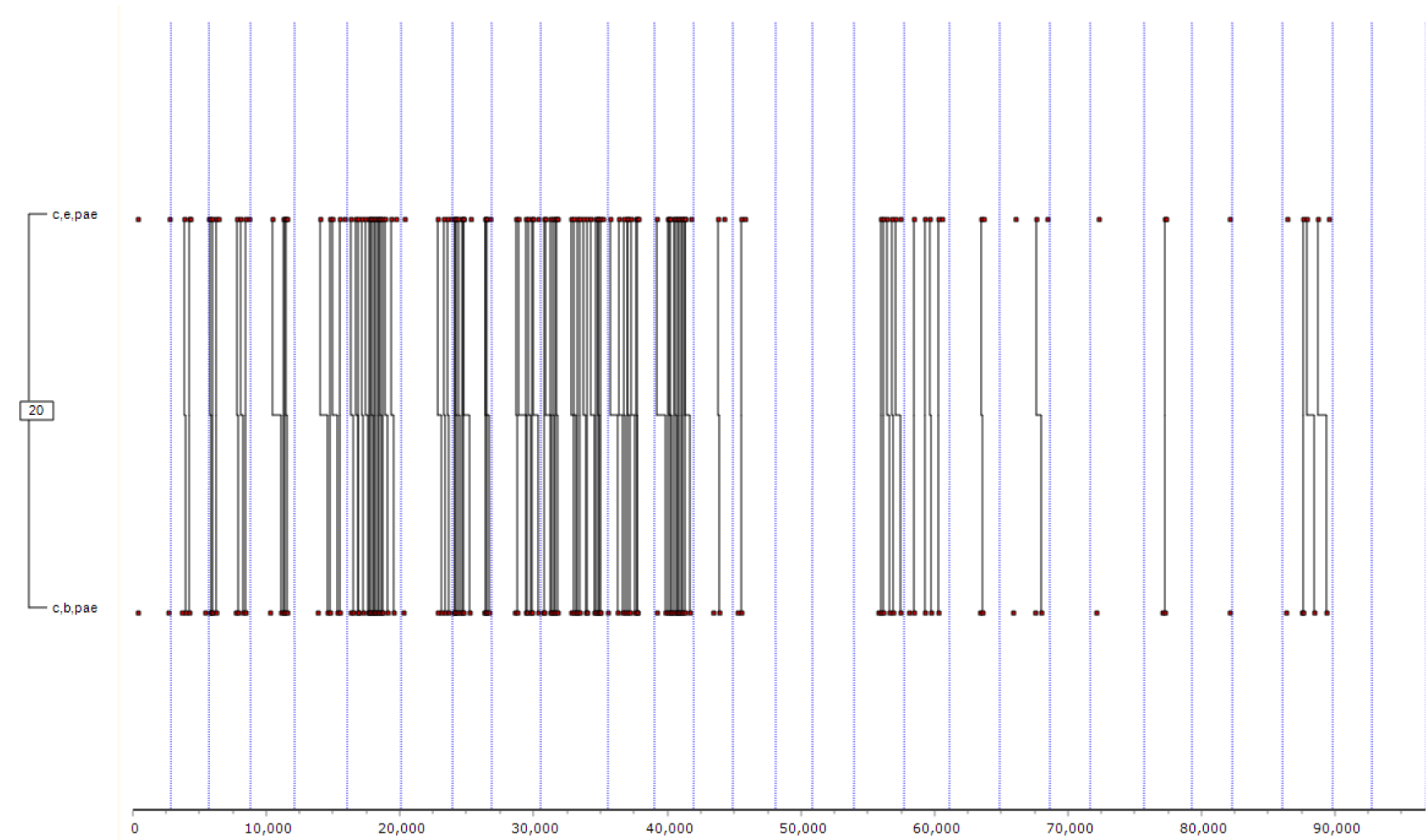


Figure 31. This emotion scheme pattern occurred with significantly greater frequency in the strong alliance group in the working phase. It is marked by expressions of repeated primary adaptive emotion.

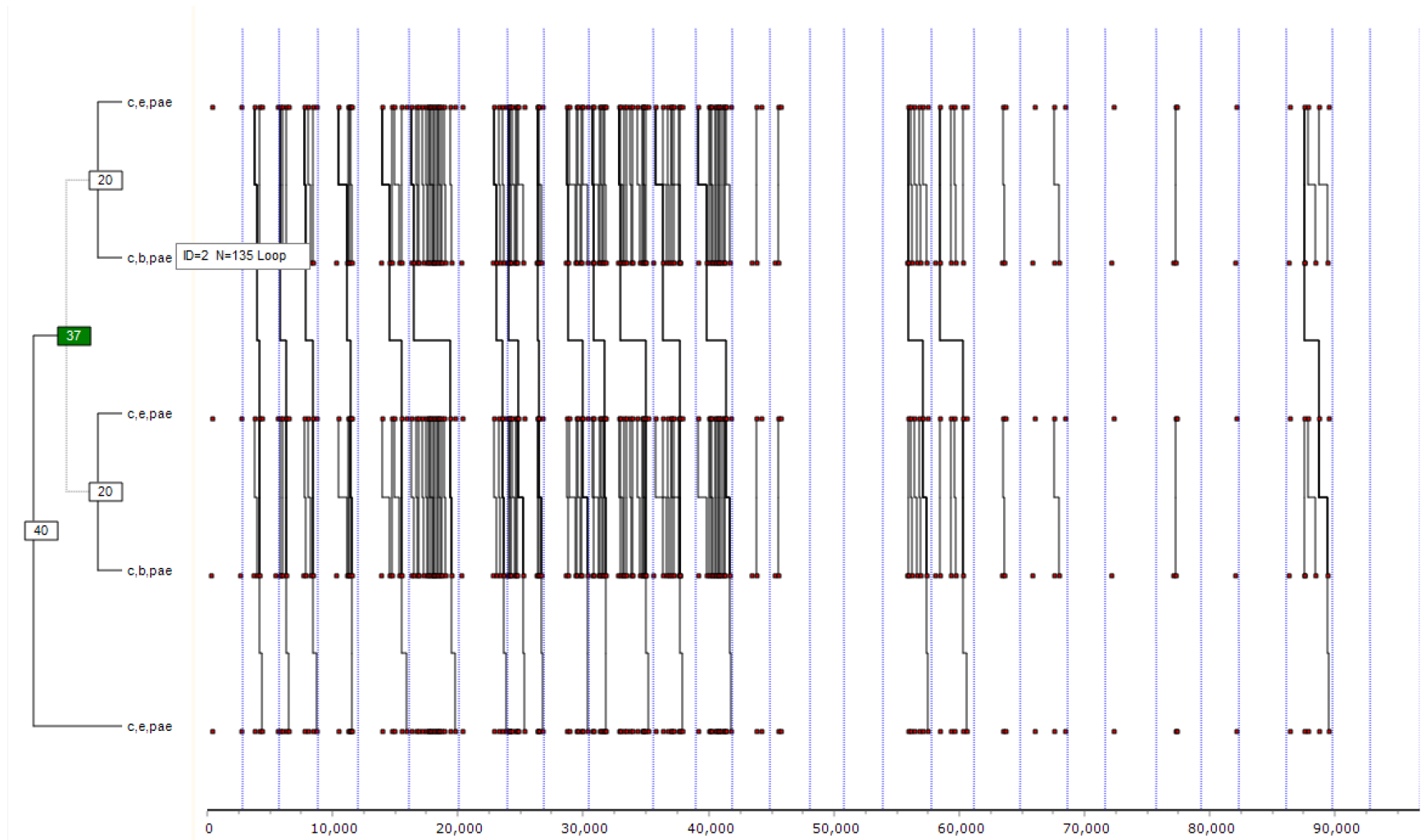


Figure 32. This emotion scheme pattern occurred with significantly greater frequency in the weak alliance group in the working phase. It is marked by expressions of repeated secondary emotion.

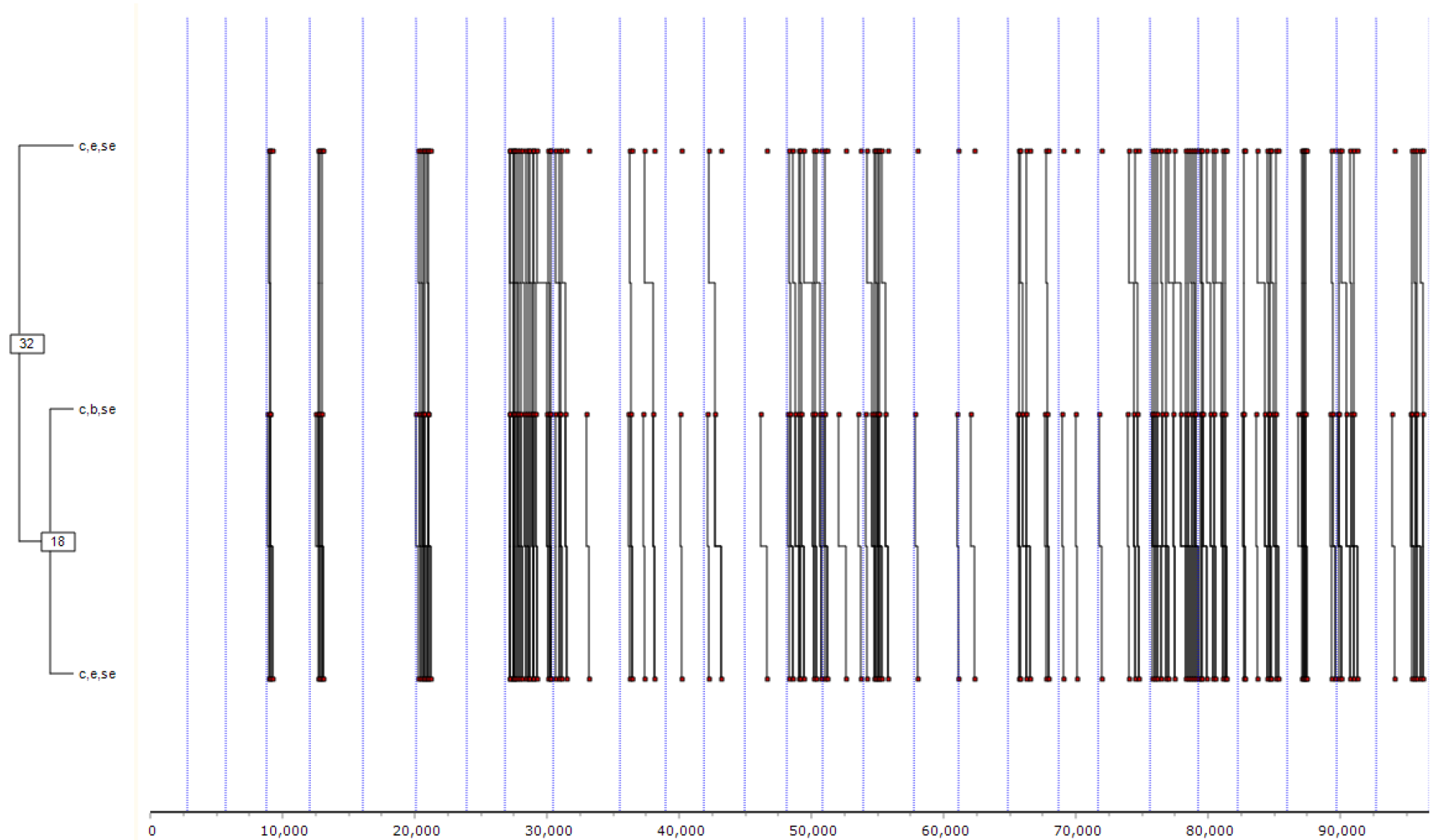


Figure 33. This emotion scheme pattern occurred with significantly greater frequency in the weak alliance group in the working phase. It is marked by expressions of repeated secondary emotion.

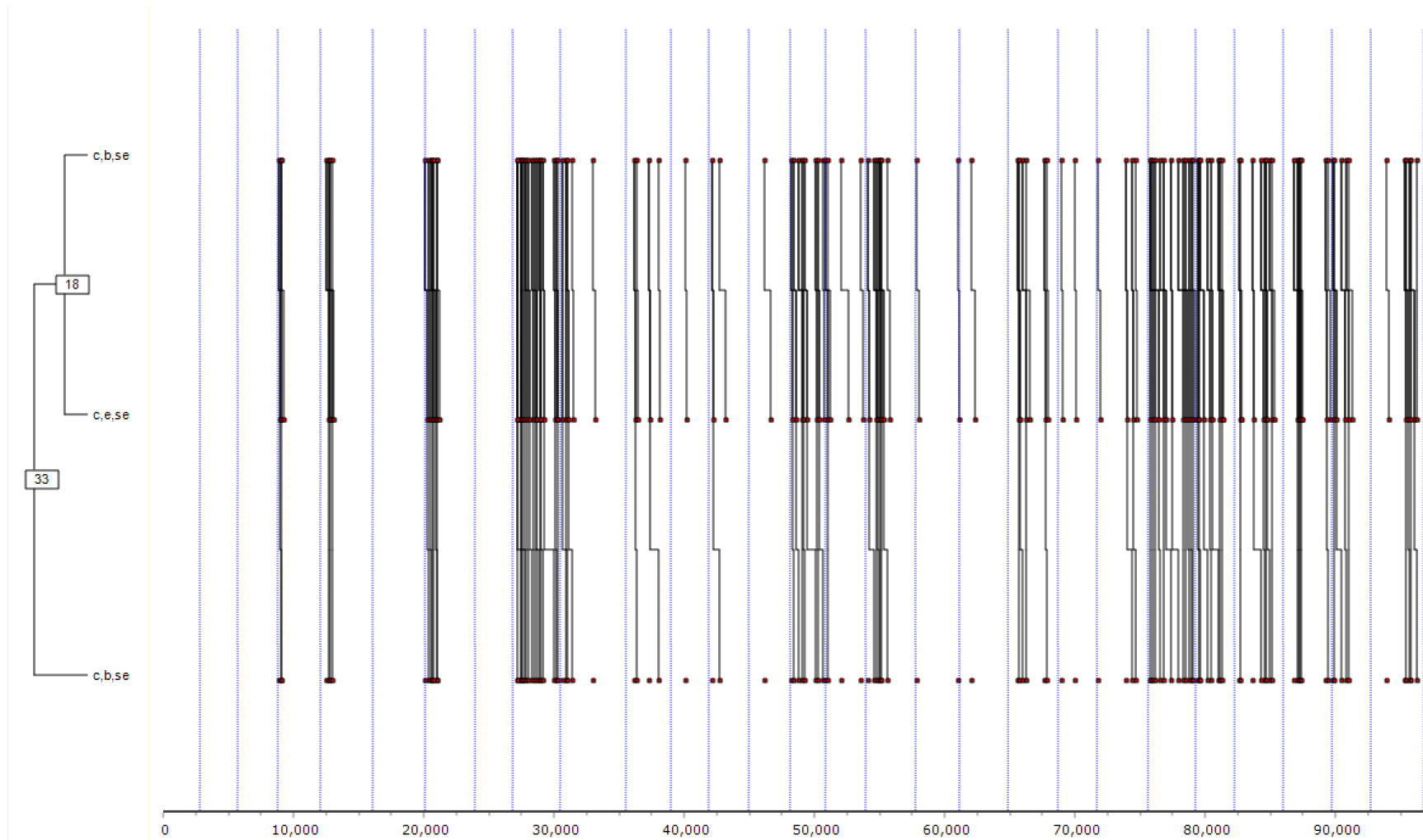


Figure 34. This emotion scheme pattern occurred with significantly greater frequency in the weak alliance group in the working phase. It is marked by expressions of repeated secondary emotion.

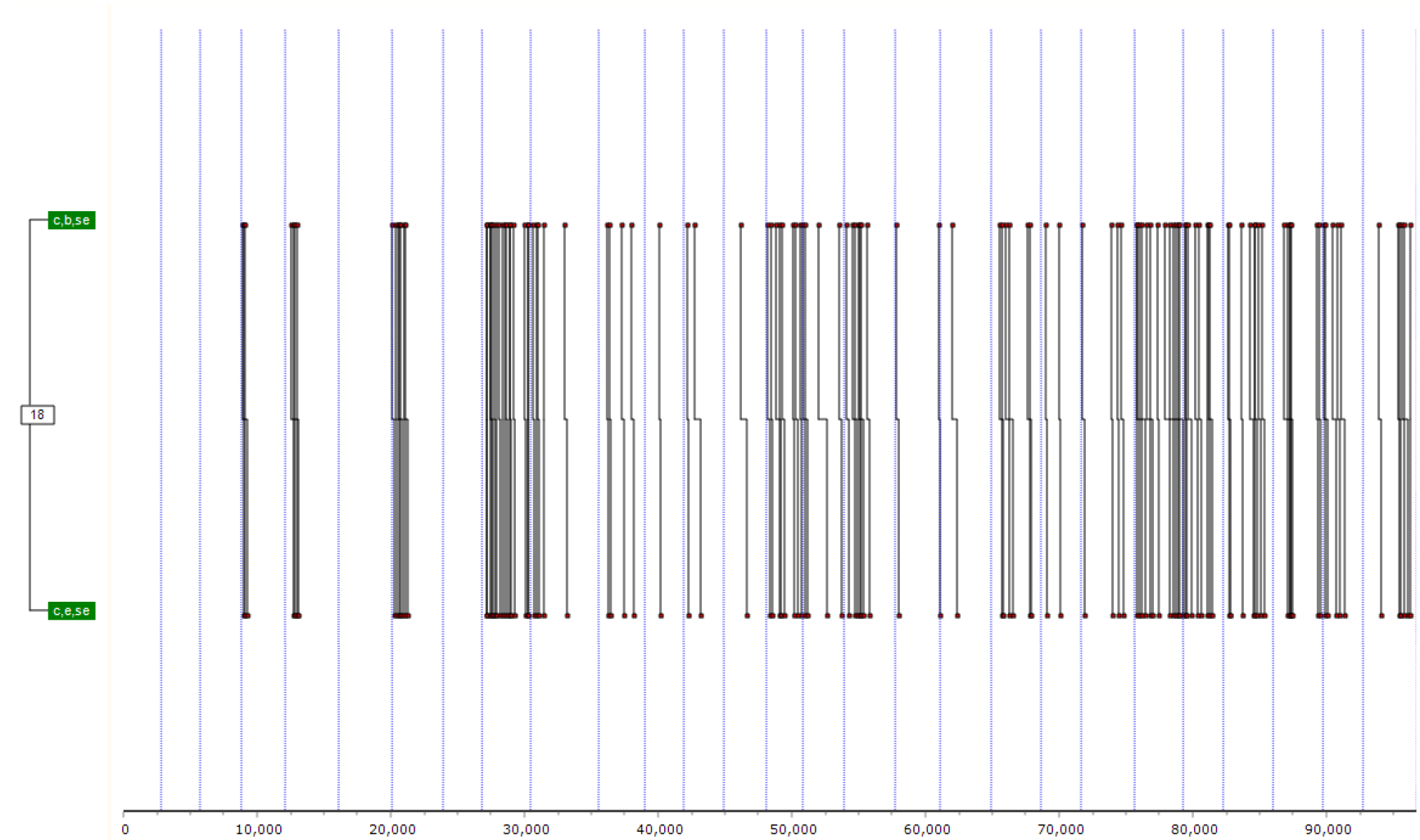


Figure 35. This emotion scheme pattern occurred with significantly greater frequency in the weak alliance group in the working phase. It is marked by expressions of repeated secondary emotion.

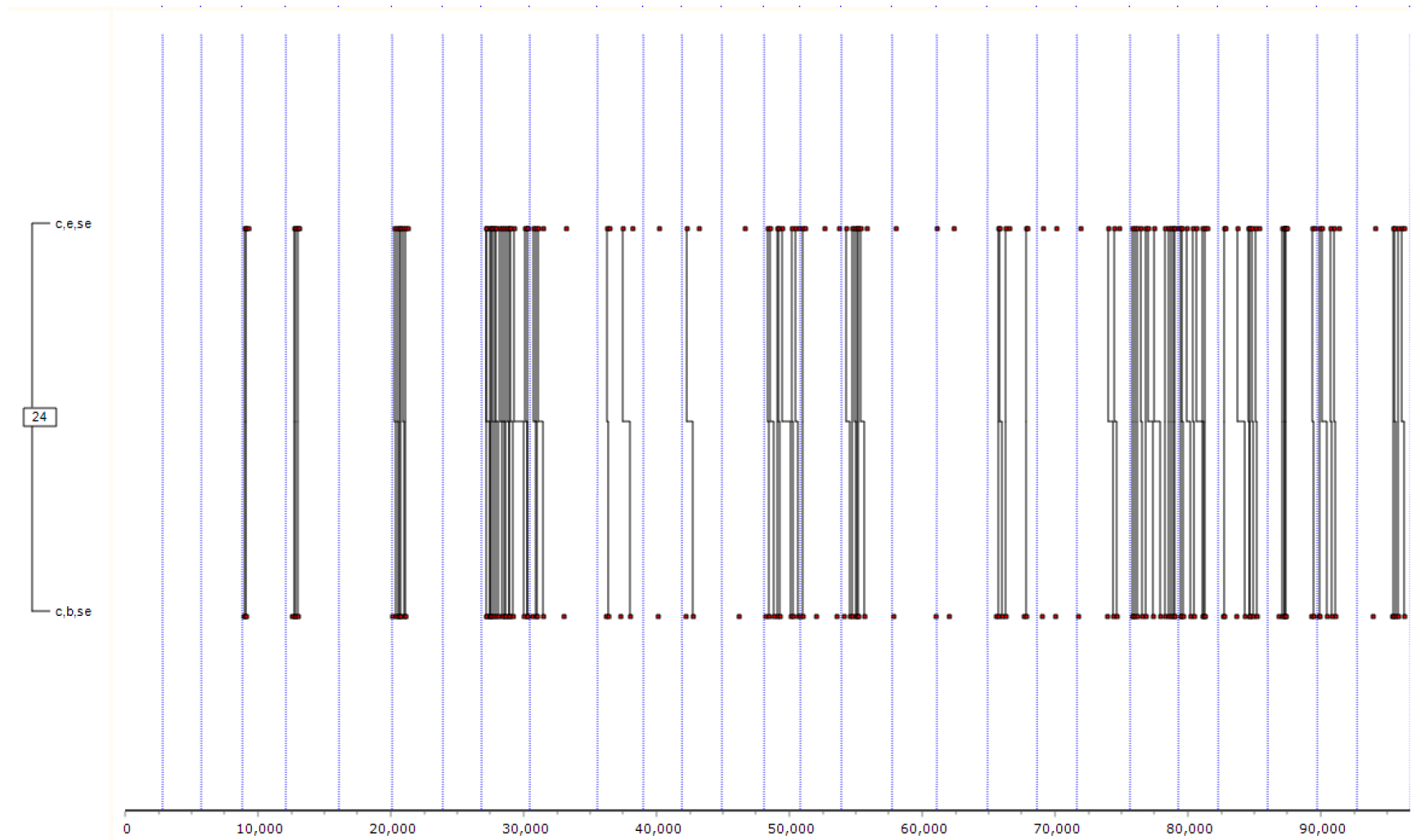


Figure 36. This emotion scheme pattern occurred with significantly greater frequency in the strong alliance group in the termination phase. It is marked by expressions of repeated primary adaptive emotion.

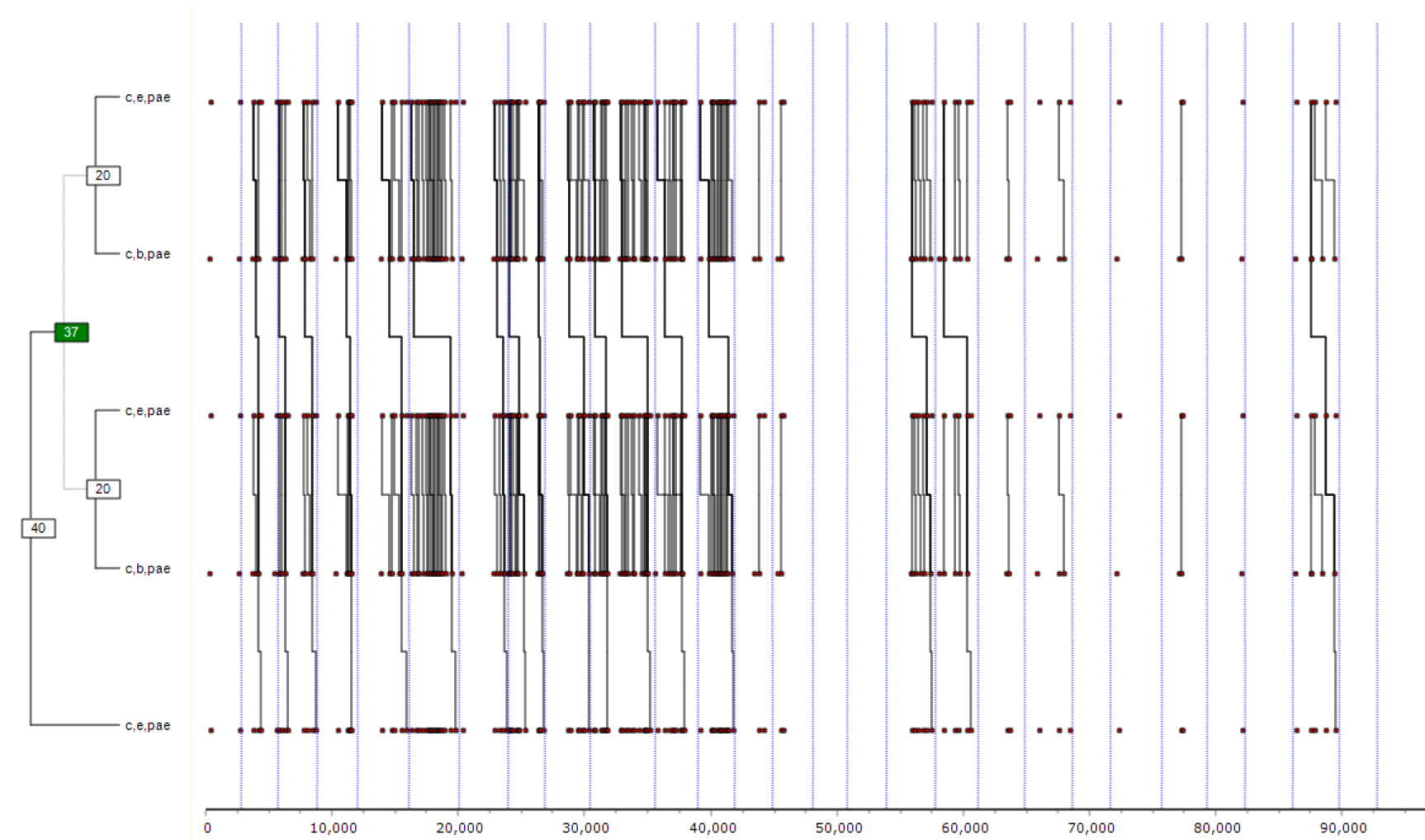


Figure 37. This emotion scheme pattern occurred with significantly greater frequency in the strong alliance group in the termination phase. It is marked by expressions of repeated primary adaptive emotion.

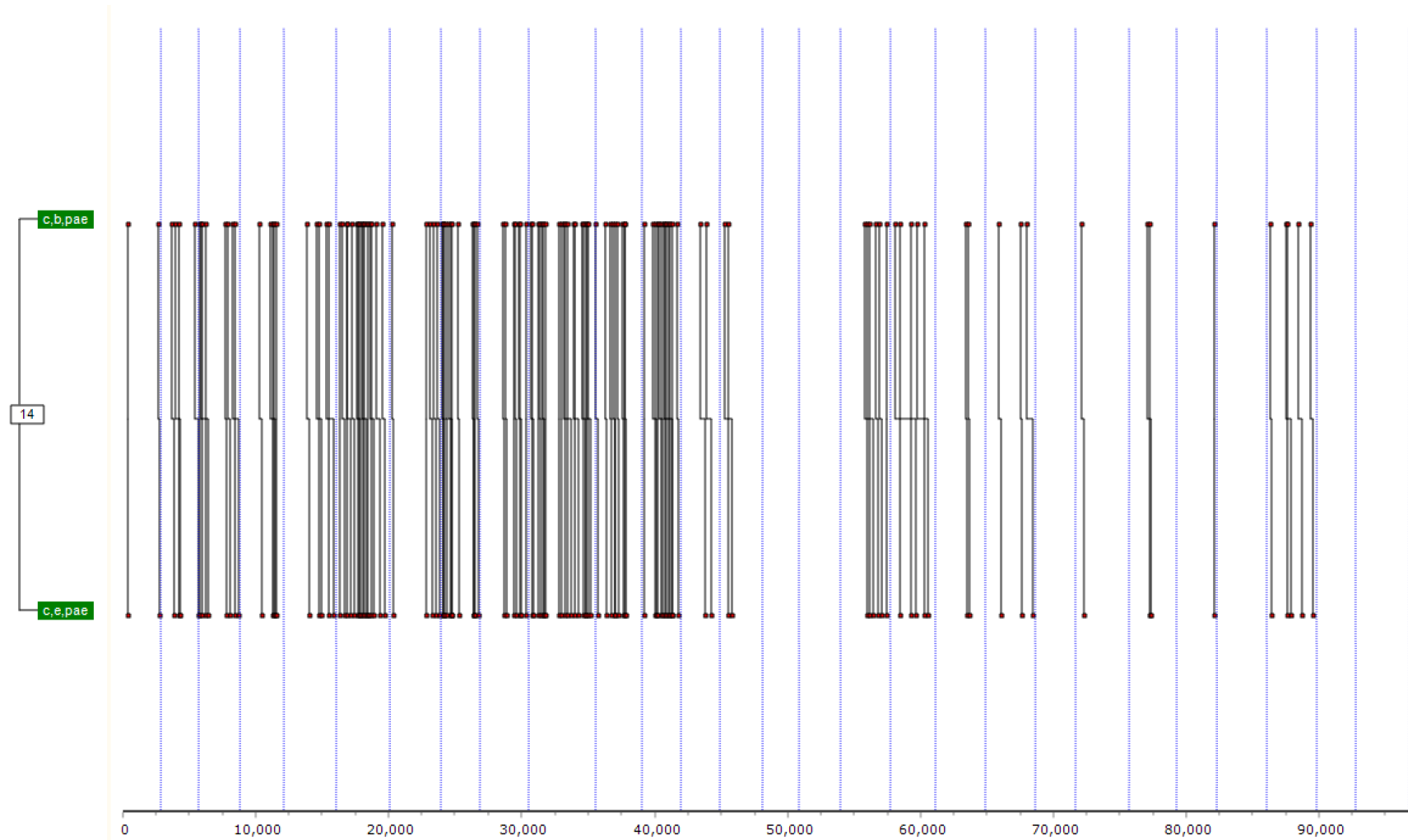


Figure 38. This emotion scheme pattern occurred with significantly greater frequency in the strong alliance group in the termination phase. It is marked by expressions of repeated primary adaptive emotion.

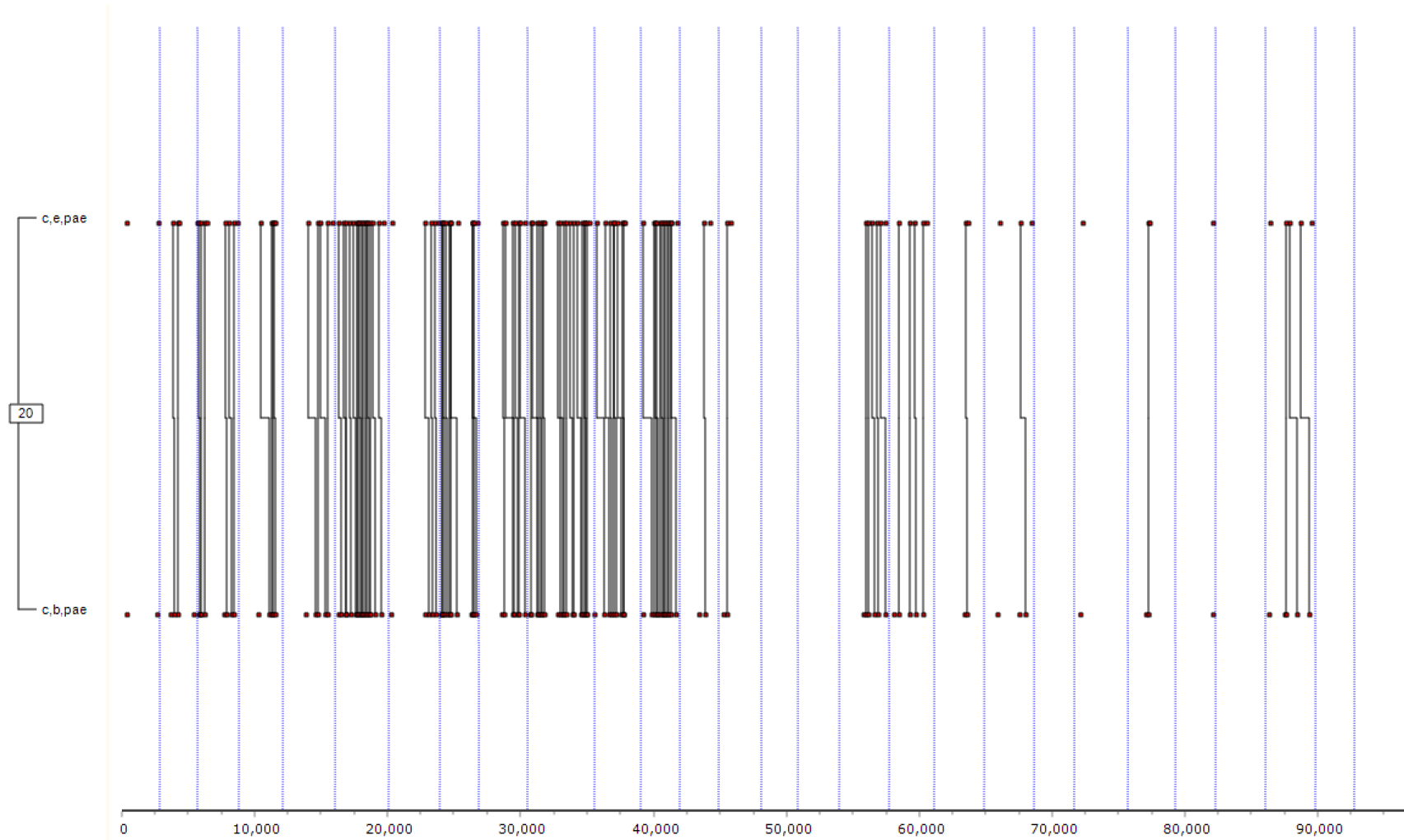


Figure 39. This emotion scheme pattern occurred with significantly greater frequency in the weak alliance group in the termination phase. It is marked by expressions of repeated secondary emotion.

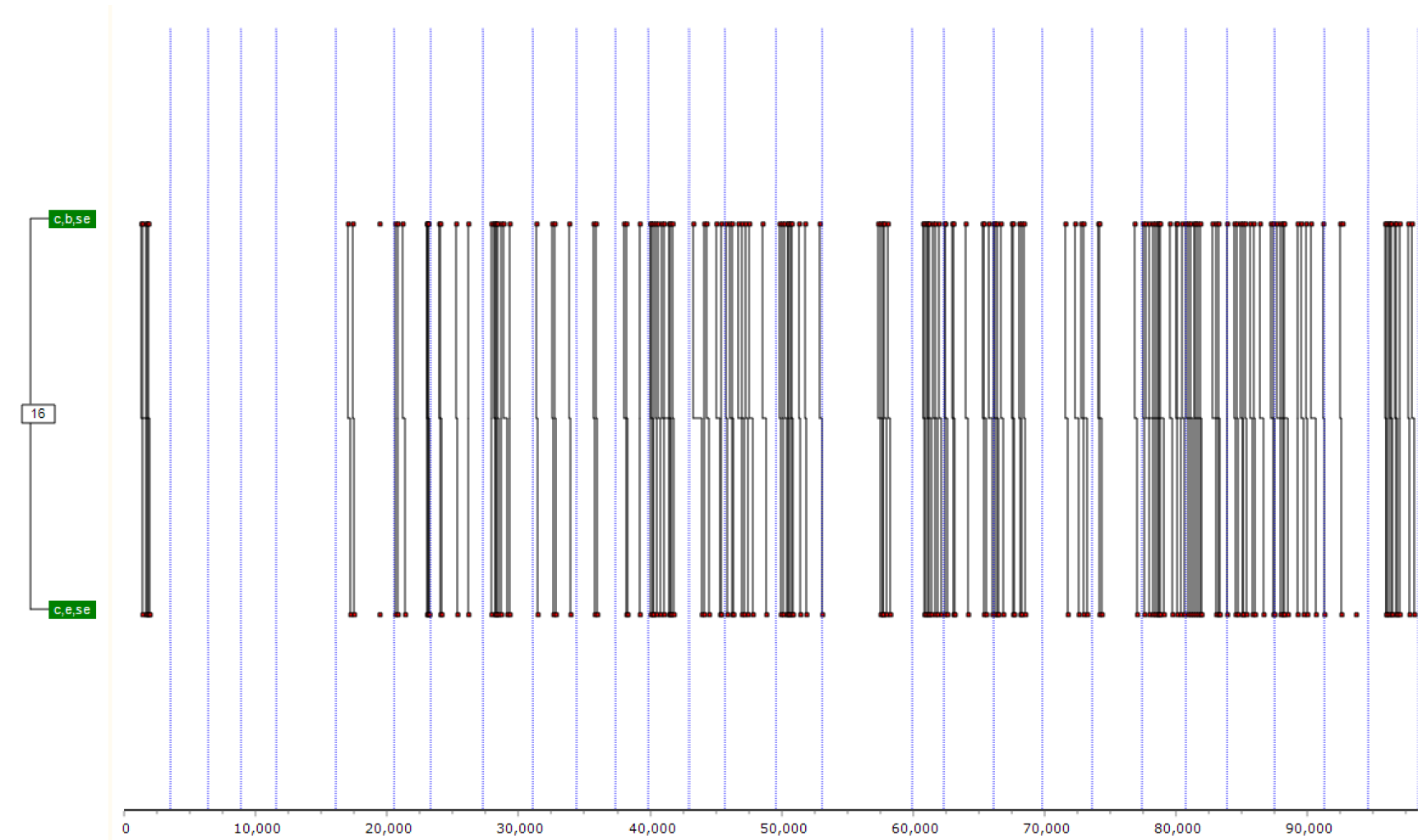


Figure 40. This emotion scheme pattern occurred with significantly greater frequency in the weak alliance group in the termination phase. It is marked by expressions of repeated secondary emotion.

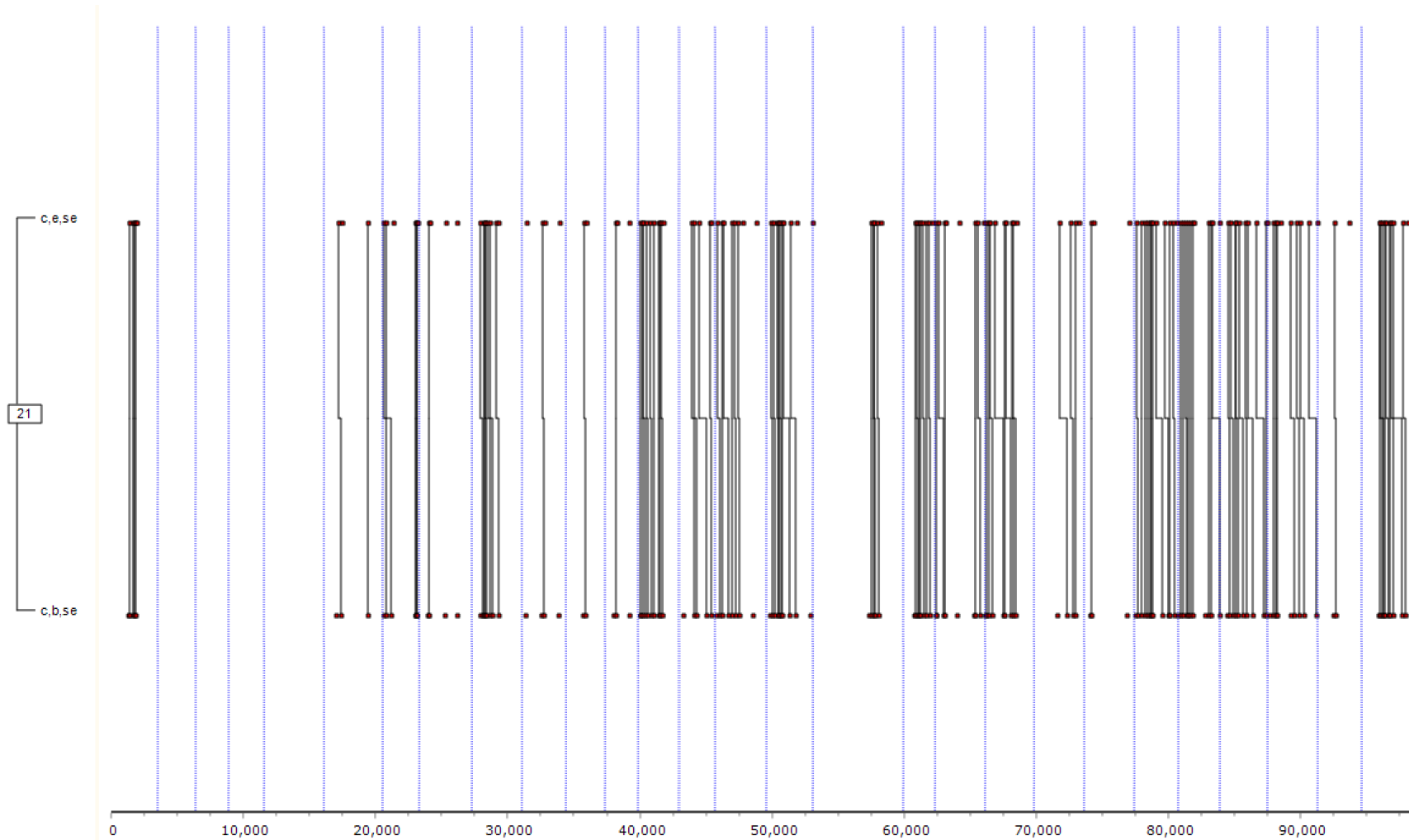


Figure 41. This emotion scheme pattern occurred with significantly greater frequency in the weak alliance group in the termination phase. It is marked by expressions of repeated secondary emotion.

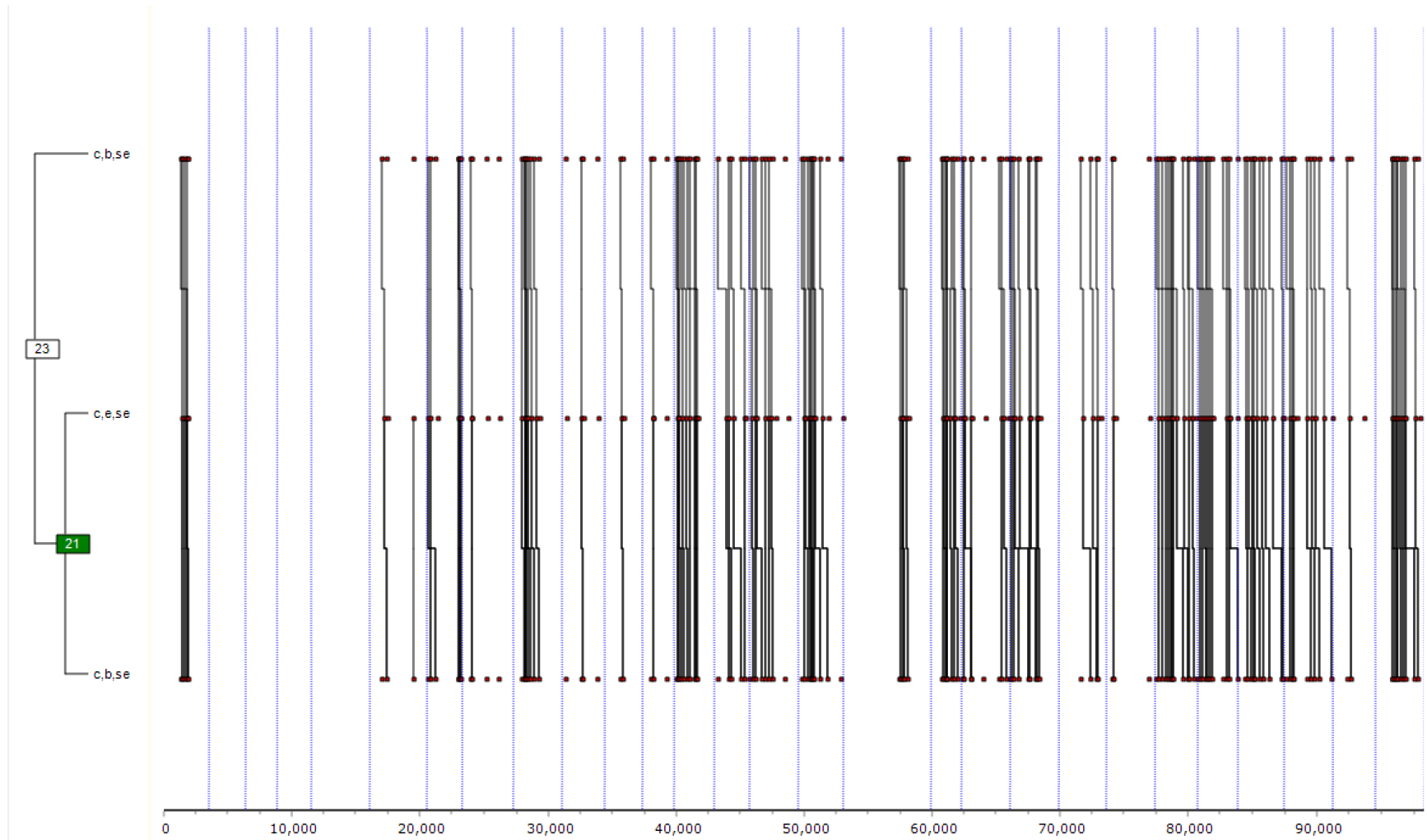


Figure 42. This emotion scheme pattern occurred with significantly greater frequency in the weak alliance group in the termination phase. It is marked by expressions of repeated secondary emotion.

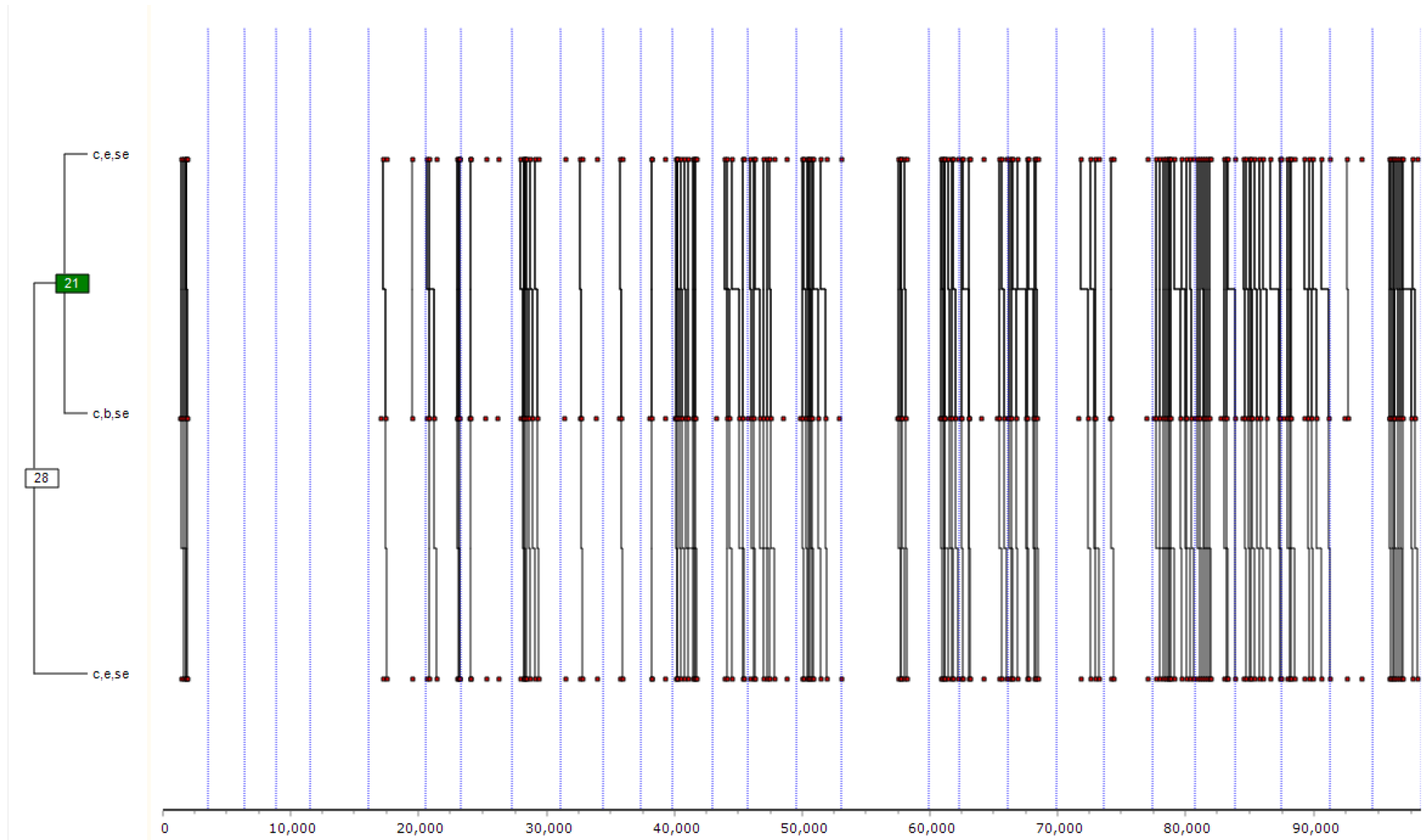


Figure 43. This emotion scheme pattern occurred with significantly greater frequency in the weak alliance group in the termination phase. It is marked by expressions of repeated secondary emotion.

