

**EXAMINING EMOTIONAL PROCESSING DIFFERENCES PREDICTING 18-MONTH
FOLLOW-UP OUTCOMES IN EXPERIENTIAL TREATMENTS FOR DEPRESSION.**

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Abstract

This study examined whether an EFT theory-based model of emotional processing would provide a good transtheoretical model for predicting good and poor long-term outcomes from experiential treatment of depression independent of therapy. Using an EFT-sourced measure of emotion states called the Classification of Affective Meaning states (CAMS) both lower order CAMS-coded emotion states as well as EFT theory based typology of CAMS-coded emotion schemes were investigated for 55 clients who had provided long-term outcomes on their BDI measures of depression after having participated in York 1 and 2 RCTs that compared Emotion-focused and Client-centered therapies. Resolved depressions were calculated as a client having a BDI less than 10 at their 18-month follow-up measure. Archival CAMS coded emotion episodes (EEs) were analyzed in two ways, using proportional differences of EEs coded with CAMS codes via Mann Whitney U analyses (MWU), as well as sequences of CAMS coded EEs using THEME time sequential analyses. EFT and CCT therapies were also examined for emotional processing that predicted their individual therapy long-term outcomes and between therapy outcome differences. Results showed EFT maintains better long-term MDD good outcomes than does CCT. Also, in general the EFT theory-based model of EP during the treatment of depression was validated, but more so through sequence analysis than from MWU analysis. Expressing sequences of primary adaptive emotion, needs, and maladaptive pain as well as reducing secondary emotion are all important EFT theory based emotional processes that were THEME validated. However, some non-validation of the EFT-EP model of change was also evident. In particular, only the adaptive emotions ‘Assertive Anger’ and ‘Hurt/Grief’ appeared to be validated as important emotion states in long-term outcomes of depression in both MWU and THEME analyses. Also questions about the previously assumed adaptive emotion ‘Relief’ were

also posed as poor outcome and CCT clients expressed sequences of this emotion state. Maladaptive emotion was also accessed in good outcomes receiving the Client-centered model without the use of active EFT interventions. Clearly, EFT and CCT therapies differ in the manner in which outcomes are achieved, with EFT showing better long-term outcomes, and EFT theory of EP holding promise as a general emotional processing model in the treatment of depression long term. The limitations of the study analyses are discussed.

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TITLE: Examining emotional processing differences predicting 18-month follow-up outcomes in experiential treatments for depression.

Introduction

In this thesis I will examine emotional processing (EP) differences (defined below) that occur in good and poor long-term outcome clients after experiential treatment for their major depressive disorders (MDD), independent of therapy in order to test whether EP as defined by the Classification of Affective Meaning States measure and Emotion Focused Therapy theory provide a valid transtheoretical measure of EP's relationship to long-term outcome for the treatment of MDD. I will also examine differences in EP in clients who have received either Client-Centered (CCT; Rogers, 1961) or Emotion focused therapy (EFT; Watson & Greenberg 2006) as EFT has been found to have better long-term outcome for treating MDD (Elliott, Watson, Greenberg, Timulak, & Freire, 2013). Accomplishing these goals may validate the importance of deep emotional change to lasting outcomes in the treatment of MDD as well as demonstrate why some experiential therapies may be better treatments for MDD than others.

Globally major depressive disorder (MDD; DSM-5, American Psychiatric Association, 2013) is the most common mental disorder affecting more than 300 million people worldwide. According to the World Health Organization (2017), MDD is the world's leading cause of disability. In Canada alone, 3 million individuals reported symptoms of depression in 2012 (Stats Can, 2013). Several psychotherapy treatments are empirically validated as effective in treating MDD, and this includes experiential therapies (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). However, the results of these treatments are often not long-lasting (Westen & Morrison, 2001). For this reason, costs of

continuing to treat depression remain huge. In 1990 this cost was estimated between 30-45 billion dollars annually in the United States alone (NIMH, 1999) and was 210 million dollars in Canada last year (Chiu, Lebenbaum, Cheng, de Oliveira & Kurdyak, 2017). Moreover, these costs clearly under-estimate the ‘real’ costs of treating MDD which would include the costs of lost work, and also the fact that treated patients often relapse and require additional treatment (Westen, Novotny, & Thompson-Brenner, 2004). Therefore, understanding how depression can be resolved long term is an important research concern with economic consequences for all western economies.

Patients may relapse for a number of reasons. It is possible that patients relapse due to (Westen & Morrison, 2001) losing provided “common factors” (Norcross, 2011) from therapy not because they have resolved their depressions. General therapy factors (Norcross, 2011), such as having had recent contact with therapy or therapist may promote wellbeing alone. For this reason, measuring outcome at termination can be unreliable due the potential confound of clients having had recent contact with a therapist. This makes it possible that client improvement has come from being provided therapist contact or from being given a common factor of therapy, a therapy relationship, and not from having been in a particular model of therapy within which clients are provided specific tasks. This confound is problematic when we wish to establish an effective long-term treatment for MDD. As well, some argue (Greenberg & Watson, 2006) that short-term therapies may not address the causes of MDD. Some treatments address superficial symptoms of MDD temporarily leaving deeper emotional causes presumed to cause depression unaddressed (Barkham, Rees, Stiles, & Shapiro, 1996; Greenberg & Watson, 2006). In order to ensure treatment is effective long-term, the causes of depression (assumed by many to be depressogenic emotion; see Pos 2006 for a review) need to be treated. For example, Teasdale

(1999) and others believe that cognitive affective structures, (whether you call them core beliefs (Beck, 1996) or core conflictual relationship themes (CCRT; Luborsky & Crits-Christophe, 1990), or depressogenic emotional processing (Pos, Greenberg & Elliott, 2008)), are what cause depression. If these assumptions are correct, then lasting change to these cognitive-affective structures or emotion schemes must occur in order to ensure long-term resilient outcome from any treatment of depression. More specifically, Teasdale (1999), a well-known cognitive therapist, proposes that MDD relapse occurs when those who have previously experienced episodes of depression have their vulnerability to negative thinking patterns (depressive vulnerability) reactivated by normal fluctuations of dysphoric states. These patterns are assumed in CBT models to typically involve negative mood activating rumination that reactivates depression.

If we can assume that change to emotion programs is a core feature of resolving MDD long-term, then in order to prevent relapse, enhancing emotional processing should reduce the power of triggering stimuli to re-activate these negative cognitions. These negative thought patterns will therefore be powerless to cause another depressive cycle. This should be evident in CBT treatments at the very least. In examine any outcome of depression Teasdale (1999) therefore has suggested that to make sure emotional change has occurred we must: 1) measure outcome long past termination in order to ensure that any recent effect of therapy's common factors is no longer impacting outcome; and 2) demonstrate that the assumed core change processes occur during the therapy (which in this case is processing and transforming underlying cognitive affective structures, or what Greenberg (2002) would call emotion schemes).

This thesis will test the assumption that emotional processing as suggested by EFT- EP theory described below will predict long-term resilient improvement in the experiential treatment

of MDD. However, an important difference from previous research examining emotional processing in the treatment of MDD (which I will review below), is that I will examine emotional processing depending on subtypes (CCT versus EFT) of different experiential therapies experienced. In previous research done in our laboratory, experiential therapies have not been separately examined, regardless of how emotional processing was measured. This is because experiential therapies are thought to be based on a core experiential therapy assumption that experiences must be brought into awareness and fully processed, including emotional experiences (Pos, Greenberg & Elliott, 2008). In fact, while testing experiential therapy for MDD, Dr. Greenberg's York Psychotherapy Lab teams (Greenberg & Watson, 1998; Goldman, Greenberg & Angus, 2006) ran two RCTs for the treatment of MDD using either Client-Centered (Rogers, 1961) or Emotion-focused Therapy (Greenberg & Watson, 2006). Both of these experiential therapies assume that processing emotions is the important mechanism of change responsible for good outcomes (Pascual-Leone & Greenberg, 2007; Pos, Greenberg, Goldman, & Korman, 2003; Pos, Greenberg & Warwar, 2009). Whether these two experiential therapies differ in how emotions are activated and processed has yet to be explored. Therefore, a sample of clients receiving two different experiential therapies is an optimal sample within which to test the hypothesis that clients who process their emotions more deeply (either because of the therapy they receive, or because of their individual outcome differences) will be those mostly likely to report long-term resilient outcomes for the treatment of MDD. Comparing emotional processing as it relates to good outcome for both therapies will also not only validly establish the importance of an EFT-EP theory of processing emotion to long term outcomes for MDD, but may also provide evidence that a particular therapy, perhaps EFT, accomplishes this outcome better than does another experiential therapy, i.e. perhaps because EFT treatment views processing emotion

as an important focus of treatment and does so in a more focal and directive manner. The difference between these two treatments may be important to establishing whether and why EFT may be more effective as an experiential treatment for MDD. I will now discuss the change process of transformation of emotion that has been researched and discussed in experiential therapy and follow this with a more pointed discussion on differences that may exist between EFT and CC therapy styles of helping clients process emotion.

Emotional Processing as a Mechanism of Change

General emotion theory (Frijda, 1986) suggests that emotions are important sources of information, motivation and action (Greenberg & Safran, 1989; Pos, 2006; Pos & Greenberg, 2007; Greenberg, 2008) and are an efficient way of automatically responding to situations (Pascual-Leone, Paivio & Harrington, 2016). An important guide for research and practice with regard to emotion is the idea of emotional processing (EP). Rachman, a behaviorist, was the first to introduce the idea of emotional processing (Rachman, 1980). This theoretical idea can organize different therapeutic schools as to how people process their emotion, and what kind of processing should take place in therapy to promote change (Auszra & Greenberg, 2007). Rachman, however, did little to unpack the subprocesses of emotional processing, but defined EP in a tautological manner, by basically asserting that if a past problematic trigger was no longer experienced as a problematic trigger then emotional processing had occurred. Today almost all schools of therapy acknowledge that the activation of emotion, its symbolization in awareness, and its expression are important in therapeutic change (Fosha, 2000; Greenberg, Auszra, & Herrmann, 2007; Samoilov & Goldfried, 2000). For example, when working with anxiety disorders cognitive-behaviour therapists arouse emotions such as fear in order to reduce and change fearful responses. CBT proponents agree that fear emotions must be activated for new

information incompatible with a pre-existing fear belief to be helpfully processed or changed (Foa & Kozak, 1986; Samoilov & Goldfriend, 2000). Patients with personality disorders also have known problems being aware of and communicating emotions. It is theorized that improving EP in these patients also may lead to symptom reduction (Kramer et al., 2016). Kramer et al. (2016), in their study examining EP in clarification-oriented psychotherapy for personality disorders, found that emotional processing measured using the Classification of Affective Meaning States (Pascual-Leone & Greenberg, 2005) predicted 18% of symptom change at the end of treatment in good outcome cases, and that this was not found in poor outcome cases. Pos, Greenberg and Warwar (2009) examined EP measured using experiencing of emotion episodes (EE-EXP; Pos, Greenberg, Goldman & Korman, 2005 also reviewed below) in experiential treatments for depression across 3 phases of therapy finding that EP in the middle (or working) phase of therapy directly predicted decreases in depressive symptoms and increases in self esteem. In his review, Whelton (2004) concluded that both EP and depth of experiencing are extensively researched and have strong associations with outcome. What these studies show us is that EP is a potential change mechanism at work across therapeutic modalities that has good implications for treatment outcomes. Emotion is also considered to be involved in meaning making and how people make sense of their experiences (Greenberg, 2008). An important question is: How should EP be measured?

Measures of Emotional processing and how EP has been operationalized in past process research

Experiential therapy writers in particular have unpacked the process of emotional processing (Pascual-Leone, 2018; Pos, Greenberg & Warwar, 2009; Greenberg & Safran, 1989). According to Pos & Greenberg (2007), the global task of emotional processing is composed of

many subtasks: awareness, regulation, reflection and transformation. By evoking awareness of emotion, clients learn what their needs are and become motivated to meet them. Over time, clients learn to attend to their inner, emotional worlds. Regulating emotions teaches clients to tolerate, soothe, and lessen the intensity of difficult feelings without eliminating them. Engaging in reflection allows clients to explore feelings, needs, and thoughts, and how they relate to clients' self-experience. Lastly, emotional transformation uncovers maladaptive emotion in order to make it available for change by accessing more adaptive emotional resources.

Many emotion measures exist which I can not review in total here. My present focus will be on the emotion *process* research field. No one measure has been able to capture all of the above nuances or processing emotional experiences. Several, however, have been used in process research. They are reviewed below.

Experiencing (EXP; Klein, Mathieu-Coughlan, & Kiesler, 1986). This was the first process measure developed by Carl Rogers and his team in the last century. It intended to capture and measure the process of using online and alive experience to solve problems. The main idea was that a fully functioning person (Rogers, 1963) is able to access and use lived experiences, including feelings and emotions, in a dynamic way as they solve their problems. The EXP scale is thought to capture this process. The EXP scale has been successfully applied to research on different therapy modalities with different populations of clients (see Hendricks 2002 for a review; Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Silberschatz, Fretter, & Curtis, 1986; also Orlinsky & Howard, 1978 for a review). EXP has shown a robust relationship to outcome, so it has been generally found that clients who experience well or highly have better outcomes (Whelton, 2004, Pascual-Leone & Yeryomenko, 2017). As a measure of emotional processing, however, EXP has normally been applied generally not specifically. What is meant

by that is that normally what is measured by this 7 point scale is the degree to which access to experiences occurs in clients by noting whether emotion words are used (Level 3 EXP), whether the client muses about or reflects on their experience in an emotional way (Level 5 EXP), or whether a client has experienced an emotional shift (Level 6 EXP). No measure of particular emotions being experienced has yet occurred using this EXP scale although this would be possible if one measured EXP only within such sampled expressions. Therefore, as a measure of emotional processing the EXP scales can be considered ‘too general’ in terms of this measure of emotional processing’s ability to capture all the emotion processes mentioned above. It can capture awareness, and perhaps be considered a tacit emotion regulation measure as well, (Pos, Paolone, Warwar, & Smith (2017), mention that one can’t EXP well if emotional arousal is too high) and can also perhaps capture aspects of reflection (Wong, 2016). However, the EXP scale can not per se be considered as a measure of emotion transformation or a measure that can capture sequences of emotions that may indicate emotional transformation suggested by EFT theory.

EE-EXP. In order to focus the process of experiencing on processing of emotion in particular, the EXP scale has been applied to samples of emotion episodes exclusively in several research projects (see Pos, Greenberg, Korman & Goldman, 2005; Pos Greenberg, Warwar, 2009). Emotion episode sampling (Greenberg & Korman, 1993) will be described more in detail below in the method section. However, what is important to note here is that the EXP process measure was now being applied to narrative during which emotion experiences were spoken about in therapy. This therefore provided a more refined measure of access to emotional experiences but still remained an emotion processing measure that was blind to particular emotion states. Therefore, as mentioned above, the same limitation for EE-EXP was present as

for the EXP scale as a whole. EE-EXP could not, per se, be considered as a measure of emotion transformation or capture sequences of emotions that may indicate emotional transformation. It could only measure the degree of accessing emotion and relate that general albeit nonspecific access to emotion to outcome or other processes. This measure therefore would not serve as an adequate measure of EFT-EP theory in the current study.

Client Emotional Productivity. In order to more accurately depict an EFT emotional processing model, Greenberg, Auszra, & Herrmann, (2007) developed the Client Emotional Productivity Scale (CEPS). Emotional Productivity can provide researchers with a map as to how to distinguish between emotional expressions that promote achieving therapeutic process goals or change and emotional expressions that hinder the change process. The CEPS samples three main dimensions of emotional behavior: 1) emotional activation, 2) emotion type and 3) manner of processing (Auszra & Greenberg, 2007). For a client's emotional expression to be considered therapeutically productive certain criteria on all three dimensions have to be met. The emotion has to be adaptive or 'productively maladaptive' and the client has to be expressing the feeling in an alive way, own the feeling as their own, not talk about feeling victimized by the feeling, not be overwhelmed by the feeling so be well-regulated, etc. There are many decisions made by raters who are trained by an expert. Unfortunately, while very coherent with Emotion-focused therapy EP-theory the scale remains unpublished, poorly articulated in research that has used it (Greenberg, Auszra, & Herrmann, 2007) and is difficult to learn. As such it was not considered as a viable measure to use in the current study.

The Classification of Affective Meaning States (CAMS; Pascual-Leone & Greenberg, 2005). This scale has become a popular measure of emotional processing in recent research. Pascual-Leone & Greenberg (2007) describe specific emotion states that may be

experienced and transformed in clients with depression. It is therefore an EFT-EP theory coherent measure of EP that was developed through studying depressed clients. According to this model of emotional processing, when clients feel pain, helplessness or hopelessness, are feeling overwhelmed or so on, they are in an initial state of ‘global distress’ which may later transform through a series of expression shifts into more adaptive emotions.

CAMS is an observer-rated measure that can be used to observe EP occurring ‘live’ in therapy using therapy videos and transcripts. It categorizes ten discrete emotion types or states. Used to code events when clients are emotionally aroused, CAMS distinguishes between productive and unproductive emotions by capturing ten different emotion states. The ten emotional states captured (in ascending order of productivity and depth of emotional process) are: (1) Global Distress (GD), described as overwhelming and undifferentiated distress; (2) Fear/Shame (FS), described as an expression of a core concern of personal pain; (3) Rejecting Anger (RA), which describes the expression of reactive and likely secondary or protective anger; (4) Negative Self-Evaluation (NSE), described as a negative belief about the self; (5) Need, described as a wish or desire; (6) Self-Soothing (SS), which describes clients beginning to self-nurture; (7) Assertive Anger (AA), describes an expression of anger that asserts a boundary or need; (8) Hurt/Grief (HG), describes clients’ acknowledgement of sadness, hurt or loss; (9) Relief (RE), describes clients feelings of reduced tension, hopefulness or accomplishment; and (10) Acceptance and Agency (ACAG), described as resolution of distress, shame or anger.

The advantage of the CAMS method is that it does capture expressions of particular emotion states. Expressions of these states can also be analyzed using several statistical methods. One can examine if more of a particular state occurs in a particular group of clients perhaps using comparisons of proportions of these expressions, or one can also examine the order or

sequence of emotion states that occur in a particular group. Furthermore, one can also examine higher order emotion schemes using the CAMS Scale. This higher order CAMS measure of emotion schemes has also been suggested by the measure's author (See method section below). This can provide a measure of the degree to which emotion scheme types suggested by EFT theory provide a general or common map for emotional processing that may be optimal to treating MDD. This measure can therefore provide the opportunity to test both the degree to which a particular state occurs and in what context of other emotion states a particular state occurs. As well, it can provide an opportunity for a higher-level examination of the importance of the EFT emotion typology to outcome in the resolution of depression long-term. Therefore, the CAMS measure was considered an optimal measure of the EFT emotional processing model of change under examination in the current study.

The cognitive behavioral manner of assessing emotional processing. In the cognitive behavioral domain emotional processing is more often measured not as a process but as an outcome. One example of a measure of this nature is the Emotional Processing Scale (EPS), developed by Baker, Thomas, Thomas, & Owens, (2007). Consistent with Rachman, this measure taps into a model of emotional processing that contains many elements suggested by EFT theory. However, the concept of emotional processing is tapped using Likert scales of clients' self-report to assess their general emotional tendencies post-hoc. This scale and others like it, such as the Degree of Emotional Regulation Scale or, DERS18 (Victor, Klonsky, (2016) therefore do not capture these tendencies in an alive manner. As such this measure or other CBT measures of EP are often not observational and do not directly provide measures of emotional process, nor allow an examination of this process independent of the client. Therefore it, nor

other CBT based self-report measures, was not considered viable for the goals of the present research.

Some CBT therapists suggest using physiological measures of emotion (Foa & Kozak, 1986). Measures of physiological processes may provide some online data of components of emotional arousal. However, physiological measures of emotional arousal are not completely able to capture many aspects of emotion, in particular, a client's emotional content or categorical state. Some believe that emotional arousal is labeled by rational processes before they are even useful measures of emotion categories (Ellsworth & Tong, 2006). For this reason, physiological measures were also not considered here.

Emotion processing in Experiential Therapy

Experiential theory of emotion (Pos, Greenberg & Elliott, 2008) is a general theory of changing an individual by helping them to better process their feelings. The basic premise underlying any experiential approach to therapy is that individuals tend to privilege others' acceptance of them over their own self-acceptance. As such, it appears that connection with others can 'trump' connection with self. When others' acceptance is conditional, human beings tend to present to an 'other' what that 'other' accepts as 'presentable'. This can leave individuals alienated from inner processes they believe are unacceptable to others. As a result, individuals become exiled from their true nature and become depressed (Pos et al., 2008). An individual's true nature is thought to be represented by their current needs and feelings. This is why to regain health the individual is helped to regain connection to their experience, in particular their emotional experiences intimately connected to need experience (Greenberg & Watson, 2006; Ferreira, 2017).

Emotion processing in EFT. Experiential theory concerning emotional processing has been more differentiated and better articulated by Emotion-focused therapy theory. From the EFT theoretical view (Greenberg & Watson, 2006), some emotions are more productive in promoting emotional transformation than others. Primary adaptive emotions are immediate and understandable helpful reactions to situations such as fear in response to danger. Secondary emotions are responses to primary emotions. They serve as defenses against experiencing or expressing primary adaptive emotion or interrupt them such as being afraid of one's sadness. Primary maladaptive emotions, once adaptive, are learned responses that do not helpfully guide present action (Greenberg & Safran, 1989) such as feelings of worthlessness or shame elicited when one experiences old triggers such as criticisms. In EFT theory one works with different emotion types in different ways: maladaptive emotions are accessed in order to transform them, and secondary emotions are brought into awareness to access the underlying primary emotion (Greenberg & Watson, 2006).

EFT holds a strong view of the importance of activating and transforming emotion during treatment of MDD (Greenberg & Watson, 2006). From an Emotion-focused therapy (EFT) perspective (Greenberg & Watson, 2006), while it is important to experience and express emotion, not all emotions are assumed to be adaptive. EFT theorizes that repeated exposure or activation of maladaptive emotions in the safety of a therapeutic relationship is needed for improvement in MDD to occur because these experiences of maladaptive emotion are likely to be important to subsequent client experiences of their needs that may lead clients to eventually express more adaptive emotion resources. The assumption that activation of maladaptive emotion can lead to the transformation of maladaptive emotion to adaptive emotion via new,

corrective emotional experiences has been theorized by many (Pos & Greenberg, 2007; Pascual-Leone, Paivio & Harrington, 2016; Greenberg, 2004).

Emotional Processing in Client-centered therapy. As mentioned above, the main focus in Client-centered therapy is to help the client become a fully functioning person (Rogers, 1961), by helping the client access, in an alive way, their experiences, including feeling experiences. A core assumption in a client centered model of treatment is that one can trust the growth potential in an individual and trust that that client will eventually express more and more of their growth potential and wholeness by knowing their needs and expressing them emotionally (Pos, Greenberg, & Elliott, 2008). Further, CCT models assume that a client cannot attend to emotion without first being provided the supportive context of a facilitative safe relationship with a CCT therapist (Rice & Greenberg, 1984). CCT therapists adopt the three relational attitudes of empathy, unconditional positive regard and congruence to create a safe, supportive environment and provide empathic understanding and validation of a client's internal frame of reference (Elliott, Bohart, Watson, & Greenberg, 2011). This is presumed to make clients feel worthwhile and valued, and not judged (Goldman, Greenberg, & Pos, 2005). Further, the assumption is that by removing conditions of worth clients can then turn their attention away from the interpersonal world with the therapist and towards their own internal feeling worlds (Pos, 2006). A core directive of a CCT model is to trust the client and to follow the CCT directive to follow the client's lead, emotionally or otherwise. A CCT therapist is not to direct client direction but is trained to follow a client's lead. Given that CCT is the least directive of all experiential treatments this following may appear in the emotional patterns found to emerge in CCT therapies. The CCT therapist is more interested in helping a client process their feelings optimally than arrive at given therapist driven affective goal. Much trust of the client's agency in

the process of emotional processing change is permitted (Rice & Greenberg, 1984). The client is the expert and can be trusted to set the appropriate direction of therapy (Elliot, Goldman, Watson & Greenberg, 2004; Rogers, 1959). Emotion is thought to then provide information to the organism so that the client can survive and grow (Rice & Greenberg, 1984).

The CCT therapist, as well, is normally asked to focus a client more on higher level integration of emotion and meaning than on emotion proper per se. Use of empathy is very important here (Elliott, Bohart, Watson, & Greenberg, 2011). The overall goal in a CCT model is to deepen a client's access to their internal worlds, thought to be accomplished by using different empathic modes such as evocative empathy (Elliott, et al., 2011). Concentrating on reflecting feelings is a core drive for a CCT therapist who assumes that this affective focus will lead the client to what is most important to them. As such, a client centered approach is not as directive as an EFT approach to emotion and communicates the humanistic principle of client trust (Elliott et al., 2004). It is therefore unclear whether the client will naturally follow an EFT emotion map when resolving their depression long term.

Research on joint EFT and CCT therapies using The Experiencing scale (EXP; Klein, Mathieu-Coughlan, & Kiesler, 1986) applied to EEs. Applying the EXP scale to EEs for the purpose of investigating emotional processing during experiential therapy has been validated a number of times. Pos et al. (2003) showed that for 34 (17 CCT and 17 EFT) clients emotional processing at the end of therapy measured as EE-Experiencing (EXP; Klein, Mathieu-Coughlan, & Kiesler, 1986 ; EEs; Korman, 1991) mediated the impact of any early emotional processing skill with which clients entered therapy. This meant that having a propensity to process feelings when one enters treatment was not enough to guarantee good outcome, therapy had to deepen that skill if depression was to be resolved by termination of therapy. Pos et al. (2009) then

demonstrated the same for an extended sample of 72 clients (36 CCT and 36 EFT) that emotional processing (EP), again measured as EE-EXP during mid-therapy sessions of experiential therapy better predicted all termination outcomes for major depression (than did EP early or late in therapy). As well, EE-EXP from mid therapy sessions better predicted outcome than the mid-therapy working relationship that clients reported having with their therapist.

Again, the EXP scales did not capture emotion-type distinctions and therefore could not be used to test emotion transformations as theorized by EFT theory. As a consequence of this limitation of the EE-EXP method emotion process researchers at York then turned to use another valid measure of emotional processing. Instead of capturing general emotional depth of processing experience in emotion, researchers captured expression of particular emotion states and how they shifted (Choi, Pos & Magnusson, 2016; Choi 2018; Rinaldi, 2017) using the Classification of Affective Meaning States or CAMS (Pascual-Leone & Greenberg, 2005).

Research Using the Classification of Affective Meaning States (CAMS; Pascual-Leone & Greenberg, 2005). Several research studies have used CAMS coded EEs in joint EFT and CCT samples of experiential therapy clients finding that expression of certain emotion states occurs more frequently in small samples of cases identified as either good or poor long-term outcomes after undergoing experiential therapy for depression (Choi, et al., 2015; Wong, 2016; Rinaldi, 2017). In his Masters thesis, Choi (2013) examined a group of nine depressed clients who were either good or poor resolvers of their self-criticism by therapy termination. He examined proportions of emotion states and higher order EFT theory-driven emotion schemes as well as THEME identified patterns of both specific CAMS codes or higher order EFT theory-driven emotion schemes. Using hierarchical linear modeling he found that across treatment, good resolvers of self-criticism increased their expression of primary adaptive emotion. Additionally,

good resolvers decreased secondary emotion from the middle of therapy to late therapy. Using THEME, Choi (2016) found that good resolvers expressed sequences of ‘hurt/grief’ and need followed by ‘assertive anger’. Additionally, good resolvers expressed a pattern of primary adaptive emotion, followed by need, and primary maladaptive emotion followed by more primary adaptive emotion and need expression. The four poor resolvers expressed patterns of repeating ‘rejecting anger’ and ‘global distress’, as well as alternative rejecting anger and ‘fear shame’ without need expression. There were also sequences found in poor resolvers of self criticism expressing alternating patterns of secondary emotion and primary maladaptive emotion. In total EFT-EP theory was validated. Choi (2018), in his dissertation, further examined whether working phase emotional processing predicted long-term outcomes within subtypes of self-critical clients to discover if it was possible to emotionally direct different self-critical types to good outcomes, based on what might work best emotionally for each type. He identified two qualitatively derived subtypes of self-criticism, core-worthlessness (CW; n = 22) self-criticism, or socially inadequate (SI; n = 20) self-criticism. The CW subtype identified clients who expressed self-defeat, and core negative beliefs such as “I am incompetent” or “I am invalid” or ‘weak,’ (Choi, 2018). The SI subtype identified clients who expressed feeling inferior or ‘bad’ as a result of being unable to meet internalized goals and standards to gain approval (Choi, 2018). Emotional processing was compared using, again, CAMS specific codes as well as emotion schematic codes. Using Mann-Whitney U tests, it was found that CW clients expressed more ‘hurt/grief’ and less un-codable emotion compared to SI clients. Using THEME, CW clients were found to express more ‘assertive anger’, ‘fear shame’, and ‘hurt/grief’ compared to SI clients. In terms of emotion schematic codes, CW clients expressed more primary adaptive and maladaptive emotion. THEME analyses also revealed that good outcome CW clients had more

sequences of secondary emotion followed by primary maladaptive emotion, need expression, followed by primary adaptive emotion compared to CW poor outcome clients. Poor outcome CW clients had more sequences of un-codable emotion and ‘global distress’. Good outcome SI clients had more sequences of ‘hurt/grief’. Poor outcome SI clients had more sequences of ‘fear shame’ followed by ‘rejecting anger’, and more emotion schematic sequences of un-codable emotion and secondary emotion. Again, EFT theory appeared to be validated.

However, problematically it was found that CW clients tended to receive EFT whereas SI clients tended to receive CCT. This was a significant found difference. As such, self-critical subtypes were confounded with both therapy-received as well as differences in emotional processing in these two types. Therefore, it was not possible to disentangle whether EP for each self-critical subtype differed as a result of the subtype or because of the therapy they had received.

Rinaldi (2017) investigated the relationship between alliance growth, emotional processing, and long-term outcome after experiential therapies, also for a small sample of 14 clients who had exhibited either strong (SAG clients $n = 7$) or weak (WAG clients $n = 7$) alliance growth during treatment. She then compared these two alliance growth groups for CAMS specific codes or emotion schematic codes expression in both the working and termination phases of therapy. Her purpose was to explore whether alliance growth that had already been shown to predict these clients’ long-term outcomes (Pos & Thompson, 2011) also predicted differences in their emotional processing. She also examined increases and decreases in CAMS coded states and CAMS coded higher order emotion schemes between the working and termination phases of therapy. In the working phase, SAG clients had more EEs with relief, ‘assertive anger’, and need expression. WAG Clients had more EEs with ‘global distress’, more

‘rejecting anger’, as well as more emotion schemes with secondary emotion, and less primary adaptive emotion. Between the working and termination phases of therapy, SAGS expressed decreased needs, and WAGS increased in ‘global distress’ expression as well as their expression of one adaptive emotion state, relief. EFT theory again appeared to be supported.

However, again, a problem with Rinaldi (2017) was that therapy groups were again significantly confounded with alliance groups. Therefore, once again one could not tell if differences in EP found were the consequence of therapy received or alliance growth group.

Wong (2016) then compared EXP and CAMS process measures, both applied to the same working phase EEs in her study of termination and long-term outcomes in 55 clients. She also parsed her sample, this time by the individual difference of clients external or internal focus. She had assumed that each process measure might differentially predict outcome for subgroups of clients who she determined were internally or externally focused. Pos (2006) had surmised that outcomes for internally focused clients might be better determined by the CAMS whereas outcomes for externally focused clients might be better predicted by the EXP scale. While she did not use THEME analysis, Wong used multiple regression analysis predicting outcome using both EE-EXP and EE-CAMS codes. Wong (2016) found the opposite of what was hypothesized and showed that GD expression during EEs was a strong predictor of outcomes for external clients and that EE-EXP at Level 6 was a strong predictor of outcome for internally focused clients. This suggested that CAMS measures of secondary emotion might be good measures of experiential avoidance and that EE-EXP Level 6, specifically might be an implicit measure of emotion schematic change.

In any event Wong’s (2016) study suggested the complexity of measuring emotional processes in therapy and for subgroups of clients. It is clear that EP appears to be important to

long-term MDD outcome; but it remains unclear if EFT theory and the CAMS measure of that theory supply a helpful model in understanding how EP should be generally measured in these MDD clients. The current study wanted to test EFT theory using the CAMS measure of that theory, in a fashion that would not confound therapy received with good and poor long-term outcomes of treatment of MDD with experiential therapy.

Emotion-focused therapy versus Client-Centred therapy for depressive relapse

Some literature (Watson & Pos, 2017; Elliot et al., 2013) has suggested that EFT and CBT both have good long-term outcomes for the treatment of MDD because of their having more structured natures. Since EFT is more structured than Client centered therapy this may also be true within experiential treatments. Some researchers have examined the effectiveness of structured treatments for depression. One such study compared usual care with a structured program that coordinated care with a health team finding that the structured intervention was superior to usual care (Bush et al., 2004). Another study compared two group treatments for depression to a wait-list control group. While there was no difference between the group treatments, members belonging to the structured therapy group improved on five out of seven outcome measures used compared that group to the wait-list control. Members belonging to the supportive psychotherapy group only showed improvement on two measures (Rice, 2001). Bondolfi et al. (2010) compared the combination of mindfulness-based cognitive therapy and treatment as usual to treatment as usual alone and found that the time to relapse was delayed significantly (29 weeks) in the combined treatment compared to treatment as usual (10 weeks). A meta analysis by Feng et al. (2011) found that cognitive-behavioural group therapy has a lasting effect over 6 months and lowers the relapse rate of depression. Since we already know that EFT and CBT are comparable treatments for MDD (Watson et al. 2003), the above research supports

the idea that a more structured treatment of MDD may be more effective. A question one might have is: Why? First of all, structured treatments may be better in general regardless of the client issues or the diagnosis suffered - that is, structured treatment may not necessarily be better at treating depression alone. Alternatively, it is possible that a structured treatment would suit a particular client or help a client with a particular diagnosis (i.e. MDD). Since depression often is associated with loss of direction and aimlessness (Greenberg & Watson, 2006) it may be that a more directive treatment is helpful because it provides direction.

An interaction between client individual difference and treatment model is also a possible explanation. For example, a depressed client may endorse helplessness or hopelessness and lack a feeling of agency. In such a case working with a therapist or within a treatment that has clear direction and structure may provide such a client with a sense of agency modeled by the therapist and therapy. Some depressions may yield to more structured treatments for this reason. Since EFT has structured interventions and balances leading and following clients (Pos & Greenberg, 2012), there is the possibility that its particular style of intervention helps a particular depressed client by providing that clients with more structured treatment.

EFT's structured focus on emotion may also be central to its effectiveness. Emotion-focused therapy specifically guides clients to access and work with their emotional experiences based on client expressions of particular emotion problem markers, which the EFT therapist meets with appropriate emotion processing interventions. Some extant evidence demonstrates that emotion-focused therapy (EFT) has better long-term outcomes for depression than client-centered therapy (CCT) because of this focus. Two Experiential therapy trials for treating MDD conducted at York University by Dr. Greenberg's York Psychotherapy Group (Greenberg & Watson, 1998; Goldman, Greenberg & Angus, 2006) compared the effectiveness of EFT and

CCT in treating depression. In both studies, clients were randomly assigned to 16-20 sessions of either EFT or CCT treatment.

The EFT treatment group followed a manual developed by Greenberg et al. (1993). In this treatment, therapists spent three sessions working within a client-centered framework. In later sessions they integrated experiential and gestalt techniques such as chair-work and focusing. Throughout this process the goal was for problematic emotional states to be transformed into adaptive ones. The first 1998 study (Greenberg & Watson, 1998) found no difference in Beck Depression Inventory (BDI) scores at termination, however, clients receiving EFT had more reductions of overall symptoms, interpersonal problems, and increases in self-esteem. The second 2006 study (Goldman, Greenberg & Angus, 2006) found that EFT clients showed superior results on all outcome measures, however, found no differences in the proportion of patients recovered at termination. This demonstrated that even though both therapies entailed common factors that worked, the addition of specific emotion-focused methods did appear to affect greater change.

In a follow-up study on the same sample, Ellison et al. (2009) examined 6 and 18-month outcomes after treatment. No differences in relapse between CCT and EFT at 6-months follow-up were found. However, at 18-months post-treatment a greater proportion of CCT clients relapsed compared to EFT clients. Ellison's survival analysis indicated that by the end of the 18-month follow-up period, approximately half of the CCT clients had relapsed, while approximately only 20% of the EFT clients relapsed (Ellison et al., 2009). In addition, while there was no difference at 6-month measures, at 18-month follow-up EFT clients reported a greater number of 'well weeks' (weeks in which clients experience no or minimal depressive symptom). In follow-up interviews, EFT clients also talked about using emotional processing

skills learned in therapy. This further suggests that emotion-focused techniques may result in more resilient resolution of depression long-term.

Another study by Watson et al. (2003) compared emotional processing, measured as Experiencing, between clients who were assigned to received 16 sessions of either CBT or EFT. This study found no difference in outcome between the two treatment groups at follow up for the most part, however, clients who received EFT treatment reported greater reductions in their interpersonal problems. In a follow-up study Watson & Bedard (2006) found that good outcome clients regardless of therapy type, had higher modal and peak ratings of Experiencing than poor outcome clients. This indicated that good outcomes for MDD appear to be linked to deeper experiential processing. As well, Wong (2016) previously had found that clients with better long-term outcomes expressed more Level 5 EE-EXP. Watson & Bedard (2006) found that clients receiving EFT had a higher percentage of Level 5 ratings of Experiencing than clients who had received CBT. EFT clients also had more Level 3 ratings, and a lower percentage of Level 2 ratings. Level 2 EE-EXP during the termination phase of therapy had previously been shown to predict poorer outcomes (Pos, 2006) in experiential therapies. These findings again suggest that clients receiving EFT were changing because they were engaged in emotional processing tasks.

The above research suggests that processing emotion is an important change mechanism for resolving depression long-term. Further, since EFT targets emotions and emotional processing specifically, EFT may be a better experiential treatment for depression than CCT. This has yet to be explored. It is well established that both experiencing and sequences of emotion scheme types (primary maladaptive, primary adaptive, and secondary) predict outcomes during experiential therapy using small samples that unfortunately confounded EP with treatment model received. If EFT emotion theory is a general common emotion theory of change, better

long-term outcomes should show the same pattern than do poor long-term outcomes independent of therapy. And if EFT is the better experiential treatment than CCT, then the EFT theory assumed sequential processing of emotion states should occur more in EFT than in CCT cases.

Current study

This study examined CAMS coded emotion episodes (EEs) to identify patterns of emotion sequences in clients who had exhibited good versus poor long-term outcomes after experiential treatment for MDD. This was to determine whether EFT emotion processing theory could offer a valid common model of emotional change in any therapy for depression. Following this, I also examined EP differences in clients who had received either emotion-focused therapy (EFT) or client-centered therapy (CCT) to compare the emotional processing between these two therapies. I examined archival working phase (between sessions 4 and the 3rd last session- see Pos et al, 2009) emotional processing measures from 55 clients who provided 18-months follow-up outcome measures, and who had also been randomly assigned to receive either 16-20 sessions of CCT or EFT treatment. Using the Classification of Affective Meaning States (CAMS; Pascual- Leone & Greenberg, 2005) a valid EFT based measure that captures specific emotion states as well as the EFT emotion typology, I examined emotional processing occurring in the working phase sessions of all 55 clients. My reasons for focusing in the working phase of therapy was because empirical evidence (Pos, 2006; Pos, et al., 2009) has indicated that working phase emotional processing best predicts experiential therapy MDD outcomes. CAMS codes were reliably applied to all working phase therapy sessions by Wong (2016).

I used two analyses, Mann Whitney U analyses of proportions of EEs coded by CAMS, and also used THEME time sequential analyses of these emotion episodes to uncover emotion states or emotion typology sequences that might illustrate differences in emotion change

consistent with long term outcome groups independent of therapy received, as well as for therapy-received groups. I measured long-term resilient outcome of depression as clients not reporting being depressed (having a Beck Depression Inventory < 10 at 18 months) at follow-up, 18 months post treatment.

Hypotheses

1. The first hypothesis was that based on EFT theory and the assumption that emotional processing (EP) drives resilient change in experiential therapies, good long-term outcome cases would demonstrate EFT theory consistent emotional processing that would predict long-term outcome groups, independent of therapy.
2. The second hypothesis was that given past research EFT cases would demonstrate stronger long-term outcomes than would CCT cases.
3. The third hypothesis was that EFT cases would exhibit EFT theory consistent EP when compared to CCT cases.

Method

Participants

The participants consisted of 55 clients who had provided 18-month follow-up data after participating in either the York 1 or York 2 randomized control trials (RCTs; Greenberg & Watson, 1998; Goldman, Greenberg & Angus, 2006) for treating MDD. These trials offered short-term (16-20 sessions) experiential therapies, either EFT or CCT. These 55 clients had had all their working phase EEs coded for emotional processes using CAMS by Wong (2016). These CAMS coded sessions were the archival data used in this present study.

The York Depression Trials. The York 1 and York 2 depression studies both compared the effectiveness of two humanistic/experiential brief psychotherapies for MDD: client-centered

therapy (CCT; Rogers, 1957) and emotion-focused therapy (EFT; Greenberg, Rice & Elliott, 1993; Greenberg & Watson, 2006). Clients were randomly assigned to one of the treatment groups, and therapists saw an equal number of clients in each treatment modality, therefore serving as their own treatment controls. The treatment consisted of 16-20 sessions of either CCT or EFT and adherence to treatments was established in both trials (see original outcome studies).

Past procedure. This study is a secondary analysis of archival CAMS coded EEs (Wong, 2016) obtained from clients' working phase emotion episodes. The following is a description of the methodology of therapy phase session selection, emotional processing and emotion episode sampling, used in Wong (2016) and originally derived from Pos (2006). Descriptions below come from Pos (2006).

Session outcome measures. The following session measures were administered after every session throughout York I and II treatment and were used in the identification of productive working phase sessions.

General Session Evaluation Questionnaire (GSEQ). This questionnaire assessed clients' evaluation of therapy sessions. It consisted of three items taken from Orlinsky and Howard's (1975) Therapy Session Evaluation Measure and 2 additional items that asked clients to identify the degree to which something changed or shifted for them as the result of the session, and then to assess the degree to which they feel they would take a different course of action as a result of the session shift. All five items were rated by clients using a 7-point Likert scale.

Helpful Aspects of Therapy Form (HAT). This frequently employed qualitative measures of client perceptions of significant therapy events (Elliot, Slatick, & Urman, 2001; Llewelyn, 1988) and was an open-ended seven-item questionnaire completed by clients.

Client Task Specific Measure (CTSM). This measure tracked post session progress on the main tasks of treatment (Greenberg, et al, 1991; Greenberg, et al, 1993). Clients rated 12 items on a 7-point Likert scale. Three items each related to self-critical processes, problematic reactions, unfinished business with a significant other, and experience of the therapist's client-centredness respectively.

Therapist session questionnaire (TSQ). This measure, developed by Greenberg and colleagues, provided the therapist perspective on client therapy progress. Therapists reported whether they felt the client had experienced a significant shift in perception or feeling, resolved a core issue in the session, as well as reported on the major themes developing in the therapy.

Sampling Method: Emotion episodes. (EE; Greenberg & Korman, 1993; Korman, 1991). EEs were the primary units of analysis in which emotional processing was investigated. An EE is a segment of psychotherapy narrative in which a client speaks about having experienced emotion in response to a situation, real or imagined. An EE segment is complete when the narrative theme changes or upon a new emotional response being expressed. A complete protocol for an EE contains five components: the situation (i.e. loss of loved one), an emotional response (i.e. sadness), a tendency toward behavior or action associated with emotion (i.e. crying), an appraisal of self or situation (i.e. 'I'm alone' / 'she's gone forever'), and a related concern or need (i.e. attachment). To be identified, only a reported situation and emotional response or action tendency had to be present. Emotion episodes typically ranged from one to two and one-half pages of transcript in length, but very occasionally were three to four pages in length. EE length was not related to any process or termination outcome variable.

EE sampling. For the working phase sessions EEs from between the fourth and the fourth last session) were sampled. Session selection was based on the following: 1) clients rated

these on the HAT as the sessions resulting in the most felt progress; 2) they reported on the GSEQ the highest degree of shift or change as a result of these sessions; and 3) they reported on the CTSM measure the highest degree of task resolution. In the case of a discrepancy between measures, priority was given to session outcome criteria 2 and 3. In the case that more than two mid-therapy sessions were equivalent by these criteria, the therapist report on the session's productiveness (TSR) was used as a tie-breaking discrimination. In the case that more than two sessions still appeared to have been equally productive, the two earliest most distal from termination productive mid-therapy sessions, were selected in order to strengthen the causal mechanism that emotional processing lead to good outcome.

EE reliability. A primary EE segmenter with six years of experience segmenting and training on the emotion episode sampling method segmented all transcripts. To obtain reliability, two other EE segmenters, one expert and one recently trained segmenter, identified the emotion episodes present in 120 transcripts. A protocol for each EE identified a situation and emotional response and/or action tendency made. Episodes selected as EEs were then compared by identification of the situation, emotion or action tendency (Korman, 1998). Agreement occurred if there was agreement on the identified situation, as well as the emotional reaction to it. Reliability was then measured as a percentage-based hit-rate of accurately identified and agreed-upon emotion episodes. The average hit rate for identified EEs measured against the primary rater was 92 % (98.8 % for the expert rater and 82% for the newly trained rater). Therefore, on average 92 % of the time there was agreement on the identified EE and its protocol.

Process Measures. The rated data in the current study came from the use of the following process measure (Wong, 2016). The entire CAMS manual can be found in the Appendix.

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

CAMS is an observer-rated measure used to categorize ten discrete emotion states. This measure is used to code expressed emotion events when clients are emotionally aroused and is thought to distinguish between productive and unproductive emotions. The ten emotional states captured (in ascending order of productivity and depth of emotional process) are: (1) ‘global distress’ (GD), described as overwhelming and undifferentiated distress; (2) Fear/Shame (FS), described as an expression of a core concern that is the source of personal pain; (3) Rejecting Anger (RA), which describes the expression of reactive anger; (4) Negative Self-Evaluation (NSE), described as a negative belief about the self; (5) Need, described as a wish or desire; (6) Self-Soothing, which describes clients beginning to self-nurture; (7) Assertive Anger (AA), describes an expression of anger that asserts a boundary or need; (8) ‘hurt/grief’ (HG), describes clients’ acknowledgement of sadness, hurt or loss; (9) Relief, describes clients feelings of reduced tension, hopefulness or accomplishment; and (10) Acceptance and Agency (ACAG), described as an agentic acceptance of resolved of distress, shame or anger.

Transforming CAMS Categories to Emotion Scheme Types. During a CAMS reliability and coding training, the author of the CAMS (Pascual- Leone, 2005) and the present supervisor of emotion process research at York University, Dr. Alberta Pos, theoretically codefined EFT emotion reaction categories. Proportions of emotion scheme categories were calculated as being comprised of the sum of the proportions of EEs coded by substituent CAMS emotion states. This was accomplished for proportional analyses. Alternatively, for THEME analyses an EE was simply recoded not as a CAMS state but as the emotion scheme reaction type to which that state had been assigned. Constituent CAMS code were recoded as indicating a particular emotion scheme category in the following fashion. Primary adaptive emotion (PAE) encompassed EEs

expressing CAMS coded ‘assertive anger’, CAMS coded ‘hurt/grief’, CAMS coded ‘relief’, and CAMS coded ‘acceptance and agency’; primary maladaptive emotion (PME) encompassed EEs expressing CAMS coded ‘fear shame’ or CAMS coded negative self-evaluation; and secondary emotion (SE) encompassed EEs expressing CAMS coded ‘global distress’ and CAMS coded ‘rejecting anger’. Need expression during EEs were maintained as their own category given that expressions of needs in EFT theory is assumed to be important in its own right by helping clients access experiences of PAE. Also, in most if not all models of chair resolution (Elliott, et al., 2004) expression of needs appears to be of central importance.

CAMS reliability (from Rinaldi, 2017). 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 further sessions (5 sessions for each of two raters) were coded by one rater after reliability was established. Disagreements in codes were resolved consensually with the consensual code used in analyses. Original codes were used to establish CAMS coding reliability. All coding was conducted independently, and all EEs coded by the two raters were included in the reliability calculations.

Outcome Measure used in this study. A suite of four outcome measures were used in the original outcome studies. These were:

The Symptom Checklist—Revised (SCL-90R; Derogatis & Melisaratos, 1983). Although this measure taps into nine separate primary psychiatric symptoms (i.e., depression, anxiety, hypochondriasis) only the Global Severity Index (GSI) was used in York I and York II studies. Reported test-retest reliability for the SCL-90R over a one-week period range from .80 to .90, and the internal consistency estimates for the nine subscales range .81 from .77 to .90 (Derogatis, 1983).

The Inventory of Interpersonal Problems (IPP; Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988). The IIP consists of 126 items describing interpersonal situations. Forty-eight items describe “things I do too much” (e.g., being critical of others) whereas the remaining 78 items describe “things I find hard to do” (e.g., being assertive). Using a five-point Likert scale, respondents rate the degree to which they find each situation problematic. The overall level of interpersonal dysfunction score was used in this investigation. Test-retest reliability for overall interpersonal dysfunction has been reported to range from .82 to .94, whereas for the five subscales from .89 to .90 (Horowitz et al., 1988).

The Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965 /SEI; Bachman & O’Malley adaptation of the RSE, 1977). The RSE is a 10-item self-report inventory designed to sample respondents’ attitudes about themselves in relation to self-esteem. Respondents rate on a Likert scale from 0 (never) to five (almost always) how frequently they hold certain attitudes about themselves. Bachman and O’Malley’s (1977) adaptation of the Rosenberg self-esteem index was standardized on a sample of 1,698 young men. Internal reliability was found to be as high as .81.

Construct validity was demonstrated by correlations with other variables such as negative affect states ($r = -.51$) and happiness ($r = .54$).

The current study only used data from the following outcome measure:

The Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock & Erbaugh, 1961; Beck 1972). The BDI is a 21-item, self-report inventory designed to measure severity of depression. For each item, respondents choose one of five alternatives that best describes them at present. Higher scores reflect greater severity of depression (possible range of the BDI = 0 - 63). In a review of 10 years of research using the BDI, Beck, Steer & Garbin (1988) reported validity coefficients ranging from .66 to .86, and internal consistency coefficients ranging from .73 to .93. The BDI also has been shown to have good discriminant and concurrent validity (Beck, et al., 1988). In the current study outcome was measured as clients who reported a BDI score of under 10 at 18 months. This is a level of depressive symptomology considered to indicate 'not-currently depressed' (Beck, Ward, Mendelson, Mock & Erbaugh, 1961).

Method of Analysis

Data preparation. Data was examined for violations of normality.

CAMS Code analyses. Group differences in the proportions of CAMS codes were analyzed using Mann Whitney U tests due to CAMS codes being given as proportions of EEs coded with a particular CAMS code. Sequences of EEs were analyzed using THEME (Magnusson, 2000). Groups were established by dividing clients into therapy groups (EFT versus CCT) or outcome groups (good or poor long-term outcome).

THEME (Magnusson, 2000). THEME is a statistical program that detects complex patterns that occur over time in behavioural data. THEME analyses behavioural codes of any kind. Coded emotion episodes (EEs) from therapy transcripts were recorded in text files for

analysis. Each line of text in a client file contained a time stamp that marked the beginning and then end of an EE with the corresponding CAMS code ('global distress', 'assertive anger', 'hurt/grief', etc.) In order to demonstrate that patterns found are non-random, THEME conducts an analysis of data comparing it to randomized possible data. The results obtained assure that the data contains observable non-random patterns in time, called T-patterns. T patterns are found sequences of EEs that are linked over time more often than expected by chance. T-patterns are then further organized by THEME into more complex patterns by other metrics such as the longest, most frequent, or most complex patterns. THEME then uses binomial analyses to ascertain whether a particular EE CAMS or ES code occurs more in one versus another group determined by the researcher's questions. All such comparison analyses used the most stringent alpha level possible for the comparison. No binomial analysis occurred at greater than $\alpha = .05$. All used alpha levels are reported in each analysis.

Results

Data preparation

As described above, the data was archival CAMS codes established by Wong (2016). Therefore, I will represent important aspects of data preparation taken in that dissertation. All variables were examined and found to normally distributed with no assumptions of normality violated.

Differences between the Current Study Sample and Overall York I & II Study Sample

The current study sample of 55 clients was compared to the combined overall York 1 and II samples to be sure that clients providing follow-up data were representative of the original 74 depressed clients, reported in the York 1 (Greenberg & Watson, 1998) and II clinical trials (Goldman, Greenberg, & Angus, 2005). Clients who did ($n=55$) and did not ($n=19$) provide 18-

month follow-up data were examined for differences on their reported pre-treatment and termination depression scores. No differences were found between those clients who did and did not provide 18-month follow-up data on all variables measuring depression (all $ps > .05$). This indicated that the as far as measures of their pre-treatment depressive distress or therapy at termination outcomes for their depressive symptoms, the follow-up sample did not differ from the York 1 and II clients not providing follow-up measures.

Analysis of Possible Confounds. Prior to the THEME analysis, potential therapy group differences were also analyzed to rule out other possible confounds. These are described below.

Demographics. No significant differences in demographics (age, sex, marital status, and education) were found between EFT and CCT groups.

Pre-treatment distress. No differences in pre-therapy distress were found between EFT and CCT groups on any outcome using the following measures: Beck Depression Inventory (BDI; Beck, et al, 1961; Beck 1972), Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureno & Villasenor, 1988), The Symptoms Checklist-Revised (SCL-90R; Derogatis & Melisaratos, 1983), and the Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965).

Long-term outcome report differences. Additionally, I examined whether clients belonging to a particular therapy group might more likely report long-term outcomes measured by the BDI. Thirty-one out of thirty-six (86%) clients who received CCT reported long-term outcomes, compared to 24/38 (63%) clients who received EFT. Chi square analysis found this relationship to be significant ($\chi^2 = 2.656$, $p = 0.51$). This result indicated that of the 74 clients who had participated in the original two trials of experiential treatment of MDD, clients who received CCT were more likely to report long-term BDI outcomes than were EFT clients. Still, at the same time, clients receiving EFT were more likely to report a lower (less depressed) BDI

score at 18 month follow up, $t(53) = 2.19$, $p = .032$, and to have a BDI score in the not depressed range, under 10, $t(52) = -2.8$, $p = 0.007$, at 18-month follow-up. So, although EFT had better outcomes (supporting H2), more often CCT clients reported long-term follow-up. It is unknown why fewer EFT long-term outcomes were reported, nor why clients who received CCT and who did report long term outcomes were more likely to have poorer outcomes. However, a number of variables may explain why EFT cases were less likely to report long-term poor outcomes. Poor outcome EFT clients might be less likely to report outcomes because they are angry at that research group because of having poorer outcomes. This is not likely unless clients knew that the researchers were likely to be pro-EFT and that they had been assigned to that treatment. No control of this would have been possible. It is also possible that clients still depressed at 18 months might be unmotivated to report long-term outcomes due to being depressed and perhaps unmotivated to report. Why one therapy group would be more depressed in that way is also not likely. Another option is that clients who received CCT did simply exhibit more frequent poorer outcomes. However, one thing was certain: clients in the poor outcome group were more likely to be CCT clients. For this reason clients assigned to the poor outcome group were compared on their BDI 18 months depending on whether they received EFT versus CCT therapy. EFT clients did report being more depressed than CCT clients at 18 months when they were in the poor outcome group, but this difference was not significant (EFT BDI= 20.40 versus CCT BDI 17.35, $p = .826$). Further it should be noted that a Chi square test of goodness of fit did not find that there was any significant frequency difference (not even a trend) between therapy types and long-term outcomes in the current data set of 55 clients ($p > .05$). The real issue is: does the fact that more EFT clients who were less depressed or had good outcomes bias the results in any way? This will be discussed in the limitations of the study below.

Additional Data preparation. A total of 108 working phase CAMS-coded EE files were THEME analyzed for the 55 long-term BDI outcome providing clients. This meant that for the majority of cases two sessions per client were CAMS coded and analyzed. The exceptions to this were two sessions for two York 1 clients who were missing data due to their audio or video not being available. This means that for these two clients only 1 working phase session was CAMS coded and THEME analyzed. Both of these clients were EFT clients from York 1. THEME files were archival, made for previously studies by Choi (2018) and Wong (2016).

Inter-rater Reliability.

Emotion episode sampling. Reliability for emotion episode sampling, established in Pos (2006), was calculated using a sample of 120 sessions including beginning, working and termination phase sessions. Reliability was measured as a percentage-based hit-rate of accurately identified and agreed-upon emotion episodes. The average hit rate for identifying emotion episodes was 92%. Therefore, EEs appeared to be reliably identified.

Rater-reliability of CAMS ratings. This was also established by Wong (2016). Cohen's (1960) kappa (k) was used to measure inter-rater agreement found for CAMS codes, as it is a nominal scale. Inter-rater reliability between raters was reported to be above .75, which is considered excellent beyond chance (Fleiss, 1981).

Descriptive Statistics

CAMS codes. Figures 1 and 2 show the reader the proportion of EEs coded with CAMS codes for treatment and outcome groups and also provides information on the proportions of EES rated depending on their emotion schematic category (i.e. secondary or primary adaptive). Significant differences relate to Mann Whitney U analyses are noted below.

Mann Whitney U Analysis: Proportional Differences in CAMS coded EEs. Due to the proportional non-normal data of CAMS codes I first tested for differences in the coded proportions of CAMS codes as well as differences in the proportion of EEs rated as belonging to emotion schematic categories for both long-term outcome groups and therapy groups using Mann-Whitney *U* tests (See Tables 1-4). When comparing outcome groups independent of therapy received there was a higher proportion of ‘hurt/grief’ ($p = 0.04$) found in the good outcome group. Three trends toward significance were also found. Needs were more often expressed in good outcome cases, and ‘rejecting anger’ and ‘global distress’ were expressed more by poor outcome cases. Further the category of secondary emotion was also a strong trend, Poor outcome cases expressed more of this emotion scheme category. No significant proportional differences were found in outcome groups for proportions of other emotion schemes. As far as therapy group differences were concerned, two CAMS codes differed significantly between therapy groups: Hurt/Grief ($p = 0.009$) and ‘assertive anger’ ($p = 0.012$). Both were expressed in higher proportions in the EFT group. There was also a trend found ($p = .082$) for EFT clients to have a higher proportion of expressed primary adaptive emotion.

THEME Analysis

I consulted with the THEME originator, Dr. Magnus Magnusson (personal communication over SKYPE sessions Summer and Fall 2019) to guide all THEME analyses and analysis interpretation.

In the THEME analysis (Magnusson, 2000) I, as researcher, set the parameters for searching for patterns in the data, as well as how the rated data were compared to randomly obtained data. Randomization of the data was performed in order to have greater confidence that obtained patterns found in the data were non-random. THEME performs a bootstrapping

procedure by shuffling and rotating the data to randomize the real data. In shuffling, the real data's time signatures for the events are randomly redistributed within the event series. In rotation, the real data's time signatures for the events are all shifted a random number of degrees in relation to other event series. Also, I set the criteria for the number of times a pattern had to occur in order for it to be detected. In the basic search pattern used in each analysis performed in this study I asked THEME to search for patterns that occurred at least 45 times (in at least 45 sessions) at an α level of $\alpha = .005$. which is the THEME default α search probability level. This ensures that THEME found patterns occur at a chance level of 99.995 certainty. This was a very stringent criterion. This criteria level and amount of times the sequence would be found ensured that my analyses were strict enough to reduce the chance of spurious findings. Choosing the minimum pattern occurrence level to be set at the necessary occurrence criteria = 45 also ensured that a found pattern *could* appear in all clients within one outcome or therapy group. For example, there were 47 samples of EFT data in the data set. As such it was possible that 45/47 or 96% of the time a found pattern could have occurred only in the EFT group. In fact, THEME output allowed me to ascertain which clients (receiving EFT or CCT) actually expressed which emotional processing state and within how many clients in each treatment group the state had been expressed. Following the analysis of any CAMS emotion states, I did a second analysis examining higher order emotion schematic patterns that were composed of lower level CAMS codes, using the same search parameters.

Parsing THEME Analyses. Once the EE data was searched for found patterns the researcher sorted through the found data for recognizable themes. So, for any analysis I first conducted a general pattern search as described above for all the data. For each data set, whether outcome groups or therapy groups, I searched for coded sequences in both CAMS states data sets

as well as emotion schemes data sets. I then statistically searched all the found patterns to establish if any found patterns occurred more frequently in one group compared to the other. THEME performs this analysis using a logistical regression statistical procedure. The researcher decides the statistical level at which these differences are found. THEME uses a default search level for differences occurring in one group versus another as $p = .05$. However, I employed a more stringent level of analysis using an alpha level of .01. Any differences between groups that were found were then tested at increasingly more stringent levels of probability until a pattern difference was rendered no longer significant. This meant for example that any pattern found to differ between EFT and CCT groups or between outcome groups at $\alpha = .01$ was again tested at $\alpha = .005, .001, .0005$ etc.

Randomization Results. The randomization procedure employed both a shuffling and rotation of the data, repeated a minimum of 20 times for each THEME analysis performed. The data in each THEME analysis was found to be non-random and the patterns found were determined to be non random and valid as a result. Figure 3 illustrates an outcome chart provided by THEME randomization procedure. It shows the reader that it is virtually not possible to obtain the results we actually obtained randomly. As such our confidence in our THEME results was increased.

THEME analysis of CAMS emotion state patterns overall. In the entire sample, 81 unique within session CAMS emotion state patterns were detected, ranging in length from 2 to 3 events. Since all CAMS emotion states are coded with a beginning and end, patterns with a length of 2 indicated only 1 emotion state and, as a result, were of no emotion state or emotion scheme sequence interest. However, 52 out of 81 found patterns (64%) contained more than 1 coded EE and were of interest.

Results of THEME analysis of sequences of CAMS emotion states relating to Outcome differences Independent of Therapy Received. The frequency of found CAMS rated emotion patterns for long-term outcome groups can be viewed in (Table 5). For the good outcome group, thirteen CAMS patterns occurred with significantly greater frequency (at the 0.01 level). In good outcome cases two patterns showed repeated expression of ‘hurt/grief’ (Figure 4), and two patterns showed significant repeated expression of ‘assertive anger’ (Figure 5; this was a different result than the MWU proportional differences found). As well as these, the good outcome cases also expressed two significant patterns of repeated expression of ‘fear shame’ (Figure 6; this was also not found in the MWU analyses), and one significant pattern of ‘fear shame’ expression followed by need expression (Figure 7). All of these found patterns were expressed more frequently in good outcome sessions independent of therapy. The remaining six patterns expressed components or sub-patterns of the above mentioned found patterns.

While these found patterns occurred significantly more frequently in good outcome cases THEME indicated they could also occur in poor outcomes. For example, found patterns of repeated ‘hurt/grief’ occurred 77.6% of the time across 11 clients in the good outcome group, and only 22.4% of the time across 6 clients in the poor outcome group. Patterns of repeated ‘assertive anger’ together occurred 75% of the time across nine clients in the good outcome group, 25% of the time across 8 clients in the poor outcome group. Patterns of repeated ‘fear shame’ occurred frequently in both outcome groups, occurring 656 times in total, 68% of the time across 28 clients in the good outcome group and 32% of the time across 17 clients in the poor outcome group. However, the pattern of ‘fear shame’ followed by need expression occurred only 140 times in total, 74.2% of the time across 19 clients in the good outcome group, and 25.8

% of the time across seven clients in the poor outcome group. The reader should therefore know that these significant differences do not represent perfectly parsed group differences.

The poor outcome group also showed unique expressions of CAMS sequences. Seven CAMS coded emotion state patterns occurred with significantly greater frequency in this group. Seven patterns illustrated an emotion theme of repeated expression of ‘relief’ in poor outcome clients (Figure 8). This was surprising, given that relief is considered a primary adaptive emotion state in EFT theory. Two of these patterns were sequences of repeated relief. Patterns of expressed relief occurred 54% of the time across 12 clients in the poor outcome group, and 46% of the time across 16 clients in the good outcome group. As a result, I re-examined the Mann Whitney U analysis this time analyzing primary adaptive emotion minus the relief coded CAMS category. There was still no difference between outcome groups noted for this emotion scheme category ($p = .251$). However, two patterns showed repeated expression of ‘rejecting anger’ (Figure 9). Also, found patterns of ‘rejecting anger’ occurred 238 times in total, 56% of the time in total across 16 clients in the poor outcome group, and 44% of the time across 17 clients in the good outcome group. Therefore, expressions of repeated relief and ‘rejecting anger’ occurred in both the good and poor outcome groups, but significantly more often in poor outcome cases.

THEME Emotion scheme differences related to outcome groups. The good outcome group expressed 16 emotion schematic patterns with significantly greater frequency. Two of these patterns, which were both repeated expressions of primary maladaptive emotion, remained significant at the $p = 0.001$ level. The longest patterns found were expression of PME followed by expressions of need (Figure 15), expressions of PAE followed by need expression (Figure 16) or repeated sequences of expressed PME. The most frequent pattern was repeated expression of PME (Figure 17) and sequences of PME followed by need expression (Figure 18). Therefore,

repeated expressions of maladaptive emotion, and expressions of adaptive emotion connected to expression of ones needs occurred more frequently in good outcome cases, independent of therapy received.

The poor outcome group, (n = 6 for EFT and n = 17 for CCT) expressed five emotion schematic patterns with significantly greater frequency than good outcome clients. Both the longest and most frequent of these patterns showed repeated expression of secondary emotion (SE; see Figure 19). These patterns remained significant at the $p = 0.0005$ level. Therefore, expression of defensive or secondary emotion occurred more frequently in poor outcome cases, independent of therapy received. This was consistent with EFT-theory.

THEME analysis of CAMS emotion states relating to Therapy differences. The frequency of found CAMS expressions can be viewed in (Table 6). Thirteen CAMS patterns occurred with significantly greater frequency (at the 0.01 level) in the EFT group. Two patterns showed repeated expression of hurt and grief (Figure 10); two patterns showed repeated expression of ‘assertive anger’ (Figure 11) and two patterns showed repeated expression of needs (Figure 12). All of these results were also mostly confirmed by MWU analyses. The remaining seven patterns expressed components or sub-patterns of the above mentioned found patterns. More frequent found patterns of hurt grief remained significant at the more stringent alpha level of $\alpha = .0001$. Both the first and second found patterns of repeated ‘hurt/grief’ occurred in total 134 times, 106 times (79%) of the time in the EFT group across 12 clients, and 28 (17%) times in CCT sessions across 5 clients. The first and second found patterns of ‘assertive anger’ occurred 120 times in total, 104 total times in total in the EFT group or 86.6% of the time across 12 clients, and 16 times or 15.3% of the time in CCT sessions across 5 clients. The first and second found patterns of need expression occurred 206 times in total, 63% of the time in the EFT

group across 15 clients, and 37% of the time during CCT sessions across 14 clients. Repeated expressions of needs was found to occur more often in EFT cases at $p = .0007$ level.

I also examined patterns that occurred significantly more often in CCT cases. In the client-centered therapy (CCT) group, eight CAMS coded emotion state patterns occurred with significantly greater frequency than in EFT sessions. Surprisingly again, given that relief is considered a primary adaptive emotion state, two of these patterns were sequences of repeated relief. Remember that the Mann Whitney U analysis showed that there was a trend found ($p = .082$) for EFT clients to have a higher proportion of expressed primary adaptive emotion. As a result, I re-examined the Mann Whitney U analysis this time analyzing primary adaptive emotion minus the relief coded CAMS category. This time I found that EFT clients expressed significantly higher proportions of PAE rated EEs or EEs expressing primary adaptive emotion at $p = .007$ when relief was not included in the analysis. This result will be discussed later in the paper. Again, expressions of ‘relief’ were not perfectly parsed as far as therapy groups was concerned. For CCT cases the two patterns of relief (Figure 13) occurred 210 times in total, 66% of the time in the CCT group across 15 clients, and 35% of the time in the EFT group across 13 clients. Two other found patterns were sequences of repeated ‘fear shame’ (Figure 14) that were not linked to expression of any other primary adaptive emotion or any need expression. Two found patterns of repeated ‘fear shame’ occurred more frequently in the CCT data (656 times in total). It occurred 62% of the time in the CCT group across 25 clients, and 38% of the time in the EFT group across 20 clients. Therefore, while repeated fear shame occurred frequently in both therapy groups, THEME analysis indicated that it was more likely to be expressed in the CCT group. However, expression of needs was more likely to occur in the EFT group albeit the connected sequence of ‘fear shame’ expression to need expression was not found given the

current search parameters. This is discussed further below in the analysis of emotion schematic ratings. Repeated patterns of ‘fear shame’ expressions were more present in CCT cases at the $\alpha = 0.005$ level.

THEME analysis of higher order Emotion schemes relating to therapy differences. In the EFT group, ($n = 24$) 60 patterns occurred more frequently (at the 0.01 level) Of these 60 patterns 77 % described more than one emotion state. Twenty of these patterns remained significant at $p = .00005$ level. The longest patterns were repeated need expression followed by expressed primary adaptive emotion (PAE; see Figure 20). The most frequent patterns were either repeated need expression (Figure 21), or PAE followed by need expression (Figure 22). No found patterns contained PME emotion schemes.

To pursue finding longer EFT-theoretically assumed sequences containing emotion schematic categories of PME expression followed by expression of needs followed by expression of PAE, I examined emotion schematic patterns that occurred in EFT or CCT cases only. I searched using qualitative THEME analysis. I first found patterns beginning with the expression of PME. Then I examined a second round for a subset of patterns with need expression in the middle and then searched once more for another subset of patterns with expressed PAE at the end. This qualitative analysis allowed me to search for a relevant EFT assumed pattern in a smaller data set. This complete pattern expressing the entire sequence of emotion schemes of ‘PME-need-PAE’ occurred in EFT cases only.

In the client-centered therapy (CCT) group ($n = 30$), six emotion schematic patterns occurred with significantly greater frequency. Both the longest and the most frequent patterns found were sequences of repeated expression of primary maladaptive emotion (PME; see Figure 23). THEME did not detect any PAE sequences attached to these expressions of PME even

though MWU analyses had indicated that there was a trend towards PAE occurring more in the EFT group when ‘Relief’ was not included. Unfortunately, PAE in the current THEME analyses did include the ‘Relief’ emotion category.

THEME Results relating to CAMS states related to the Interaction between therapy and long-term outcome groups. To my surprise, in the 24 clients who received EFT no patterns distinguished good EFT (n = 19) from poor EFT cases (n = 6) in terms of CAMS states. This will be discussed below.

Some patterns did distinguish outcome groups within the 30 clients who received CCT who were good (n = 13) versus poor (n = 17) long-term outcome cases. THEME sequences of CAMS rated emotion state patterns distinguishing outcome groups within CCT therapies can be viewed in (Table 7). Good outcome CCT cases expressed more repeated ‘fear shame’ ($p=.00005$; see Figure 24). These repeated ‘fear shame’ patterns occurred 58% of the time across 11 good outcome CCT clients, and 42% of the time across 13 poor outcome CCT clients. So, expressing ‘fear shame’ was again found not to perfectly parse good and poor outcomes in CCT cases. Poor outcome CCT cases expressed more ‘global distress’ ($p=.01$; see Figure 25) and ‘rejecting anger’ ($p = .00005$; see Figure 26) sequences. The first repeated ‘global distress’ pattern occurred 31% of the time across 8 good outcome CCT clients and 69% of the time across 15 poor outcome CCT clients. The second ‘global distress’ pattern occurred 103 times in total; 31% of the time across 8 good outcome CCT clients and 69% of the time across 15 poor outcome CCT clients. So, ‘global distress’ patterns occurred 69% of the time in poor outcome CCT cases. In the case of the three ‘rejecting anger’ patterns found, the first ‘rejecting anger’ pattern occurred 110 times in total; 16% of the time across five good outcome CCT clients and 84% of the time across 12 poor outcome CCT clients. The second ‘rejecting anger’ pattern occurred 112 times in

total; 18% of the time across 5 good outcome CCT clients and 82% of the time across 12 poor outcome CCT clients. The third ‘rejecting anger’ pattern occurred 114 times in total; 18% of the time across 5 good outcome CCT clients and 82% of the time across 12 poor outcome CCT clients. In total 336 ‘rejecting anger’ patterns occurred 82.7% of the time in poor outcome CCT cases.

THEME Results relating to Sequences of Emotion Schemes related to the Interaction between therapy and long-term outcome groups. THEME found 21 higher order emotion scheme patterns distinguishing good EFT (n = 19) from poor EFT cases (n = 6). The longest obtained patterns for good outcome EFT cases were repeated sequences of need expression followed by expression of PAE (Figure 27). Significant patterns of repeated expression of sequences of PAE followed by expressions of PME were also found (Figure 28). THEME indicated that the most frequent of these patterns was need expression followed by PAE (Figure 29) or PAE followed by PME (Figure 30). Conversely no patterns were found to occur more frequently in poor versus good outcome EFT clients.

Six patterns distinguished the good (n = 13) versus poor (n = 17) long-term outcome CCT clients. The longest and most frequent of good outcome CCT patterns were repeated expressions of PME (Figure 31). In poor outcome CCT cases, 27 patterns occurred more frequently than in good outcome CCT cases. The longest were repeated sequences of secondary emotion (SE) followed by un-codable (UC) emotion (Figure 32). The most frequent patterns found were repeated expressions of SE sequences (Figure 33).

To help the reader understand results of both analyses (Mann Whitney U for proportions of EEs and THEME analyses or sequences of EEs found) a summary table of both the Mann-Whitney U and THEME analyses in Table 8.

Discussion

This study looked at CAMS coded emotion episodes (EEs) to identify proportions of emotion sequences or patterns of EEs that might differentiate clients' emotional processes independent of whether they received either emotion-focused therapy (EFT) or client-centered therapy (CCT). This was to establish if EFT theory and a CAMS measure of that theory could describe emotional processing that would differentiate long-term good from poor outcomes in the treatment of major depression, perhaps indicating that an EFT theory description of EP could serve as a common description of an EP process for all treatments of depression irrespective of therapy received. As well, this study also compared emotional processing that occurred in two experiential therapies, EFT and CCT. To accomplish these tasks, I examined archivally EE CAMS-coded data from two working phase sessions (between sessions 4 and the 3rd last sessions) that had already been established as important emotional processing sessions in both therapies (Pos, 2006). My goals were accomplished using 55 clients who had provided 18-month follow-up outcome measures in both York I and II outcome studies, after being randomly assigned to receive 16-20 sessions of either CCT or EFT treatment. Using the Classification of Affective Meaning States (CAMS; Pascual- Leone & Greenberg, 2005) all working phase emotion episodes had been previously coded using the CAMS by Wong (2016). CAMS is a valid measure that captures ten specific emotional processing states as well as provides measures of the higher order EFT emotion typology. Further, CAMS was considered as a more valid measure of EFT based emotion theory concerning emotional processing than EE-EXP (Wong, 2016) because it could capture EFT emotion theory in terms of emotion schemes that EFT theory suggests. This would provide a stronger test of EFT-EP theory, potentially providing a common EP factor for treating MDD. I first examined differences in proportions of CAMS-coded EEs

between groups using Mann Whitney U tests in SPSS. I did this to establish if there were differences in the non-normally distributed proportions of particular emotion states in the working phase EEs. I then used THEME time sequential analyses (Magnusson, 2000) to examine emotional processing EE sequences that occurred in the working phase sessions of the 55 clients included in this study. I performed these two analyses for either groups identified as good versus poor long-term outcomes independent of therapy received and also for therapy-received groups. For the interaction between good outcome and therapy received I only performed theme analyses. The Mann Whitney Us tested differences in proportions of emotion states. The THEME time sequential analyses of these CAMS-coded emotion episodes illustrated statistical differences in patterns of emotion change consistent with long-term outcome whether long-term outcome in depression was independent of therapy or depended on the therapy received. To remind the reader, long-term resilient outcome of depression was measured by clients reporting not being depressed (having a Beck Depression Inventory < 10) at follow-up, 18 months post treatment. I will start by discussing each hypothesis, and within each hypothesis I will first discuss results based on the analysis that used Mann Whitney U or THEME). I will also discuss results depending on the levels of coding used, both CAMS specific state codes and EFT derived emotion schematic codes. I will follow this by a discussion of analyses within the context outcome groups and of therapy received groups. Finally, I discuss the interaction of therapy and outcome.

A methodological question: Why do Mann Whitney U and THEME analyses yield different support for hypotheses?

One thing I would like to first discuss is the general difference between my two analytic methods. Mann Whitney U's tested for the sheer proportional differences in an expressed

emotion type whether at the CAMS state level or the higher level of emotion schemes. On the other hand, THEME analyses detected sequences of emotion episodes whether in CAMS states or emotion schemes. These two methods provide different information. The reader is reminded of Table 8 which summarized the results from both methods used.

Mann Whitney U (MWU) analysis tells us that a difference in the sheer amount of an expressed state has been found but it cannot tell us the emotion that preceded or followed that state. THEME analysis can tell us this. For example, according to the MWU, outcome groups were found to differ in the amount of hurt grief expressed, with good long-term outcomes expressing more hurt grief. Outcome groups did not differ in the amount of ‘assertive anger’ proportions expressed which, in addition to more ‘hurt/grief’ proportions *were found* to occur more in EFT versus CCT cases of therapy.

So, information about the amount of expression of an emotion state when viewed in isolation from other states is what MWU tests provided. THEME analysis on the contrary often provided evidence that linked lower order CAMS-coded EES or linked higher order EFT-theory driven CAMS-Coded emotion schemes. For example, outcome groups were indeed found to differ in sequences of hurt grief, ‘assertive anger’, ‘fear shame’ sequences connected to need expression, and repeated sequences of expressed ‘fear shame’. Therefore, sometimes both Mann Whitney U and THEME analyses yielded similar results, but sometimes not. So, Mann Whitney U did not find significant differences in the amount of ‘assertive anger’ expressed in good versus poor outcome cases but THEME analyses *did* find sequences of expressed ‘assertive anger’ distinguishing outcome groups with good outcomes expressing more ‘assertive anger’.

This suggests to me is that perhaps it is not how frequently an emotion state is expressed but the context of other emotions within which that expression occurs that is the most important

information. A THEME analysis, thus, can tell us that what comes before and after a particular expression of emotion can differ statistically when comparing EP in outcome or therapy groups, more so than does the sheer amount of a particular expression. It will serve therapists well in the future treatment of depression to be aware of this.

However, a limitation of THEME analyses should also be mentioned. THEME is a mathematical analysis. It seeks invariance in distances between EEs in order to arrive at the sequences it finds. Therefore, one weakness in THEME analysis is that if too much variance in the length of particular states occurs THEME will not be able to detect that state and locate it in a sequence of emotions. It is for this reason that some figures identify the end of a state but not the beginning of that state. I, as researcher, know that this EE beginning must have occurred but that THEME sometimes did not detect this because EEs vary too much in length for THEME to capture the beginning of the pattern. Also, if a CAMS coded emotion state occurs very infrequently it would not be detected in the present analysis that asked for a sequence to occur at least 45 times (or at least in half the sessions) before it was detected. This was another reason to check for sequences of PAE emotion scheme emotion which were constructed as a sum of all possible PAE states suggested by EFT theory, including such things as self-soothing and acceptance/agency. For this reason, it is possible that THEME analyses missed some lower level emotion states due to that emotion occurring either too rarely or being presented too variably. To redo the analyses with less stringent criteria is possible in the future.

In any case it is difficult to parse emotion in therapy data sets and researchers must continuously try to capture what really happens in therapy. THEME is an important and useful tool, among many, but more refined analyses will continue to be necessary. Qualitative analyses may be required to do this.

What results presently support EFT emotion theory as a common theory of change in the treatment of MDD? A common change factor will be one that is consistent in its capacity to predict long-term outcomes independent of any therapy received. As such, my outcome data results support to a point the assumption that EFT emotion theory is a general change process in the treatment of MDD with some caveats.

Hypothesis 1: Good and poor long-term outcomes will show EFT-EP theory consistent emotional processing independent of therapy.

As discussed earlier, it is theorized that better emotional processing leads to better long-term outcomes (Pos et al., 2003; Pos et al., 2009). I also therefore hypothesized that if EFT theory was true and described EP in a manner that could be accepted as describing a common factor of EP, then EP should be strong in an EFT-EP consistent manner, in any good outcome case independent of therapy. Analyses supported this hypothesis for the most part. However, some differences between EFT-EP theory and a potential general theory of EP for treating MDD appeared.

Proportional analysis for specific emotion states. There was a significant difference of ‘hurt/grief’ between outcome groups, but all other CAMS coded emotion state differences were found to be non-significantly different in the proportions of EEs expressing particular emotion states. The expression of needs did trend toward being significantly different ($p = 0.08$) with more needs expressed in the good outcome group. This was again consistent with EFT literature and with other findings (Ferreira, 2017). Two other trends in the MWU analyses were consistent with EFT-EP theory as well, good outcomes were less likely to express ‘global distress’ and ‘rejecting anger’ ($p < .12$). Further poor outcomes showed a trend to expressing less secondary emotion schemes also consistent with EFT-EP theory ($p = .07$). Since EFT theory tries to guide a

client towards adaptive emotional resources through the expression of needs, this may indicate how important need expression is to deep emotional processing. As well, helping a client not express or get past expressing secondary emotion also seems important to deeper EP and to long-term gains in MDD treatment. In terms of adaptive emotion categories good outcomes expressed more ‘hurt/grief’, but not significantly more ‘assertive anger’. This was surprising since theory (Blatt, 1974) suggests the importance of expressing anger in treatment of MDD. Again, the difference between Mann Whitney U analyses and THEME analyses may be relevant here. Mann Whitney U tests indicated that the sheer amount of ‘assertive anger’ expressed did not differ between outcome groups but good outcomes did differ from poor outcomes in expressing ‘assertive anger’ sequences. As such, not the sheer amount but repeated expression of ‘assertive anger’ appeared to drive good outcome in treatment of MDD with experiential therapy. Why good outcome clients expressed significantly more ‘hurt/grief’ is not clear. Better emotional processing may mean that ‘hurt/grief’ expression is an important emotion state in the treatment of MDD long-term. Perhaps when clients can admit to their hurt in front of their therapist, they are both showing their vulnerability which is hard to do for some depressed clients but they may also be expressing some internal strength important for their long-term resilient outcomes for MDD. At least we know that good resilient outcome clients do more often express their pain (Greenberg & Watson, 2006; Bolger, 1999). We also know that expression of needs and less secondary emotion is important as well. More research must examine the importance of hurt grief expression to good-long term outcomes.

CAMS THEME analysis for outcome groups. THEME analyses more clearly supported hypothesis 1, and the potential for EFT-EP theory, to provide a common emotional map for good long-term outcome clients. They expressed sequences including repeated

expression of ‘hurt/grief’, ‘assertive anger’, or ‘fear shame’, as well as patterns of expressed ‘fear shame’ followed by need expression. All occurred with greater frequency in the good outcome group. So, while the proportion of ‘assertive anger’ did not differ between outcome groups, repeated expression of adaptive anger did appear to be important according to THEME. Again, this means that not only the amount of an expressed emotion state may count towards good outcome but also the order or relative ‘location’ of that expressed state compared to itself and other emotion states counts. This points to the advantage of THEME analyses that can capture these phenomena. And further, ‘hurt/grief’ and ‘assertive anger’ appeared to be two particularly important PAEs needing expression during the treatment of MDD. Since MDD theory (Blatt, 1974; 2004; Beck, 1996) suggests that individuals who are dependent have difficulty asserting themselves while individuals who are self-reliant have difficulty expressing vulnerable feelings it seems fitting that ‘assertive anger’ and ‘hurt/grief’ states may be important emotions to express in treatments of MDD long-term (Choi, Pos & Magnusson, 2016; Greenberg, 2002; Greenberg & Paivio, 1997; Wong, 2016). These two emotion states may also be connected to particular client depressive subtypes. More research is needed here.

‘Fear/shame’ and ‘fear shame’ followed by needs also were emotion states expected in an EFT theory-based model of EP. These sequences indicate that clients are touching core pain relating to unmet needs (Feirrera, 2016) or are following their pain compass (Goldman & Greenberg, 2015). Recall too, that Greenberg and Pascual-Leone’s (2007) model of emotion, proposes that good outcome clients begin in unproductive emotion states such as ‘fear shame’ and transform these emotion states into productive, adaptive ones. Therefore, we would expect to find good outcome clients experiencing unproductive emotion states, and for such expressions to also be followed by productive emotion expression, such as need expression, ‘assertive anger’

and hurt. What we did not expect to find is more expressions of the primary adaptive emotion ‘relief’. This was a contradictory finding and will be discussed more below.

As for still depressed clients at follow-up, or poor outcomes, THEME analysis found them to express more patterns of repeated ‘relief’ or repeated ‘rejecting anger’. Expressions of repeated ‘rejecting anger’ made EFT-EP theory (Greenberg & Watson, 2006) sense. ‘Rejecting anger’ is a secondary emotion that interferes with the expression of ‘assertive anger’ or can cover PME experiences. However, the finding that expressions of ‘relief’ predicted poorer outcomes was an EFT inconsistent finding. ‘Relief’ is thought to be a primary adaptive emotion. Sequences of relief expression occurred often, 210 times in the data overall. Moreover, it occurred 70 times in good outcome cases. Previous small sample studies that unfortunately confounded therapy alliance or therapy and self-criticism have found that expressions of ‘relief’ occurred in good outcome cases (Rinaldi, 2016; Choi, 2013). The only sense we could make of this result is that perhaps ‘relief’ in good outcome and poor outcome cases is quite different. ‘Relief’ is considered adaptive in EFT theory. Interestingly proportions of expressed ‘relief’ had not been found to significantly differ between therapies when examined by Mann Whitney U tests but significantly more relief sequences were found by THEME in poor outcome cases. It is possible that ‘relief’ was not an adaptive emotion in these cases. Alternatively, there may be different types of ‘relief’ expression. Perhaps some clients say they feel better when not feeling emotional experience and thereby avoid further processing whereas others may genuinely have new positive insights. This suggests the need for parsing rated episodes of ‘relief’ further to ascertain the content of these episodes.

Another potential problem with this result is the possibility of the CAMS measure not being adequate in capturing the PAE category. If it turns out that ‘relief’ can be considered both

a possible PAE as well as an avoidant strategy for some clients, then that CAMS category will have to be better refined. Avoidance appears to predict poor outcome in the treatment of many disorders (Pos, 2014) this should be investigated further.

THEME CAMS pattern interactions between therapy and outcome. Within EFT therapy, THEME found no patterns distinguishing good outcome clients. This was likely the result of the selection criteria that I had set of a minimum of 45 patterns having to be detected. No patterns were likely to be detected to occur only in good outcome EFT cases. It is possible that some very rare emotional events occurred in good outcome EFT cases (such as ‘self-soothing’ or ‘acceptance and agency’) that too rarely occurred to be detected by THEME using this criterion. These emotion states might have been particularly important to the best EFT outcomes. This was the risk I took deciding on this criterion. There could also be client differences that made a difference, for example Pos (1996) found that older clients preferred EFT and did better within this model. Perhaps all the poor outcomes in this sample (n = 6) were younger individuals and an age demographic was at work within one therapy group. This too will require further research.

THEME did find patterns distinguishing good CCT outcomes. These good CCT outcome clients expressed more patterns of ‘fear shame’. Poor outcome CCT clients expressed sequences with significantly more ‘global distress’ and ‘rejecting anger’. These findings again are EFT-EP theory coherent and support hypothesis 1 and once more validate EFT emotion theory. Why would this be so? Perhaps within CCT, therapists follow many clients’ lead, and as a result allow their clients to naturally avoid their deep pain. The possibility of avoidance is pointed to because from the EFT perspective poor outcome clients express more patterns of CAMS coded secondary ‘global distress’ and ‘rejecting anger’, which poor outcome CCT clients did in fact express more often.

THEME emotion schematic pattern interactions between therapy and outcome group. I

also used THEME to analyse sequences of emotion schemes related to long-term outcome differences within therapy groups. These results supported hypothesis 1 also with some caveats. Good outcome EFT clients expressed all of the following patterns: repeated need expression followed by PAE emotion schemes expression (EFT-EP theory consistent), repeated PAE followed by PME (EFT-EP theory inconsistent), and need expression followed by PAE (EFT-EP theory consistent). Repeated PAE expression followed by PME expression was a surprising finding since EFT theory states that processing of PME experiences normally precedes expression of a PAE. Often EFT theory states that expressing PMEs leads to experiences of unmet needs that then when fully experienced and supported by the therapist support client access of primary adaptive emotion. EFT EP-theory appears to be challenged here; as it seems as if it is possible that the experience of PAE can make it easier for clients to experience PME and then perhaps subsequently their needs.

No patterns occurred with greater significant in the poor outcome clients within the EFT group. This suggests that EFT therapists were following EFT EP-theory guidelines, and that poor outcome EFT cases were not poor outcomes because they were not accessing PME or PAE emotions and needs, but perhaps due to their particular autobiographical memories. As such they might have been less resilient EFT clients. These EFT poorer outcome were not, however, expressing problematic secondary emotions. This will also need finer research to unpack. In such cases poor outcome in EFT may have less to do with emotional processing and more to do with autobiographical memory or narrative (Angus & Greenberg, 2011) processes.

THEME found that good CCT outcomes expressed more repeated PME. This was coherent with EFT EP-theory. As such, good outcome CCT clients stayed with their expressions of

maladaptive pain. They stayed with their painful experiences (Goldman & Greenberg, 2015). Poor outcome CCT clients expressed repeated SE followed by un-codable emotion, or repeated expressions of SE. Both of these results are EFT-EP theory consistent and support hypothesis 1 as well. EFT-EP theory would expect poorer emotional processing clients to be poor outcome CCT clients. Being “stuck” in problematic and unproductive emotion states would be of that nature.

Summary: Does EFT-EP theory generally serve as a model for EP in MDD treatment?

In general, my overall results support H1 and the possibility that EFT-EP theory is a potential transtheoretical EP theory for the treatment of depression. Generally, the tenets of EFT-EP theory were validated, with some caveats. Emotional processing could predict long term outcome differences from Experiential treatments of MDD.

In summary it was found that better outcome cases whether irrespective of therapy received or within therapy received expressed more needs and fewer secondary emotions as well as expressed both more adaptive and maladaptive emotion.

However, some discrepancies with EFT-EP and the CAMS measure were found. First of all, MWU analyses found that only particular adaptive emotions occur more often in good long-term outcome cases (‘hurt/grief’ and ‘assertive anger’). Trends to less ‘global distress’, ‘rejecting anger’ and more ‘need’ expression were also present in good outcome cases. EFT emotion schemes such as primary adaptive emotion did not occur more in good outcome cases. Rather, THEME analyses indicated the importance of PAE schemes, needs, and PME emotion schematic experiences. All of these emotion schemes figured prominently in good long-term outcome cases as did the expression of secondary emotion (SE) in poor long-term outcomes.

Three findings suggest that either the CAMS measure needs refinement or EFT-EP theory is ‘off’. First of all, poor outcome clients expressed more relief. This was a concern, showing the need to further clarify that emotion state. As was mentioned above this emotion category may need further parsing, or subtyping. Second of all, EFT-EP theory has not normally suggested that the experience of primary adaptive emotion makes accessing of primary maladaptive emotion easier. Good outcome cases expressed this sequence so it may be important for therapists to be aware that movement through a client’s emotional field may necessitate first being able to express stronger adaptive emotions before one can fully experience pain and unmet needs connected to that pain. Thirdly, it was of interest to discover that good CCT outcome clients expressed more patterns of ‘fear shame’. It is clear that some CCT therapists were able to help CCT good outcome clients process their pain. Why these clients were able to use empathy to access and express pain indicates that some CCT clients do not need active chair interventions to process their pain well. How CCT therapists were able to accomplish this deep emotional access for clients armed only with empathic reflections will be an important area for future research.

Hypothesis 2: EFT cases should have better long-term outcomes than CCT cases

It was hypothesized that EFT cases should have better long-term outcomes because EFT targets emotions and emotional processing specifically, and may therefore be a better experiential treatment for depression than CCT. It is well established that emotion scheme types (primary maladaptive, primary adaptive, and secondary) predict outcomes during experiential therapy. If these ES types are important to resilient outcome in the treatment of MDD, then EFT may be the better experiential treatment than CCT.

My results showed support for hypothesis 2 using t tests. This basic hypothesis suggested that EFT cases would have better long-term MDD outcomes. The t tests of EFT versus CCT

outcome scores indicated that EFT clients reported being less depressed at 18-month outcomes in two ways. EFT clients had significantly lower actual BDI scores at 18 months, $t(53) = 2.19$, $p = .032$) and also fewer EFT clients reported having an 18-month BDI over to or equal to 10, $t(53) = -2.8$, $p = .007$). One caveat is that twenty-nine out of thirty-six (81%) clients who received CCT reported long-term outcomes, compared to 23/38 (61%) clients who received EFT. Chi square analysis marginally found that there was a trend for clients who received CCT being more likely to report long-term outcomes on the BDI than EFT clients were, ($\chi^2 = 2.656$, $p = 0.051$). However, at the same time, clients receiving EFT were more likely to report a lower BDI 18-month score on average, as well as report a BDI score under 10 at 18-month follow-up. Therefore, t tests indicated that EFT clients did report better long-term outcomes, supporting hypothesis three. Still, since CCT clients did report long-term follow-up more frequently, for this reason, poor outcome clients assigned to the CCT were compared to EFT poor outcome clients on their BDI 18 months. On average EFT clients who reported being still depressed at 18 months were more depressed than CCT clients were at 18 months (BDI= 20.40 versus 17.35). As such, one might assume that being more depressed at 18 months did not motivate long-term reports for the EFT group. This difference was not significant ($p = .826$). So, although EFT clients had better outcomes on average (supporting H3), more CCT clients reported long-term follow-up. It is unknown why clients who received client centered therapy more frequently reported poor long-term outcomes or conversely why fewer EFT clients reported long term outcomes. However, a number of variables suggest themselves. For example, poor outcome EFT clients may have been less likely to report outcomes because they were angry at the research group because of having a poorer outcome. The assumption here is they somehow expected to fair better than they had. This as stated above was not a controllable variable as clients were

assigned to treatments randomly in this RCT. No difference reported in depression at pre-treatment (Pos, 2006) however were found. Also, no demographic variable explained these differences either, $p > .05$. As such, although this difference in frequency of long-term outcome reports was found, it was not explainable in a manner that could be established to effect outcomes. The issue is one of uneven groups to compare long-term outcomes. This might have influenced findings and must be admitted to as a potential limitation of this study. Still, one is allowed uneven group numbers in comparisons. However, it is possible that missing data from clients who had undergone treatment could have pulled or biased results. This would only be more likely to have occurred if results were very inconsistent with past results. This was not in fact found, as other writers have also found EFT cases to have better long-term outcomes (Ellison et al., 2009; Elliot et al., 2013; Greenberg & Pedersen, 2001).

As far as EFT client reporting better long-term outcomes, reasons have been reported as to why this may be so. As mentioned in the introduction, EFT is a more structured treatment than CCT and structured treatments such as CBT and EFT appear to do better in treating depression (Elliott et al., 2013; Watson & Pos, 2017). The reason why a more structured treatment would fair better in the treatment of depression is an interesting problem. The APA section 12 website (<https://www.div12.org/diagnosis/depression/>) identifies 12 effective treatments for MDD, and EFT is one of them. Depression is often chronic or recurring and is best managed like a chronic illness (Unützer & Park, 2012). Some researchers suggest that structured treatments for depression have better outcomes for treating MDD (Elliott et al. 2013). EFT may be more effective for this reason. For example, CCT therapists are asked to ‘follow their clients lead’ whereas EFT therapists employ specific empirically based interventions (Elliott et al., 2003) that have more structure. Due to the marker-driven nature of EFT, it is also possible that if emotional

processing is so important to MDD outcomes then these added interventions in response to specific markers might be better at changing emotion schemes than does less directive CCT therapies (Goldman et al., 2006). Some studies have provided support for this possibility. For example, Watson & Greenberg (2006) found that using marker-driven interventions in EFT led to deeper emotional processing and better outcomes compared to CCT cases. One study examined two-chair work for self-criticism finding that clients who resolve their criticism or “soften” their critics, have more “emerging experience”, or insight into one’s feelings or experiences (Sicoli & Hallberg, 1998). As well, clients who softened their critics expressed more wants and needs compared to those who did not (Ferreira, 2017; Sicoli & Hallberg, 1998). A more recent study also found that two-chair work lead to reductions in self-criticism, anxiety and depression symptoms, and increases in self-compassion (Shahar et al., 2012). One study examined the use of empty-chair work finding that clients who successfully resolved their unfinished business had reductions in their symptom distress and interpersonal problems both outcomes also relating to MDD (Greenberg & Malcolm, 2002). All these studies suggest the efficacy of EFT chair tasks as well as point to the importance of emotional change while engaging in these structured tasks.

Recall also that in a follow up study by Ellison et al. (2009), during follow-up interviews, EFT clients talked about using emotional processing skills learned in therapy. There seems to be evidence in the literature that added skills and interventions may improve outcomes for depressed clients (Bondolfi et al., 2010; Elliott et al., 2013; Rice, 2001). Clients may feel more skillful, as some come to therapy seeking “solutions” in the form of ‘new skills’ to help solve their problems. Having tangible skills and interventions could be contributing to better EFT outcomes. However, few studies have examined clients subjective ‘take’ from having engaged in

active EFT interventions as compared to being offered CCT. Future research would need to examine EFT marker-guided interventions asking clients to provide what they seemed to gain from engaging in these structured interventions. In particular sessions that do, and do not, have client engagement in these structured tasks might be compared.

Hypothesis 3: Are EFT cases better emotional processors than CCT cases?

In EFT theory (Greenberg & Watson, 2006) one works with different emotion types in different ways: maladaptive emotions are accessed in order to transform them, and secondary emotions are brought into awareness to access the underlying primary emotion. Since EFT targets emotions and emotional processing specifically, it was hypothesized that EFT cases would demonstrate ‘better general emotional processing’ than CCT cases.

Also remember that Teasdale (1999) among other theorists suggested that the cause of depression is the activation of depressogenic emotion schemes or schemas, and that a valid change process (i.e. good emotional processing) should relate to good outcome long-term. That emotional processing predicts good outcome from experiential therapist at termination has been well established by (Pos et al., 2003; Pos et al., 2009) using EE-EXP. It was therefore also hypothesized that because EFT is a more structured and emotionally focused treatment EFT clients should fair better in outcomes long-term that do CCT clients. This was found to be true through t-tests. Hypothesis 2 was supported. EFT cases did show better long-term BDI outcomes both in their BDI scores and in their tendencies not to relapse (Greenberg & Pedersen, 2001).

I also explored potential EP differences between EFT and CCT cases by again looking at proportional differences in either CAMS coded EEs or ES-coded EEs using both Mann Whitney U tests and THEME analyses. I will discuss both sets of results below.

According to EFT theory (Greenberg & Watson, 2006) ‘better emotional processing’ is mainly defined as expressing more primary adaptive emotion (PAE) and less secondary emotion (SE). Theoretically, if the emotional processing is better in EFT cases, then EFT cases should have exhibited both higher proportions of CAMS emotion states that contribute to the PAE emotion scheme category and lower proportions of CAMS coded emotion states contributing to SE (‘global distress’ and ‘rejecting anger’).

Proportional analysis for specific emotion states. Proportional analyses of CAMS states somewhat supported Hypotheses 3. MWU analyses of CAMS codes revealed significant differences between ‘hurt/grief’ ($p = .009$) and ‘assertive anger’ ($p = .012$), with EFT clients expressing more of these states. Significantly less ‘global distress’ and ‘rejecting anger’ were not found in EFT cases. However, a trend to a difference in ‘global distress’ was found. Global distress did trend towards being significantly expressed more frequently in CCT cases ($p = 0.055$).

Why only ‘hurt/grief’ and ‘assertive anger’ were found to have differences and not others is not clear. However, EFT-EP theory does point to these two emotion states as particularly important in the treatment of depression (Greenberg & Watson, 2006). This is specifically true for active chair interventions which are very interpersonal (Pos & Paolone, 2019) and pull for these states in terms of being assertive and grieving loss. Choi (2018) also found that depressed clients with the self-critical subtype of core worthlessness (CW) had higher proportions of ‘hurt/grief’. Recall, however, that CW clients were more likely to have received EFT. Additionally, Rinaldi (2017) found that clients with a strong alliance had higher proportions of ‘assertive anger’. Again, in this sample, clients with a strong alliance were more likely to receive EFT. Perhaps EFT clients were encouraged to express their hurt and anger more than were CCT

clients due to differences in the modality and that more EFT structured tasks such as chair work may pull for these emotion states. Another possibility is that the discreet states of ‘hurt/grief’ and ‘assertive anger’ are particularly important in the treatment of depression but that other emotion states, also considered adaptive, are not. It makes sense that expression of ‘assertive anger’ which is agentic and leaves clients feeling empowered would impact reports of depression (Choi, 2013). Expression of hurt grief has also been linked to improvement in depression (Choi, Post & Magnusson, 2016; Greenberg, 2002; Greenberg & Paivio, 1997; Wong, 2016). Again, more research on the relationship between expressing hurt and grief and resolving depression long term is needed. At present a dissertation is being conducted in our lab that will do this in part.

It is also possible that EFT clients who express these two states more often are getting better not because of expressing these states but for some other reason. That is, expressions of hurt or anger may be a consequence of receiving EFT but not the cause of its effectiveness. Perhaps for this reason no emotional processes distinguished good and poor outcomes for EFT. Perhaps it is not accessing and expressing these emotional states but sharing them with another human being that is the most corrective emotional experience (Alexander & French, 1946) that impacts MDD. However, that these ‘assertive anger’ and ‘hurt’ states have been expressed around session 11 (Pos, 2006) during a 16- 20 session therapy and the expression of these states is correlated with outcome measured 18 months later suggests a potential causal connection. Also, Wong (2016) found that the proportion of expressed hurt grief expressed in middle sessions of therapy could also predict outcomes for experientially distant clients 18 months post termination. Wong’s (2016) research therefore echoes the current findings here.

CAMS THEME analysis. EFT cases also expressed more sequences involving repeated expressions of ‘hurt/grief’, ‘assertive anger’, and need expression in comparison to CCT cases.

This supported hypothesis 3 as well, again providing tentative support for the validity of EFT-EP theory and that EFT cases are engaging frequently in ‘good EFT-EP’. Again, EFT-EP theory identifies that these two specific emotion states, are particularly important for resolving depression (Greenberg & Watson, 2006). THEME analyses indicated that EFT cases were expressing these two states repeatedly (as evidenced by repeated EEs expressing these states) and therefore appeared to be ‘staying with’ these experiences. This ‘staying with’ indicates emotional tolerance (Greenberg, 2002). The opportunity to make sense of these experiences would thus be optimized in EFT cases. This is another indicator that EFT cases were processing their emotional experiences well. These results are also consistent with the other experiential therapy literature, as sequences of ‘hurt/grief’ were found more often in clients with a strong alliance (Rinaldi, 2017), and sequences of both ‘hurt/grief’ and ‘assertive anger’ were found more often in core-worthlessness self-critical clients (Choi, 2018). These results also support the EFT-EP model of emotional transformation that models the importance of experiencing these emotion states (Watson & Greenberg, 2006). Unfortunately, THEME analysis did not indicate what emotions preceded the ‘hurt/grief’, ‘assertive anger’, or need expression, likely because too many possible states were included in this analysis. Remember that THEME uses constant distance between expressions as a marker of invariance and pattern extraction and variability in the length of EEs would work against THEME finding invariant sequences. Therefore, state categories that may be important precursors to expressions of hurt, anger or needs, must be identified and coded as such in future analyses. Finer analysis than even THEME can provide is again needed to accomplish this. This will have to be more closely examined.

Additionally, CCT cases that were poor outcome cases (analysed above) expressed more repeated ‘relief’. They also expressed more sequences of ‘fear /shame’ compared to EFT cases.

Again, I would like to remind the reader that both CCT and EFT cases expressed both ‘relief’ and ‘fear shame’, but CCT cases expressed significantly more of these states according to THEME. This result is consistent with Rinaldi’s (2017) study that found clients with a weak alliance growth expressed increases in relief from the working phase to the termination phase of therapy. However, within the termination phase, it was found that clients with strong alliance growth expressed more relief than clients with weak alliance growth. Recall that clients with strong alliance growth were more likely to receive EFT, and that all clients with weak alliance growth in Rinaldi’s sample had received CCT. Therefore, this result appeared to indicate that relief expressed in the middle of therapy was adaptive. Relief normally is considered adaptive in EFT theory. But what does CCT therapy theory suggest about such an emotion state? All emotion is allowed and followed by clients in CCT therapy. As such, if relief can be an expression of avoidance, avoidant relief would also be allowed and followed in in this particular model of therapy. Also, when I re-analyzed Mann Whitney U PAE proportional differences minus the relief coded CAMS category, I found that EFT clients expressed significantly higher proportions of PAE rated EEs or EEs expressing primary adaptive emotion at $p = .007$ when relief was not included in the analysis. This further suggests according to EFT-PM theory that it is possible that something may not be adaptive about some expressions of relief. Interestingly proportions of expressed relief have not been found to significantly differ between therapies when examined by Mann Whitney U tests but significantly more relief sequences were found by THEME in both poor outcome and in CCT cases. Perhaps some clients (highly rational clients, for example, who prefer not to ‘feel’) say they feel better when not feeling emotional experience and thereby avoid further processing whereas others may genuinely have new positive insights. A CCT model would allow this tendency in a client.

CCT cases also expressed more sequences of ‘fear /shame’, In EFT-EP theory ‘fear /shame’ is considered maladaptive, and difficult to experience. Therefore, it is thought to often not be expressed without therapist help. This result therefore again appeared to indicate that empathy and the CCT condition are adequate to helping clients arrive at their core pain. However, in CCT cases transforming pain appears to be less common which we also discovered from the THEME analysis. No patterns were found with ‘fear /shame’ being linked to another emotion in CCT cases. EFT cases also expressed ‘fear /shame’ but appeared also able to transform these emotions, since more patterns of ‘hurt/grief’, ‘assertive anger’, and need expression were found among EFT cases. On the other hand, while good outcome CCT clients did appear to access significant amounts of ‘fear /shame’ it is possible that some CCT cases may have been getting “stuck” in their ‘fear /shame’ (Pascual-Leone & Greenberg, 2007). This may have occurred because CCT therapists are trained to follow clients and not be directive. As such, CCT cases might have fallen into their pain, not been able to transform it, and the CCT therapist would stay with their client and their stuck pain. This should be qualitatively examined further within CCT cases of expressed ‘fear /shame’. In EFT, therapists are encouraged to follow clients’ “pain compass” (Goldman & Greenberg, 2015) and lead EFT clients to ‘fear /shame’, but they are encouraged to do so in order to transform PME pain through accessing emotion states such as ‘assertive anger’ and expression of needs which EFT cases did express more often. Still, another possibility is that, as in the case of ‘relief’ expressions, different types of ‘fear /shame’ can be expressed and the way ‘fear shame’ is transformed or resolved may depend on that ‘fear shame’ type. A fear shame type may also be affected by the therapy model’s manner of influencing emotional processing. Future research would need to examine the differences in ‘fear/shame’ experienced by clients who undergo either CCT or EFT.

Proportional analysis for emotion schemes. Between EFT and CCT cases, the sheer proportions analysis revealed no differences in Pascual-Leone's manner of parsing CAMS codes into primary adaptive emotion (PAE), secondary emotion (SE), or primary maladaptive emotion (PME). However, the obtained p-value of the proportion of PAE expression did trend toward significance ($p = 0.082$). This result was surprising since we expected a difference of the proportion of PAE between groups as has been found previously (Ahani, 2019; Rinaldi 2017; Choi, 2013, 2018). I would remind the reader however that when we removed the relief code from the PAE category there was a significant difference indicated by Mann Whitney U analyses between EFT and CCT cases in the PAE category. EFT cases expressed more PAE-minus relief than did CCT cases ($p = .007$). In THEME analysis the PAE category included relief codes. Again, this points the reader to the possibility that relief codes as rated by the current raters might require further parsing.

THEME analysis for Emotion schemes. Within EFT cases, the longest found pattern alternated expression of needs and PAEs. The most frequent patterns were repeated sequences of need expressions, or expression of a PAE followed by need expressions. We know that EFT clients more frequently expressed anger and hurt and it may be that these emotions in particular, that the proportional analysis did show EFT cases expressed more of the PAEs that lead the depressed client to expression of needs. However, expression of PMEs was not indicated in EFT sequences as expected. This could be for a number of reasons the main one being that the expression of PMEs was pervasive across both therapies.

In CCT cases, THEME analysis indicated that both the most frequent and longest pattern detected was repeated expression of PME. The expression of PME was not linked to any other emotion so it appears that in CCT cases emotional transformation was not found. This indicated

the possibility that CCT clients got stuck in expressing PME consistent with Pascual-Leone & Greenberg's (2007) suggestions. Case studies have found that EFT clients transform their PMEs into PAEs (McNally, Timulak & Greenberg, 2014; Pascual-Leone & Kramer, 2019).

Additionally, studies from our lab have also shown clients transforming PMEs into PAEs (Choi, 2013; 2018; Rinaldi, 2017). Choi (2013) found that good resolvers of self-criticism expressed sequences of PME followed by PAE and need expression. Poor resolvers of self-criticisms showed little transformation, as more patterns of SE and PME were found. Rinaldi (2017) also found more patterns of PAEs in clients with a strong alliance, and more SEs in clients with a weak alliance.

My overall emotion schematic results support hypothesis three – EFT cases showed superior emotional processing than CCT cases as defined by more frequently transforming their PME by expressing needs and PAEs. It may therefore be due to this superior EFT-EP consistent EP processing that EFT cases have better long-term outcomes in the treatment of their MDD. It does appear that in the treatment of depression emotional transformation may lead depressed clients to resilient change as Teasdale (1999) has suggested, and that EFT better resolves depression than does CCT when both outcome is measured long-term, and emotional processing has been shown to occur. Further, it may be that EFT theory of emotional change provides a common map for emotional change's impact in the treatment of depression.

Still, CCT clients did report experiencing more 'fear/shame' than EFT clients in my analysis, which was not expected. As such, while the majority of results from THEME analysis supported Hypothesis 2, it became clear to the researcher that it is not so much arriving at pain but transforming pain through accessing particular needs and adaptive emotions that may be most

important in the long-term resolution of depression. Therefore, EFT emotion theory may require further editing, which only future RCTs of EFT versus CCT can empirically investigate.

Limitations of the current study

All research has limitations and this study is no exception. The following limitations are noted.

First one limitation relates to the fact that emotional processing (EP) as a transtheoretical factor can not be strongly empirically validated without examining the power of EP to predict long-term outcomes in other non experiential therapies. If EP is a common change process in the treatment of MDD than it will also be found to predict outcomes in other models of therapy. Future research must examine the EFT-EP theory for other treatments of depression.

Another problem may relate to culture. Emotional permission, display, and expression may be highly influenced by cultural differences and these were not discussed or accounted for in the current study. It would be interesting for future research to explore whether certain cultures are more depressed than others, or fit better with certain models of treatment. Another limitation appears to be methodological. The CAMS measure used here to test EFT-EP theory was found to have potential limitations so this measure must be further examined. The manner in which EFT-EP theory is parsed into emotion scheme types may perhaps be too crude and refinement of the measure should be explored. This has already occurred for the ‘global distress’ category (Piccirilli, 2018), as this emotion has been found to occur in both good and poor outcome in previous studies. Furthermore, parsing of ‘hurt/grief’ is also occurring in future dissertations. Qualitative parsing (Rennie 2000; 2012) of the ‘relief’ category should occur, and closer examination of types of ‘rejecting anger’ and maladaptive emotion could also perhaps be identified.

The analyses chosen were adequate but measures of emotional processing appear to continue to be difficult to develop. Measures of emotional processing are still in their infancy and must be improved. THEME analyses can also be limiting and are correlational in nature so perhaps THEME analyses and the criteria of selection could have limited the results. Reanalyzing the data with different search criteria should also be considered.

While length of EE episodes was only tangentially discussed in the limitation of the THEME analyses and has been found not to be of significant importance in other studies (see Pos 2006 for a review). It should still be considered. Rinaldi (2017) found a trend for poorer outcomes to have longer EEs than good outcome clients and this could be revisited.

Finally, it must be admitted to the reader that marginally significantly more CCT cases from the original trials ($p = 0.051$) provided outcome data than did EFT cases. While no Chi square in the present study indicated that therapy groups were not adequately balanced, it is possible that missing EFT cases could have skewed results.

Conclusions.

This study examined CAMS coded emotion episodes (EEs) to identify patterns of emotion sequences in clients who had good versus poor *long-term* outcomes independent of therapy received. Clients who received either emotion-focused therapy (EFT) or client-centered therapy (CCT) were also compared for differences in long-term outcomes and for differences in the emotional processing between these two therapies. I compared emotional processing differences using both Mann Whitney U and THEME time sequential analyses. Results provided evidence for differential processing between outcome groups and therapy groups, and tended to validate core principles of EFT-EP theory. THEME results appeared to be more robust overall. THEME findings revealed good outcome clients having more CAMS sequences of ‘hurt/grief’, ‘assertive

anger', and 'fear /shame' followed by need expressions. Additionally, good outcome clients had emotion schematic sequences of PME followed by need, and PAE followed by need. Poor outcome clients had more sequences of CAMS codes relief and 'rejecting anger', as well as sequences of the emotion schematic SEs. These results taken as a whole indicate that both good outcome clients and EFT clients had more expressions of adaptive emotions, and also more transformation of emotion, whereas CCT and similarly poor outcome clients had more expressions of maladaptive emotions and more blocking of transformation of emotions via the activity of secondary emotions. Both analyses consistently indicated differences between groups of the CAMS codes of 'hurt/grief' and 'assertive anger' specifically, indicating these are important emotion states expressed during therapy for MDD that will predict long-term resilience of depression treatment 18 months later. It is presently unclear whether THEME selection criteria or the manner in which CAMS coded higher order emotion schemes are coded affected results. Future research using different search criteria for THEME or using a CAMS measure that is more refined may be needed, however EFT-EP theory provides a solid base of emotion theory that may direct treatment of MDD for long-term success. This theory of emotional change must also occur across other therapies before it can be considered a truly transtheoretical measure of emotion change in therapy for MDD.

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Appendix A

The Classification of Affective-Meaning States (CAMS)

Classification of Affective-Meaning States

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Purpose of the Coding System

The Classification of Affective-Meaning States (CAMS) is a measure that was developed to rate the presence of emotion states relevant to the model of this research project. The measure is applicable to coding emotion events when participants are engaged, emotionally involved, and aroused. Thus, the following coding system assumes that participants are not explicitly avoiding or interrupting arousal or emotional experiencing. Although clients may be naturally ambivalent about engaging, heightening and essentially allowing upsetting emotions, the events used for coding should follow the initial “allowing” of feeling (Greenberg & Paivio, 1997; Greenberg & Safran 1987). The codes themselves are intended to describe emotional experiences that are being “allowed” by the individual¹.

That having been stated, the coding system is designed to track the changing “flow of emotions”: Which emotions are occurring and in what sequence. The measure was created in light of preceding research that has shown some emotional experiences are more productive than others (Greenberg, Rice, & Elliott, 1993; Greenberg & Paivio, 1997; Sicoli & Greenberg, 2005).

¹ For observable criteria that might identify emotionally resistant and interruptive processes see the work of Davenloo (1990) from a short-term dynamic perspective or of Weston & Greenberg (2005) from an experiential perspective.

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Criteria

Each emotion state is evaluated on up to five criteria, which address three distinct facets:

Emotional tone

- A. Emotion/ Action tendency

Involvement

- B. Expression (i.e. non-verbal behaviours, emotional arousal...)
- C. Vocal Quality

Meaning

- D. Stance and/or Adaptivity
- E. Specificity

These criteria capture key affective-meaning (i.e. “emotion”) states. In the first criterion, emotion words and action tendencies serve as a rough guide suggesting the type of self-organization that a client is in. Some categories of coding are based on Greenberg’s (2002; Greenberg & Paivio, 1997) categorizations of primary vs. secondary and adaptive vs. maladaptive emotion. Those qualitative distinctions are captured mainly by the two “meaning criteria” listed above in addition to the Vocal Quality Scale (Rice & Kerr, 1986)².

Fosha’s (2000) distinction between core affects and core states is also quantified in this measure through a combination of criteria. The core affects are captured by higher

² Note that although the Experiencing Scale (Klein, Mathieu-Coughlan, & Kiesler, 1986) would be a well suited contribution to these criteria, it was not included so that it could be used later as a dependent variable, providing construct validity to the current measure and model.

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ratings on “emotional involvement criteria” including the Emotional Arousal Scale (Warwar & Greenberg, 1999) in particular. Core states, on the other hand, are reflected by the meaning criteria as well as certain types of vocal quality, i.e. the focused voice (Rice & Kerr, 1986).

A richer degree of conceptual differentiation and integration in the clients’ discourse is characteristic of productive meaning states (Wexler, 1974). Two types of criteria in this measure are intended to reflect, at least in part, this richness and level of formulation. “Specificity” is a criterion for some facet of meaning differentiation while “Stance and/or Adaptivity” is a criterion for the degree to which meaning is integrated and/or formulated to a healthy end.

Because the observational rating of a client’s subjective “involvement” is quite limited, involvement is judged in the context of previous arousal and engagement. In this classification system, it is a reasonable assumption that a client’s expressed arousal is carried on internally unless there has been a dramatic change in topic. From this perspective, the involvement criteria are met if emotional expression is observable and/or if clients provide a detailed physical description of their emotional experience. In this way, clients who are reticent about outwardly expressing arousal yet disclose that they are, i.e. “on the brink of tears” (without ever actually tearing), have met the criteria for affective involvement (assuming all other verbal and non-verbal indicators are consistent with the verbal report).

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Minimum Unit for Coding

For a rater to make any given code the participant must utter a minimum of two consecutive statements that indicate the same emotion class. This requirement is consistent with what has been used in other ratings of comparable clinical material (i.e. see Sicoli & Greenberg, 2005). There are two theory-driven exceptions to this rule. In the case of coding either a “Need” or a “Negative Evaluation” (see classifications to follow) a single clear statement is sufficient to make the code. The justification for this exception is that, by definition, both these classifications are crystallized statements of meaning.

1. Global DistressDiagnostic definition:*Emotional tone*

A. Presence of at least one of the following:

1) An experience clearly labelled by either client or therapist as any of the following:

- a) hurt,
- b) pain,
- c) confusion,
- d) hopelessness,
- e) helplessness,
- f) resignation,
- g) unelaborated loneliness,
- h) unelaborated emptiness,
- i) self-pity,
- j) vague self-blame, guilt,
- k) irritability,
- l) undifferentiated complaint/whining...

2) An experience that is described by the client as:

- a) undesired,
- b) aversive, and

c) producing suffering.

(i.e. engaged, high emotional arousal that the client describes simply as feeling bad, awful, turmoil, miserable, etc.)

Involvement

B. Presence of at least one (or both) of the following:

- 1) The experience is of high expressive arousal and is rated to be > 4 on the Emotional Arousal Scale (Warwar & Greenberg, 1999).
 - 2) The client verbally reports his or her arousal, indicating that the emotional tone is activated.
- There is non-verbal behaviour reflecting a state of suffering or collapse, which may include one (or more) of the following:
 - a) tears,
 - b) lowered head,
 - c) slumped body language,
 - d) sighs,
 - e) eyes to floor...

C. Presence of at least one (or both) of the following vocal qualities:

- 1) “Emotional voice quality”, which is disrupted or distorted as a result of overflowing feeling. This is characterized by:
 - Disruption of vocal pattern
(i.e. the voice may break, tremble, rise to a shriek, become very low),

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- Uneven pace,
 - Irregular accentuation pattern,
 - Unexpected terminal contours.
- 2) “External voice quality”, which has a premonitored quality, suggesting that the content being expressed is not being newly experienced and symbolized. It is characterized by:
- a “talking at” quality,
 - moderate to high energy, which is fairly full and directed outward,
 - extremely regular accentuation achieved primarily by a rise in pitch,
 - there is an even pace with highly expected terminal contours.

Meaning

D. The client is non-agentic, lacks a sense of direction, and there is no adaptive action tendency associated with the distress state.

- I.e. not clearly knowing what to say or do,
- feeling stuck.

E. The object of distress is one or the following³:

1) Unknown and elusive.

“Unknown Distress”

³ Examples of “Unknown Distress” are found in 076#7, 516#2; “Minimally Explored Distress” in 507#3; “Limited and Avoided Distress” in 512#3.

- I.e. the client is uncertain of what the feeling is or why the feeling exists – i.e. “I’m feeling X and I don’t know what it is about or why I am feeling it”.
- When answering the question, “What is the problem?”, the observer is unable to determine what the suffering is about in concrete or specific terms.
- It is as if the client were making the statement:
 - “I don’t know what it is but it bothers me”.

2) Known but minimally elaborated in terms of its subjective experience.

“Minimally explored Distress”

- There is little elaboration of the client’s experience beyond that it is distressing – i.e. “It feels bad when someone does not understand or care”. (Note that who is not specified).
- Clients do not convey their idiosyncratic experience:
 - They use global terms, like feeling “bad”;
 - They refer to their concern in second or third person, i.e. “one feels bad when people don’t care”;
- It is as if the client were making the statement:
 - “I know what it is but not how I feel about it”.

3) Unaddressed beyond the subjective sense of victimhood.

“Limited & Avoided Distress”

- Any meaning is heavily other/circumstance-oriented.
- The client has a marked lack of agency, (as if being helpless was itself the object of distress, i.e. “I’m so upset that I’m helpless”).
- The client makes excuses, rationalizations, justifications with a quality of defensiveness and whininess.
- The client makes pathetic or desperate pleas.
- The client seems avoidant yet is unable to disengage from the distressing material. Sometimes the client refers to “it” indicating the emotional distress in non-elaborative terms.
- The meaning is as if the client were making the statement:
 - “It just happened to me and I feel like a victim”.

Conceptual definition:

Global distress could alternatively be referred to as “undifferentiated distress”. This category of emotion is best characterized as an emotionally expressive reaction to some deeper underlying concern. Distress is global in the sense of all embracing or undifferentiated, such that the presenting undifferentiated feeling might allude to specific negative emotions but those emotions remain “fused”. If deeper core concerns are not being articulated but clients are aroused and distressed about some (general) aspect of their circumstances the rater must code this category.

Expressions of global distress do not capture any meaningful object of emotion or meaningful action tendency. As a result this experience gives the client no meaningful

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sense of direction; i.e. “I’m feeling bad”, as opposed to a more differentiated statement like, “I resent him for what he did and don’t want to overlook it.” Thus, in global distress the object of emotion is usually referred to in generalities and the emotional response is also one of generality, -- i.e. “The way I feel now about all that stuff, it freaks me right out”.

The experience of global distress can be described as being of high expressive arousal and low meaningfulness in regards to some personally sensitive theme. It indicates to the person that something is happening that is undesired, aversive, and is producing pain. The person wants the experience to be over with yet cannot seem to get over it. This affective-meaning state is characterized by feeling as if one is a victim of emotional suffering.

Examples:

Some case examples of statements that typify this category follow. One must be aware, however, that such statements in isolation do not necessarily merit a code but are given support by the meaning-context in which they are expressed.

- “I could cry for a really long time.”(Nt. Cry about “what” is not specified.) (hurt)
- “I feel hopeless, lost, sad, discouraged.” (hopeless, no sense of direction)
- “I wish I could get past it or turn it off.” (no sense of direction, complaint)
- “I feel alone, it’s so hard.” (self-pity, unelaborated loneliness)
- “I’ll never get there. There’s no use.” (hopeless, helpless)
- “It’s so awful and I don’t know what to do.” (pain, confusion)

Points of discrimination:

The observer will notice that what many clients describe as “sadness” will be coded here as global distress. In doing so a distinction is drawn between feeling “tearful and troubled” (sad, in more popular parlance) and feeling tearful over a clearly recognized loss (see “specific adaptive hurt/grief” below). An example of this was when a client said, “I felt sad for no apparent reason. I was teary and just had this sadness that came over me. All of a sudden I feel like I want to cry and I don’t know where it’s coming from. Something’s going on deep inside”. In this example, the client is using “sadness” to describe the subjective experience of an undifferentiated state -- global distress. Thus, sadness may or may not be global distress depending on the quality with which it is expressed. Greenberg’s (2002) emotion-focused approach would describe this type of sadness as secondary sadness, indicating that there is some underlying and more primary emotional concern.

Note that especially in cases of complaint, whining, and the like, global distress tends to be very other/circumstance-oriented, such that there is little elaboration on the client’s experience beyond the fact that it is distressful.

Aroused statements such as, “It’s just too painful” or “It’s so hopeless!” are expressions of emotion in their own right – they are pain or hopelessness, respectively. Nevertheless, these statements suggest some underlying emotion that remains unarticulated, herein that feeling/concern has only been referred to as “it”. The underlying feeling may or may not be within the client’s scope of awareness. Again, if

deeper core concerns are not articulated but clients are aroused and distressed about some (general) aspect of their circumstances the rater must code this category. Thus, raters should consider:

- What does ‘it’ refer too? What is the client *actually* upset about?
- Has the concern at hand been sufficiently differentiated?
- Is the client grappling with the concern’s specific and personal nature?
- Is the object of emotion grounded in relatively concrete terms?

Answering “No” to all or some of these questions is indicative of global distress.

Some clients have developed a way of interrupting or curtailing their emotion when this emotion-state becomes unbearable for them. Upon such an occasion, either the interruption is successful and the client’s level of arousal drops dramatically or it is unsuccessful and the person continues to express aroused global distress.

General description of content:

Although the affective-meaning state describes a quality rather than content per se, some types of content seem to be prototypical expressions of this state. The following, which is not an exhaustive list by any means, are descriptions of content that characterize global distress when deliberated with high emotional arousal. Some of these descriptions use examples of client statements as illustrations.

- Statements of a “poor me” quality are characteristic expressions of this state. Such statements are usually made from the position of victim and are made in a tone of complaint and often self-pity.
- Statements that protest the eternity of the injury or suffering. Since universals are almost always overly simplistic, they are also a sign of limited differentiation. Therefore, words like always, never, forever, etc. may serve as indicators of Global Distress. These statements also often have a “poor me” quality. For example:
 - “I have been suffering every day of my life”.
 - “I’ve been saddled with this difficulty my entire life and the pain is really, really intense”.
- Statements that the client makes about perennial doubt or uncertainty.
 - “I don’t know, I don’t know”
 - “I’m so doubtful about whether that is the truth or not.”
 - “I need to know why you did that” (...in a desperate tone of voice. If it were an angry tone of voice this may indicate another affective-meaning state).
- Statements that are hypersomatic. Very detailed descriptions of physiological experiences of affect can sometimes lack any description of personal or idiosyncratic meaning. Although such physical accounts are very detailed they are

usually only specific on a somatic level and are non-specific on a meaning level, making them characteristic of global distress.

- Statements that clients use to describe themselves as out-of-control, insane, or overwhelmed by emotional intensity are all characteristic of global distress. In this type of statement self-pity is often only implicit and emphasis is put on the client's sense of disorganizing and intense arousal.
 - "It makes me crazy to think..."
 - "It absolutely enrages me that you don't even care"
- Taking an argumentative position or a complaining position regarding one's "stuckness" is a strong indicator of undifferentiated emotional distress.
- Statements of character assassination may border on a different state (i.e. Rejecting Anger) but otherwise should be considered expressions of Global Distress. For example:
 - "You are selfish and self-centred!"
- Statements of vengefulness from a position of distance (rather than anger).
 - "Screw you. If you don't have any consideration for my feelings I won't have any consideration for yours".
- Statements indicating avoidance rather than emotional engagement.
 - "I don't want to have to deal with him".
 - "I don't want to imagine him" (Note that these comments do not comment on what the client would like to do, they are simply negations).

Relating Global Distress to the literature:

This sort of affective-meaning state has been referred to as secondary emotion in Emotion Focused Therapy and therapists are encouraged to go underneath this feeling (Greenberg, 2002). Other instances of global distress are labeled as emotional pain by the experiential tradition, in which case therapists are encouraged to validate and differentiate the emerging emotion (Bolger, 1999; Greenberg & Bolger, 2001). Sicoli and Greenberg (2005) talk about verbal and non-verbal markers of hopelessness, some of which are also in these criteria.

In psychodynamic therapies this state is referred to as defensive emotion or anxiety (in the broad sense) and the intervention is to interpret this state as a defense (Greenberger & Mitchell, 1983). Reik (1948) has referred to a particular affective-meaning he observed in his clients as the “masochistic morass”. His use of that term captures many of the same experiential features of the global distress construct (although not the motivations he attributed to it). Some psychodynamic authors have referred to instances of collapse into global distress as a mini-dissociative defence (Fosha, 2003).

It appears that both the psychodynamic and Emotion Focused approaches agree on the apparent lack of depth of Global Distress. From another perspective, the cognitive behavioural tradition refers to this state simply as negative emotion, something to be regulated and bypassed (Greenberger & Padesky, 1995).

Experimental research on the fundamental dimensions of subjective emotion states has identified “Distress” as a common factor that underlies aspects of cognitive, emotional, and motivational domains of experience (Mathews et al., 2002).

2. Specific Maladaptive Fear & Shame

Diagnostic definition:

Emotional tone

A. Presence of at least one (or more) of the following:

- 1) An experience clearly labelled by either client or therapist as any of the following. Note that the client must be “in” the state and suffering by the state – not avoiding it.

Shame-based emotion:

- a) Shame
 - i.e. feeling inadequacy, humiliation, embarrassment...
- b) “Feeling Empty” (elaborated)
 - Other forms of a Shame-Sadness blend,
 - i.e. “I’m withdrawn, miserable about my defectiveness”
- c) Collapsing in the face of self-contempt

- The client makes specific and harsh statements of self-contempt while at the same time collapsing into an obvious state of suffering (i.e. crying, etc.).

Fear-based emotion:

d) Fear

- i.e. feeling threatened, unsafe, defenseless, incompetent...

e) “Feeling Lonely” (elaborated)

- Other forms of a Fear-Sadness blend, i.e. dread.

f) Shame-Anxiety

- i.e. “I’m afraid I will be humiliated”

g) Guilt

- i.e. “It’s all my fault”, “I deserve to be punished”.

- 2) The action tendency is to withdraw in some way (i.e. escaping, hiding, turning sadly inwards...) from something/someone aversive. Generally the client reacts defensively sometimes even passively by “closing down” under the weight of this “dreaded state”.

Involvement

B. The experience may range widely from minimum to high expressive arousal.

- Non-verbal behaviour which may include one (or more) of the following:

- a) covering face with hands,
- b) lowered head,
- c) closed eyes or diverted/downcast gaze,
- d) fear brow (eyebrows raised and straitened),
- e) fear mouth (open but with lips tense and drawn back tightly),
- f) tears...

C. Presence of at least one (or both) of the following vocal qualities:

- 1) “Emotional voice quality”, which is disrupted or distorted as a result of overflowing feeling. This is characterized by:

- Disruption of vocal pattern
(i.e. the voice may break, tremble, rise to a shriek, become very low),
- Uneven pace,
- Irregular accentuation pattern,
- Unexpected terminal contours.

- 2) “Focused voice quality”, which is described as turning attention inward with a concentrated use of energy and the quality of groping toward new meaning.

This is characterized by:

- Uneven pace,
- Ragged, unexpected terminal contours,
- Stop-and-go, unexpected pattern,
- Accent is done with loudness or a drawl (rather than a pitch rise).

Meaning

D. The presenting concern is the source of deep and enduring personal pain.

- The emotion is full of suffering but familiar in quality.
- It is clear to the observer that this state moves the client in a destructive/unhealthy direction.
- The core concern is self-referencing, e.g.:
 - “I am defective”,
 - “I am insecure, abandoned”.

E. The object of emotion is clear and specific – i.e. “I feel ashamed/afraid of X”.

Conceptual definition:

This category of emotion is best characterized as the emotional expression of a core underlying concern, which is the source of deep and enduring personal pain.

Although emergence of the emotion may involve a significant other, (as in “feeling shame in the eyes of the other”), this type of emotion is clearly self-oriented (as in “I am the one who is shameful”).

Idiosyncratic meaning is usually quite important for this type of affective-meaning state. It represents an unhealthy and very painful way of viewing and experiencing oneself that is regrettably familiar to the client, like an age-old emotional wound. For this reason this category can be described as being of high arousal and high meaningfulness. The nature of this category is that it represents a highly personalized pathogenic state, which is imbued with emotion and sets the clients on a trajectory of

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destructive self-organization. The client is completely taken over by the emotion and experiences it as insuperable. There are action tendencies associated with this state (i.e. withdrawing, escaping, etc.) but the familiarity of this highly aversive state gives the sense that the client has no real expectancy of getting away, as it were.

The expression of specific maladaptive emotion often requires a good deal of meaning exploration. More often than not there is eventually the elaboration of some implicit need and an evaluation of client's relation to that need. For example the client may come to the painful conclusion that, "I am not loved or understood".

General description of content:

Although clients almost never use such statements, the essence of these core concerns are captured in summary phrases such as, "I am shamefully unlovable, worthless, or incompetent" or "I am afraid I will die/be annihilated". In any of these cases the client's own description and expression of the concern must be done in a manner that is relatively concrete, specific and personal. In short, this affective-meaning state should be coded when clients make clear and emotionally expressive statements about their sense of fearfulness and/or shamefulness.

Points of discrimination:

The expression of these feelings is done in a specific and detailed fashion (otherwise they may be better represented as global distress). Often clients will not actually use the word "shame" since it is not usually found in common parlance and is perhaps too penetrating. Nevertheless, harsh, overt self-criticism and self-disparagement

may accompany statements indicating that clients feel shame about their shortcomings. Deeply seated objects of shame are more often than not either in regards to (1) clients' competence in the world or (2) their ability to have relationships. Also, in this affective-meaning state, the object of fear is usually the danger of utter destruction possibly as a result of abandonment, rejection, or personal incompetence.

Fear and shame are by far the predominant families of emotions subsumed under this category although variations of these may blend with sadness. Some clarification on the common experience of feeling "lonely" or "empty" will be helpful here. The maladaptive state of "sad loneliness" is conceptualized as existing in the transition (i.e. a loop) between global distress and specific maladaptive fear. Although loneliness is often discussed as a form of sadness, what make loneliness such a painful feeling are its ramifications, which are always tinged with an element of fear. Ultimately, what makes loneliness maladaptive is the tacit meaning it entails of, "Somehow if I'm alone I won't be OK/secure/able to cope". Inevitably, when loneliness is elaborated there is a colouring of fear that gives the idea of being alone its bite. This is consistent with the observations of several authors who have pointed out that attachment disorders are all primarily fear based (Freud, 1995/1913; Bowlby, 1997/1969; Sartre, 2001).

Similarly, feeling "empty" is understood as somewhere between global distress and maladaptive shame, depending on the degree of meaning elaboration the client is able to create. In either case, raters will have to make a judgment on the level of meaning

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differentiations and personalization that the client makes in order to determine the code that is most fitting: global distress vs. specific maladaptive fear and shame.

The differentiation of meaning and the freshness of the experience are two of the most discriminating characteristics between global distress and specific maladaptive distresses (i.e. fear or shame). In contrast to global distress, which seems to state: “I feel awful but I don’t know why or what it is about”, maladaptive fear or shame state: “I feel awful and I do know exactly why!” Although some instances of global distress may have a familiar quality to clients especially if distress is part of a maladaptive personality/social style (i.e. self-pitying), the familiar maladaptive emotion is always being felt freshly in the moment. It is not just being talked about, it requires a high level of experiencing.

Sadness is sometimes maladaptive and at other times adaptive. The following comments help demarcate the difference between healthy and unhealthy types of sadness. Sadness (in the sense of grief or loss) has been described as having two distinct action tendencies that are sequentially ordered (Bowlby, 1997/1969). Initially, the action tendency in response to a loss is to cry out and essentially to reach out. A prototypic illustration is when a child gets lost in the supermarket and cannot find mother and cries out. Should crying for help prove unsuccessful the second action tendency of sadness is to withdraw and conserve energy for the hard times that evidently lie ahead.

When this second action tendency of “closing down” in sadness becomes an enduring or chronic emotional pattern, it represents a maladaptive version of sadness. The

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more it becomes an enduring source of personal and self-referencing pain the more it acquires a sense of shame and becomes “shame-sadness” (i.e. “I have lost because I am defective/inadequate”). Needless to say, a lost child is also frightened and so it makes intuitive sense that fear, shame and sadness in their maladaptive forms are amalgamated together here as specific core maladaptive states.

Some forms of shame-anxiety, guilt, and self-contempt are more particular variants of this maladaptive rubric and identifying them will assist in coding. Shame-anxiety is a hybrid feeling. It alerts individuals to the imminent danger of being shamed (Mindell, 1994). This maladaptive state highlights once again the intimate relationship between fear and shame based emotions. The clearest instances of shame-anxiety can be commonly found in social phobias.

Guilt is maladaptive when it rallies self-blame and self-punishment. The most easily recognizable instance of this is found in “survivor guilt” (Garwood, 1996). Guilt is related to the family of fear-based emotions through the dread of punishment and inescapable culpability. Once again, withdrawal and “closing down” signals the maladaptive action tendency of this category.

The expression of contempt in self-criticism, especially during two-chair work can be understood as reflecting a maladaptive way of coping with unhealthy shame (Mindell, 1994; Whelton, 2000). For this reason, when a client expresses obvious emotional suffering at the same time as making specific statements of self-contempt the suffering (i.e. tearing, etc.) is considered a reflection of maladaptive shame.

Other discrete maladaptive emotions such as anger or disgust clearly exist but are not distinct parts of this model. This affective-meaning criteria does not apply to those discrete emotions because of their radically different action tendencies. Although they may be experienced as unpleasant, anger and disgust are not “dreaded” emotional states, to use the words of Horowitz (1987). Accordingly, their action tendencies are not of withdrawing and “closing down” as is the case in this model component.

During the elaboration of meaning some clients become very emotionally aroused⁴. Alternatively, clients begin to intellectualize and in a literal sense distance themselves from the specific and emotionally evocative details that facilitate maladaptive emotion. This form of loop can be referred to as a distancing. If this happens before the rater is able to confidently code the maladaptive emotion the occurrence should not be rated. Alternatively, if the maladaptive emotion is sufficiently aroused and activated then the occurrence will be rated and distancing will likely mark the end of that code.

Similarly, some clients have developed a way of self-interrupting or curtailing their emotion when this emotion-state becomes unbearable for them. Upon such an occasion the interruption is often not fully successful and clients will revert to the less specific expression of aroused global distress (in an attempt to distance themselves from the painful specifics). This occurrence would signal a change in code from one affective-meaning state to another. Otherwise, the interruption is successful and the client’s level

⁴ In this project it could be helpful to raters to know that soothing by the therapist is usually critical around this point to allow the client to tolerate unpleasant feelings and continue with the task at hand – avoiding either distancing or self-interruption. However, unless it is in the form of explicit and adaptive self-soothing, such soothing should not be coded.

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of arousal drops dramatically perhaps accompanied by a change in topic. In that case, the occurrence would not be rated or it would signal the end of the code if there had already been sufficient expression to make one.

Relating Fear & Shame to the literature:

Authors writing on Emotion Focused Therapy have referred to this type of emotion as a primary maladaptive emotion. In that tradition, therapists encourage their clients to “own” these maladaptive feelings as their own, to experience them fully and then attempt to help the client transform these feelings. In other words, this type of state must be actively engaged rather than avoided so that it can eventually be changed by the emergence of another subsequent feeling (Greenberg, 2002).

Psychodynamic theorists have referred to this category of experience using various terms. Horowitz (1987) has referred to this as a class of “dreaded states” that must be regulated, while McCullough et al. (2003) has referred to “pathogenic affect”, which must be “faced” by the client. This affective-meaning structure is also represents the “response from self” in a core conflictual relationship theme (CCRT) described by Luborsky et al. (1994). Thus, the psychodynamic tradition generally treats this type of emotion as something that must be willfully tolerated and believes it will eventually change through insight. Doing that is considered the most central target of Psychodynamic therapies.

Both experiential and psychodynamic approaches understand the maladaptive state as one that the client is embedded in, such that within its framework the client has

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great difficulty finding any viable alternative to hopelessness and despair (Safran & Muran, 2000). Cognitive and behavioural approaches to therapy have not found it useful to differentiate these fear and shame states from a more global state of distress; consequently (like global distress) it is referred to generically as “negative emotion”. As with more global distress CBT therapist work toward helping the client regulate these unpleasant feelings (Greenberger & Padesky, 1995)

Ekman and Friesen (1975) described the fear-mouth and fear-brow as well as some of the other expressive criteria for this state.

3. Generic Rejecting-Anger

Diagnostic definition:

Emotional tone

A. Presence of at least one (or more) of the following:

1) An experience clearly labelled by either client or therapist as any of the following:

- a) rage,
- b) reactive anger/ feeling mad,
- c) hate,
- d) resentment,
- e) frustration,
- f) angry protest (not wining),

- g) repulsion,
- h) anger-disgust,
- i) angry-tears.

2) The action tendency is an attempt to rid oneself of something/someone noxious. Sometimes clients swear and use name-calling. Generally the client reacts with an angry tone to avoid suffering and to defend/protect the Self. This is embodied by one of two sub-categories⁵:

- a) “Distancing Anger”
 - pushing away and producing distance,
- b) “Destructive Anger”
 - attacking, lashing out and destroying.

Involvement

B. Presence of at least one (or both) of the following:

- 1) The experience is of relatively high expressive arousal and is rated as > 4 on the Emotional Arousal Scale (Warwar & Greenberg, 1999). Arousal does not render the expression as out of control or incoherent.
- 2) The client verbally reports his or her arousal, indicating that the emotional tone is activated.
 - There is non-verbal behaviour reflecting a state of anger and protest, which may include one (or more) of the following:

⁵ “Distancing anger” can be seen in 516#12; “destructive anger” in 076#7.

- a) Shaking a fist, chopping, pointing,
- b) Dismissive gestures - i.e. waving away,
- c) Shaking the head,
- d) Emphatic nodding with statements,
- e) Angry mouth (i.e. pressing lips together - or - firm lower lip with mouth open in a squarish shape as if shouting),
- f) Squinting and angry tears.

C. Presence of at least one (or both) of the following vocal qualities:

- 1) “Emotional voice quality”, which is disrupted or distorted as a result of overflowing feeling. This is characterized by:
 - Disruption of vocal pattern
(i.e. the voice may break, tremble, rise to a shriek, become very low),
 - Uneven pace,
 - Irregular accentuation pattern,
 - Unexpected terminal contours.
 - 2) “External voice quality”, which has a premonitored quality, suggesting that the content being expressed is not being newly experienced and symbolized. It is characterized by:
 - A “talking at” quality,
 - Moderate to high energy, which is fairly full and directed outward,
-

- Extremely regular accentuation achieved primarily by a rise in pitch,
- There is an even pace with highly expected terminal contours.

Meaning

D. The client takes the position of plaintiff rather than victim and does not make specific self-affirmations.

For example, the client:

- Expresses “angry tears” vis-à-vis some concern.
- Acts as a plaintiff voicing an injury/concern.
- The tone is of agentic protest rather than powerless complaint.
- There is no explicitly declared positive self-evaluation.

E. The client stresses the noxiousness of the experience rather than the violation of values and self worth per se.

For example, the client:

- Is angry about some wrongdoing or how offending circumstances were injurious.
- Limits concern to the immediate noxious experience of transgression rather than referring to the violation or injury.
- The experience of violation is not articulated in specific, concrete, and personalized terms but rather is only addressed in generic and broad statements.

Conceptual definition:

This category of affective-meaning state is represented by the expression of anger. The main thrust of this instinctive and reactive anger, however, is in rejecting some offensive object. Often this anger is expressed from an “underdog” position such that the client seems to speak from the position of plaintiff or even victim. The almost instinctive expression of rejecting-anger might be described as one of hedonistic righteousness, where the client reacts defensively to avoid pain. The arguments used in expression of this anger often contrasts the Self’s status against what the offender did wrong or how the offending circumstances were injurious.

This affective-meaning category is described as generic because it relates to a class of angry feelings rather than a specific or specialized one. When clients express this state it usually entails high arousal and moderate meaningfulness (on account of its limited-specificity). It is generally a state of anger that sets the client on a trajectory of productive (albeit limited) self-organization. The meaning carried by this state is conveyed by a sense of self-righteousness against being hurt but is generally limited to the immediate experience of transgression (i.e. “I’m upset because you hurt me”). Thus, it is described as being moderately meaningful and can represent some organization toward recovery from injury although this is a state, which individuals often gets “stuck in”.

It is important to understand that although rejecting anger can be somewhat adaptive for the organism experiencing and expressing it, it is fundamentally aggressive.

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Under normal circumstances anger and aggression can provide an important and adaptive service in self-preservation and sometimes even the preservation of attachment ties. In this way, sometimes those needs are defended even before they are concretely experienced. This is the adaptive side of rejecting anger. In other instances, instrumental or operant expressions of rejecting anger become so automatized that the expression becomes consolidated developmentally and form maladaptive personality structures of anger. A chronically reactive angry disposition is a structuralized (and pathologized) rendition of rejecting anger.

Examples:

Some prototypical statements that capture the spirit of this affective-meaning class might be:

- “I hate you for injuring me.” (hate, outrage)
- “F-you!” (reactive anger, rejection)
- “I’m pissed off!” (protest)
- “I’m just angry that it happened.” (protest, frustration)
- “You are sick! Disgusting, pathetic.” (repulsion)
- Character assassination, when the client insults and disparages the other, are usually also examples of Rejecting Anger.

Points of discrimination:

Complaint/protest may be either an expression of rejecting-anger or global distress depending on the context and on the proportion of protest vs. pain/helplessness in

which the complaint is expressed. Neither should hostility be taken as synonymous with rejecting-anger. For example, insults directed at the offending object or person are indicative of rejecting-anger if they serve to punctuate a more articulate statement of rejection. Belligerent swearing, on the other hand, especially with either a tone of whining/complaint or with a tone of unbridled and inarticulate rage suggest that the client is more in a state of global distress, depending on the tone and context. The focused intent to harm another and the tendency to escalate out of hand are both characteristics of “malignant” aggression or rage, which is not the same as Rejecting Anger. Consequentially, aggressive rage might be codable as Global Distress but is likely to be better considered uncodable within the current classification system.

The category of “assertive-anger” is described further on (see code #7, below) but it is useful at this time to highlight the features that discriminate rejecting-anger from assertive-anger. There are at least seven discriminating features:

- 1) Rejecting anger is characterized by hedonistic righteousness. For example, “I’m upset because what you did *hurt me*”, is an expression of rejecting-anger and hedonistic righteousness. As contrasted with, “I’m upset because what you did to me *was wrong* and I deserve to be treated with respect”, which is an expression of assertive-anger and ethical righteousness. This difference is that rejecting-anger stresses the noxiousness of individuals experience rather than the violation of their values, ethics, and self worth per se.

- 2) Rejecting-anger is somewhat healthy and adaptive in that it is defensive against some offending object, as seen in the acts of repulsion or anger-disgust. However, the characteristic action tendency of “general rejection” is not explicitly self-affirming of any declared positive self-evaluation. This is one of the reasons that swearing and name-calling is more prominent in rejecting-anger than in assertive-anger. In this sense, rejecting-anger embodies a moderate level of meaningfulness while assertive-anger embodies higher, more developed meaning of self-affirmation.
- 3) In rejecting-anger an individual characteristically speaks from the position of “underdog” or plaintiff. Thus, the client is less agentic than in assertive anger (albeit not entirely devoid of agency, since no agency would be characteristic of global distress).
- 4) Rejecting-anger principally produces negative statements aimed at creating distance. In contrast, assertive-anger principally yields positive statements in an effort of affirmation (which, of course, will also imply some sort of distancing). The affirmation effort of assertive-anger puts a person in the position of an “advocate and activist” with equal footing against the offending object. This also suggests that assertive-anger embodies a more differentiated level of meaning.

- 5) Rejecting-anger tends to make use of more “you” language given its stance of general rejection. This language, however, relates “you” to “my injury”, unlike the language used in global distress, which is restricted to one or the other. Conversely, assertive-anger tends to make more use of “I” language by way of self-affirmation. “I” statements in assertive anger often give a sense of genuineness.
- 6) Rejecting-anger involves more emotional arousal than assertive-anger, (but less arousal than disorganized rage, which is a form of global distress).
- 7) Rejecting anger is the type of anger that an individual feels he or she needs to “get over” or “get rid of”. Harboring such feelings of anger/resentment/hate/etc. is inherently unpleasant. This is not the case, however, for assertive-anger. An individual who is faced with feelings of anger that are well oriented toward the assertion of personal needs and rights often feels positively about his or her anger. In some sense assertive anger can be followed through to “completion” while rejecting anger tends to be more ongoing.

It is not uncommon for the client who expresses anger to eventually feel suddenly overwhelmed or unable to continue. This is best described as a collapse of the Self. In essence, this happens when clients are organized to fight but their initiative precipitously

turns into a flight response. Thus, the client collapses into fear and hopelessness and regresses toward “global distress”.

General description of content:

Expression of generic rejecting-anger is frequently elicited by being confronted with or imagining making contact with the offensive object – whether that be self-critical statements or some significant other, etc.

Interrogatory, rhetorical questions and accusations may characterize rejecting-anger if the client refers to a specific injury and directs reasonable accusations toward an (imaginary) offending other. Otherwise, raters should consider global distress as an alternative code. For example, “Why did you do X, Y & Z?” in a protesting tone is best represented as global distress; whereas “Did you ever for one minute take into consideration X?” in an accusing tone may very well be rejecting-anger.

Relating Rejecting Anger to the literature:

EFT theorists have referred to this as secondary anger on account of its reactivity regarding some concern that is not fully articulated (Greenberg, 2002). Many psychodynamic theorists, on the other hand, have referred to rejecting anger as a sense of entitlement or narcissistic rage. Whereas in the language of Short Term Dynamic Psychotherapy, which focuses explicitly on affective processes (as does EFT), this has been referred to as “murderous rage” (Davenloo, 1990) (although the use of that particular term may suggest more malignant rage than defensive aggression, to use Fromm’s, 1973, terminology).

In discussing attachment and separation, Bowlby (1997/1996) similarly identified two types of anger, one stemming from hope the other from despair. He referred to the “anger of despair” as desperate and coercive, a feeling state that becomes destructive both toward the self and the other. By definition, rejecting anger is experienced from the position of underdog or plaintiff, and in this sense it is an expression of desperation and an “anger of despair”. However, it is not always self destructive and in other instances Rejecting Anger is best captured by Fromm’s (1973) description of “defensive aggression”, an aggressive response to a general immediate threat.

. The combination of being both generic and somewhat adaptive is possible because Rejecting Anger is an immediate here-and-now response to an ill-defined threat. Of course, this adaptive role refers to normal circumstances and normal psychological/emotional functioning. The expression of rejecting anger as a structuralized facet of personality is described in several cluster B personality disorder. Authors such as Linehan (1993) and Korman, (2005) have discussed this as being part of personality structures of people with Borderline Personality Disorder and dysfunctionally angry individuals in particular. The emotion theory presented by Greenberg has referred to this type of deeply rooted and destructive emotion as primary maladaptive anger (Greenberg & Paivio, 1997; Greenberg, 2002).

Non-verbal expressions of anger and protest such as those described in this criteria were documented by Ekman and Friesen (1975) and have also been observed by Whelton (2000) in a psychotherapeutic setting.

Introductory note on “Negative Evaluation” and “Existential Need”

The following two codes (**4 & 5**) reflect a well-differentiated level of meaning and clear symbolization, rather than distinct and separate emotion states per se. Occasionally a client may accomplish this by using a complex metaphor but it will always be highly personalized. Since these two codes are more reflective of how meaning is symbolized than some other codes, these events are often coded in the context of other emotion states. Usually this will occur near the climax of a state, when clients are making sense of and putting words to their experienced arousal.

As a heuristic for coding, if emotional arousal appears prior to a statement of negative evaluation or existential need then the appropriate emotion should be coded first (even if only briefly), followed by the statement. Otherwise if the statement occurs in the middle of some emotion state, then the state should be coded before the statement (and again after the statement if it is appropriate).

4. Negative Evaluation
Diagnostic definition:
Emotional tone

- A. The client clearly makes a statement (or endorses a therapist statement) of negative self-evaluation reflecting at least one of the following prototypes:

1) “I am not lovable (i.e. unwanted, unable to love, defective...)”

- 2) “I am worthless (i.e. useless, incompetent, inadequate...)”
- 3) “I will be destroyed (i.e. fall apart, go crazy, die, be annihilated...)”
- 4) “I will be abandoned and unable to survive on my own”

Involvement

- B. The meaning state is currently activated.
- C. Presence of at least one (or both) of the following vocal qualities:
 - 1) The client has a “focused voice quality”, which is described as turning attention inward with a concentrated use of energy and the quality of groping toward new meaning. This is characterized by:
 - Uneven pace,
 - Ragged, unexpected terminal contours,
 - Stop-and-go, unexpected pattern,
 - Accent is done with loudness or a drawl (rather than a pitch rise).
 - 2) “Emotional voice quality”, which is disrupted or distorted as a result of overflowing feeling. This is characterized by:
 - Disruption of vocal pattern
(i.e. the voice may break, tremble, rise to a shriek, become very low),
 - Uneven pace,
 - Irregular accentuation pattern,
 - Unexpected terminal contours.

Meaning

D. In a short statement, the negative evaluation crystallizes the meaning behind a client's deep and enduring personal pain.

As a belief, it is:

- 1) Absolute and unqualified,
- 2) Internally attributed,
- 3) Stable in time.

E. The negative evaluation occurs in the context of some congruent emotional arousal (i.e. fear, shame, guilt...).

Conceptual definition:

It is common for the clear articulation of a negative evaluation to emerge as a statement that crystallizes in plain words the essential meaning of a client's emotional experience. Nevertheless, the emphasis of this code is not on the emotion but rather the distillation of meaningfulness. In the clearest examples, negative evaluations are stated as if they were simple "observations" and they reflect some belief about the client or the client's emotional experience.

This is a code that reflects a level of symbolic precision vis-à-vis the Self rather than a change in affective tone, per se. The negative evaluation has also been called a core negative belief and is the kernel of the presenting emotion. A negative evaluation does not denote an emotion per se. However, in using this code the rater should be confident that this is the crystallization of meaning related to the current negative

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emotion. In this sense the negative evaluation is often an elaboration of a presenting fear or shame based emotion.

Examples:

Appropriate examples include:

- “If I get angry then I will fall apart”. (Emotion will destroy me)
- “I guess I just can’t handle it”. (I am worthless/I will be destroyed)
- “I don’t have what it takes”. (I am worthless, incompetent)
- “I’m broken, defective”. (I am worthless)
- “I must have deserved to be ignored”. (I am not lovable)

The spirit of this last statement has appeared often enough to make it a prototypic embodiment of a negative evaluation.

Points of discrimination:

The articulation or even efforts to articulate and symbolize negative evaluations are usually extremely painful to the client. Given the noxiousness of symbolizing these negative evaluations regarding the Self, it is not uncommon for the client to experience negative emotion perhaps even before the code can be made.⁶

A negative evaluation usually is a statement made in first person (i.e. an “I” statement). In some instances, when the criticisms are very specific, a negative evaluation may also be expressed in second person if there is clear contact with the “self”, as during

⁶ It could be helpful for raters to be aware that soothing is usually very important here in allowing clients to tolerate distress just long enough to spell-out the meaning of their negative emotion. However, unless, it is a specific response to a specific and articulated need, self-soothing would not be coded.

an imaginary dialogue between parts of the self. Relatively benign statements, such as, “I’m too emotional, over reactive, hypersensitive, crying” are ambiguous in the degree to which they express negative judgments and could simply indicate plans or intention, i.e. “I would like to be less reactive.” Thus, coding a negative evaluation should be reserved for relatively harsh self-criticisms.

General description of content:

In case examples a negative evaluation is usually identified when the client makes some statements about specific and central self-criticism. Another scenario in which this code could be used is when the client gives concise autobiographical examples, which crystallizing the ultimate self-related “reason” for their negative emotion (i.e. “I was never very good at getting stuff done and that’s sad”). This code is not appropriate for other-related evaluations (i.e. “He doesn’t love me”).

Relating Negative Evaluation to the literature:

Negative evaluations have been referred to by Cognitive Behavioural Theorists as “core dysfunctional beliefs”, negative thoughts, or negative assumptions about the Self and one’s emotion. That tradition handles negative cognitions by actively engaging them and attempting to modify them through reason (Greenberger & Padesky, 1995). Doing so is considered to be the most central target of Cognitive Behavioural Therapy.

This type of negativity has also been described in psychoanalysis as the “Superego” (Freud, 1961). Similarly, some psychodynamic theorists have referred to this as the “expected response from other” in a core conflictual relationship theme (Luborsky

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et al., 1994). In these approaches, therapists encourage the analysand/client to simply acknowledge that they harbor such negative evaluations and expectancies.

The humanist tradition of psychotherapy has also referred to negative evaluations by a number of names. In Client-centred therapy these are the “conditions of worth” that a person has assimilated (Rogers, 1961). In Gestalt therapy (Perls et al., 1951) and approaches influenced by Gestalt (i.e. Process-Experiential Therapy) harsh negative evaluations are referred to as the “self-critic”. In these humanist therapies clients are encouraged to expand their awareness of negative evaluations; an aim which is similar to that of the psychodynamic approach, although the methods differ. More process-directive approaches in the humanist tradition attempt to actually arouse and vivify the client’s experience of the self-critic (Greenberg, Rice, & Elliott, 1993; Greenberg & Paivio, 1997).

Negative evaluations are essentially consciously verbalized appraisals about one’s inability or inadequacy in the arenas of personal agency and/or communion. These two aspects of life are of most central importance to human existence. As such, a negative evaluation is an expression of impotency and/or alienation (Bakan, 1966). The criteria stating that a negative evaluation must be (1) absolute and unqualified, (2) internally attributed, and (3) stable in time, are three features of negative attribution styles that research has found to be characteristic of depression and anxiety (Weiner, 1985; Seligman, Abramson, Semmel, & von Baeyer, 1979).

5. Existential Need

Diagnostic definition:

Emotional tone

A. The client explicitly makes a statement (or endorses a therapist statement)

describing the need they have for healthy functioning – i.e. “I need X”. The statement may reflect a need for any one (or more) of the following:

1) recognition/affirmation

- i.e. admiration, praise, respect, have accomplishments recognized

2) approval/acceptance

- i.e. to be liked, to be believed in

3) affiliation/affection

- i.e. love, tenderness, warmth, intimacy, friendship, belonging, co-operate, socialize

4) support

- i.e. help, protection, emotional support

5) nurturance

- i.e. ‘mothering’, soothing, validation, sympathy

6) autonomy

- i.e. independence, freedom, avoid feeling confined or restrained, resist influence or coercion

7) inviolacy

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- i.e. to preserve one's self respect, psychological distance, immunity from criticism
- 8) joy, beauty, or playfulness in life
- i.e. specific positive feelings in relation to the experience of life itself
- 9) A metaphorical image or autobiographical example that conveys the client's need for one of the above.

Involvement

- C. The meaning state is currently activated and in the context of some emotional arousal.
- D. The client has a "focused voice quality", which is described as turning attention inward with a concentrated use of energy and the quality of groping toward new meaning. This is characterized by:
- Uneven pace,
 - Ragged, unexpected terminal contours,
 - Stop-and-go, unexpected pattern,
 - Accent is done with loudness or a drawl (rather than a pitch rise).

Meaning

- E. The existential need is something enduringly essential to the client for healthy functioning and development. As a need, it is usually:
- Uncompromisable & straight forward,
 - Internally attributed,

- Stable in time.

F. The need is unmet, has not been sufficiently attained.

- It may be stated using past or present tense but should be a currently felt need.
- It is stated as an observation or discovery about the Self rather than with anger or as a demand on others.
- It emerges as an insight and/or as heralding acts of agency.

Conceptual definition:

The symbolization of a primary need often emerges as an “I” statement formulated in plain language. This is sometimes done with a sense of child-like vulnerability or simplicity. It is not uncommon for such a declaration to be embedded in some form of aroused emotion. Nevertheless, the emphasis of this code is not on the affect but rather on the distillation of meaning.

Meaning may be presented in the form of a wish, need, desire, or sense of direction. Examples may also be in the form of metaphorical images or autobiographical examples but will often be disarming and direct statements of the client’s needs relating to essentially three overarching categories: attachment (i.e. “I need love -- to feel valued, important, special, supported...”), personal agency (i.e. “I need freedom -- individuality, to feel separate, independent...”), or survival (i.e. “I need to feel safe -- protected...”). On some occasions clients will express a need only after a direct query by the therapist. If

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that is the case, raters should be sure that the need is specific and well articulated before they code it as such.

Examples:

Some case examples of client statements regarding needs include:

- “I need to be worth it”. (I need love/value)
- “I have been waiting for the eyes for love.” (I need love, metaphorical image)
- “I need encouragement”. (I need love/support)
- “I want protection, support, ... ” (I need love/parenting relationship)
- “I felt like I was his adopted daughter, It was so nice.”
(I need support/parenting relationship)

As a helpful hint, observers should look for the words:

I need...

I want...

I wish...

I don't need...

I don't want...

...or equivalent.

Points of discrimination:

Phrases that begin with, “I want you to...” or “I need you to...” are usually not statements of an existential need. To satisfy this code the statement must be more grounded in the client's Self. Thus, the statement of a need will more likely begin with

turns of phrase like, “I want or need to feel...”, without reference to any other party on which the demand might be made. Need statements are not demands but rather self-observations, if you will, of what the organism requires to function in a healthy way.

Note that making plans or setting goals is not sufficient to be coded as a “need”. Occasionally, clients will make statements such as, “I want to be able to love myself”. Without a context that serves to buttress it, this is an ambiguous statement with respect to a “need”. In isolation it is unclear if the speaker is making a statement of what is essential and missing from his or her life (i.e. an existential need) or whether the speaker is beginning a list of goals, objectives, or mantras, which would not meet criteria for coding a need (i.e. “I want to be able to love myself, to take better care of myself, I need to work harder, I need to visit my mother more often,...”).

The expression of a need should be coded when it appears as a statement of self-discovery or self-observation. Specific and adaptive assertive-anger also will usually have a clear statement of need that is being affirmed. The distinction between the two codes can be found in the fact that assertive-anger is not only an expression of need but also of the client feeling entitled and deserving of having that need met. Thus, a statement of feeling entitled or deserving of the need may be better coded as Assertive-Anger. Generic demanding may be better coded as Rejecting Anger.

Relating Existential Need to the literature:

By their very nature, humanist psychotherapies highly value a client’s articulation of personal needs. The statement and significance of certain needs has been discussed at

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great length in the theory and practice of Emotion Focused Therapy (Greenberg, 2002; Greenberg & Paivio, 1997; Greenberg, Rice & Elliott, 1993). Therapists in that and some other experiential approaches actively encourage and support clients to acknowledge and more importantly experience their needs more fully. Doing this is considered to be main target and catalyst of change in Emotion Focused Therapy.

The “need” is a term that was elaborated by Murray (1938) from a psychoanalytic approach. A need, as referred to by this category of meaning, is what some psychodynamic researchers have called the “wish” in a core conflictual relationship theme (Luborsky et al., 1994). Psychoanalytic and psychodynamic approaches direct their efforts at bringing a client’s need or wish into consciousness.

Both experiential and the psychodynamic approaches agree that clients suffer from some unmet concern. Work by both Murray (1938), and Prager (1995), formed the basis for the classification of client needs in this coding system. Pedersen (1996) synthesized and elaborated their works for coding in this type of therapeutic context. The need for “joy” and “playfulness” has been contributed by the school of Gestalt therapy as part of an individual’s need for positive experiences vis-à-vis life (Perls et al., 1951). In essence, statements of existential needs are statements that address the overarching concerns of human agency and communion, described by Bakan (1966) as the core dynamic drives in human existence.

Cognitive Behavioural Therapy does not conceptualize the the expression or experience of an existential need as relevant to its approach. In their manual Greenberger

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and Padesky (1995) have referred to the formulation of a more “balanced belief”, contrasting it against a presenting core negative belief. In this regard, it is apparent that cognitive and behavioural approaches have a categorically different conception of the healing process. Nonetheless, the nature of an expressed need as internally attributed and stable in time is consistent with cognitive attributional theories of motivation and emotion (Weiner, 1985).

6. Specific Self-Soothing

Diagnostic definition:

Emotional tone

- A. The presence of caring, tenderness, soothing, or nurturing. Perhaps in one (or more) of the following forms:
 - 1) In an explicitly reflexive manner,
 - 2) Imagining nurturance/soothing,
 - 3) Attributed nurturing/soothing,
 - 4) Acknowledging existing resources and recalling current examples

Involvement

- B. The meaning state is currently activated. If arousal is present it is sufficiently regulated and is compatible with the process of self-soothing.
- C. Presence of at least one (or both) of the following vocal qualities:

- 1) “Emotional voice quality”, which is disrupted or distorted as a result of overflowing feeling. This is characterized by:
 - Disruption of vocal pattern
(i.e. the voice may break, tremble, rise to a shriek, become very low),
 - Uneven pace,
 - Irregular accentuation pattern,
 - Unexpected terminal contours.
- 2) “Focused voice quality”, which is described as turning attention inward with a concentrated use of energy and the quality of groping toward new meaning. This is characterized by:
 - Uneven pace,
 - Ragged, unexpected terminal contours,
 - Stop-and-go, unexpected pattern,
 - Accent is done with loudness or a drawl (rather than a pitch rise).

Meaning

- D. Attending to the unmet need is done with a positive self-evaluation (which could be either explicit or implicit). It is self-evident that this is adaptive and healthy for the client.
- E. The object being soothed is clearly the Self.

Conceptual definition:

This affective-meaning state is distinctly reflexive in its nature. Intimately tied to the existential need, in this state clients move to an agentic position and begin to meet their own expressed need. This may be done in a variety of ways but will be characterized by caring, tenderness with oneself, and the act of self-nurturing. If the client attributes the role of soothing to another person, place or thing through role-play or some other imaginative exercise, it is ultimately considered to be an act of the client unto him or herself.

Examples:

Clients might do this by:

- Using an explicitly reflexive manner;
 - Soothing or nurturance of “child self” by current “adult self”
 - Positive self-talk: i.e. “I know that I’m going to be alright”.
- Imagining nurturance/soothing;
 - “I can imagine being hugged or going to a safe place”
 - “I can imagine a better situation in the future”
 - “I know God’s love is always out there”.
- Attributed nurturing/soothing;
 - Offering words of soothing or nurturance toward oneself while role-playing the position of some significant other, (i.e. speaking from the other chair as mother, “I do care for you”).

- Imagining the apology/regret of some offending other in a way that is tantamount to imagining the other taking a nurturing stance.
- Acknowledging existing resources and remembering current autobiographical examples,
 - “My existing family/friends care for me and protect me now”
 - “My mother in law gives me what I needed. For example...”
 - “...My sister loves me, my husband brought flowers”.

Points of discrimination:

A need and a positive self-evaluation are events rather than states per se. However, when there is a confident expression of positive self-evaluation and at the same time an organization toward actively attending to some unmet need, that is the state of self-soothing. Self-soothing should be only coded if there is an explicit effort to grant an explicit need.

Self-soothing can be understood as an implicit expression of self-assertion. Although a state of self-assertion (elaborated below) is much more combative and anger-based both of these affective-meaning states are built upon a clear sense of some existential need and a positive self-evaluation. Note that if self-soothing represents a healthy way of being in the personal domain, self-assertion (or assertive anger, below) represents a similarly healthy way of being in the interpersonal domain (or when problems are couched interpersonally, as in dialogues).

Relating Self-Soothing to the literature:

Self-soothing is a concept that first emerged out of the literature on attachment (see Bowlby, 1997/1969). Kohut explicitly discusses “Self-soothing” as a specific client behaviour that demonstrates healthy maturation. He describes this as the healthy enactment of “mothering” vis-à-vis oneself in a manner adopted from prior caregivers (Kohut, 1977). Despite the contributions of Self Psychology, this reflexive state has been most highly valued and is perhaps most often referred to in humanist psychotherapies. In an experiential treatment manual Bierman (2003) explicitly refers to “Self-nurturing” as an auto-intervention that should be fostered when clients feel vulnerable.

Although it has not been extensively elaborated as a construct, the gist of this affective-meaning state has been referred to in various ways. The “focusing attitude” in many experiential therapies (Gendlin, 1981; Cornell, 1996) is a less explicitly active state but still has the same intentionality as self-soothing. Similarly, “compassion for the Self” (Nhat Hanh, 1976) reflects a certain disposition or preparedness for self-soothing but does not denote the explicit behavioural engagement that is required in this affective-meaning state. Likewise, Fromm’s (2000/1956) conception of “self-love” also suggests the self-soothing disposition.

In the cognitive and behavioural traditions to therapy, self-soothing has taken on different forms. The cognitive approach refers to collecting “evidence against” a core negative belief (Beck, J., 1995). And depending on its tone, this can be suitably understood as a rationally driven method by which an individual is lead to acknowledge

his or her existing resources. In that approach, more affectively laden forms of self-soothing occur only incidentally as part of skills training and positive self-talk. In a behavioural vein, Dialectical Behavioural Therapy explicitly treats self-soothing as a skills set that is discussed, taught, and deployed as one of the steps toward emotional regulation (Linehan & Schnidt, 1995). In an integrative fashion, Dialectical Behaviour Therapy has provided a practical operationalization of self-soothing for clients in the form of “self caring behaviours” (Korman & Bolger, 2000; Linehan, 1993b).

7. Specific & Adaptive Assertive-Anger

Diagnostic definition:

Emotional tone

A. The presence of anger in one (or more) of the following:

- 1) Self-affirmation/assertion
 - (i.e. “I am OK”),
- 2) Entitlement to an already stated existential need
 - (i.e. “I deserved to be protected, cared for”),
- 3) Affirmation/assertion of ethical standards & rights
 - (i.e. “What you did was wrong”),
- 4) Boundary setting or separation
 - (i.e. “I won’t allow it to happen anymore”).

Involvement

B. Presence of at least one (or both) of the following:

- 1) The experience is of moderate to high expressive arousal and can be rated as > 3 on the Emotional Arousal Scale (Warwar & Greenberg, 1999). Any arousal is sufficiently regulated and useful to the process of assertion.
 - 2) The client verbally reports his or her arousal, indicating that the emotional tone is activated.
- There is non-verbal behaviour that reflects active assertion in a considered and deliberate manner, which may include one (or more) of the following:
 - a) Head nodding,
 - b) loud voice,
 - c) body leaning forward,
 - d) assertive gestures (i.e. finger pointing, chopping, stop signal...),
 - e) steady gaze directed outward.

C. Presence of at least one (or both) of the following vocal qualities:

- 1) “Emotional voice quality”, which is disrupted or distorted as a result of overflowing feeling. This is characterized by:
 - Disruption of vocal pattern
(i.e. the voice may break, tremble, rise to a shriek, become very low),
 - Uneven pace,
 - Irregular accentuation pattern,

- Unexpected terminal contours.
- 2) “Focused voice quality”, which is described as turning attention inward with a concentrated use of energy and the quality of groping toward new meaning.
- This is characterized by:
- Uneven pace,
 - Ragged, unexpected terminal contours,
 - Stop-and-go, unexpected pattern,
 - Accent is done with loudness or a drawl (rather than a pitch rise).

Meaning

- D. The client is agentic and assumes a position of being both entitled and deserving of the need.
- The client takes the role of advocate or activist for him or herself.
 - The client seems to have a sense of equal footing against the offending object.
 - The client takes a reflective stance that allows anger to be active yet sufficiently regulated to be useful for self-assertion.
- E. The object of anger is clear and specific.
- It is clear to the observer what injustice or unfairness was done and by whom.
 - The assertion may be anchored in some specific autobiographical context.

Conceptual definition:

This category of affective-meaning is represented by the expression of anger, which is a clearly an empowered expression of the Self. The main thrust of this anger is

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in its self-assertion, whether that be the assertion of personal boundaries or of some stated need. The client is strong, clear, well-grounded, and speaks with a sense of growing confidence. Often this anger is expressed from an “advocate” or “activist” position such that clients seem to speak and confront their objects of anger like opponents of potentially equal force. Ultimately, assertive-anger defends some Positive Evaluation (i.e. “I am lovable”) and to the extent that it does this it is self-affirming. This type of anger is often founded upon a new, positive evaluation of the Self. The positive evaluation, however, is usually tacit until some point where the anger becomes sufficiently activated.

On the other hand, a need is usually explicit in this form of anger (the client is battling for something specific) and it is also often anchored in some specific autobiographical context. One might describe the assertion of need and/or Self as driven by a sense of ethical righteousness. When clients express this type of state it entails moderate to high arousal and high meaningfulness. It represents a healthy state rich in specific, personally relevant meaning and organizes the client on a productive and ultimately positive trajectory.

Examples:

Typical expressions using this anger are:

- “I cannot accept this”. (Ethical righteousness & separation)
- “You are not a valid judge of me”.(Ethical righteousness & separation)
- “I have value!” (Self-assertion)
- “It’s not OK, because I need more”. (Assertion of need)

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- “I’m angry I have been mistreated”. (Ethical righteousness)

Some case examples are given below:

- “We are not the same”. (Boundary setting/ Self-assertion)
- “I am finished with you”. (Boundary setting/ Self-assertion)
- “I can love, I am loveable”. (Self-affirmation/need)
- “I have been mistreated and abused”. (Ethical righteousness)
- “I was not put here to be mistreated. I have to be whom I am”.
- “I resent being stepped on when I’m trying to move forward”.
- “How dare you! I feel gritted teeth. Stay away from me and mine”.

(Ethical righteousness/assertion of Self)

Points of discrimination:

Some more aggressive statements, for example, “Give me a break! That’s stupid. You don’t even know me”, are bordering on “rejecting-anger”. However, given the right context this could be a statement representing, ‘you are not a valid judge of me’ – which would be “self-assertion”. The distinction between these two codes is made based on supporting statements and contextual evidence given that no code should ever be made based on a single statement.

In this project it could be useful for raters to note that EFT therapists often attempt to encourage and facilitate the arousal of this affective-meaning state. Similarly, self-validation is also a common part of this emotional process as clients try to accept support from their therapist and try to buttress their own assertion. Albeit healthy, the

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effort to assert oneself against some negative evaluation of the self or offending other/circumstance is usually very difficult and sometimes frightening for the client. One critical difference between the development of anger and fear is individual's appraisal of their ability to cope with the negative stimulus. Given that such appraisals are ongoing, it is not uncommon for the client's self-assertion to collapse into negative emotion (either global distress or specific maladaptive fear/shame). This is literally a client's change of trajectory from an organization for "fight" to some organization for "flight". Validation and/or soothing can play a part in the prevention of such collapses.

Relating Assertive Anger to the literature:

This self-affirming category represents "primary adaptive anger" in the language of Emotion Focused Therapy. Therapists using that approach aim at actively engaging and elaborating this healthy type of anger in the hopes of having it propel the client forward into a healthier, more active, and more resolved state of being. Whelton (2000) referred to this affective-meaning state as self-resilience or assertion when discussing client behaviours within a therapeutic context. Gestalt therapists introduced the notion of "assertiveness" and assertiveness training in psychotherapy as a healthy form of anger to be allowed and made use of (Perls, et al., 1951; Perls, 1969).

Comparably, psychodynamic theorists have referred to this type of client activity as a demonstration of "good ego strength" or a "healthy sense of entitlement". This is contrasted with the more usual sense of entitlement, which by default is considered to have a narcissistic and unhealthy quality (Greenberg & Mitchell, 1983). Even so,

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psychodynamic and Cognitive Behavioural theorists and therapists tend to have strong reservations about arousing the expression of anger and consequentially have not developed or used refined distinctions among client's experiences of anger.

Assertive-anger is a construct that has not proved relevant at all to Cognitive Behavioural Therapy. This is probably on account of the fact that, whether adaptive or not, the experience of anger is a generally a negative one for clients. Nonetheless, if collecting rational "evidence against" a core negative belief (Beck, J., 1995) is imbued with a sense of deserving and agency then it might meet criteria for assertive-anger.

Assertive Anger is well described by Bowlby's (1997/1996) "anger of hope", which may be found in the context of attachment. The "anger of hope" is an emotion that aims to rectify an undesirable relationship situation. Anger is the impetus to repair close relationships when the other is inaccessible. In both the contexts of attachment as well as personal agency (i.e. survival and competence) Assertive Anger, like the "anger of hope" in relationships, engages the person in adaptive problem solving and the expression of non-hostile anger. Fromm (1973) aptly described this as "benign aggression" – a beneficial expression of anger that promotes well-being.

The notion that individuals literally fight for the assertion of their rights from a position of anger is consistent with rights theory (Ignatieff, 2000). Social actions and assertions of the self by an individual are built upon an emerging positive self-evaluation, which then takes its momentum from the emotional experience of anger. Thus, specific

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and adaptive self-assertion is an anger-based experience whether it be personal or socio-political (Ignatieff, 2000).

8. Specific Adaptive Grief/Hurt

Diagnostic definition:

Emotional tone

A. The presence of one (or more) of the following:

1) Sadness over a loss

- i.e. loss of person, of innocence, of a thing one never had, loss of a missed opportunity, etc.
- i.e. regret, remorse...

2) Recognizing one's woundedness,

- i.e. reporting and reflecting on past emotional/physical damage.

3) Specific and idiosyncratically elaborated pain,

4) Realistic hopelessness over regaining lost object (but not out of despair).

- The above emotional tones must be without blaming, self-pity, or resignation.

Involvement

B. Presence of at least one (or both) of the following:

1) The experience is of high expressive arousal and is rated as > 4 on the Emotional Arousal Scale (Warwar & Greenberg, 1999). Any arousal is

sufficiently regulated and useful to the process of grief or recognizing one's woundedness.

- 2) The client verbally reports his or her arousal, indicating that the emotional tone is activated.

C. Presence of at least one (or both) of the following vocal qualities:

- 1) "Emotional voice quality", which is disrupted or distorted as a result of overflowing feeling. This is characterized by:
 - Disruption of vocal pattern
(i.e. the voice may break, tremble, rise to a shriek, become very low),
 - Uneven pace,
 - Irregular accentuation pattern,
 - Unexpected terminal contours.
- 2) "Focused voice quality", which is described as turning attention inward with a concentrated use of energy and the quality of groping toward new meaning. This is characterized by:
 - Uneven pace,
 - Ragged, unexpected terminal contours,
 - Stop-and-go, unexpected pattern,
 - Accent is done with loudness or a drawl (rather than a pitch rise).

Meaning

D. The client takes a reflective stance that allows Grief/hurt to be active yet sufficiently regulated to be useful for the healing process. This means the emotion is self-oriented, personalized and integrative. I.e.:

- Hurt: The client takes the position of one who is recognizing and describing the impact of a deep wound. The client acknowledges that wound as a personal loss.
- Grief: The client takes the position of one who is grieving or saying “good-bye” to bad memories, good memories, hopes and dreams, and finally “good-bye” to either the relationship as a whole or to a part of one’s life.

E. The object of grief/hurt is clear and specific:

- It is clear to the observer what object has been lost and/or what is the source of hurt – (i.e. the loss of X relationship, i.e. the hurt from being neglected in the manner of X).
- The grief/hurt may be anchored in some specific autobiographical context – (i.e. “This is what happened...” or “When I was younger, this is what it was like...”).

Conceptual definition:

This category of emotion is imbued with very specific and often profound meaning that acknowledges the genuine sadness of a loss or injury. Reporting past emotional/physical damage while being in an aroused state especially if it is done with a

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sense of self observation or reflection, can be a very new and insightful experience.

Although grief is unpleasant and usually entails some form of withdrawal, this type of sadness is described as adaptive because of its well-grounded, underlying tone of realism and acceptance of things as they are. This allows for one to move on. Note that grief is a healthy way of experiencing loss in the personal domain, while hurt similarly represents an adaptive way of experiencing injury in the interpersonal domain (or when problems are couched interpersonally). Both of these feelings are considered to represent the same broader affective-meaning state. Adaptive grief or hurt often flow from some sort of implied positive evaluation of Self, i.e. “I am lovable... but nevertheless, I have lost”.

This affective-meaning state will usually involve a discussion of needs although, at this point, the reference to needs will be in the spirit of, “what I missed and will never have again”. In other words, this state of grief or hurt will essentially describe a process of mourning or saying “good-bye” to the bad memories, the good memories, the hopes, and dreams and finally to a part of one’s life. Alternatively, the state may entail recognizing and describing the impact of a deep emotional wound, which is acknowledged as a personal loss.

When clients express this state it is with moderate to high arousal and with high meaningfulness. Given its adaptiveness this represents a healthy state rich in personally relevant meaning and organizes the client on a productive trajectory of “letting go”.

Examples:

Some case examples of specific and adaptive grief/hurt follow:

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- “I’ll never know who I could have been”. (Grief)
- “I would have liked to have had a mother who cared for me”. (Grief)
- “You have made life very difficult for me”. (Sadness/regret)
- “My Sister and parents have no intention of coming to visit and that’s sad”.
(Sadness/describe loss)
- “Until I moved out I didn’t realize how uncared for I was. I hadn’t noticed the
abuse I had to endure, until much later when things were better”.
(Recognizing one’s hurt)
- “I’m sorry you are wasting your life, and father’s and sister’s lives, but I will
not let you waste mine”. (Sadness/describe loss)

Note that this last example is bordering on angry self-assertion; therefore this coding might be swayed by the emotional context and depending on the angry vs. sad tone.

Points of discrimination:

The difference between “specific adaptive grief/hurt” vs. “global distress” is shown, for example, in mourning the loss of a loved one vs. the helplessness and vague despair of being without that loved one. Similarly, both blaming the other and self-pity are indicative of global distress rather than grief/hurt. Raters must also be careful to discriminate between the acceptance of hurt/loss vs. resignation, the latter is a rendition of hopelessness and therefore should be categorized as “global distress”.

When a client talks about how much he or she has suffered the observer must make a judgment call: Is the elaboration a broad, sweeping and generalizing complaint?

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Is it in a whining tone? (If so, these suggest global distress). -- Or is the client making a specific observation regarding his or her Self? The latter is grief/hurt in the form of “recognizing one’s hurt” and “acknowledging a past wound”. Thus, if a statement about how bad life was is specific and from a position of, “oh, I’m understanding it better now ... the nature of my suffering is clearer now” – that is indicative of grief/hurt.

The degree to which an individual assesses him or herself as “damaged” is also a discriminating criterion for coding grief/hurt. If an individual essentially states, “I’m so badly damaged, I can’t function”, the appraisal is that he or she is broadly and permanently damaged. The grave and enduring nature of this statement suggests it is an expression of fear/shame and given its incisiveness would likely be coded as a negative evaluation. In contrast, if an individual states, “Although I’ve been very badly damaged, I can function”, the appraisal is that he or she had been locally rather than totally damaged, as it were. Acknowledging one’s wounds or losses while appraising them as at least somewhat repairable is indicative of grief/hurt. Describing oneself as unsalvageable or hopeless is not.

The counterpoints of grief and hurt are self-soothing and self-assertion, such that depending on the presenting concern, grief acts as the complement to self-soothing and hurt often serves as the complement to assertive-anger. In this coding system, the two feelings of grief and hurt have been collapsed together into a single category/ In contrast, self-soothing and assertive-anger have been preserved as independent classifications in the coding. The reason for this is that hurt and grief are believed to be experientially

much closer to one another than self-soothing and assertive anger. Even so, the natures of adaptive grief/hurt vs. assertive-anger/self-soothing is such that both sets of emotions entail highly personalized and complementary meaning constructions and as such are healthy trajectories of development.

In rating affective-meaning states the consequence of this is that the two types of affective-meaning categories (grief/hurt vs. self-soothing and assertive-anger) form an experiential couplet and it is not uncommon for clients to pass back and forth between the two, while remaining on a highly meaningful level. This must be taken into consideration, as it will assist raters who are attending to the variation of emotionally aroused segments of video.

Relating Grief/Hurt to the literature:

Theorists in Emotion Focused Therapy have most often referred to this affective-meaning state as “primary adaptive sadness” (Greenberg, 2002; Greenberg & Paivio, 1997). On some other occasions it has also been referred to as a type of “primary hurt” (Greenberg & Bolger, 2001; Bolger, 1999). Emotion Focused Therapists actively engage and facilitate the experience of these special types of sadness. The aim therein is to have clients recognize and symbolize the most poignant source of their hurt or grief so that they can “complete” it, as it were. In this approach to therapy, feeling specific hurt and grief more “fully” allows clients to “let go” and move forward to a healthier, more active, and more resolved state of being. Other experiential therapists, such as Bierman (2003), have developed the expression of grief into a formal treatment intervention. In this

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structured task clients are encouraged to literally, “say good-bye”, to the good things and bad things related to some aspect of their lives ‘that will never come again’, and say good bye to any previously anticipated ‘hopes and dreams’ that will never happen.

Taking an experiential-dynamic approach, Fosha (2000) has also referred to certain grief experiences as being part of what she calls the “healing affects”. In her approach, which is a variant of Short-Term Dynamic Psychotherapy, this state is also to be elaborated and fully experienced for positive therapeutic results.

The notion of a healthy and adaptive grief/hurt state is not entirely new. The unique meaning captured by this type of reflexive sadness is akin to the Buddhist notion of, “seeing oneself with the eyes of compassion” (Naht Hanh, 1976). The specificity and reflexivity of this experience is essential and is what sets this type of state apart from the simplistic experience of global distress and catharsis, in the sense of emotional-purging (as described by, i.e. Janov, 1970, 1991, or Stone, 1995).

9. Relief

Diagnostic definition:

Emotional tone

A. The presence of one (or more) of the following:

- 1) An experience clearly labelled by either client or therapist as any of the following:
 - a) Feeling better,

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- b) Feeling lighter,
- c) Hopeful,
- d) Positive,
- e) A small sense of accomplishment...

2) The client feels a “bodily shift”

- i.e. less tense, can breath more easily, feels less choked up...

Involvement

B. The meaning state is currently activated. If arousal is present it is sufficiently regulated and is compatible with relief.

- There is non-verbal behaviour reflecting a slightly positive state, which may include one (or more) of the following:

- a) Crying “tears of self-recognition”,
- b) Deliberate sighing often with an open mouth or with voice,
- c) Smiling,
- d) Nodding,
- e) Making eye contact..

C. Presence of a “focused voice quality”, which is described as turning attention inward with a concentrated use of energy and the quality of groping toward new meaning. This is characterized by:

- Uneven pace,
- Ragged, unexpected terminal contours,

- Stop-and-go, unexpected pattern,
- Accent is done with loudness or a drawl (rather than a pitch rise).

Meaning

- D. The client has articulated some aspect of personal meaning and now feels oriented toward adaptive self-development. The client's sense of relief is of "finally, being on the right track".
- E. The client is finished working on the issue for the moment. There is no requirement for a high degree of specificity in meaning. The state of relief is a "pause" or "resting place" between the difficult thoughts and feelings involved in a change process.
- Note: The issue is usually not fully resolved and it is not being avoided.

Conceptual definition:

The affective-meaning state of relief is one of the few states in this coding system that denotes "feeling good". As they pause to reflect on the process in which they are immersed clients sometimes feel the ramifications of what they have just expressed or realized on a bodily level. This creates a reduction in tension or a sense of relief. In this sense the client (deliberately or not) takes a moment and acknowledges his or her efforts in the process. The client has made some step in emotional processing and is able to recognize the progress on some level. The experience is a sense of relief, hopefulness, or accomplishment in having produced a shift.

Given that positive experiences tend to have an inherently lower degree of specificity in meaning than negative experiences, sometimes it is difficult to determine precisely what is relieving to a client. Nonetheless, based on the task analytic research, there is some reason to believe that there are at least two levels of “Relief” and it may be helpful for raters to be aware of them. The first level of relief (#1) is related to an expressive event, exemplified by the statement, “I feel better now that I’ve symbolized and captured my distressing experience in words”. The second level of relief (#2) is related to a micro-change event. Relief #2 is exemplified by the statement, “I feel better about the whole situation and although it’s not resolved I’m relieved that it had actually changed a bit”.

Although this is an important affective-meaning state for describing the emotional processing of clients, in some ways it is epiphenomenal to the actual meaning-making, expression, or change it refers to. It is believed that relief may not be explicitly required for emotional processing. However, it may provide a useful function in meaning consolidation, emotional-regulation, and as an opportunity for interpersonal bonding.

Examples:

Some case examples of relief follow:

- “I feel like I can breath again”
- “I feel a bit better, it feels good having said that”
- “I don’t know why I’m crying, it’s good to get that off my chest”
- “It’s like a big burden is lifting off of me”

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- “I’m glad to know that I’m finally doing something”

Points of discrimination:

The “Relief” code was developed later in the development of this classification system. Initially, this positive state was not being coded at all and was a source of confusion for raters. By default raters were obliged to note this state as being either “uncodable” or a “mixture” of other available codes. This did not occur with a very high frequency but occurred often enough the relief code was developed from a homogeneous set of states that had hereto been unidentified. Identifying such recurrent states reduces the likelihood of their being confused with other more common affective-meaning states that occur in the session.

The two affective-meaning states that are most similar to relief are self-soothing and the state of acceptance and agency (see code #10). Although self-soothing at times is a suitable code for when an individual feels good, the good feelings must be functionally directed toward meeting some need. That is not the case for relief, which is a “good feeling” with no functional intention. Acceptance and agency (below), otherwise known as resolution, should be coded when content appears to be resolved. Relief should be coded when content is clearly not yet resolved but is still progress. In this way, Relief is a state that refers to “feeling better” in light of any progress that is being made.

Relating Relief to the literature:

As an affective-meaning state relief has not been addressed in much detail by the literature. In part, this is because it is not a “problem state” and as such is not often

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targeted by psychotherapy therapists and researchers. Nonetheless, Gendlin (1964, 1981, 1996) has referred extensively to the concept of a “felt shift” as a small moment-by-moment outcome, some of which are positive experiences of relief. He has referred to the “tears of self-recognition” as a form of positive experience that can follow a felt shift. Following in the experiential school, Rennie (1998) has discussed the role of reflection upon an ongoing emotional experience in perpetuating the development of that same experience (also see Greenberg, 2002). Relief as a pause for reflection on one’s progress, which is in turn experienced in a positive way, is captured but the work of these experiential theorists.

Fosha (2001) has also made special note of the role of positive affective experiences and good feelings, such as the feeling of relief, in therapeutic change. Like experiential theorists, she has also given attention to “the experience of the experience”, indicating that although the transforming power of affect may be painful the meta-experience of that transformation may be a positive one (Fosha, 2000).

10. Acceptance & Agency

Diagnostic definition:

Emotional tone

A. The presence of one (or more) or the following:

- 1) Letting go or moving on,
- 2) Feeling, comfort, calm or good,

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- 3) A goal to carrying positive feeling forward into the future or to tell someone,
- 4) Recognition of positive as well as negative aspects involved in change,
- 5) Feeling stronger when coping with the original concern,
- 6) Pride-assertiveness.

Involvement

- B. One notes a dissipation of arousal. The experience is of low expressive arousal and can be rated as < 3 on the Emotional Arousal Scale (Warwar & Greenberg, 1999).
- C. “Focused voice quality”, which is described as turning attention inward with a concentrated use of energy and the quality of groping toward new meaning. This is characterized by:
 - Uneven pace,
 - Ragged, unexpected terminal contours,
 - Stop-and-go, unexpected pattern,
 - Accent is done with loudness or a drawl (rather than a pitch rise).

Meaning

- D. The presence of “new meaning”. Defined by any one (or more) of the following:
 - 1) Broadening appreciation of oneself and surrounding circumstances,
 - 2) The consideration of somewhat new, alternative perspectives,
 - 3) Sense of greater clarity,
 - 4) Being the owner of self worth.

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E. The presence of a “novel feeling”. Defined by any one (or more) of the following:

- 1) Expression in a clearly integrative and affirmative manner,
- 2) No longer feeling disoriented,
- 3) Having some plan of action.

Conceptual definition:

This is the complete resolution of distress in all its varieties. In other words, there are little or no lingering feelings of global distress, fear, shame, anger, or grief. This affective-meaning state is characterized by high meaningfulness and low arousal. The affective-meaning state of “acceptance and agency” has three salient features. They are the dissipation of arousal, the emergence of a novel feeling and the creation of new meaning (as detailed in the criteria, above).

By definition, a state of acceptance and agency usually has a broad and global focus. Unlike the other adaptive states listed, which are highly specific in their meaning, a resolution state like acceptance and agency is relatively global. Of course, unlike global distress it can be positive and the new general meanings and feelings it engenders are often projected into the future.

Examples:

Clients may describe an experience of Acceptance & Agency by:

- Using positive feelings,
 - “I feel warm and secure.”
 - “I feel at peace with this”.

- Carrying the positive forward,
 - “I liked feeling like that it felt good. Somehow I think I’m going to start feeling it a lot more”.
 - “I’m going to try to work on positive images of you, mother, and try not focus in on your suicide.”
 - “I’m going to tell my wife about this. I don’t know if she will understand but...”
- Taking the positive with the negative:
 - “It does hurt but I feel OK about it. I feel stronger about letting it go. I can get on.”
 - “This part of my life has a bitter-sweet feeling to it.”
- Feeling stronger:
 - “I think I could handle that now”.

Points of discrimination:

Although the client often develops a sense of greater clarity as part of the Acceptance & Agency state, it is often not necessarily an easy affective state to negotiate. Current forgiveness and acceptance may also be signs of Acceptance & Agency. Even so, raters must heed discussion of such topics with a grain of skepticism. One must not assume that when a client refers to “forgiveness” or “acceptance” it necessarily involves letting go, per se. As it happens, clients often have their own understanding of what they

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mean when they use these words.

Relating Acceptance & Agency to the literature:

Greenberg, Rice, and Elliott (1993) introduced the notion of a resolution state regarding certain therapy tasks and goals. Work by Pedersen (1996) has verified and elaborated a model of the resolution process regarding “unfinished business”. Although the construct is a universal one, describing this affective-meaning state is an attempt to capture the “finished”, healthy state using criteria taken from systematic observation. In the Buddhist tradition, this affective-meaning state has been described as a mindful and authentic acceptance of the Self and its circumstances (Nhat Hanh, 1976).

Introductory note to “Mixed/Uncodable” and “End”

The following two codes (**11 & 12**) are distinct from all other codes in that they are not intended to code particular affective-meaning states. These two codes are included in the classification system because of their structural function in coding. If there is a change in the type of affect and meaning a client is experiencing that cannot be adequately represented using the other 10 codes one of these two codes will be used. For that reason these final two codes in the classification system do not follow the same set of criteria as the affective-meaning states (i.e. Emotional tone, Involvement, Meanings...).

11. Mixed/UncodableDiagnostic definition:

- A. The presence of some change in state that is different from the preceding state but is not accounted for by any other code.

For example, as in any one of the following:

- 1) There is not sufficient information/disclosure in the video to make a code.
- 2) There are no two contiguous statements that could coherently represent the client's experience.
- 3) There are potential codes for the sequence but they cannot be made with any degree of confidence.

- B. It is clear some code must be made for the sake of continuity.

- C. Note: When this code is used, any potential codes should be listed in parentheses.

- When two codes seem emergent but are not sufficiently strong each in their own right one might code:
 - I.e. "Mixed/Uncodable: (Self-Soothing/Relief)".

Conceptual definition:

When categories cannot be separated with confidence by the rater, the code of "Mixed/Uncodable" must be used. This code will be useful for the purposes of taxonomy and reliability. Obviously, specific codes are more useful than the code "Mixed/Uncodable". However, it is preferable to the omission of phenomena (when the

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rater is relatively confident that some code is required) and also much more preferable to any code that would otherwise be made with poor confidence.

General description of content:

The two most frequent scenarios for this code are:

- The client's line of process-development gets interrupted or is cut short before the rater has a clear sense of which category coding may have been most appropriate. Even so, the rater is relatively certain that the event in question does merit a code of some sort.
- A client uses therapist-fed statements for several moments but seems to neither endorse nor reject them, thus blending and obscuring the actual affective-meaning process.

Relating Mixed/Uncodable to the literature:

This category is a standard category in continuous comprehensive coding systems used in ethology (Bakeman & Gottman, 1986; Martin & Bateson, 1986). It is used to prevent raters from being obliged to code phenomena with low confidence in their ratings (for whatever reason) or to prevent forced coding of phenomena that do not fit any of the available categories. If a large number of Mixed/Uncodable codes are made in a data set the phenomena they refer to can be examined for patterns.

Patterns may indicate coding confusions. Alternatively, if there is a coherent cluster of phenomena that have hereto been mixed or uncodable, this could yield the identification of another affective-meaning state not yet included in the existing

classification system. The state of Relief (code #9) described above was identified and described through this method. Since this classification is intended for continuous coding, from the perspective of ratings there cannot be any missing data. However, when data is deemed uncodable will likely acts as missing data from the perspective of most analyses. For these reasons, research of all kinds that makes use of observational methods requires such a code in order for continuous rating to be valid. This type of code is also frequently used to insulate rating systems against inflated error in reliability.

12. End Code

Diagnostic definition:

- A. A dramatic drop in emotional arousal. The experience is of low expressive arousal and can be rated as < 3 on the Emotional Arousal Scale (Warwar & Greenberg, 1999).
- B. A content change in conversation through one of the following:
 - 1) A change of topic, (which is not emotionally evocative).
 - 2) A change to a different, less emotional level of analysis.

Case examples include:

- a) Psycho-educational discussions initiated by the therapist,
- b) Unfocused intellectualization by the client,
- c) Humour diverts and ends a state of arousal,
- d) The therapist begins to end the session.

3) The client remains silent (and not visibly aroused for two whole minutes).

C. Criteria A and B are sustained for a period of at least two minutes.

Conceptual definition:

The classification system of affective meaning states is designed to code emotionally aroused streams of experience. When the client's experience is no longer regarding emotionally involved material the coding system ceases to be appropriate. The end of a segment is delineated with an End Code.

Points of discrimination:

The segment may include some subsequent moments of discussion if they are immediate commentaries on the current emotional experiences. Note that either therapist or the client may initiate shifts in the content or level of discourse that marks the ends of a segment (assuming the other person in the dyad does not resist the change in content). Note that occasionally (but not necessarily) a change of task entails a shift in topic and/or analysis. An example of this is when the therapist initiates an intervention in order to help the client find a focus or to vivify the client's emotion. Thus, a change in task may also indicate the end of a segment assuming arousal is low.

Naturally, a change in topic marks the end of a segment if it is not emotionally linked. Similarly, two minutes of silence is considered to be enough to suggest the end of an emotion segment or at least that there is no longer direct continuity to the state that follows.

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Relating End Code to the literature:

This category is a standard category in continuous comprehensive coding systems used in the observation of behaviour (Bakeman & Gottman, 1986; Martin & Bateson, 1986).

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Appendix:

Additional resources for coding and reliability

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Figure 1:
Coding criteria at a glance

		Global Distress	Fear & Shame	Rejecting Anger
<i>Emotion</i>	A. <i>Emotion/Action</i>	Vague, whining, hopeless, pain, self-pity, irritable, confusion	withdraw/ close down: fear, shame, lonely, empty	distance/ destroy: frustration, hate, disgust
<i>Involvement</i>	B. <i>Arousal</i> C. <i>Voice</i>	high, >4 emotional; focused	emotional; focused	high, >4 emotional; external
<i>Meaning</i>	D. <i>Stance</i> E. <i>Specificity</i>	non-agentic, no direction unknown, avoid, minimal	deep & enduring pain clear & specific	protestor stress wrongdoing not Self
		Negative Evaluation	Need	
<i>Emotion</i>	A. <i>Emotion/Action</i>	"I am...unlovable/worthless/abandoned/destroyed	"I need... recognition/support/ approval/affection/autonomy...	
<i>Involvement</i>	B. <i>Arousal</i> C. <i>Voice</i>	emotional; focused	focused	
<i>Meaning</i>	D. <i>Stance</i> E. <i>Specificity</i>	absolute, internally attrib., stable	simple, internally attrib., stable need is unmet, observation	
		Self-Soothing	Assertive Anger	Hurt/Grief
<i>Emotion</i>	A. <i>Emotion/Action</i>	caring/tenderness/nurturing reflexive, imaginary, attributed	Anger: self/rights -affirmation entitlement, boundary setting	Hurt: recognizing one's hurt Grief: sadness over loss
<i>Involvement</i>	B. <i>Arousal</i> C. <i>Voice</i>	emotional; focused	moderate-high, >3 emotional; focused	high, >4 emotional; focused
<i>Meaning</i>	D. <i>Stance</i> E. <i>Specificity</i>	adaptive & healthy action refers to Self	agentive, entitlement position clear & specific	wound Impact/Say goodbye clear & specific

con't

	Mixed/Uncodable	End Coding
A.	Presence of emotional state • not sufficient info for id • no 2 coherent statements • potential codes, w no certainty	Absence of emotional state • drop in arousal, and evocativeness
B.	A code must be made for continuity	• change in topic, not evocative OR
C.	List potential codes	• change in level of analysis, not evocative

- I.e.
- o Process interrupted,
 - o Blending states.

- I.e.
- o Psycho-educational discussions,
 - o Unfocused intellectualization,
 - o Humour dissipates a state of high arousal,
 - o therapist begins to end the session.

Start: 

Code:	GD								
Note:	Hurt, helpless								

Note: codes will be easiest recorded in a vertical fashion, so that quotations can be given as notes etc.

Reliability

Aligning CAMS Ratings for Reliability

Following is a detailed description of the rules by which independent ratings were aligned for reliability purposes in the absence of inherently fixed anchors. This procedure protocol also identifies the different sources of error or agreement in reliability. Aspects of this alignment process are illustrated in figure 2. The two independent raters are referred to as “A” and “B”. There are four rules in this procedure:

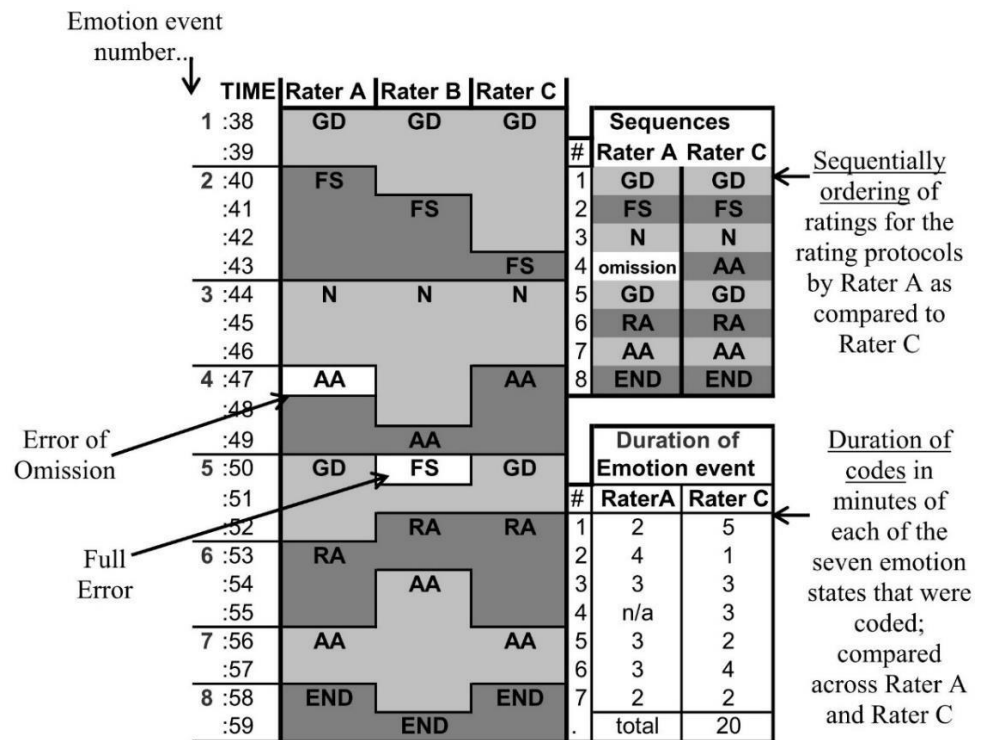
1. Rater A and rater B’s codes are matched according to sequence, which is measured in 30 second intervals.
 - a. A and B are matched in time on the marker code (Global Distress), which they make, confirming the initial event selection for Global Distress.
 - b. If they agree on the subsequently ordered codes then those codes are all counted as agreements.
2. There are three types of errors (see figure 2)
 - a. If a code is missing by rater A in relation to B it is an error of omission.
 - b. If a code is superfluously made by rater A in relation to B it is an error of commission.
 - Note that omissions and commissions are essentially the same error depending on who is the primary rater (i.e. depending on the perspective of A vs. B). For this reason I will simply refer to both of these as error of omission.

- c. If A and B each have a commission/omission error in the same sequential order relative to one another this is considered to be a full (pure) error. A full error is when A and B have coded the same sequentially occurring event in different ways. In other words, the raters disagree on the event in question (rather than it having been overlooked or overcoded, which is omission or commission, respectively). This type of pure error is best examined using a confusion matrix (an example follows, see figure 4).
 - Note that if there is agreement subsequent to an error of omission then one of the sequential ratings lacks a “placeholder” and the two ratings are misaligned (even though they may demonstrate some accordance). Thus, any codes that match following an omission must be put into question until the ratings can be re-aligned. The tools used to reinitiate the alignment of codes are the matching time rule and the rationalist analysis of continuity (the next two rules).
3. Aligning rating of A and B is always done within the constraints of a matching time rule. There must be a minimum of one minute overlap between A and B’s codes for one to assume that the two raters are coding the same event. This rule is especially useful following an omission of one rater’s codes relative to the other’s codes, and when the sequential order of coded events is lost. However, this rule is also used as a guiding principle to all code alignment.

4. Moreover, the continuity of codes is also being checked using a rational analysis of continuity. This is possible because some affective-meaning codes are more likely to be confounded than others. Primary examples of this are (i) Negative Evaluation and Fear/Shame, or (ii) Assertive Anger and Rejecting Anger. For example, if rater A were to code a particular event at a particular time as Assertive Anger and rater B were to code a particular event at around the same time as Rejecting Anger, it would be considered a full error for the purposes of reliability. This is because the two raters have made different ratings at the same point in their sequence of codes and it is fair to assume from a rationalist perspective that they were coding the same event. This continuity analysis, like the matching time rule, allows rating alignment to continue despite interruptions (i.e. errors).

Reliability. Finally, reliability between independent rater was measured by agreement in the ratings of A vs. B.

Figure 2: An example of aligned ratings
of three hypothetical raters



Two of the three aspects of reliability measurement (sequential reliability and duration reliability) were produced using comparative tables similar to those on the right of this figure.

Reliability of the Measure

Of the total sample of 34 cases used in the doctoral research of Pascual-Leone (2005), 27 cases (79.4%) were randomly selected and independently re-rated in their entirety by a second rater for the purposes of establishing reliability. With respect to the number of actual codes made during data collection 352 out of 395 individual codes (89.1%) were re-rated. Ratings produced by continuous cross-classification must be aligned (see preceding section) and then require different forms of reliability depending on how data are being used. First, the continuous nature of ratings required that independent rater agreement on what constitutes a discrete *change in state* be demonstrated; this is referred to as the *unitization of observations* and reached a percent agreement of 85.9% (see figure 3). Second, the classification of eleven different codes in the measure required that the *sequential ordering* of those classes also be reliable in the ratings; which they were, Cohen's $k = 0.91$ (see figure 4). Third, the continuous nature of ratings required that an agreement be demonstrated between independent raters on the *duration of any given unit* of coding and this was also show to be high, $r = 0.76$. According to Fleiss (1981), levels of agreement above .75 can be considered excellent agreement above chance. Thus, the measure demonstrated high overall reliability.

Figure 3: Agreement about unitization of observations

Rater A	Rater B	
	Event	Not
	Event	265
A	No	43

Estimated total events: 308.5;

Agreement: 85.90%

Total Agreements / [(Total Agreements) + (Omissions of A + omissions of B)/2]
This agreement formula was developed by Dr. F. F. Strayer at the LESC. Note that a Kappa statistic cannot be calculated for unitization because the frequency of events left uncoded by both raters is unknown.

Figure 4: Confusion matrix to examine pure errors

Rater A	Rater B													sub-totals	Base rates
	GD	FS	NE	N	RA	AA	SS	HG	A&L	End	Relief	Mix	Omi		
1 Global Distress	61			1				2				1	8	73	24%
2 Fear/Shame	1	38										1	5	45	15%
3 Negative Evaluation	1	3	21									1	4	30	10%
4 Need				32									10	42	14%
5 Rejecting Anger		1			20	2		1					6	30	Total 10%
6 Assertive Anger				1	1	12							1	15	# 5%
7 Self Soothing	1						8				1	4		14	codes 5%
8 Hurt/Grief		1					1	23				6		31	made 10%
9 Acceptance & let go														0	by 0%
10 End Code										24				24	Rater 8%
11 Relief										1	2			3	A: 1%
12 Mixed/Uncodable	1											1		2	306 1%
13 Omission	12	8	2	7	7	2	3	2						42	
sub-total:	77	51	23	41	28	16	12	28	0	25	3	4	44	# of observations:	
Total # of codes by Rater B:													308	Absolute obs. 352	
Coding base rates by rater:	25%	17%	7%	13%	8%	5%	4%	9%	0%	8%	1%	1%		Mutual obs.. 260	

NB: Marginal homogeneity is found by comparing raters' base rates.

Representative Proportion		
Full Study N =	Reliability sample	Proportion
# Cases 34	27	79.4%
# Codes 395	352	89.1%

Table 1

Mann Whitney U test results of proportional tests for CAMS codes across outcome groups.

CAMS Coded Emotion State Category Compared Distributions		
Null Hypothesis	Sig.	Decision
The distribution of FEAR/SHAME is the same across categories of therapy.	.175	Retain the null hypothesis.
The distribution of REJECTING ANGER is the same across categories of therapy.	.118tr	Retain the null hypothesis?
The distribution of NEGATIVE SELF-EVALUATION is the same across categories of therapy.	.475	Retain the null hypothesis.
The distribution of NEED EXPRESSION is the same across categories of therapy.	.077tr	Retain the null hypothesis?
The distribution of RELIEF is the same across categories of therapy.	.497	Retain the null hypothesis.
The distribution of HURT/GRIEF is the same across categories of therapy.	.040	Reject the null hypothesis.
The distribution of ASSERTIVE ANGER is the same across categories of therapy.	.691	Retain the null hypothesis.
The distribution of SELF-SOOTHING is the same across categories of therapy.	.496	Retain the null hypothesis.
The distribution of 'GLOBAL DISTRESS' is the same across categories of therapy.	.118tr	Retain the null hypothesis?
The distribution of ACCEPTANCE AND AGENCY is the same across categories of therapy.	.846	Retain the null hypothesis.

Note: Distribution of CAMS codes was tested using Mann-Whitney U tests. Bolded results are significant; $p < .13 = tr$ was considered a trend towards significance

Table 2

Mann Whitney U test results of proportional tests for emotion schematic categories across outcome groups.

CAMS Coded Emotion State Category Compared Distributions		
Null Hypothesis	Sig	Decision of Mann Whitney U test
The distribution of SECONDARY EMOTION is the same across categories of therapy.	.063tr	Retain the null hypothesis?
The distribution of PRIMARY MALADAPTIVE EMOTION is the same across categories of therapy.	.131	Retain the null hypothesis.
The distribution of PRIMARY ADAPTIVE EMOTION is the same across categories of therapy.	.427	Retain the null hypothesis. (
Distribution of UNCODABLE is the same across categories of therapy.	.219	Retain the null hypothesis.

Note: Distribution of CAMS codes was tested using Mann-Whitney U tests. Bolded results are significant; Greyed ps note trends to significance with $p < .13$,

Table 3

Mann Whitney U test results of proportional tests for CAMS codes across client-centered and emotion-focused therapy groups.

CAMS Coded Emotion State Category Compared Distributions		
Null Hypothesis	Sig	Decision of Mann Whitney U test
The distribution of FEAR/SHAME is the same across categories of therapy.	.647	Retain the null hypothesis.
The distribution of REJECTING ANGER is the same across categories of therapy.	.491	Retain the null hypothesis.
The distribution of NEGATIVE SELF-EVALUATION is the same across categories of therapy.	.857	Retain the null hypothesis.
The distribution of NEED EXPRESSION is the same across categories of therapy.	.124 tr	Retain the null hypothesis?
The distribution of RELIEF is the same across categories of therapy.	.620	Retain the null hypothesis.
The distribution of HURT/GRIEF is the same across categories of therapy.	.009	Reject the null hypothesis.
The distribution of ASSERTIVE ANGER is the same across categories of therapy.	.012	Reject the null hypothesis.
The distribution of SELF-SOOTHING is the same across categories of therapy.	.680	Retain the null hypothesis.
The distribution of 'GLOBAL DISTRESS' is the same across categories of therapy.	.055	Retain the null hypothesis?
The distribution of ACCEPTANCE AND AGENCY is the same across categories of therapy.	.719	Retain the null hypothesis.

Note: Distribution of CAMS codes was tested using Mann-Whitney U tests. Bolded results are significant. Greyed ps note trends to significance with $p < .13$,

Table 4

Mann Whitney U test results of proportional tests for emotion schematic categories across client-centered and emotion-focused therapy groups.

CAMS Coded Emotion State Category Compared Distributions		
Null Hypothesis	Sig	Decision of Mann Whitney U test
The distribution of SECONDARY EMOTION is the same across categories of therapy.	.270	Retain the null hypothesis.
The distribution of PRIMARY MALADAPTIVE EMOTION is the same across categories of therapy.	.892	Retain the null hypothesis.
The distribution of PRIMARY ADAPTIVE EMOTION is the same across categories of therapy.	.082tr	Retain the null hypothesis.
Distribution of UNCODABLE is the same across categories of therapy.	.734	Retain the null hypothesis.

Note: Distribution of CAMS codes was tested using Mann-Whitney U tests. Bolded results are significant; Greyed p's note trends to significance with $p < .13$,

Table 5

Occurrence and number of clients exhibiting THEME Detected differences in found patterns between outcome groups for CAMS Codes.

Repeated Pattern Found	Total Number of the coded patterns found	Direction of found difference with p value	Good outcome n = 32		Poor outcome n = 22	
			Frequency of pattern = # of occurrences in the data	# of clients, i.e. n = out of 32/ % percentage of clients	Frequency of pattern = # of occurrences	# of clients n out of 22/ % of clients
Hurt/Grief	134	Good > Poor p = 0.001	104	11/34%	30	6/27%
Assertive Anger	120	Good > Poor p = 0.01	90	9/28%	30	8/36%
Fear/shame followed by Need	140	Good > Poor p = 0.01	104	19/59%	36	7/32%
Fear/shame	656	Good > Poor p = 0.0005	446	28/87%	210	17/77%
Relief	210	Poor > Good p = 0.005	96	16/50%	114	12/54%
Rejecting Anger	238	Poor > Good p = 0.01	112	17/53%	126	16/72%

Note: This table shows the CAMS pattern and the frequency of occurrences in each outcome group, all patterns are significant. Pattern differences expressing relief during EEs were significant; later analyses excluded relief from the primary adaptive emotion category for theoretical reasons.

Table 6

Occurrence and number of clients exhibiting THEME Detected differences in found patterns between therapy groups for CAMS Codes.

Repeated Pattern Found	Total Number of the coded patterns found	Direction of found difference with p value	EFT, n = 24		CCT, n = 30	
			Frequency of pattern = # of occurrences in the data	# of clients, i.e. n = out of 24/ percentage of clients	Frequency of pattern = # of occurrences	# of clients n out of 30/ % of clients
Hurt/grief	134	EFT>CCT p = .0001	106	12/50%	28	5/ 17%
Assertive anger	120	EFT>CCT p = .01	104	12/50%	16	5/17%
Need expression	206	EFT>CCT p = .007	130	15/63%	76	14/ 47%
Relief	210	CCT > EFT p= .005	70	13/54%	140	15/50%
Fear/shame	656	CCT > EFT p= .005	252	20/ 83%	404	25/ 83%

Note: This table shows the CAMS pattern and the frequency of occurrences in each therapy group, all patterns are significant. Pattern differences expressing relief during EEs were significant; later analyses excluded relief from the primary adaptive emotion category for theoretical reasons.

Table 7

Occurrence and number of clients exhibiting THEME Detected differences in found CAMS Codes patterns between outcomes in clients who received CCT

		CCT n = 30			
		Good Outcome n = 13		Poor Outcome n = 17	
Repeated Pattern Found	Total Number of the coded patterns found	Frequency of pattern = # of occurrences	# of clients n out of 13/ % of clients	Frequency of pattern = # of occurrences	# of clients n out of 17/ % of clients
Fear/shame	398	232	11/85%	166	13/76%
‘global distress’	104	32	8/62%	72	15/88%
‘global distress’	103	32	8/62%	71	15/88%
Rejecting Anger	110	18	5/38%	92	12/71%
Rejecting Anger	56	10	5/38%	46	12/71%
Rejecting Anger	57	10	5/38%	47	12/71%

Note: This table shows the CAMS pattern and the frequency of occurrences in client-centered clients and outcome group, all patterns are significant. No significant differences were found between emotion-focused therapy clients.

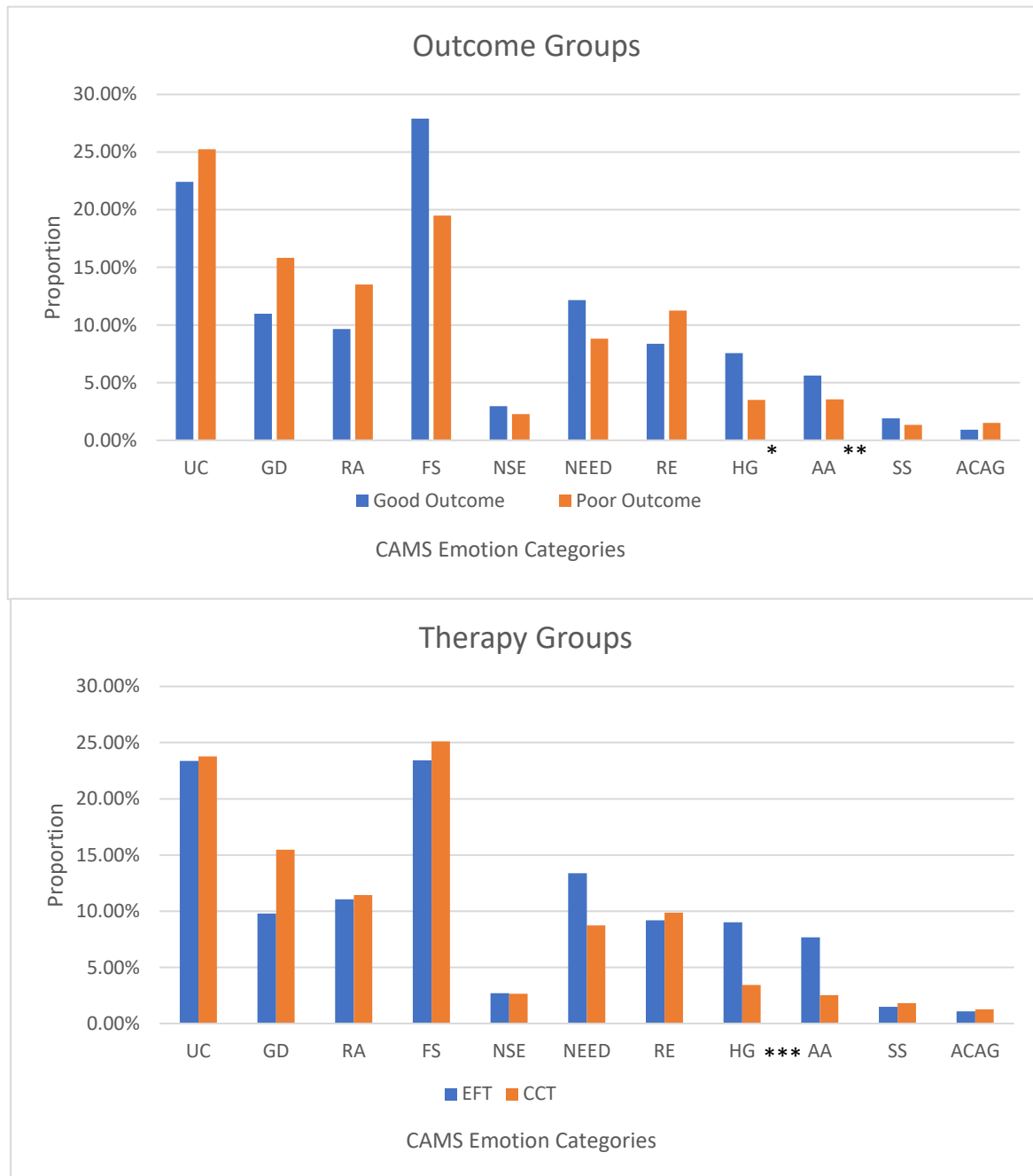
Table 8

Summary table of Mann-Whitney U and THEME analysis results for CAMS and emotion schematic codes between therapy and outcome groups.

	Mann-Whitney U	THEME		Mann-Whitney U	THEME	
	Therapy	EFT	CCT	Outcome	Good outcome	Poor outcome
CAMS	H/G & AA different	More H/G, more AA, more need	More RE, more F/S	H/G different	More H/G, more AA, more F/S-need, more F/S	More RE, more RA
ES	No Differences	More PAE, more need, PME-need-PAE	More PME	No Differences	More PME-need, PAE-need	More SE

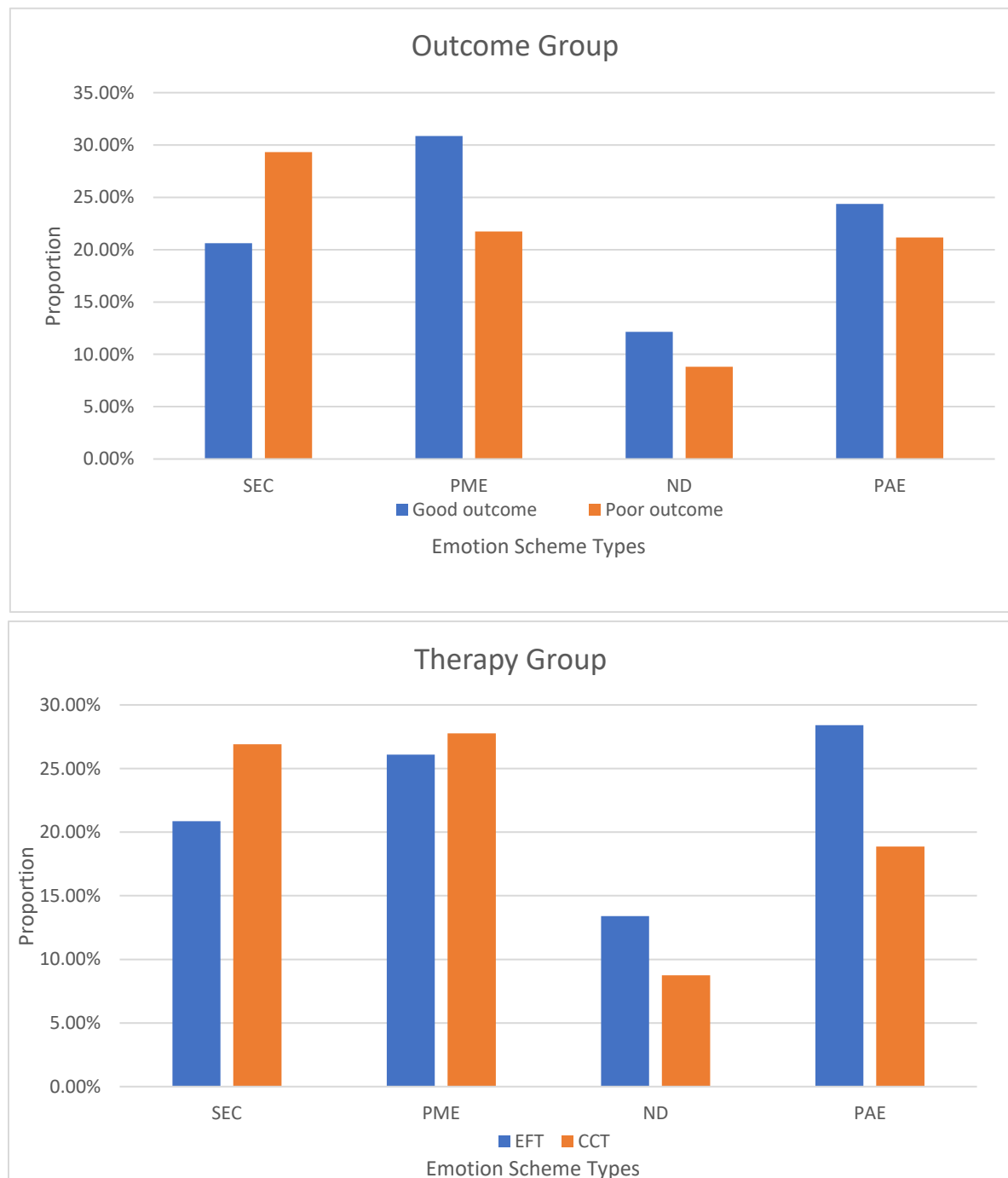
Note: H/G = hurt/grief; AA = assertive anger; need = need expression; RE = relief; F/S = fear/shame; RA = rejecting anger; PAE = primary adaptive emotion; PME = primary maladaptive emotion; SE = secondary emotion; “-“ indicate pattern sequences.

Figure 1. Bars represent the mean proportion of emotion episodes with CAMS codes for therapy and outcome groups.



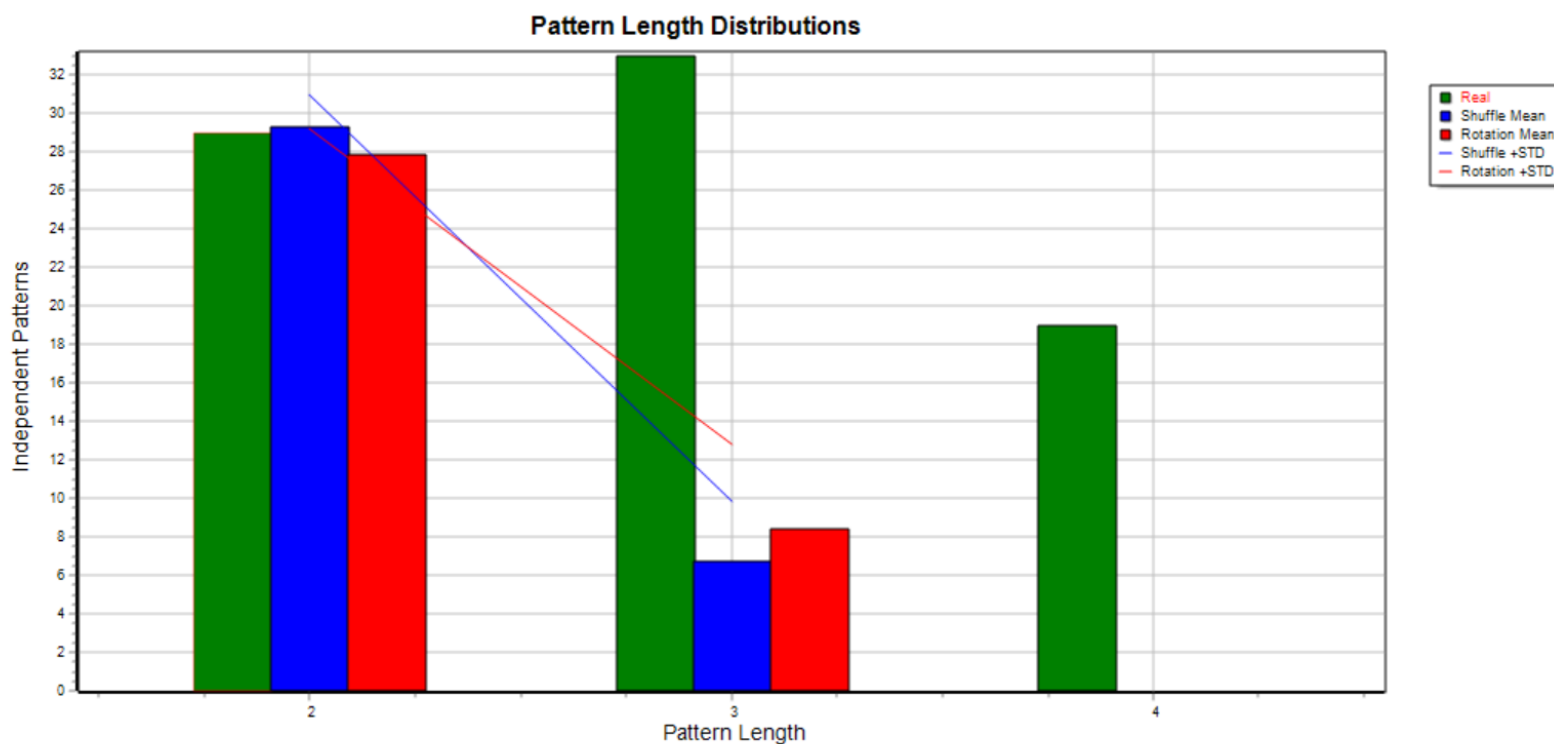
Note: UC = uncodable; GD= 'global distress'; RA= rejecting anger; FS= fear/shame; NSE= negative self evaluation; Need = need; RE = relief; HG = hurt /grief; AA= assertive anger; SS = self soothing; ACAG= acceptance and agency; HG was significantly different in therapy groups Mann Whitney U analysis at * = $p < .01$; and AA was found to differ significantly at the ** = $p < .05$ level on Mann Whitney U analysis; for outcome group analysis on the a Mann Whitney U analysis, HG was found the differ between outcome groups at *** $p = .04$.

Figure 2 The mean proportions of emotion episodes with emotion schematic codes for therapy and outcome groups.



Note: SEC = secondary emotion= GD + RA CAMS codes; PME= primary adaptive emotion= Fear/shame + NSE CAMs codes; ND= CAMS Need codes; PAE = primary adaptive emotions = HG + AA+ RE+ SS+ ACAG CAMS codes; difference in PAE showed a trend to significant differences on the Mann Whitney U analyses for therapy groups, $p = .082$.

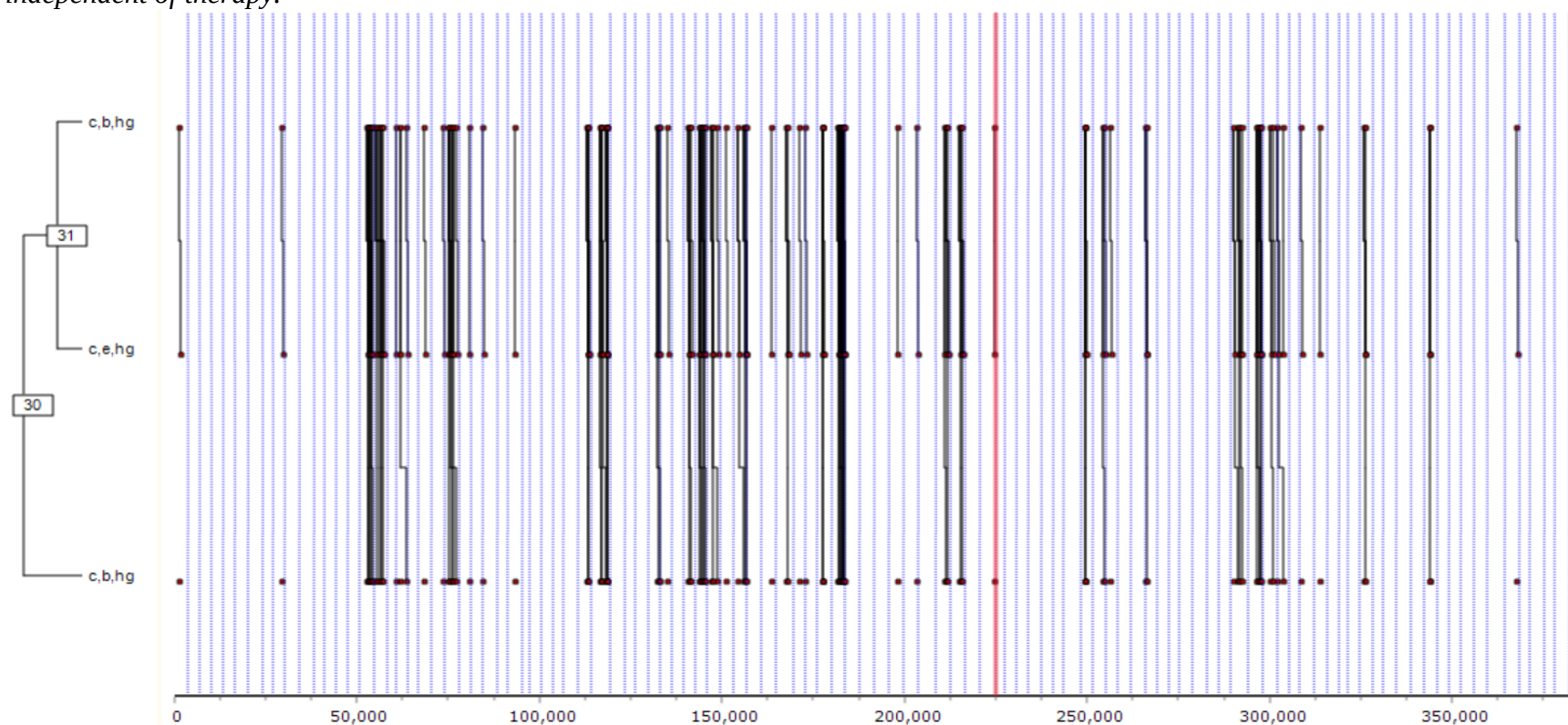
Figure 3.
Randomization procedure output from *THEME*



Note: the above figure notes that the probability of detecting a pattern of more than one emotion episode long was virtually impossible given either a rotation(red) or shuffling (blue) randomization procedure, for random data with the criteria I used. Criteria was for the pattern to occur in at least 45 times.

Figure 4.

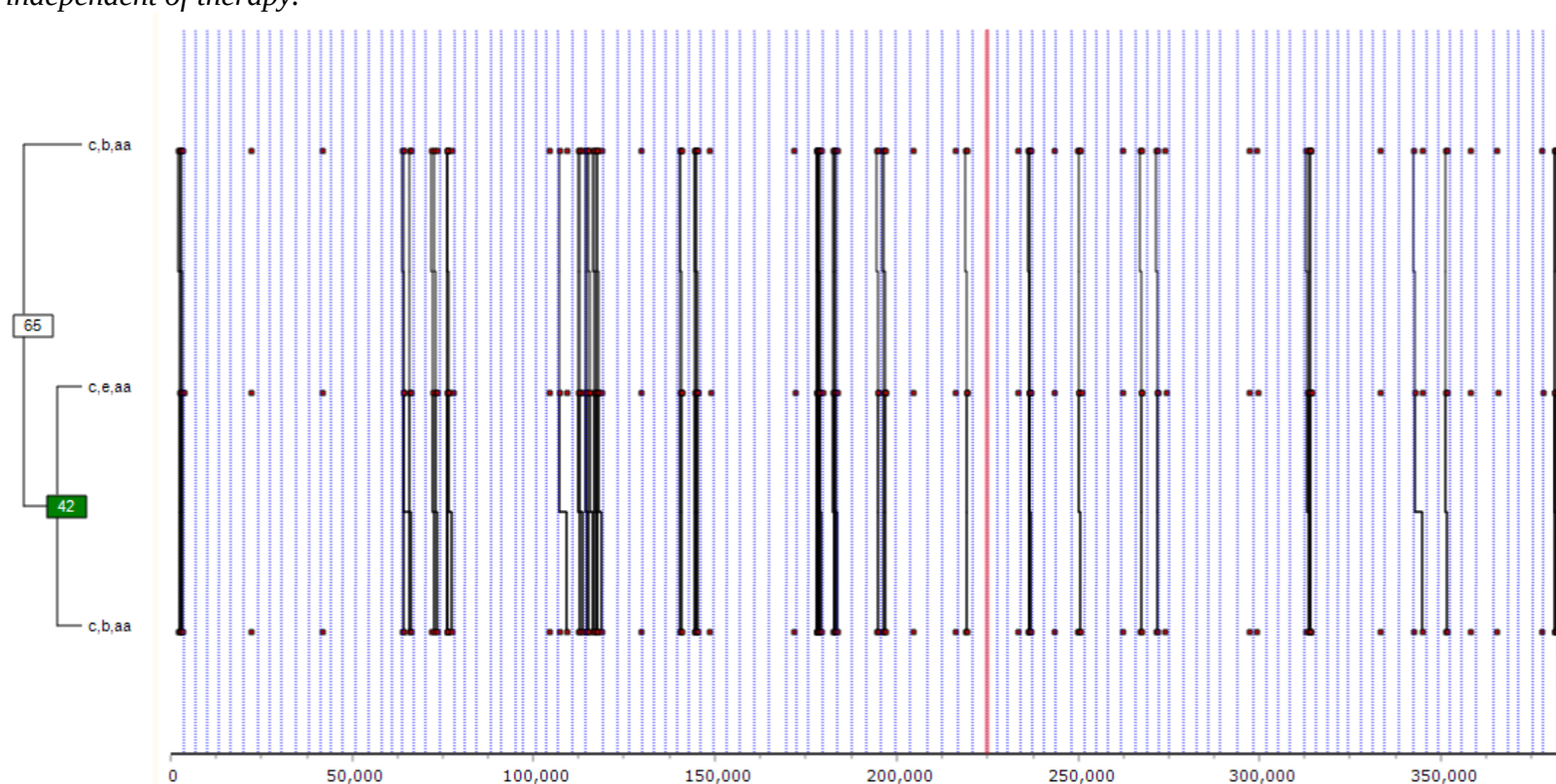
Repeated expressions of hurt/grief detected by THEME that occur with greater frequency in the good outcome group independent of therapy.



Note: Blue lines indicate a client session. Black dots indicate a CAMS code, the black lines indicate sequences of CAMS codes. The red line indicates the division between good outcome clients and poor outcome clients, good outcome clients are on the left, and poor outcome clients are on the right. THEME detected two patterns of this type.

Figure 5.

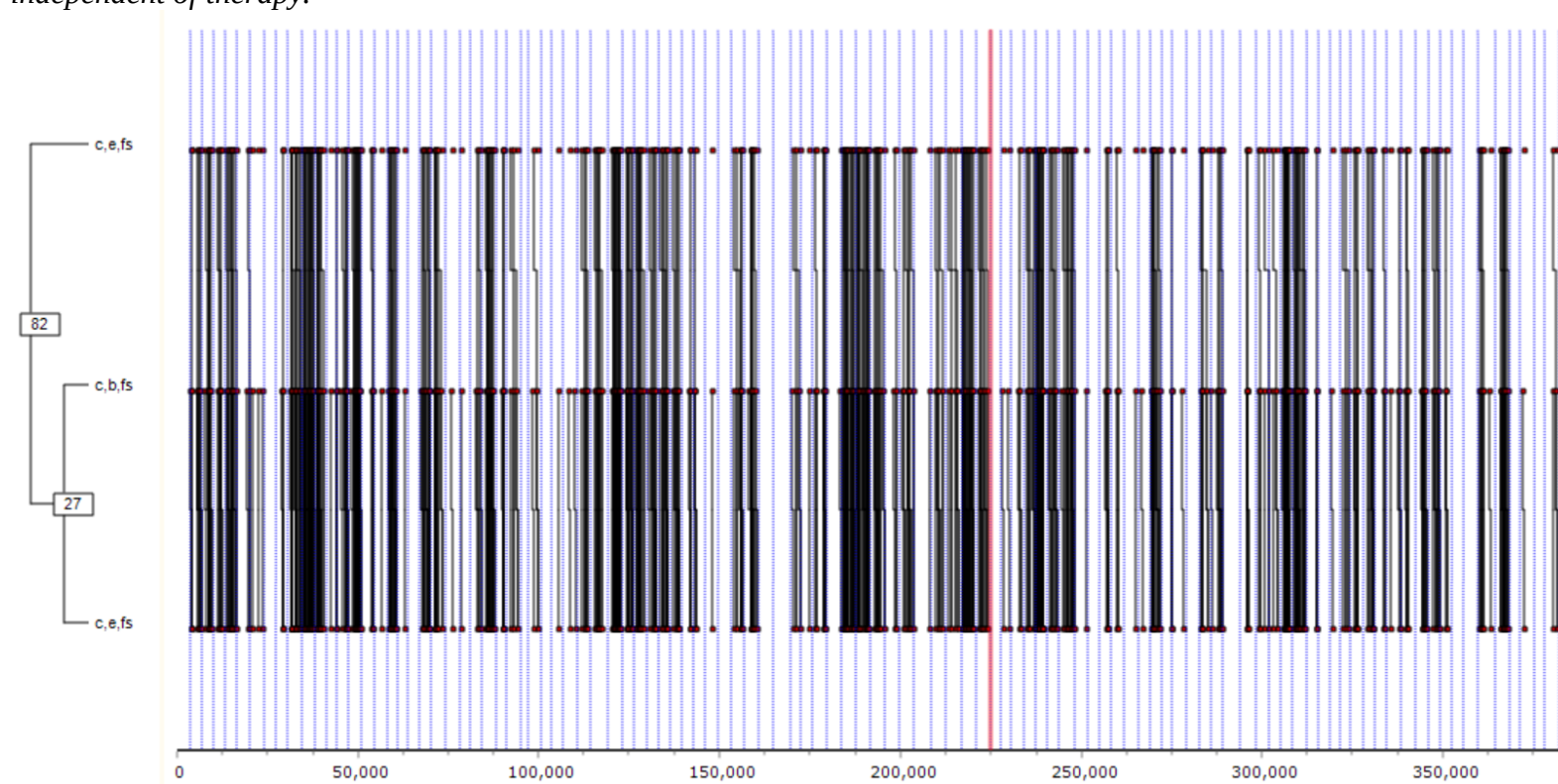
Repeated expressions of assertive anger detected by THEME that occur with greater frequency in the good outcome group independent of therapy.



Note: Blue lines indicate a client session. Black dots indicate a CAMS code, the black lines indicate sequences of CAMS codes. The red line indicates the division between good outcome clients and poor outcome clients, good outcome clients are on the left, and poor outcome clients are on the right. THEME detected two patterns of this type.

Figure 6.

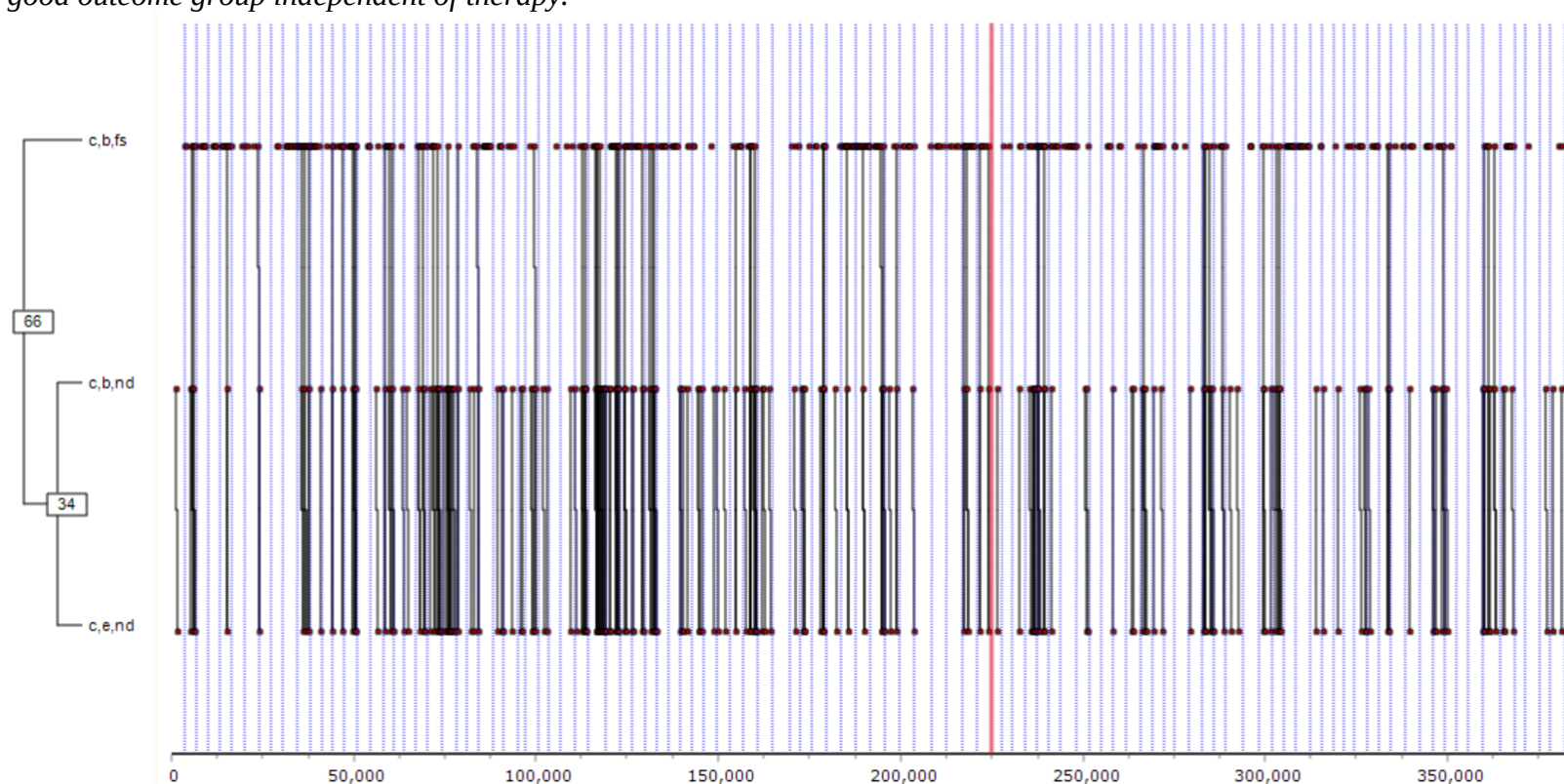
Repeated expressions of fear/shame detected by THEME that occur with greater frequency in the good outcome group independent of therapy.



Note: Blue lines indicate a client session. Black dots indicate a CAMS code, the black lines indicate sequences of CAMS codes. The red line indicates the division between good outcome clients and poor outcome clients, good outcome clients are on the left, and poor outcome clients are on the right. THEME detected two patterns of this type.

Figure 7.

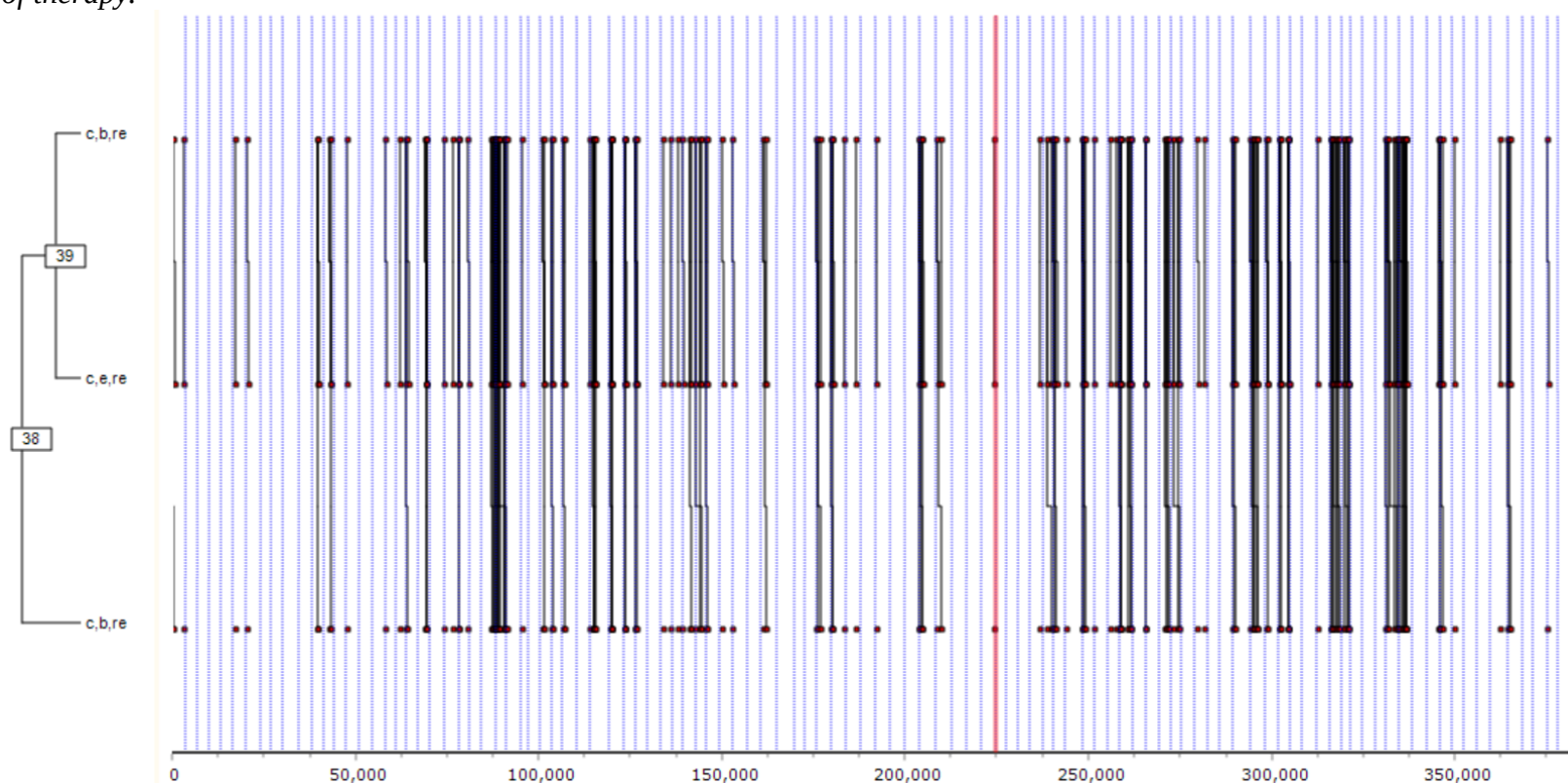
Expressions of fear/shame followed by repeated need expression detected by THEME that occur with greater frequency in the good outcome group independent of therapy.



Note: Blue lines indicate a client session. Black dots indicate a CAMS code, the black lines indicate sequences of CAMS codes. The red line indicates the division between good outcome clients and poor outcome clients, good outcome clients are on the left, and poor outcome clients are on the right. THEME detected one pattern of this type.

Figure 8.

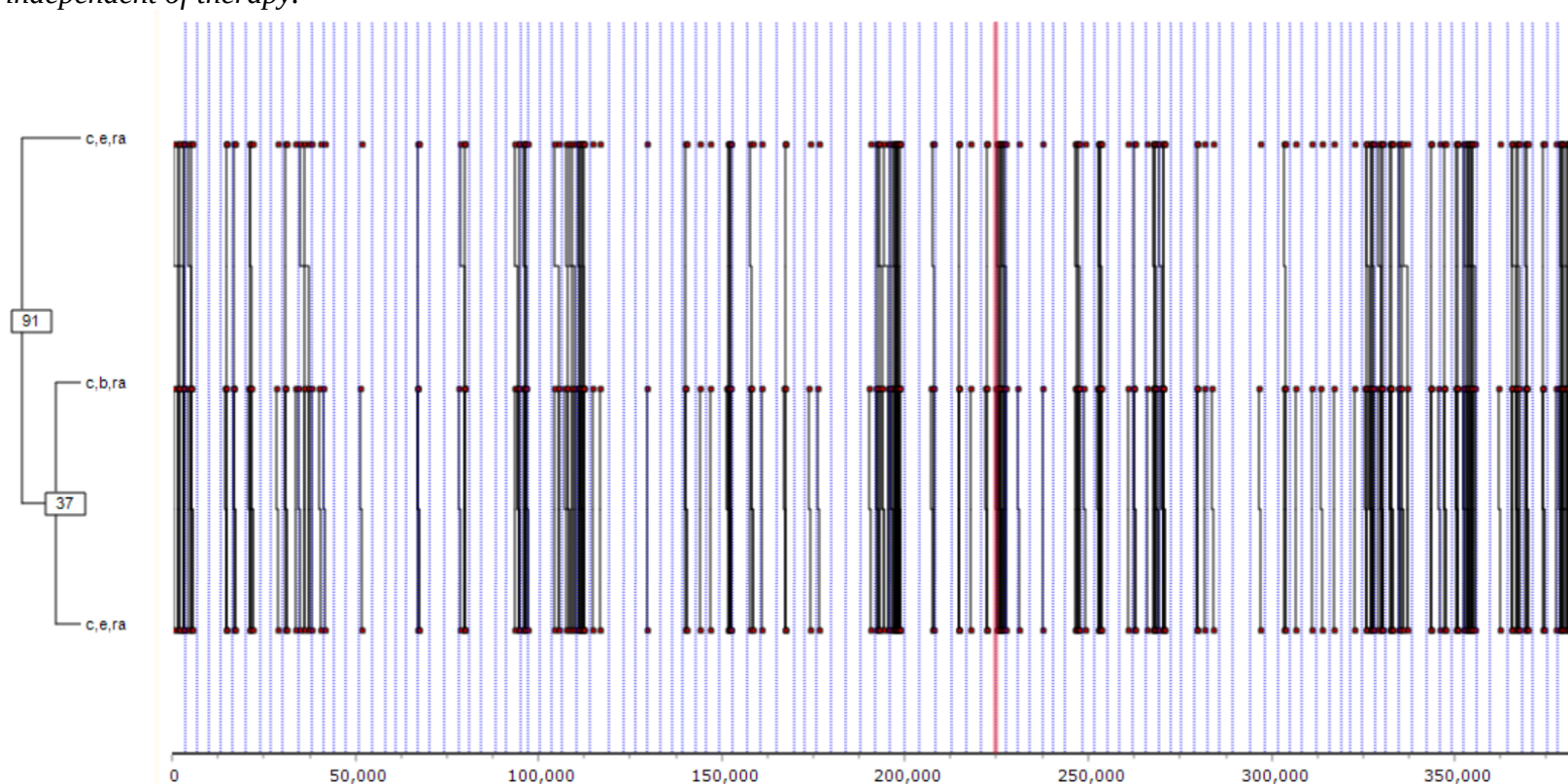
Repeated expressions of relief detected by THEME that occur with greater frequency in the poor outcome group independent of therapy.



Note: Blue lines indicate a client session. Black dots indicate a CAMS code, the black lines indicate sequences of CAMS codes. The red line indicates the division between good outcome clients and poor outcome clients, good outcome clients are on the left, and poor outcome clients are on the right. THEME detected two patterns of this type.

Figure 9.

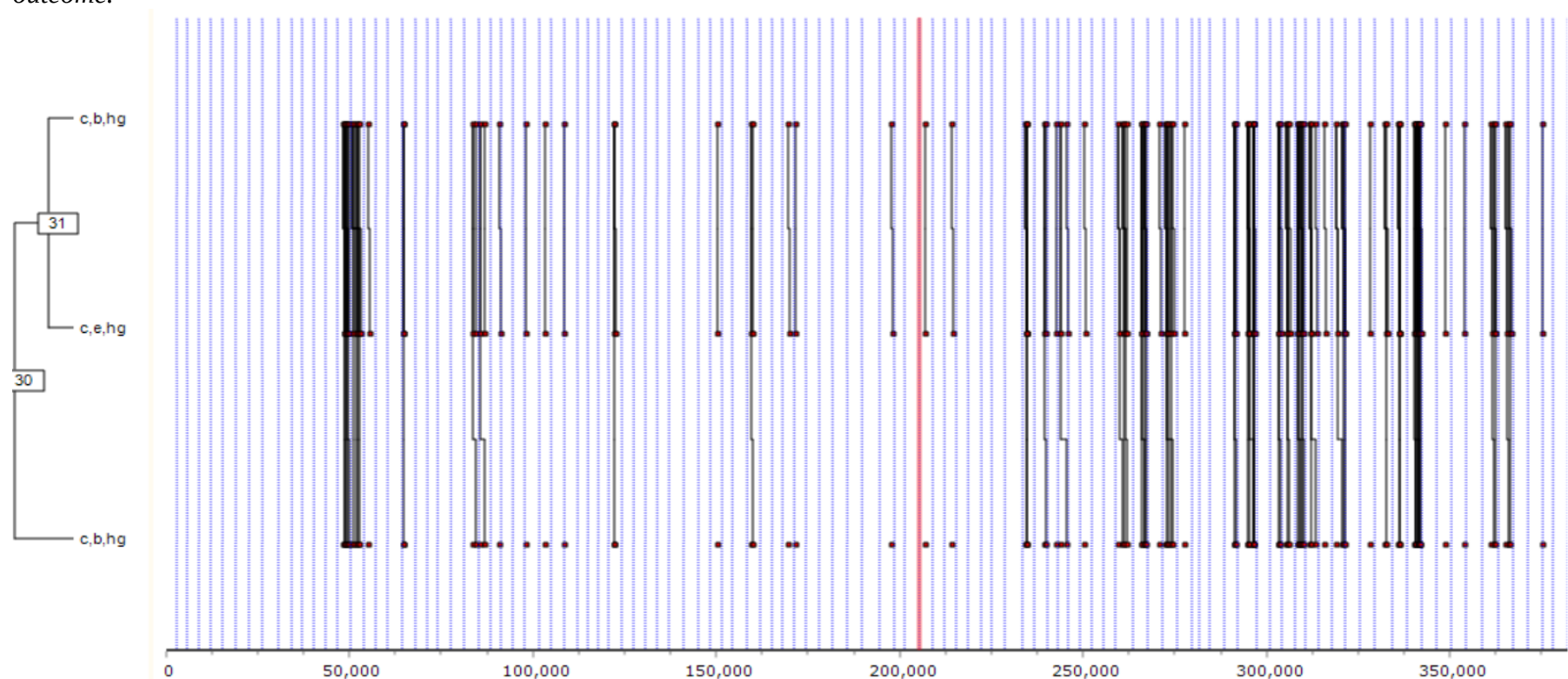
Repeated expressions of rejecting anger detected by THEME that occur with greater frequency in the poor outcome group independent of therapy.



Note: Blue lines indicate a client session. Black dots indicate a CAMS code, the black lines indicate sequences of CAMS codes. The red line indicates the division between good outcome clients and poor outcome clients, good outcome clients are on the left, and poor outcome clients are on the right. THEME detected two patterns of this type.

Figure 10.

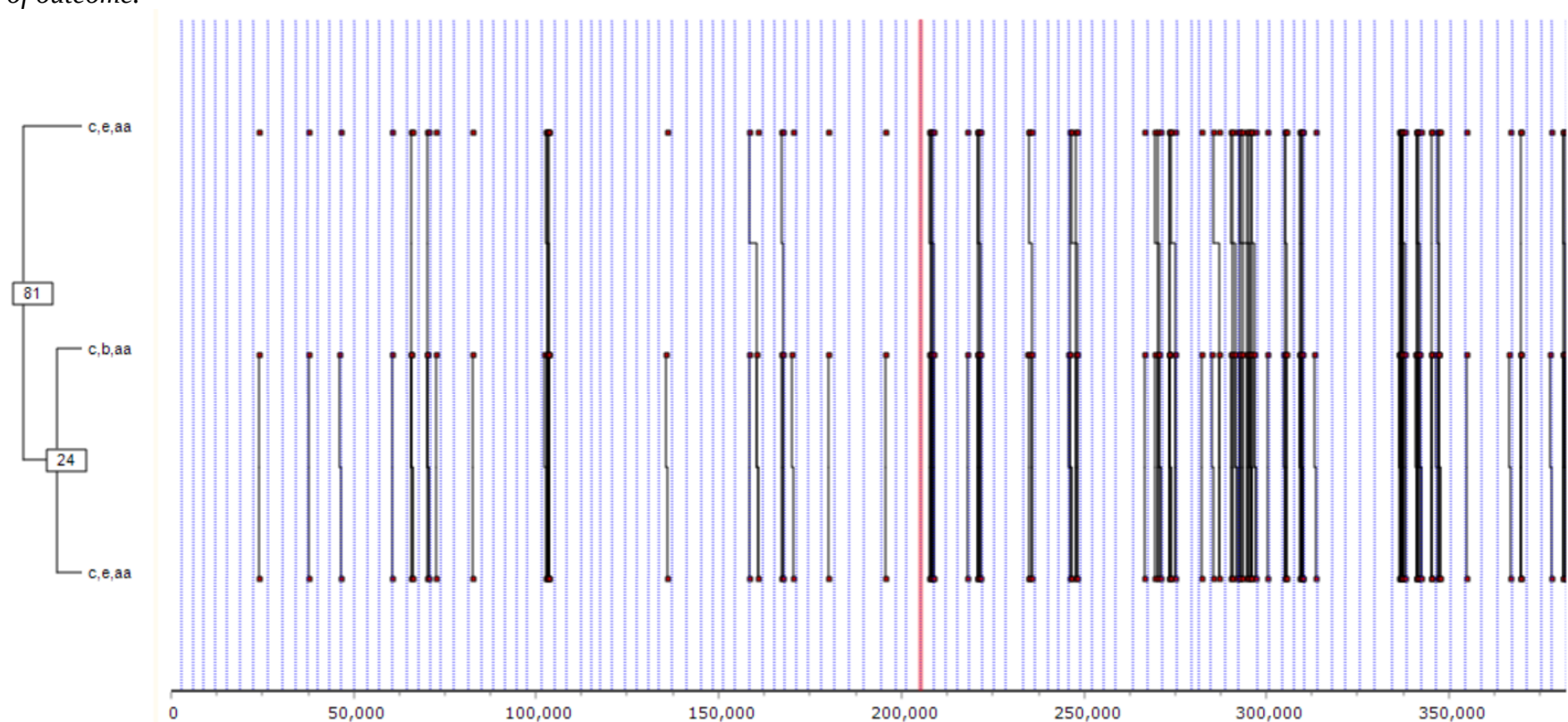
Repeated expressions of hurt/grief detected by THEME that occur with greater frequency in the EFT group independent of outcome.



Note: Blue lines indicate one client session. Black dots indicate a CAMS code, the black lines indicate sequences of CAMS codes. The red line indicates the division between CC clients and EFT clients, CC clients are on the left, and EFT clients are on the right. THEME detected two patterns of this type which this THEME output figure shows occurring more often in EFT sessions.

Figure 11.

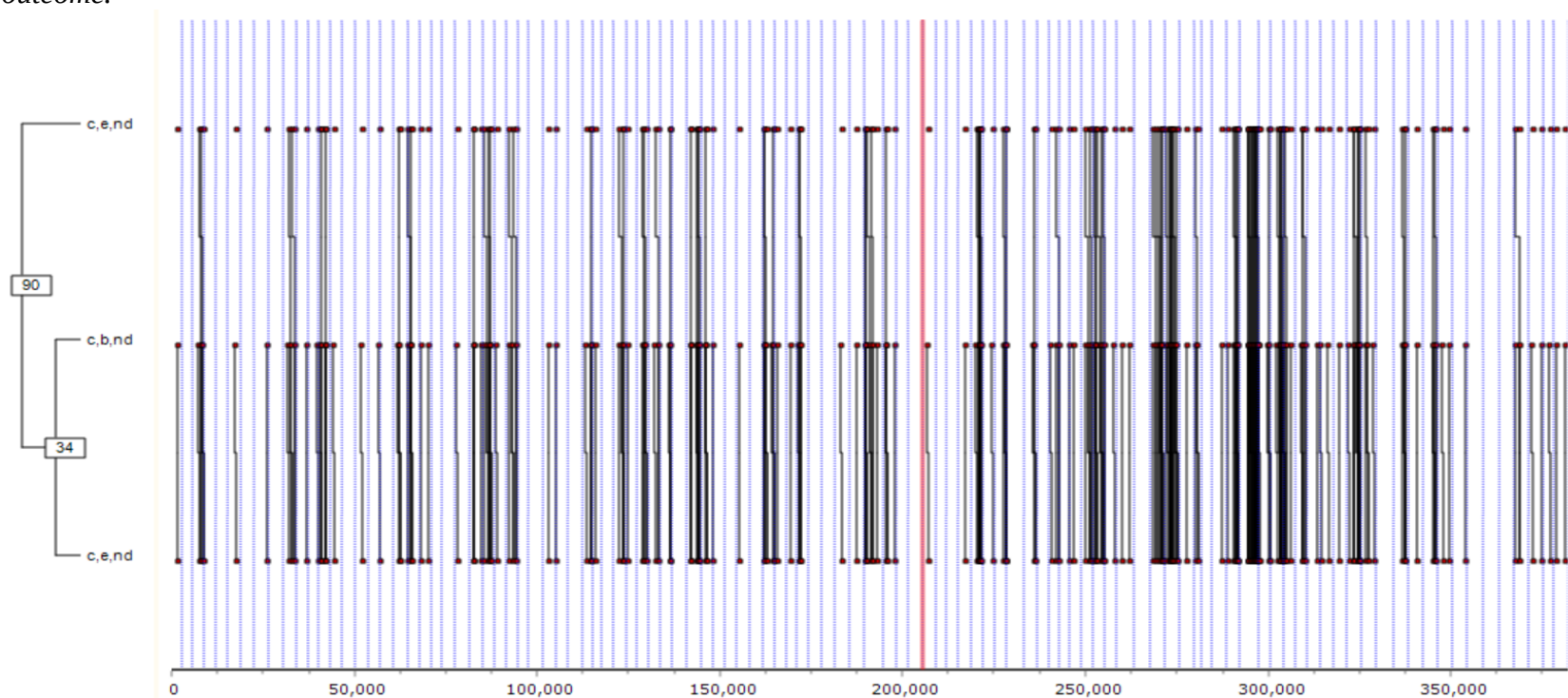
Repeated expressions of assertive anger detected by THEME that occur with greater frequency in the EFT group independent of outcome.



Note: Blue lines indicate a client session. Black dots indicate a CAMS code, the black lines indicate sequences of CAMS codes. The red line indicates the division between CC clients and EFT clients, CC clients are on the left, and EFT clients are on the right. THEME detected two patterns of this type.

Figure 12.

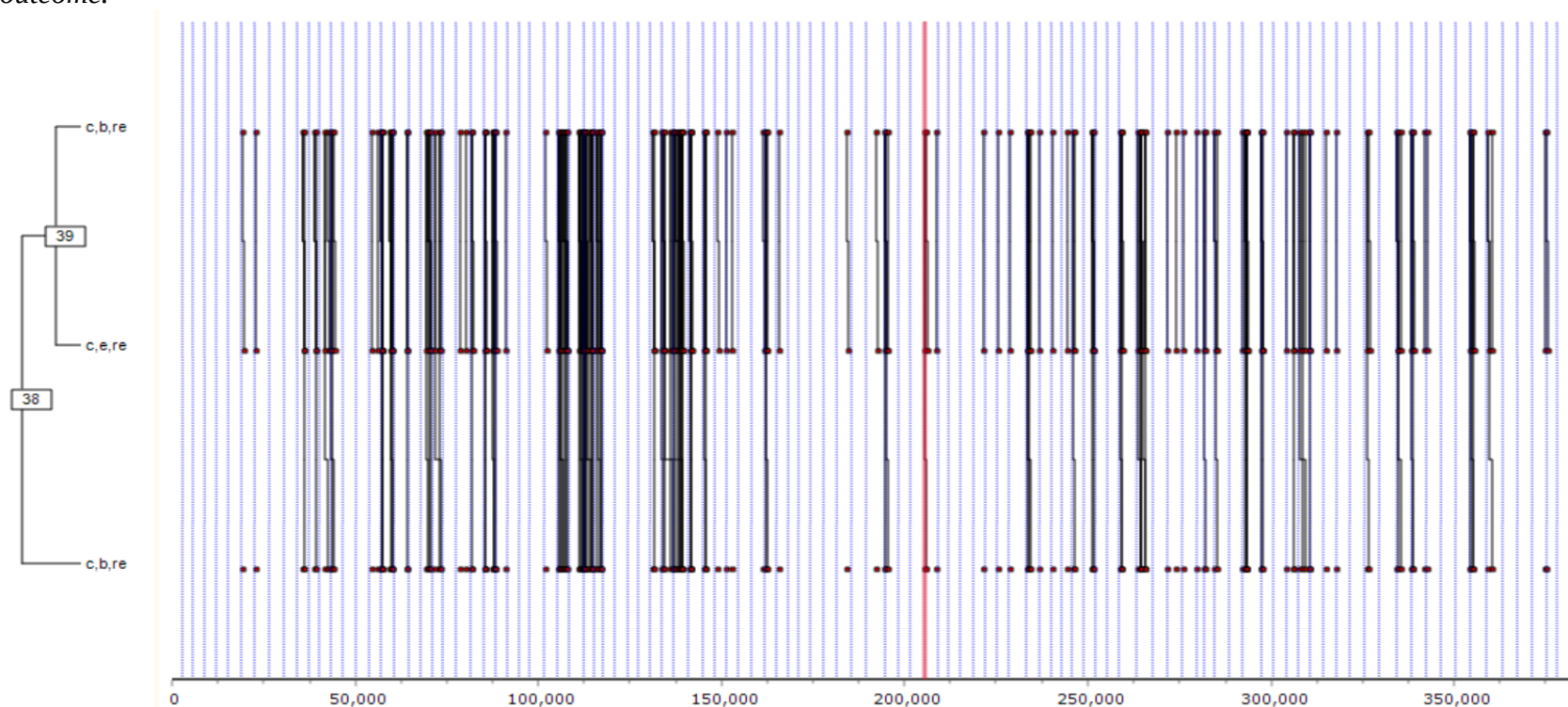
Repeated expressions of needs detected by THEME that occurred with greater frequency in the EFT group independent of outcome.



Note: Blue lines indicate a client session. Black dots indicate a CAMS code, the black lines indicate sequences of CAMS codes. The red line indicates the division between CC clients and EFT clients, CC clients are on the left, and EFT clients are on the right. THEME detected two patterns of this type that this THEME output figure also shows occurring in CCT sessions.

Figure 13.

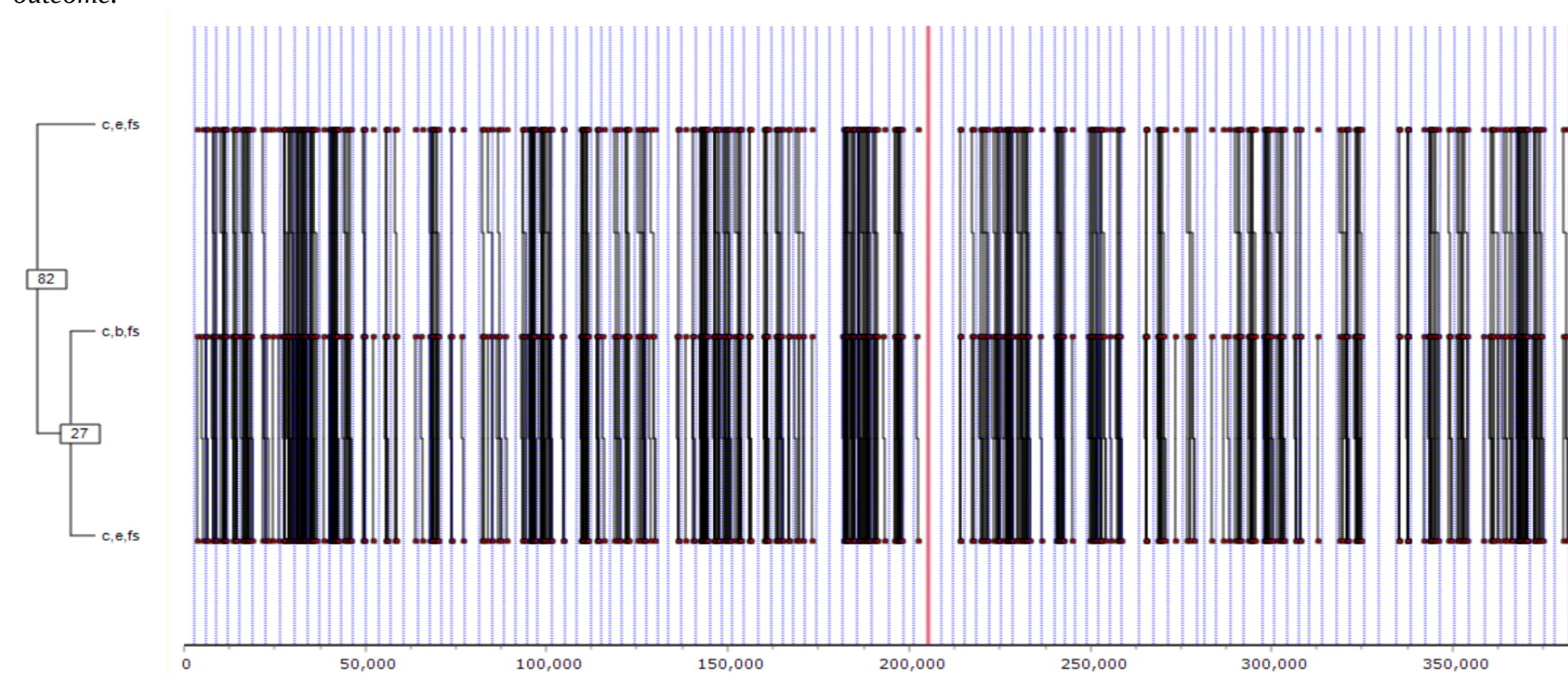
Repeated expressions of relief detected by THEME that occur with greater frequency in the CCT group independent of outcome.



Note: Blue lines indicate a client session. Black dots indicate a CAMS code, the black lines indicate sequences of CAMS codes. The red line indicates the division between CC clients and EFT clients, CC clients are on the left, and EFT clients are on the right. THEME detected two patterns of this type that this THEME output figure also shows occurring in EFT sessions.

Figure 14.

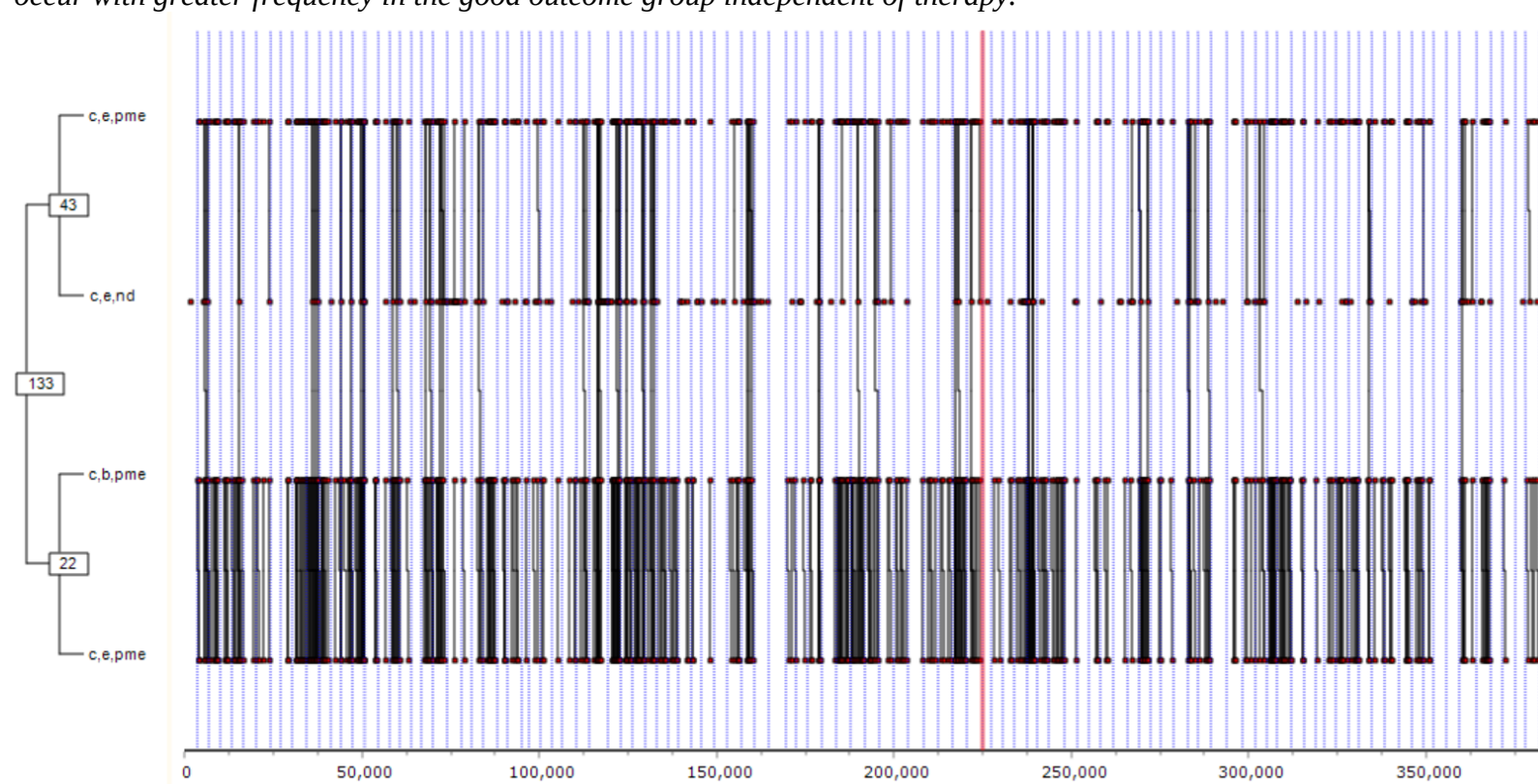
Repeated expressions of fear/shame detected by THEME that occur with greater frequency in the CCT group independent of outcome.



Note: Blue lines indicate a client session. Black dots indicate a CAMS code, the black lines indicate sequences of CAMS codes. The red line indicates the division between CC clients and EFT clients, CC clients are on the left, and EFT clients are on the right. THEME detected two patterns of this type which occurred in EFT sessions as well but more often in CCT sessions.

Figure 15.

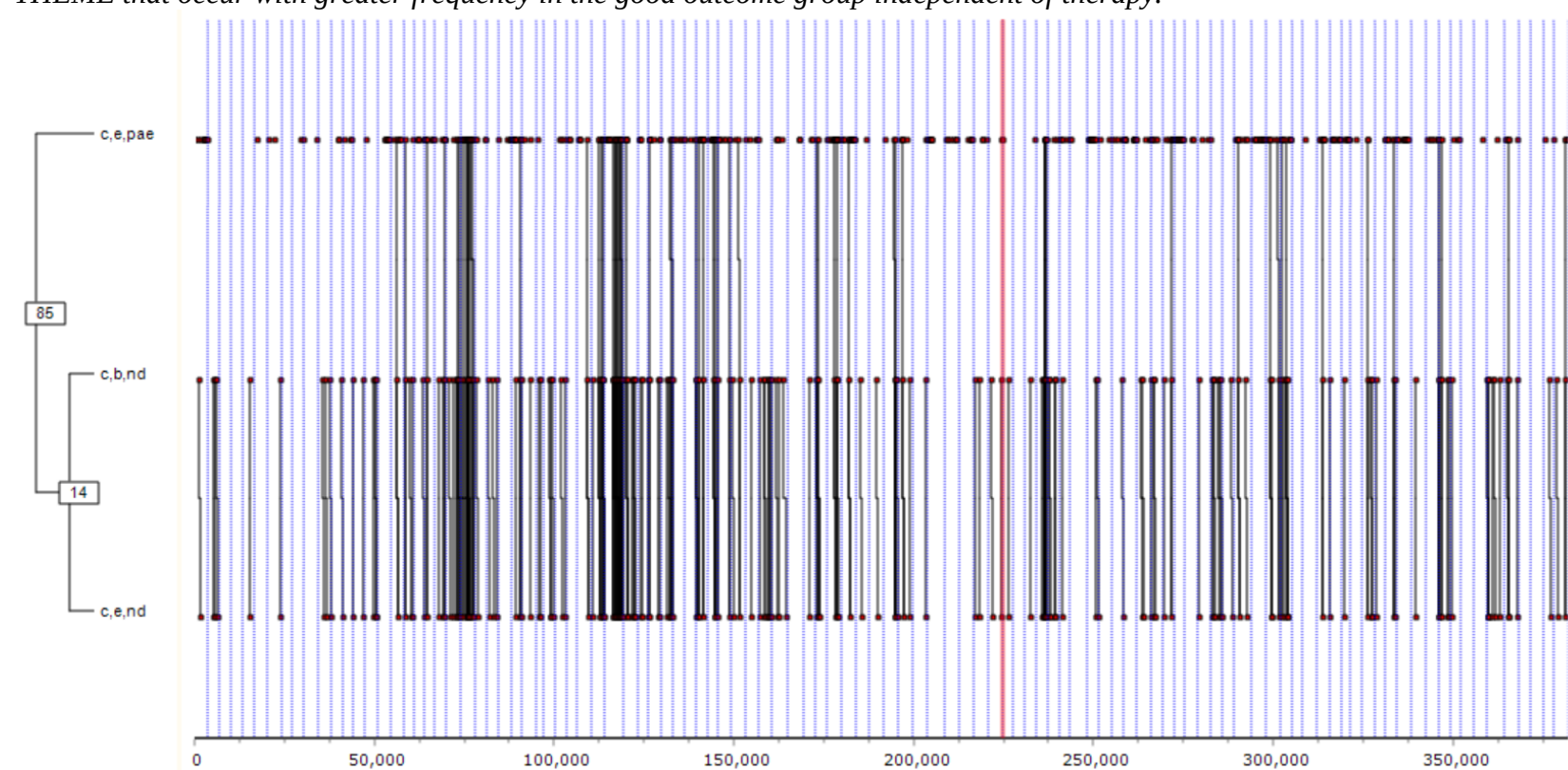
The longest found pattern of repeated expressions of primary maladaptive emotion followed by needs detected by THEME that occur with greater frequency in the good outcome group independent of therapy.



Note: Blue lines indicate a client session. Black dots indicate an emotion schematic code, the black lines indicate sequences of codes. The red line indicates the division between good outcome clients and poor outcome clients, good outcome clients are on the left, and poor outcome clients are on the right.

Figure 16.

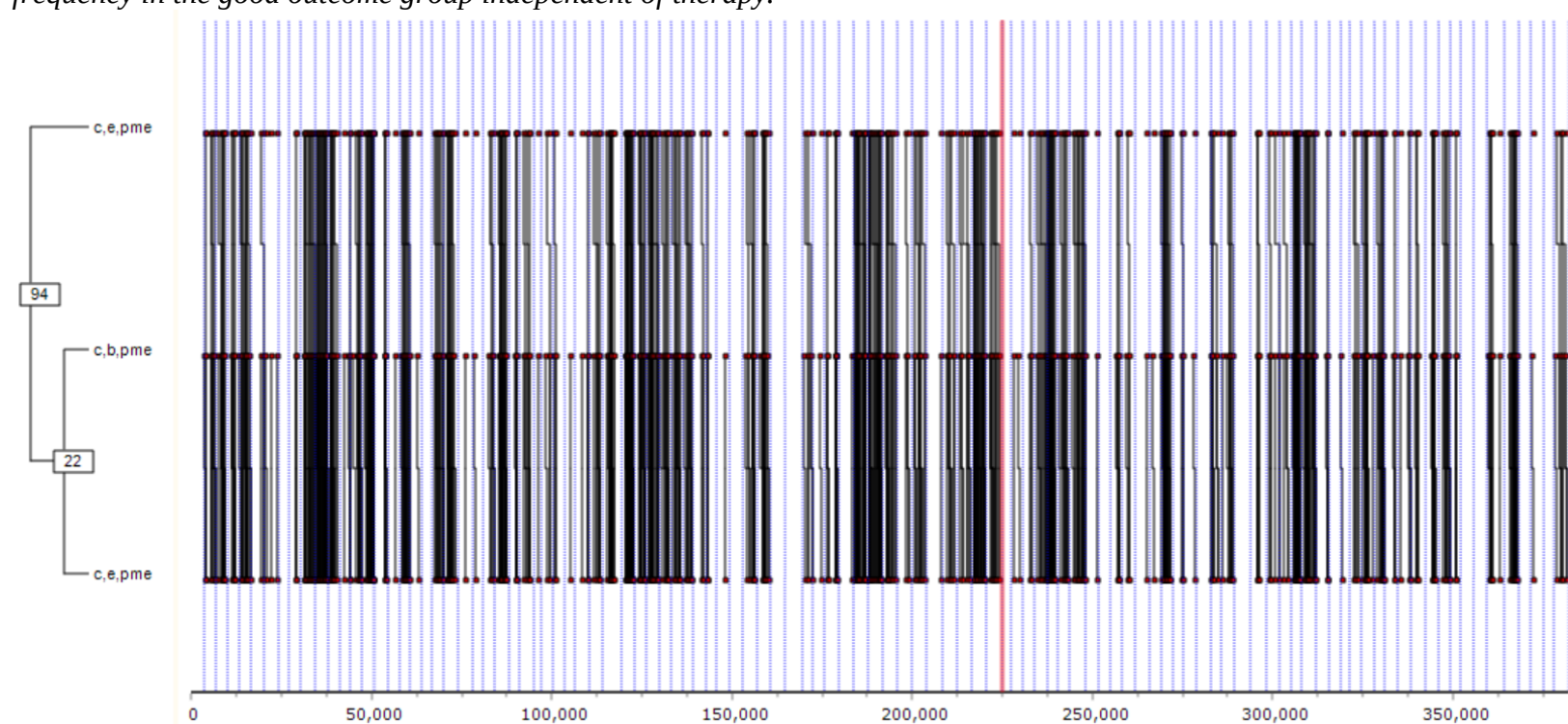
The longest found pattern of expressions of primary adaptive emotion followed by repeated expression of needs detected by THEME that occur with greater frequency in the good outcome group independent of therapy.



Note: Blue lines indicate a client session. Black dots indicate an emotion schematic code, the black lines indicate sequences of codes. The red line indicates the division between good outcome clients and poor outcome clients, good outcome clients are on the left, and poor outcome clients are on the right.

Figure 17.

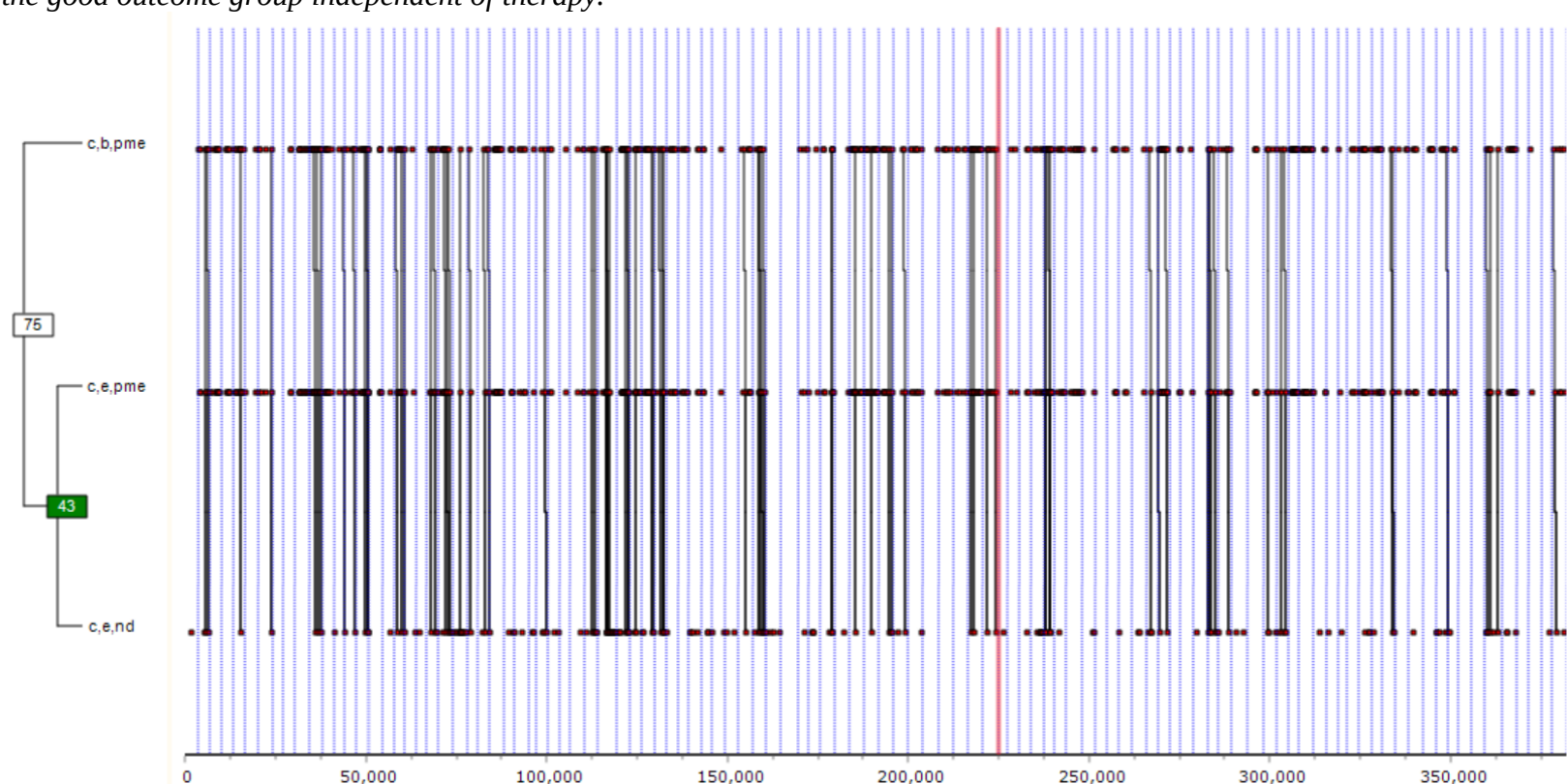
The longest found pattern of expressions of repeated primary maladaptive emotion detected by THEME that occur with greater frequency in the good outcome group independent of therapy.



Note: Blue lines indicate a client session. Black dots indicate an emotion schematic code, the black lines indicate sequences of codes. The red line indicates the division between good outcome clients and poor outcome clients, good outcome clients are on the left, and poor outcome clients are on the right.

Figure 18.

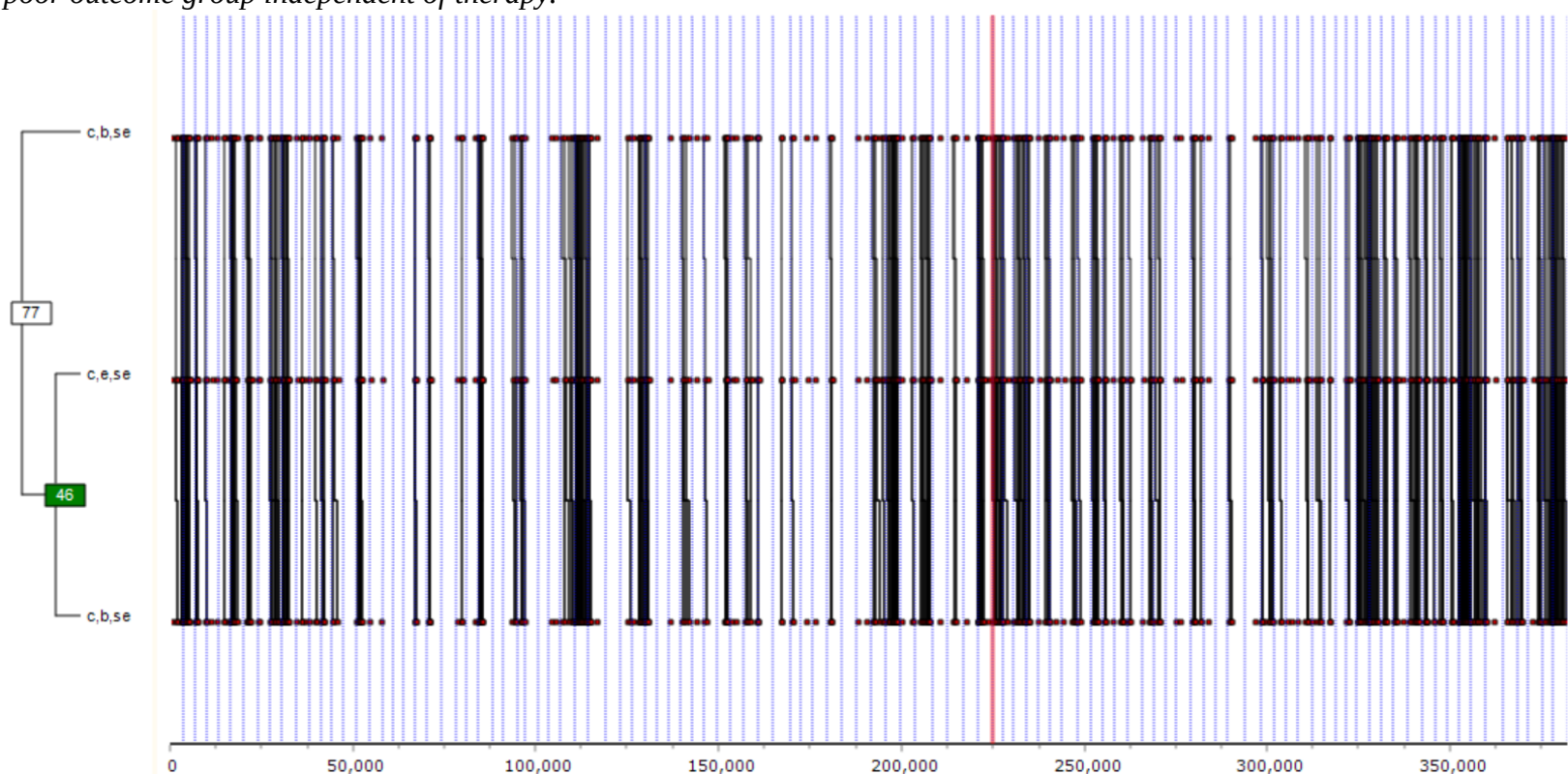
The most frequent pattern of repeated primary maladaptive emotion followed by need that occurred with greater frequency in the good outcome group independent of therapy.



Note: Blue lines indicate a client session. Black dots indicate an emotion schematic code, the black lines indicate sequences of codes. The red line indicates the division between good outcome clients and poor outcome clients, good outcome clients are on the left, and poor outcome clients are on the right.

Figure 19.

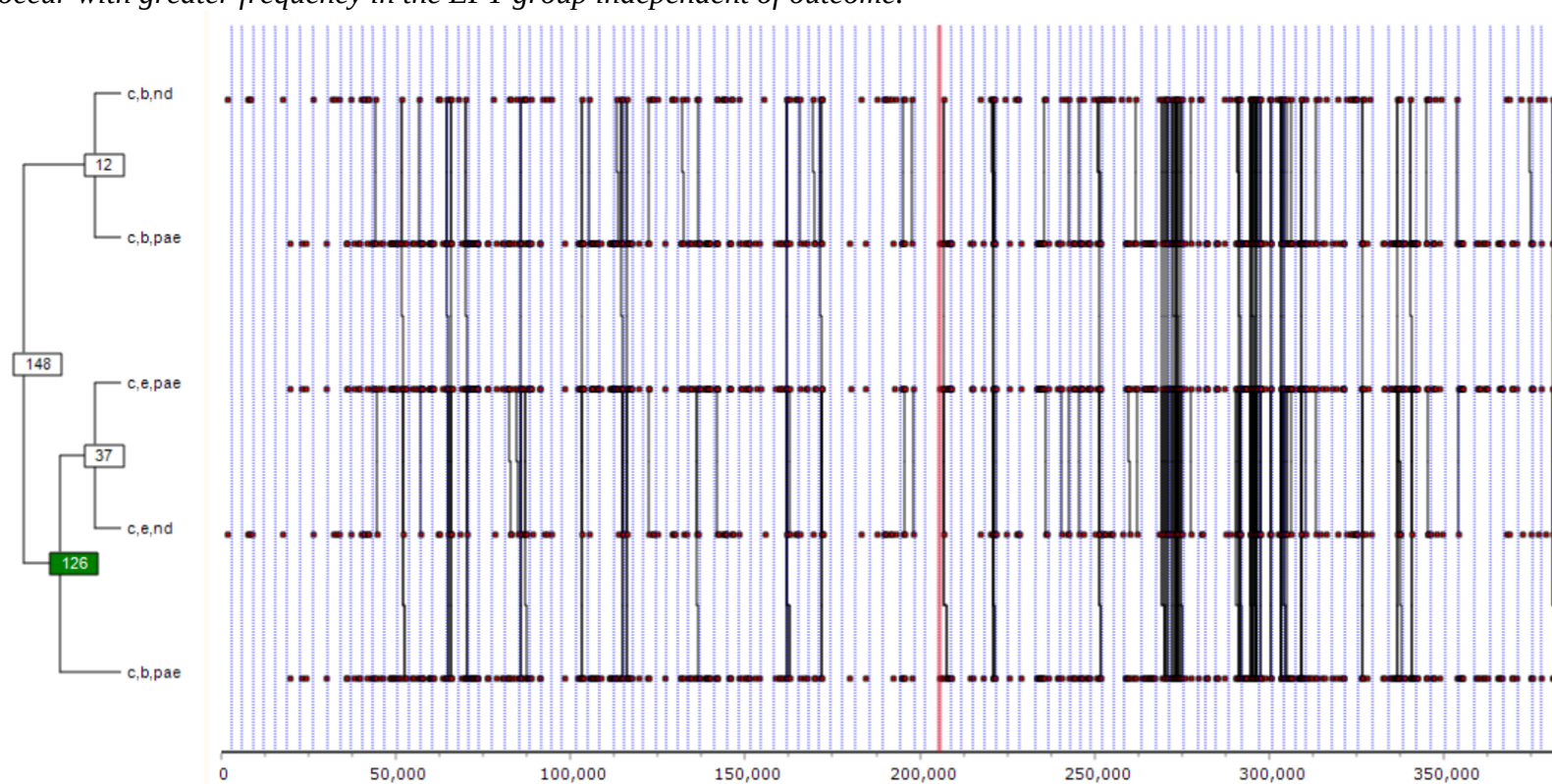
The most frequent and longest pattern of repeated expression of secondary emotion that occurred with greater frequency in the poor outcome group independent of therapy.



Note: Blue lines indicate a client session. Black dots indicate an emotion schematic code, the black lines indicate sequences of codes. The red line indicates the division between good outcome clients and poor outcome clients, good outcome clients are on the left, and poor outcome clients are on the right.

Figure 20.

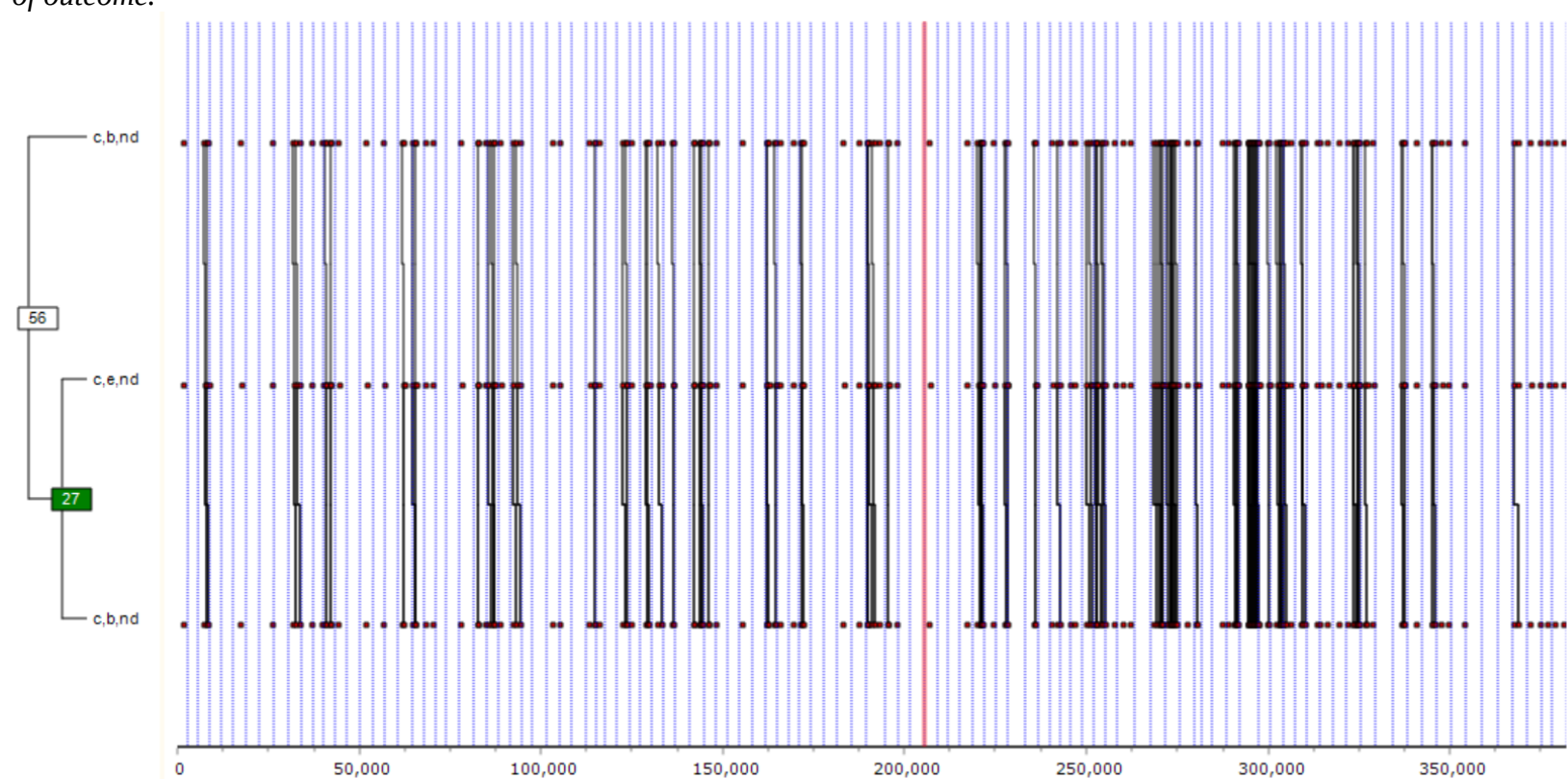
The longest found pattern of repeated expressions of needs followed by primary adaptive emotion detected by THEME that occur with greater frequency in the EFT group independent of outcome.



Note: Blue lines indicate a client session. Black dots indicate an emotion schematic code, the black lines indicate sequences of codes. The red line indicates the division between CC clients and EFT clients, CC clients are on the left, and EFT clients are on the right.

Figure 21.

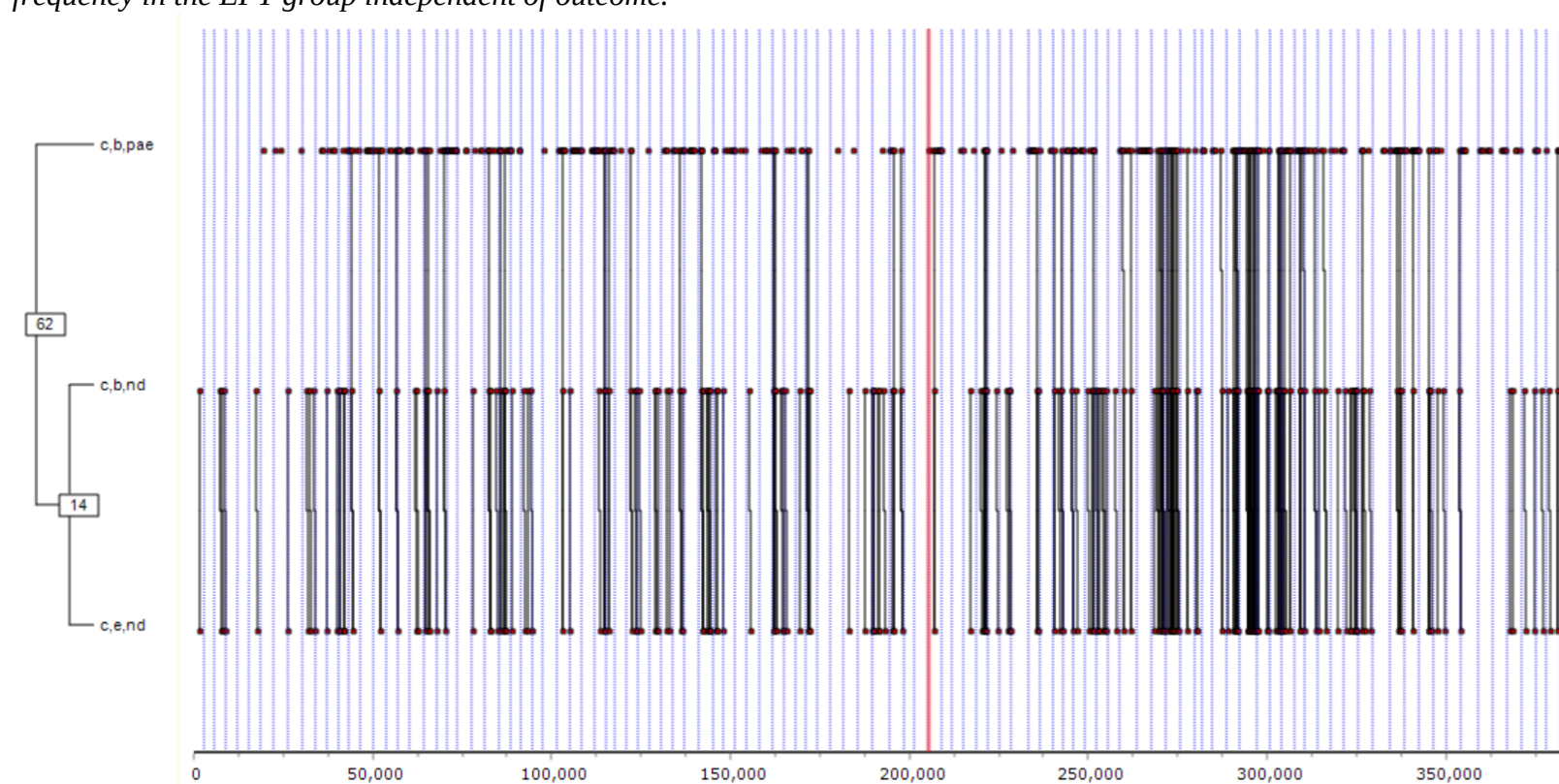
The most frequent pattern of repeated expression of needs that occurred with greater frequency in the EFT group independent of outcome.



Note: Blue lines indicate a client session. Black dots indicate an emotion schematic code, the black lines indicate sequences of codes. The red line indicates the division between CC clients and EFT clients, CC clients are on the left, and EFT clients are on the right.

Figure 22.

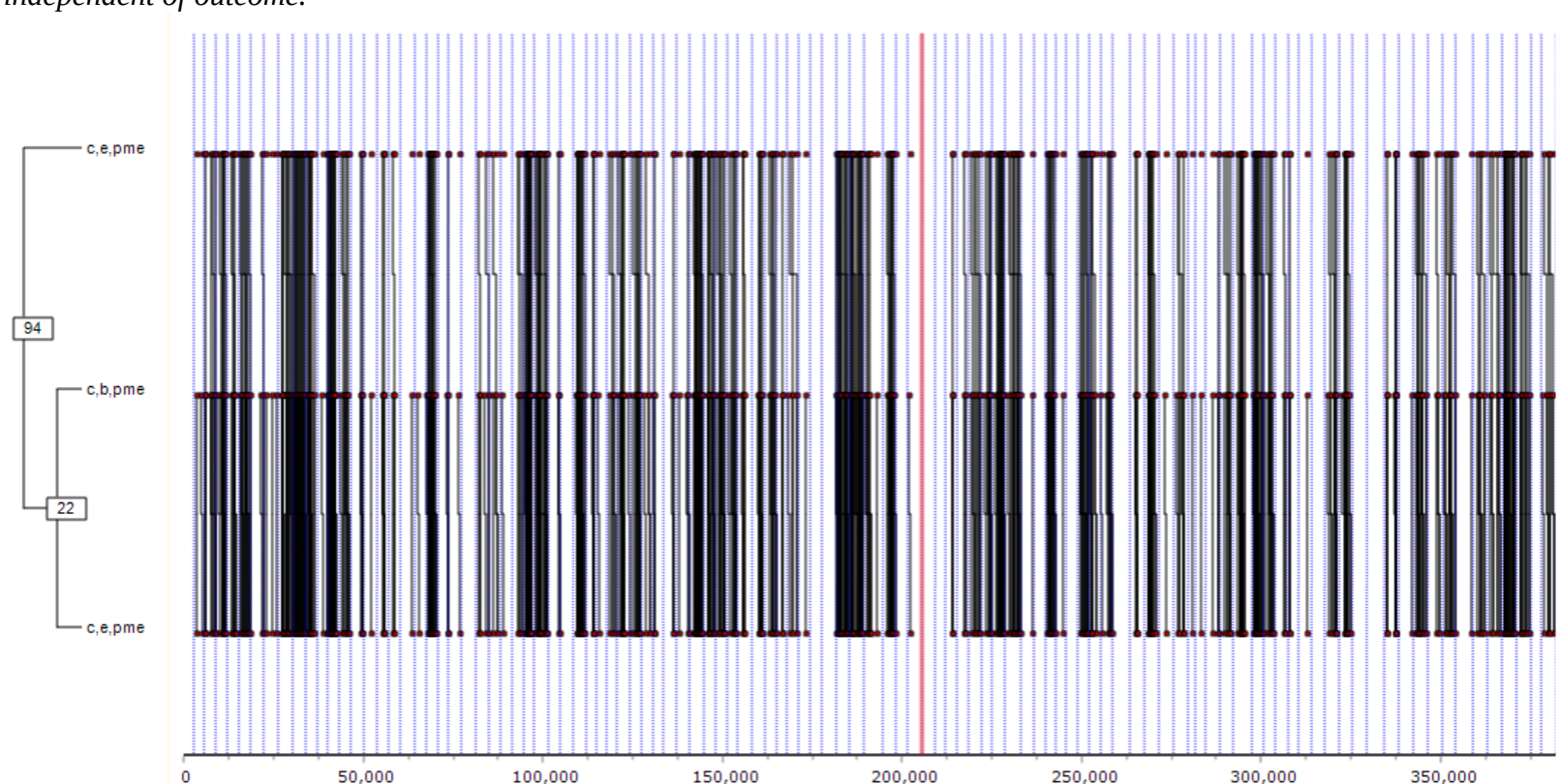
The most frequent pattern of repeated expression of primary adaptive emotion followed by needs that occurred with greater frequency in the EFT group independent of outcome.



Note: Blue lines indicate a client session. Black dots indicate an emotion schematic code, the black lines indicate sequences of codes. The red line indicates the division between CC clients and EFT clients, CC clients are on the left, and EFT clients are on the right.

Figure 23.

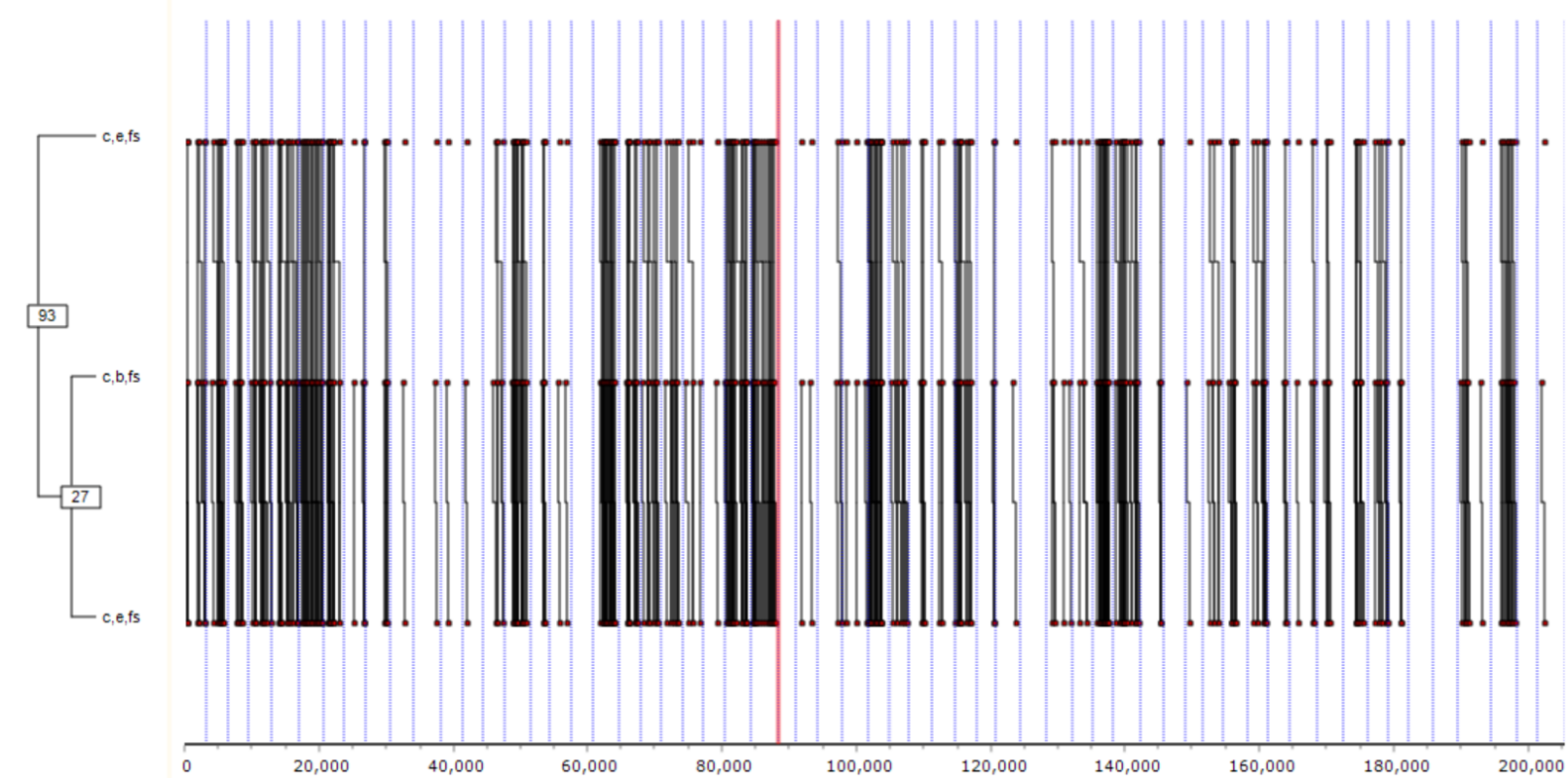
The most frequent pattern of repeated primary maladaptive emotion that occurred with greater frequency in the CC group independent of outcome.



Note: Blue lines indicate a client session. Black dots indicate an emotion schematic code, the black lines indicate sequences of codes. The red line indicates the division between CC clients and EFT clients, CC clients are on the left, and EFT clients are on the right.

Figure 24.

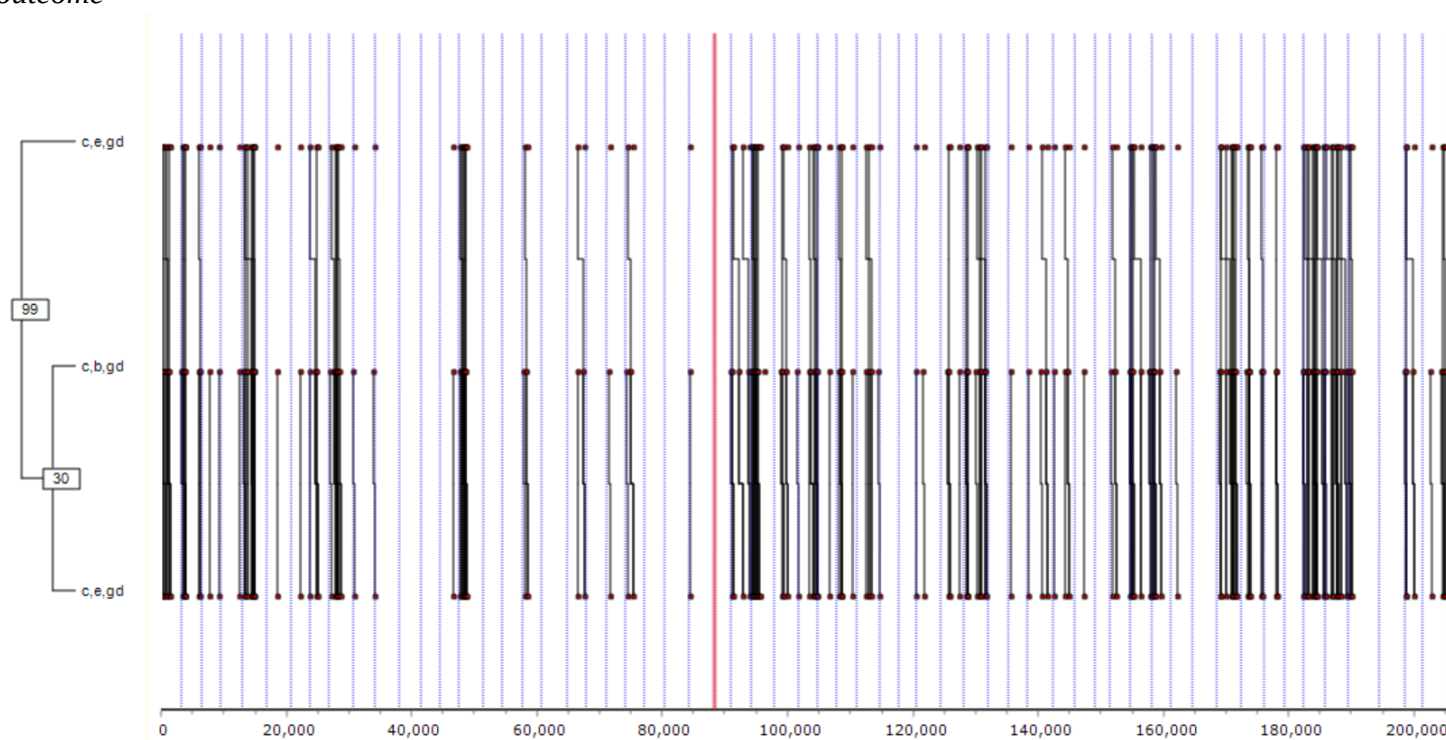
Repeated expressions of fear/shame detected by THEME that occur with greater frequency in CC clients with good outcome.



Note: Blue lines indicate a client session. Black dots indicate a CAMS code, the black lines indicate sequences of CAMS codes. All of the clients in this output are CC clients. The red line indicates the division between good outcome clients and poor outcome clients, good outcome clients are on the left, and poor outcome clients are on the right. THEME detected two patterns of this type.

Figure 25.

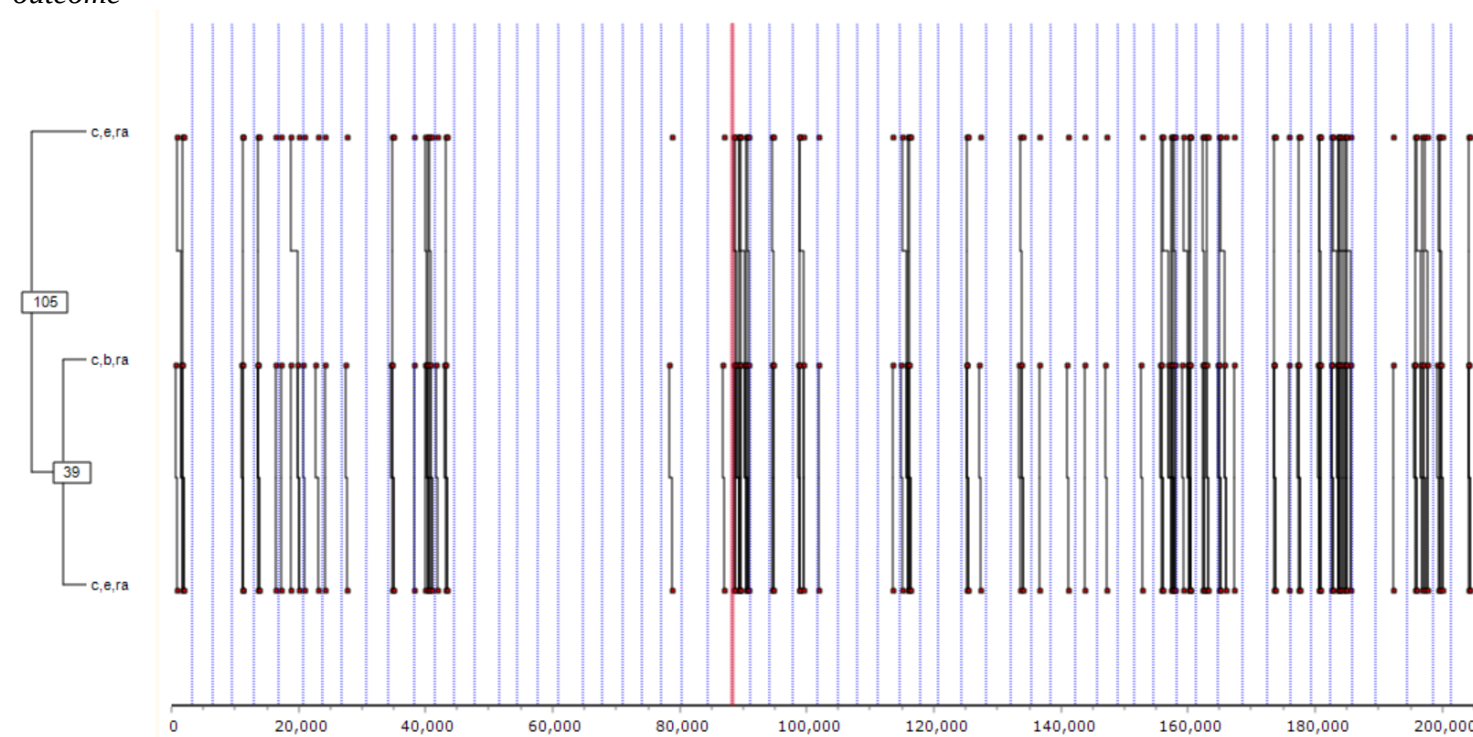
Repeated expressions of 'global distress' detected by THEME that occur with greater frequency in CC clients with poor outcome



Note: Blue lines indicate a client session. Black dots indicate a CAMS code, the black lines indicate sequences of CAMS codes. All of the clients in this output are CC clients. The red line indicates the division between good outcome clients and poor outcome clients, good outcome clients are on the left, and poor outcome clients are on the right. THEME detected two patterns of this type.

Figure 26.

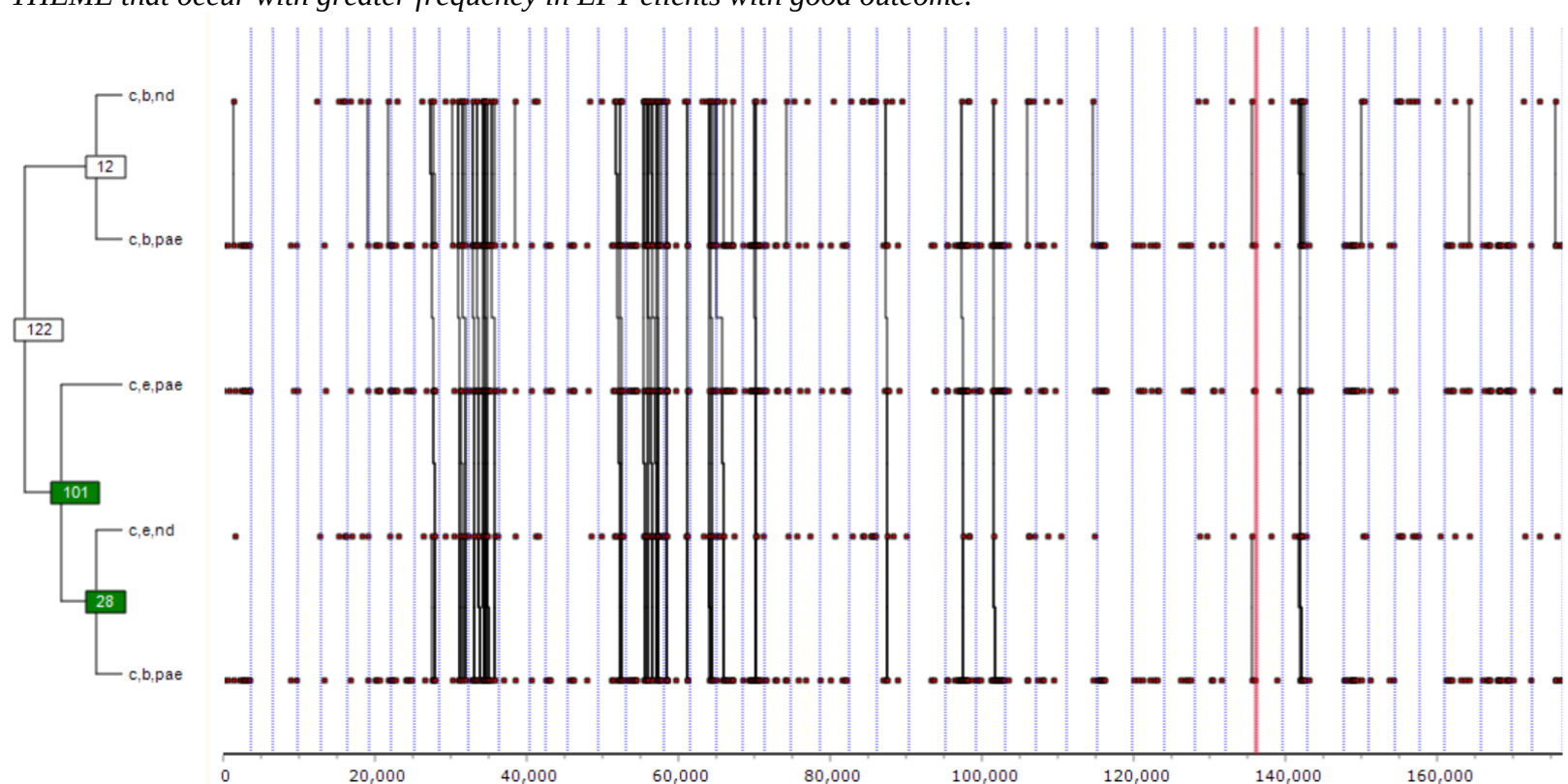
Repeated expressions of rejecting anger detected by THEME that occur with greater frequency in CC clients with poor outcome



Note: Blue lines indicate a client session. Black dots indicate a CAMS code, the black lines indicate sequences of CAMS codes. All of the clients in this output are CC clients. The red line indicates the division between good outcome clients and poor outcome clients, good outcome clients are on the left, and poor outcome clients are on the right. THEME detected three patterns of this type.

Figure 27.

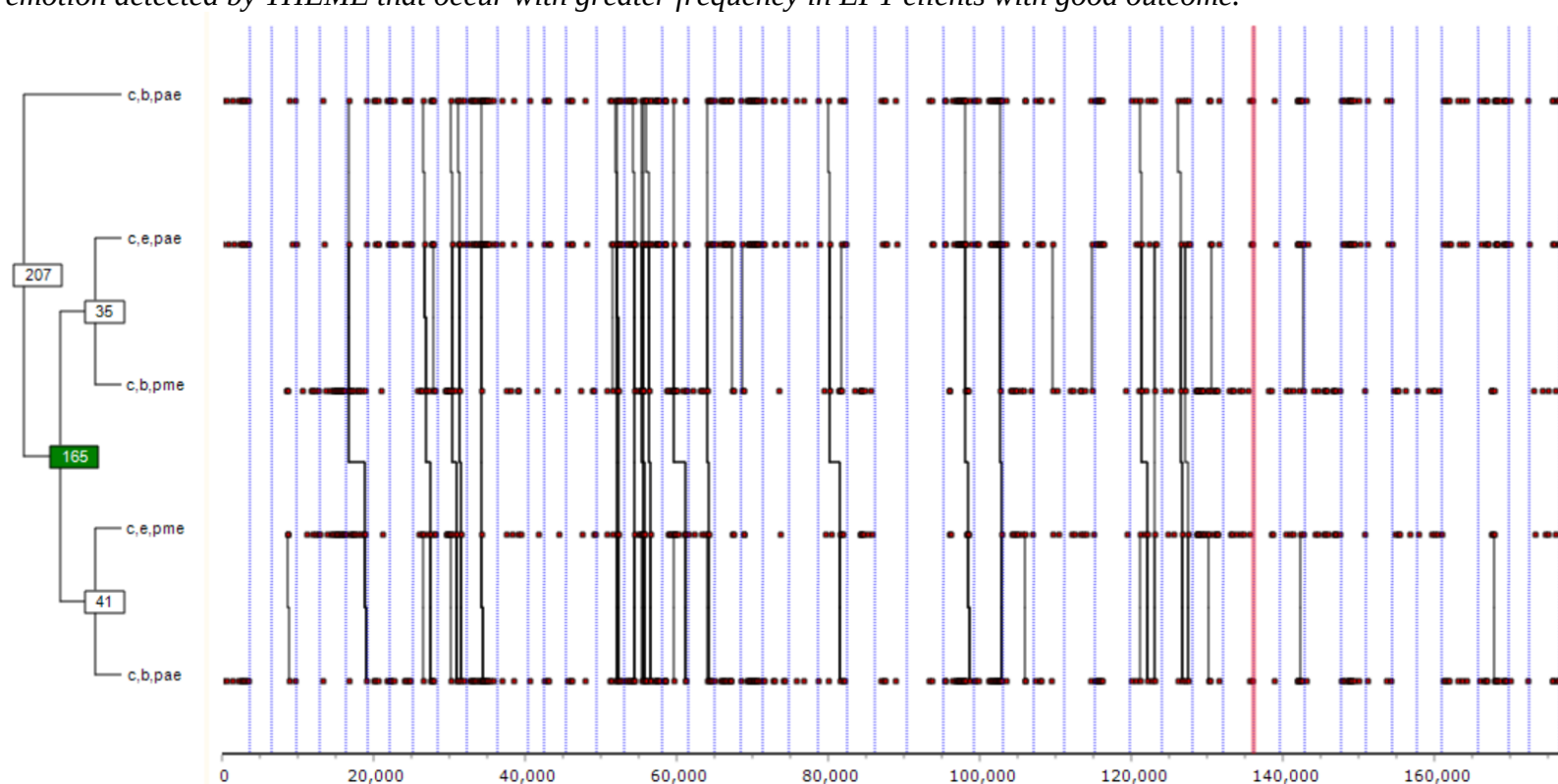
The longest found pattern of expressions of repeated need expression followed by primary adaptive emotion detected by THEME that occur with greater frequency in EFT clients with good outcome.



Note: Blue lines indicate a client session. Black dots indicate an emotion schematic code, the black lines indicate sequences of codes. All of the clients in this output are EFT clients. The red line indicates the division between good outcome clients and poor outcome clients, good outcome clients are on the left, and poor outcome clients are on the right.

Figure 28.

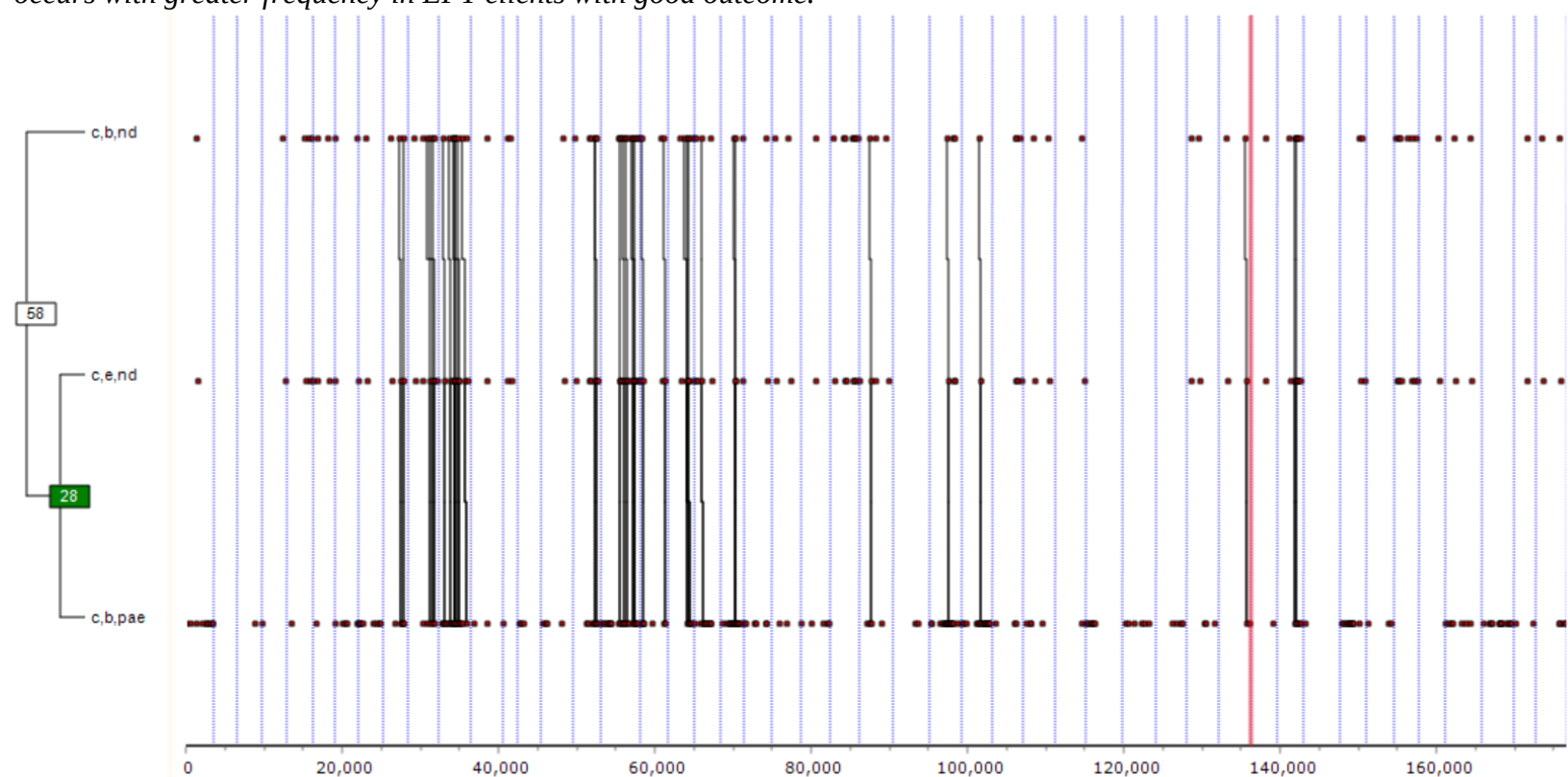
The longest found pattern of repeated expressions of primary adaptive emotion followed by repeated primary maladaptive emotion detected by THEME that occur with greater frequency in EFT clients with good outcome.



Note: Blue lines indicate a client session. Black dots indicate an emotion schematic code, the black lines indicate sequences of codes. All of the clients in this output are EFT clients. The red line indicates the division between good outcome clients and poor outcome clients, good outcome clients are on the left, and poor outcome clients are on the right.

Figure 29.

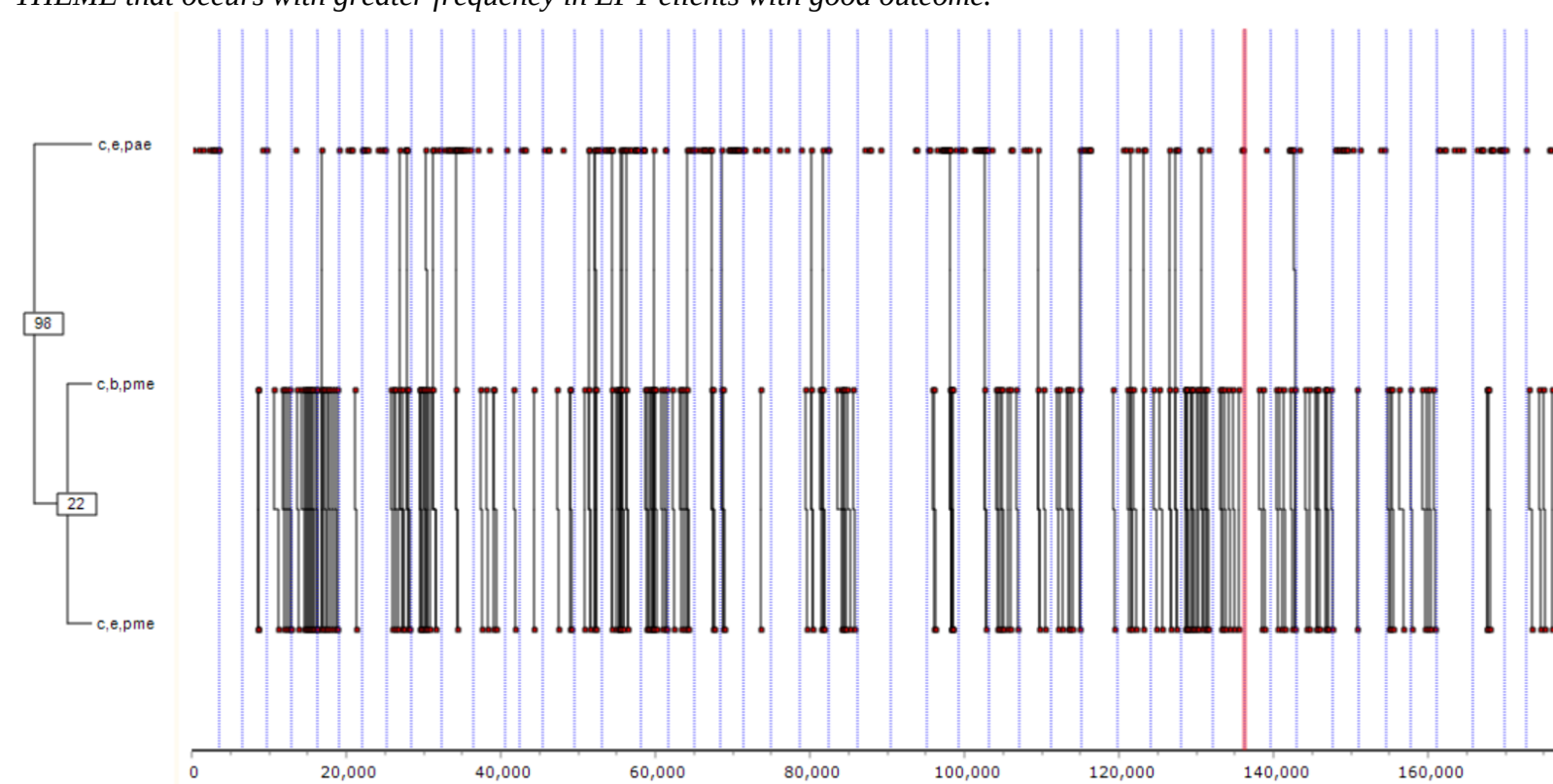
The most frequent found pattern of repeated need expression followed by primary adaptive emotion detected by THEME that occurs with greater frequency in EFT clients with good outcome.



Note: Blue lines indicate a client session. Black dots indicate an emotion schematic code, the black lines indicate sequences of codes. All of the clients in this output are EFT clients. The red line indicates the division between good outcome clients and poor outcome clients, good outcome clients are on the left, and poor outcome clients are on the right.

Figure 30.

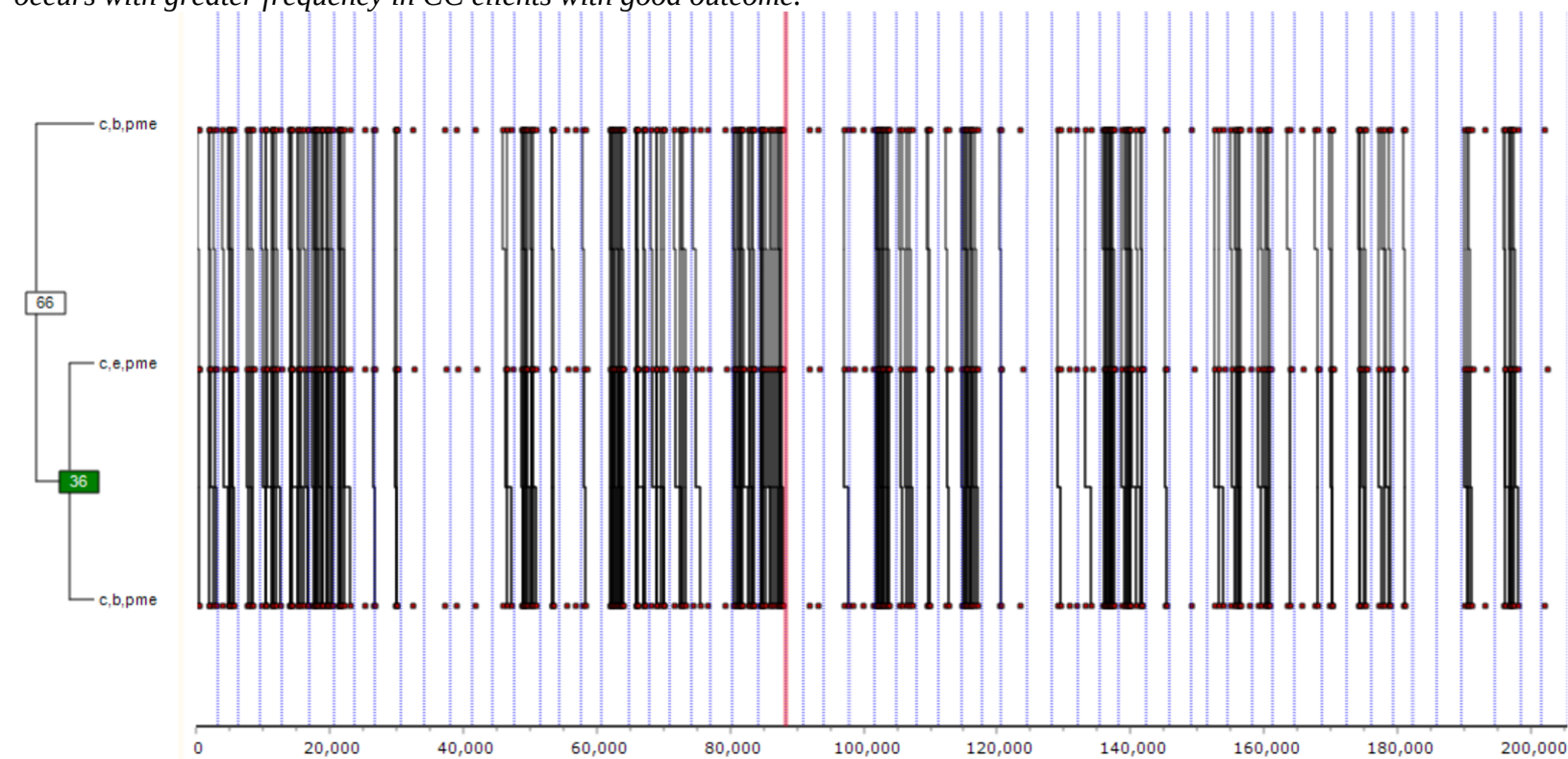
The most frequent found pattern of primary adaptive emotion followed by repeated primary maladaptive emotion detected by THEME that occurs with greater frequency in EFT clients with good outcome.



Note: Blue lines indicate a client session. Black dots indicate an emotion schematic code, the black lines indicate sequences of codes. All of the clients in this output are EFT clients. The red line indicates the division between good outcome clients and poor outcome clients, good outcome clients are on the left, and poor outcome clients are on the right.

Figure 31.

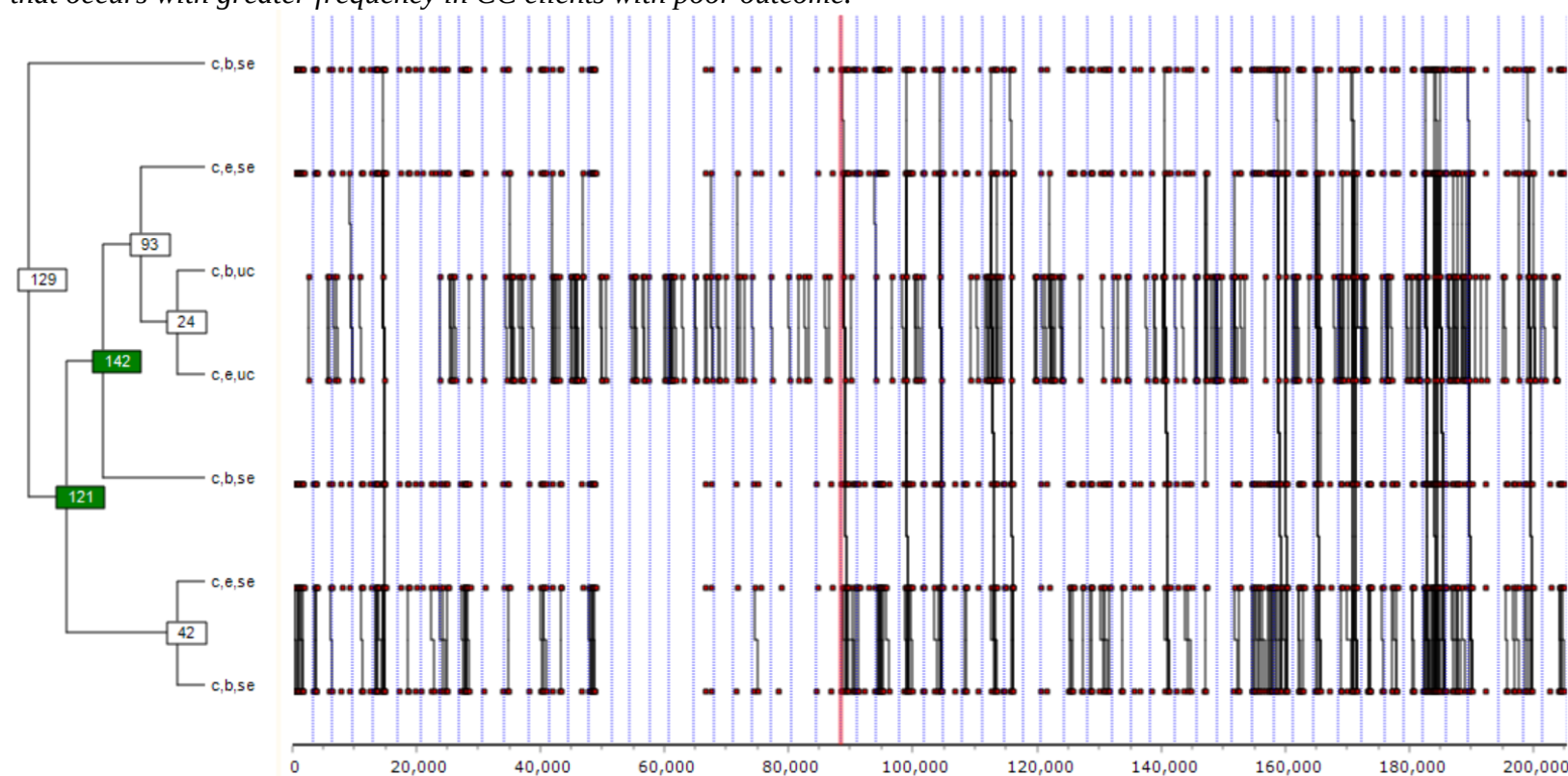
The longest and most frequent found pattern of repeated expressions of primary maladaptive emotion detected by THEME that occurs with greater frequency in CC clients with good outcome.



Note: Blue lines indicate a client session. Black dots indicate an emotion schematic code, the black lines indicate sequences of codes. All of the clients in this output are CC clients. The red line indicates the division between good outcome clients and poor outcome clients, good outcome clients are on the left, and poor outcome clients are on the right.

Figure 32.

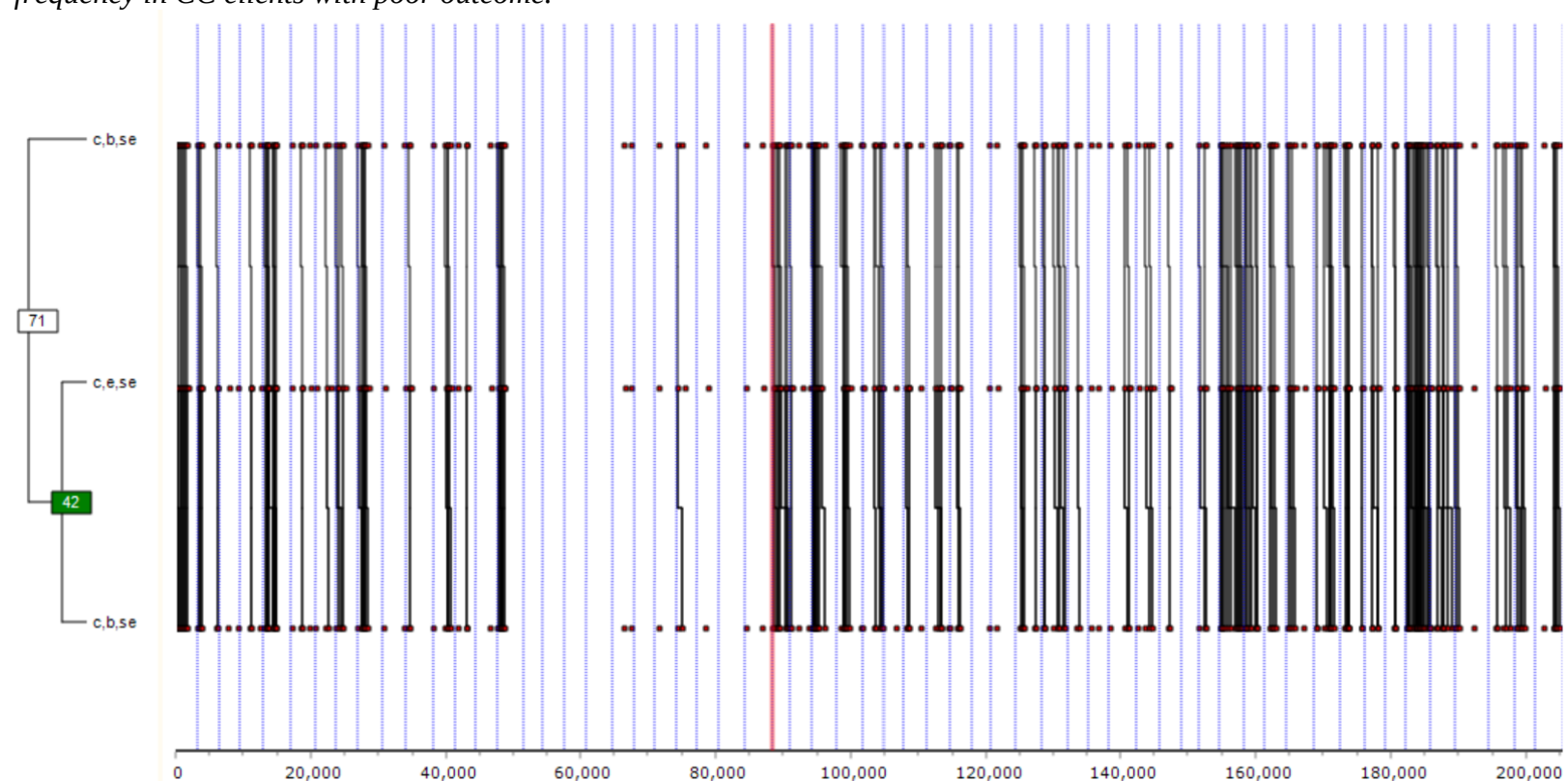
The longest found pattern of repeated expressions of secondary emotion followed by uncodable emotion detected by THEME that occurs with greater frequency in CC clients with poor outcome.



Note: Blue lines indicate a client session. Black dots indicate an emotion schematic code, the black lines indicate sequences of codes. All of the clients in this output are CC clients. The red line indicates the division between good outcome clients and poor outcome clients, good outcome clients are on the left, and poor outcome clients are on the right.

Figure 33.

The most frequent found pattern of repeated expressions of secondary emotion detected by THEME that occurs with greater frequency in CC clients with poor outcome.



Note: Blue lines indicate a client session. Black dots indicate an emotion schematic code, the black lines indicate sequences of codes. All of the clients in this output are CC clients. The red line indicates the division between good outcome clients and poor outcome clients, good outcome clients are on the left, and poor outcome clients are on the right.