

**RESOLUTION OF SELF-INTERRUPTION  
IN EMOTION-FOCUSED THERAPY:  
A MODEL OF CLIENT PROCESSES**

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A DISSERTATION SUBMITTED TO THE FACULTY OF GRADUATE STUDIES  
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF  
DOCTOR OF PHILOSOPHY

GRADUATE PROGRAM IN PSYCHOLOGY

YORK UNIVERSITY

TORONTO, ONTARIO

DECEMBER 2021

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## **Abstract**

The aim of this study was to develop and preliminarily validate a transdiagnostic model of how clients overcome Aversion to Emotion/ Self-Interruption (AESI) over the course of a session of emotion-focused therapy. The study employed task analytic methodology and consisted of two phases: a Discovery Phase and a Validation Phase. In the Discovery Phase of the study, a model of the resolution of AESI was developed through the intensive analysis of 5 cases (3 Resolved, 2 Unresolved). The model identified 7 component processes involved in this task: Marker of AESI, Awareness of How Interrupting, Awareness of Purpose of Interruption, Realization of Negative Impact of Interruption, Reduction of Fear of Emotion, Desire to Allow Emotion, and Resolution of AESI. Rating scales were developed to measure each component, so that they could be used to verify the model in the Validation Phase of the study. These rating scales consisted of the Marker of AESI Rating Scale (MARS), the Components of Resolution of AESI Rating Scale (CRARS), and the Resolution of AESI Rating Scale (RARS).

In the Validation Phase of the study, segments of therapy sessions from a sample of 24 clients (13 Resolved, 11 Unresolved) were rated for the presence of model components, using the MARS, CRARS and RARS. Significant inter-rater reliability was obtained on each scale. Preliminary support for the validity of the model of resolution was established. The two early mid-model components (Awareness of How Interrupting and Awareness of Purpose of Interruption) were present among all clients, while the three late mid-model components (Realization of Negative Impact of Interruption, Reduction of Fear of Emotion, and Desire to Allow Emotion) occurred more frequently among Resolved clients, compared to Unresolved clients. Resolution of AESI had a perfect positive relationship with Reduction of Fear of

Emotion, a fairly strong positive relationship with Desire to Allow Emotion, and a moderate positive relationship with Realization of Negative Impact of Interruption. Support for the structure of the model was mixed. Clinical and theoretical implications of these findings are discussed and contextualized within current psychotherapy research literature.

## Acknowledgements

I would like to express my gratitude to those who have supported me along the journey of completing this dissertation. First and foremost, to my supervisor, Dr. Leslie Greenberg: Thank you for deciding to take me on as your graduate student and introducing me to emotion-focused therapy and psychotherapy process research. I appreciate you sharing your expertise in the method of task analysis and guiding me on this project. Without your support, this dissertation would not have been possible.

To my committee member, Dr. Alberta Pos: Thank you for your generosity with your time and your support over the years. I appreciate you lending an ear and offering invaluable input, which challenged me to think more deeply about my work.

To my committee member, Dr. Lynne Angus: Thank you for sharing your expertise in narrative processes and for your constructive feedback, which improved the quality of this document.

To my statistical consultants, Nataly Beribisky, Dr. Michael Friendly, Naomi Martinez Gutierrez, Adam Zhong, and Dr. Phil Chalmers: Thank you for your calm presence and statistical wisdom, which eased my re-entry into the world of quantitative methods after having stepped away for several years.

To my raters, Yehuda Gabler, Flora Roudbarani, Meghan Ford, and Megan MacLean: Thank you for dedicating your time and sharp clinical instincts to complete the ratings that were essential to this study. It was a pleasure getting to know each of you better over the course of this project.

To my research assistants, Nadia Mehdizadeh, Nicole Shantz, Sharon Bae, Melanie Bretecher, Farshid Rashidifar, Kareena Gurbaxani, Nicole Schulz, Dina Nekseresht, Seyedeh-Dena Hosseini, Oshin Manghirmalani, and Sara Keshavarzi: Thank you for dedicating hours of hard work to this project, including transcribing, digitizing, reviewing session recordings, and entering data. This project could not have been completed without each of you.

To my colleagues, mentors, and friends who cheered me on along the way, especially Dr. Karen Wong, Dr. Lili Tarba, Dr. Patsy Sutherland, Dr. Sarah Gray, Dr. Mélanie Joly, Mahta Kakvan, Dr. Odilia Yim, Alexandra Potapenko, Dr. Kristine Iaboni, Dr. Patricia Steckley, Dr. Sarah Thompson, and Dr. Mirisse Foroughe: Thank you for all of the ways in which each of you has supported me, whether it was through lending an ear, encouraging me, or sharing with me the lessons you learned while completing your own dissertations. Your support helped me bounce back from setbacks and keep going in the face of challenges.

To my family, including Mom and John, Dad and Louise, Andrew and Liane, Sarah, and the Lucases: Thank you for always believing that I could succeed in this undertaking. Your confidence in me fueled me toward the finish line. I am grateful to my parents for fostering my intellectual curiosity, supporting my academic endeavors, and instilling in me the value of hard work and perseverance.

Last, but not least, to my partner, Mike: Thank you for helping through video and audio file editing, graphic design, tech support, and consultation. I am grateful for your patience and unwavering support over the course of this journey, which ended up taking longer than either of us expected. You were with me through the highs and lows, always there to validate, problem-solve, offer practical support, and cheer me on. Thank you for being you.

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## **Chapter 1: Introduction**

The avoidance or inhibition of emotions is central in the development and maintenance of psychopathology (e.g., Gross, 1989; Gross & John, 2003; Kashdan et al., 2006; Pennebaker, 1989) and is a focus of change in various psychotherapy models, including emotion-focused therapy (EFT; Elliott, Watson et al., 2004; Greenberg & Watson, 2006), an integrative humanistic-experiential approach. Research on change processes in psychotherapy has also demonstrated that the extent to which clients productively activate, experience, and express their emotional experience and use this information for adaptive problem-solving is predictive of reduction in symptoms and distress (e.g., Greenberg et al., 2007; Pos et al., 2009). Accordingly, therapists need to recognize when barriers or blocks to productive emotional processing emerge during sessions and support clients in working through them. Aversion to Emotion/Self-Interruption (AESI) is one indicator of problematic emotional processing that has been identified in EFT (e.g., Greenberg & Watson, 2006; Elliott, Watson, et al., 2004; Paivio & Pascual-Leone, 2010; Watson & Greenberg, 2017). It involves clients conveying a dislike for, or disinclination toward, their emotions and/or displaying efforts to prevent, stop, or over-control the experience or expression of their emotions. While a model of how clients can overcome AESI has been proposed (Greenberg et al., 1993, Elliott, Watson et al., 2004), no systematic research has been conducted on this subject. The current study aims to address this gap by employing a task-analytic methodology to develop and preliminarily verify a transdiagnostic model of the client processes involved in the resolution of AESI in EFT.

In this chapter, the role of emotional avoidance and inhibition in the development and maintenance of psychopathology will be examined. Next, relevant literature on the evidence base, theory, and practice of EFT, including the nature and resolution of AESI, will be discussed. This will be followed by a review of findings from studies examining the relationship between emotional processing and outcome in psychotherapy. Finally, a rationale for the current study and an overview of the research design will be provided.

## **Review of Related Literature**

### ***Role of Emotional Inhibition and Avoidance in the Development and Maintenance of Psychopathology***

Emotional experiences are fundamentally adaptive, providing the most basic mode of information processing (Le Doux, 1996; Greenberg, 2010). Emotions are connected to our most essential needs, rapidly alerting us to situations important to our well-being and preparing us for action (Damasio, 2003; Frijda, 1986; Izard, 2002; Tomkins, 1962). For example, fear can quickly alert us to danger, making swift escape possible; anger can signal that our boundaries have been violated, promoting assertive responding; sadness or grief can indicate a loss, encouraging us to seek comfort and support from others. Conversely, joy and contentment can inform us that we are safe and that threats to our survival are absent. When emotions and related needs or action tendencies are repeatedly avoided or inhibited, however, we are robbed of the adaptive information that they provide and psychological dysfunction can occur.

The avoidance or inhibition of unwanted emotions has been recognized as problematic, either implicitly or explicitly, within most systems of psychotherapy. From the psychoanalytic

perspective, a key process contributing to psychopathology is repression, which refers to the relegation of conscious material that is emotionally painful or threatening to the unconscious (Freud, 1914). To help their patients recover, psychoanalysts facilitate conscious awareness of repressed memories and the re-experiencing and expression of associated painful emotions (“abreaction”; Breuer & Freud, 1893). As well, in existential psychotherapy, emotional distress is seen as resulting from attempts to deny the inevitability and reality of death, due to the fear that it evokes (Frankl, 1959; May, 1977; Yalom, 1980). Existential therapists strive to help clients overcome their avoidance of fear of death, in order to facilitate their personal growth and development of meaning.

Moreover, modern cognitive-behavioral therapies, such as dialectical behavioral therapy (DBT; Linehan, 1993) and acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999), are focused on accepting negative emotional experiences rather than controlling them. In DBT, painful emotions are seen as inevitable, while the non-acceptance of emotions is seen as contributing to suffering (Linehan, 1993; Linehan et al., 2001). Individuals’ symptoms and destructive behaviors are conceptualized as maladaptive attempts to avoid or escape these emotions. Exposure to these emotions, along with learning to tolerate, regulate and accept them, is considered central to recovery. Similarly, in ACT, attempts to avoid or over-control internal experiences (e.g., thoughts, feelings) are viewed as impeding individuals from living meaningful lives in accordance with personal values and goals, thereby contributing to psychological problems (Hayes et al., 2012). Treatment from this model involves establishing “defusion” or detachment from these uncomfortable internal experiences, so that they can be accepted as they arise from moment to moment.

Furthermore, emotion-focused theory (Greenberg & Safran, 1987) holds that psychological dysfunction occurs when the naturally occurring emotional processes that organize us for adaptive action, or the maladaptive emotions that are based on past wounds, are interrupted. In EFT, the in-session experiential activation of previously disallowed emotions is central to facilitating change. Once activated and fully experienced, these emotions, if adaptive, can be re-owned and drawn on to motivate adaptive action and to facilitate growth, or, if maladaptive, they can become accessible to change. Therapy creates the opportunity for clients to experience new emotional reactions and self-experiences, along with alternative and more adaptive ways of meaning making (Greenberg & Watson, 2006; Pos, 2006) and story reconstruction (Angus & Greenberg, 2011).

In line with the aforementioned theoretical perspectives, Bullis and colleagues (2019) propose the grouping of several DSM-V diagnoses (i.e., depression, anxiety, borderline personality disorder, eating disorders, and insomnia) under the transdiagnostic umbrella term “emotional disorders,” given their shared etiologic and maintaining factors, namely (a) the experience of frequent and intense negative emotions, (b) negative reactivity to intense emotional states, and (c) maladaptive efforts to dampen, escape, or avoid negative emotional experiences. Although a biological or personality predisposition to experiencing negative emotions more frequently and more intensely may be present among individuals with emotional disorders (Barlow et al., 2014), it has been argued that it is individuals’ appraisals of or reactions to their emotions, rather than their discrete emotional experiences, that contribute to the development and maintenance of pathology (Barlow, 1991).

According to Bullis and colleagues (2019), individuals with emotional disorders are susceptible to responding to their emotions with aversion, because they may experience them as uncontrollable and unpredictable, have difficulty tolerating the subjectively unpleasant experience of their emotions, do not perceive the utility of their emotions in relation to the attainment of their goals, and/or expect negative social or interpersonal consequences or negative self-evaluations to result from experiencing their undesired emotions. As a result of their aversion, individuals with emotional disorders are more likely to engage in efforts to down-regulate their emotional experiences through suppression, inhibition, or avoidance, which paradoxically increase the intensity and duration of their aversive emotional states (Barlow et al., 2014). For instance, one study showed that in response to viewing an emotion-provoking film, individuals with anxiety and depression experienced increases in negative emotions comparable to that of a nonclinical control group, but engaged in more emotional suppression than the control group (Campbell-Sills et al., 2006a, 2006b). Moreover, the relationship between high levels of negative emotions and suppression was found to be mediated by individuals' perceptions of their emotions in response to the film as unacceptable.

These findings are consistent with a larger body of research demonstrating that efforts to suppress, inhibit, or avoid aversive internal experiences are often ineffective and detrimental to well-being. Firstly, research on cognitive avoidance strategies (i.e., attempts to suppress thoughts or to control them through distraction and worry) has shown that they can be ineffective and often lead to paradoxical increases in the occurrence of avoided thoughts (Clark et al., 1991; Gold & Wegner, 1995; Wegner et al., 1987; Wegner et al., 1991). Secondly, the chronic inhibition of thoughts, feelings, and behavior requires effort. It can deplete internal resources and

place cumulative stress individuals (Pennebaker, 1989). Accordingly, experimental and correlational research has demonstrated the deleterious effects of chronic emotional avoidance. For instance, the avoidance of feelings and thoughts related to traumatic events can result in an increased risk of health-related problems (Pennebaker, 1989), depression (Beblo et al., 2021), and reductions in self-esteem, life-satisfaction, and optimism (Gross, 1989; Gross & John, 2003). In addition, emotional suppression, defined as the inhibition of outward signs of inner feelings, has been related to poor psychological and health (Gross, 1989; Gross & John, 2003). Clients high in emotional suppression experience significantly worse outcomes in cognitive-behavioral therapy (Scherer et al., 2017). Similarly, avoidance coping, which refers to the tendency to engage in behavioral avoidance strategies in response to stressful situations, has been associated with mental health difficulties (Penley et al., 2002). Moreover, experiential avoidance, describing the chronic avoidance of unwanted internal experiences, has been linked to a number of specific mental health problems, including substance abuse (Stewart et al., 2002; Westrup, 1999), post-traumatic stress (Batten, 2001; Marx & Sloan, 2003; Orcutt et al., 2005; Tull et al., 2004), generalized anxiety (Kashdan et al., 2006; Roemer et al., 2005), trichotillomania (Begotka et al., 2004), and deliberate self-harm (Chapman et al., 2006; Chapman et al., 2005).

It has also been suggested that chronic emotional avoidance can lead to a decrease in the frequency of positive events and to the dampening of one's experience of positive emotions (Gross & John, 2003; Gross & Levenson, 1993, 1997; Kashdan et al., 2006). A decrease in positive emotions, such as love, can impede one's ability to form healthy attachments with others. As well, difficulties with communicating emotions in relationships negatively impact

interpersonal functioning (Gross & John, 2003). Thus, long-term reliance on avoidance for coping with negative emotions is detrimental to physical and emotional well-being.

### ***Emotion-Focused Therapy***

Emotion-focused therapy (EFT) is an integrative experiential approach to psychotherapy that emphasizes the centrality of human emotion in psychological functioning and therapeutic change. The therapeutic model draws on gestalt (Perls et al., 1951), person centered (Rogers, 1957), existential (Frankl, 1959; Yalom, 1980) and family systems (Minuchin, 1974) theories, as well as contemporary research on affective neuroscience (Damasio, 1999; Frijda, 1986; Izard, 2002; Tamietto & de Gelder, 2010). EFT is recognized as an evidence-based treatment for depression (Elliott, Greenberg et al., 2004; Goldman, Greenberg et al., 2006; Greenberg & Watson, 1998, 2006; Watson et al., 2003) and it has demonstrated positive outcomes for a range of presenting concerns, including complex relational trauma (Paivio & Nieuwenhuis, 2001; Paivio & Pascual-Leone, 2010), anxiety disorders (MacLeod et al., 2012; Shahar, Bar-Kalifa et al., 2017; Watson & Greenberg, 2017), and interpersonal problems (Greenberg & Malcolm, 2002; Greenberg et al., 2008; Paivio & Greenberg, 1995). The effectiveness of EFT as a group treatment has also been investigated for eating disorders (Wnuk et al., 2015) and self-criticism in young adults (Thompson & Girz, 2019). Additionally, EFT is recognized as an evidence-based intervention for reducing distress and improving relationships among couples (Johnson, 2004; Johnson & Greenberg, 1985a, 1985b; for a review see Wiebe & Johnson, 2016), as well as among parents and their children and adolescents with mental health concerns (Foroughe et al., 2019; Girz et al., 2013; Robinson et al., 2014; Robinson et al., 2015).

**Centrality of Emotion.** Although EFT uses an integrative framework, the approach emphasizes experiential engagement with felt emotions as a primary vehicle of change. People form internal models of their lived experiences and the emotions evoked alongside them, which are referred to as “emotional memories” (Greenberg, 2011). These emotional memories are a part of organizing networks referred to as *emotion schemes* (Oatley, 1992; Greenberg et al., 1993; Greenberg & Paivio, 1997). Emotion schemes are comprised of several elements: 1) *situational-perceptual* experiences, including emotion-laden episodic memories and immediate appraisals, such as noticing that you are alone in the present and remembering an experience of abandonment from childhood); 2) *bodily sensations and expressions*, such as pressure in the chest or butterflies in the stomach); 3) *implicit verbal-symbolic* representations, including meanings and self-labels (e.g., “failure” “weak”); and 4) *motivation-behavioral* elements, including needs and action tendencies, like wanting to set boundaries with another person or seeking comfort from a supportive other (Elliott & Greenberg, 2017). Optimal emotional processing requires the integration of all of these schematic elements (Leijssen, 1998). One way dysfunction is believed to occur is when one or more of these elements remain outside of awareness, as potentially meaningful implicit information that is necessary for meeting one’s needs through adaptive action remains inaccessible. Another route to dysfunction is when maladaptive emotion schemes built from past experience are activated in the present.

**Therapist as an Emotion Coach.** Consistent with the humanistic tradition (Rogers, 1957), the therapist’s role in EFT is to first and foremost provide an environment conducive to therapeutic change (Greenberg et al., 1998). This is accomplished through the provision of genuineness, empathy, and unconditional positive regard for the client. The establishment of a

bond between client and therapist, in which the client feels safe, trusting, and empowered to explore and express their emotions and needs, is critical.

Within the context of a strong therapeutic alliance, the therapist is fully present and highly attuned to the client's moment-by-moment emotional experience (Greenberg, 2011). The therapist's empathic reflections of the client's experience encourage an inward focus on their lived emotions, including physical sensations and feeling states. All the while, the therapist engages in "process diagnosis" (Greenberg et al., 1993). This involves tracking aspects of the client's manner of emotional processing, including vocal quality and depth of experiential engagement, as well as listening for themes in the client's narrative. Using this information, the therapist assesses for markers of problematic emotional-processing states and intervenes accordingly. The therapist guides productive processing by directing what clients attend to and by using explicit interventions designed to facilitate specific emotional processes at certain points in time. Thus, along with empathically following the client, the therapist also engages in marker-guided process-directive interventions.

In EFT, these interventions are guided by the following six overarching principles of emotional change: awareness, expression, regulation, reflection, transformation, and corrective emotional experience (Greenberg, 2021). This indicates that the therapist needs to facilitate the client's verbal symbolization and non-verbal expression of their core emotional experiences. The therapist also needs to support the client in sufficiently regulating their emotions; when emotional arousal is too high, emotions cannot help with adaptive action (Pascual-Leone & Greenberg, 2007). The therapist can promote the down-regulation of intense emotions through their calm and reassuring presence, by promoting compassion toward the client's painful

emotional experiences, or by coaching the client in the use of self-soothing techniques, such as paced breathing or imagery (Elliott & Greenberg, 2017).

Additionally, the client needs to be guided to reflect on and make sense of their emotions by symbolizing their bodily felt sensations using language, in order to construct new experiences (Pascual-Leone, 1991; Greenberg & Pascual-Leone, 2001; Guidano, 1991, Mahoney, 1991; Neimeyer & Mahoney, 1995). In this process, the client's feelings, needs, thoughts, and goals are identified and incorporated into coherent stories, or narratives. This can lead to increased self-knowledge, as situations are understood in new ways and new views of self, others, and the world emerge. Research has shown that emotional expression and narrative expression need to be integrated to attain the best therapeutic outcomes (Boritz et al., 2011). Thus, the therapist needs to help the client not only feel their emotions, but also facilitate the making of new meaning and narrative reconstruction (Angus, 2012; Angus et al., 2017; Angus et al., 2004; Greenberg & Angus, 2004; Paivio & Angus, 2017).

Moreover, the most important mechanism for changing old, familiar, painful emotions is that of transforming or undoing them with more adaptive emotions, or "changing emotion with emotion" (Greenberg, 2011, 2021). This process of transformation is described in the context of different types of emotion in the next section below. Furthermore, lived interactions between client and therapist also provide corrective emotional experiences. For example, a client's core maladaptive shame can be altered when they experience it alongside acceptance and compassion from the therapist. Introducing new experiences into currently activated memories of past events leads to memory reconsolidation, as new material is incorporated into past memories (Nadel & Bohbot, 2001). This further contributes to emotional and narrative reorganization.

**Types of Emotion.** While the expression of emotions is central to therapeutic change in EFT, not all emotions expressed by clients are considered productive. Accordingly, EFT therapists need to be able to distinguish between different types of emotional expression, in order to promote productive expression. Emotions can be organized into four distinct classes, each of which necessitates a different intervention (Greenberg & Safran, 1987). Of these four classes, only one is truly adaptive, while the other three are considered problematic for adaptive functioning. Within this emotion classification system, primary emotions are distinguished from secondary and instrumental responses. *Primary* emotions reflect our most fundamental and initial responses to provoking stimuli, such as fear in response to our perception of physical threat. In contrast, *secondary* emotions are reactions to more primary feelings. They are defensive in nature and obscure our awareness of the primary emotions, leading to inappropriate action, such as acting out in anger when shame has been evoked by a stimulus. Secondary reactions can occur so quickly that the underlying primary emotion does not have a chance to enter into awareness. The vague feelings of sadness and irritability that characterize depression are often secondary reactions to underlying primary emotions that have not been fully processed (Greenberg, 2002). Thus, secondary emotional experiences are best bypassed or explored to get to the underlying primary emotions at the core of clients' distress.

Moreover, *instrumental* emotions occur when we react to a situation by enacting an emotion intended to influence or manipulate others in order to get something we want. For instance, we might cry "crocodile tears" in order to elicit caring reactions from others (Greenberg & Watson, 2006). It is important to note that the instrumental nature of these emotions may be either within or outside of an individual's awareness. When instrumental

emotions arise, EFT therapists need to help clients become aware of their effects and of the intentions of their expression (Greenberg, 2002). Clients also need to be guided to find more direct ways of expressing their emotions and corresponding needs.

Another important differentiation is made between two types of *primary* emotions; specifically, those which are biologically adaptive and those which are overlearned maladaptive reactions (Greenberg et al., 1993, Elliott, Watson et al., 2004). *Primary adaptive* emotions are clients' initial, core responses to situations. They are the emotions which have clear value for our survival and well-being (Greenberg, 2002). They need to be accessed in order to make use of the adaptive information they contain, so that they can be used in problem solving. On the other hand, while *primary maladaptive* emotions are also direct responses to situations, they are learned through previous, often traumatic, experiences. Primary maladaptive emotions are pervasive in individuals with depression, anxiety, and other pathology, and are sometimes described as chronically experienced bad feelings (Greenberg & Paivio 1997; Greenberg & Watson, 2006; Paivio & Pascual-Leone, 2010; Watson & Greenberg, 2017). They are often accompanied by negative internal voices or destructive thoughts, which can leave clients feeling pervasively shaky, insecure, worthless, or defective. Once adaptive in a past situation, these primary maladaptive emotions reflect a current disorganization of the emotion system and do not give clients a clear sense of direction in the present. For example, fear of abandonment may be an adaptive emotion for a child whose parents are inconsistent in meeting his needs. However, the ongoing activation of this fear in subsequently safe adult relationships can be maladaptive and may disrupt the individual's ability to develop healthy connections with others.

Primary maladaptive emotions need to be accessed, so that they can be brought into

contact with more adaptive emotional responses for the purpose of transformation (e.g., replacing maladaptive shame with self-soothing or pride; Elliott, Watson et al., 2004; Frederickson et al., 2000; Greenberg, 2002). EFT theory proposes that maladaptive emotions can be transformed by dialectically-opposing, adaptive ones, a process referred to as “changing emotion with emotion” (Greenberg, 2021). For instance, changes in longstanding painful emotions, such as core fear of abandonment, can occur through the activation of incompatible, adaptive experiences, such as empowering anger, sadness of grief, or self-compassion, which undo old responses (Greenberg, 2010). Similarly, maladaptive shame can be transformed by accessing anger, sadness of grief, self-compassion, pride, or self-worth (Greenberg, 2010). Moreover, hopelessness and helplessness can be transformed through the expression of adaptive anger. Once alternate emotions have been accessed, these new emotional resources begin to undo the schematic programming that previously determined the person’s mode of processing. New emotional states enable the person to challenge their perceptions of self and others that are associated with their maladaptive emotions (Greenberg, 2011).

**Nature of Aversion to Emotion/Self-Interruption (AESI).** Given the importance of accessing and expressing primary emotions in EFT, therapists need to recognize when indicators of clients’ difficulties with doing so emerge in session. One such indicator is Aversion to Emotion/Self Interruption (AESI), which is observed when clients convey a dislike for or disinclination toward their primary emotions and/or display efforts to prevent, stop, or over-control their experience or expression of these emotions, or corresponding needs or action tendencies. The ways in which AESI can manifest in therapy sessions have been described in EFT literature (Elliott, Watson et al., 2004; Goldman & Greenberg, 2015; Greenberg, 2002,

2011; Greenberg et al., 1993; Greenberg & Watson, 2006; Paivio & Pascual-Leone, 2010; Sicoli, 2005; Watson & Greenberg, 2017; Weston, 2018). Overt ways include clients communicating reluctance or refusal in response to therapists' direction to explore or express their primary emotions, or related needs or action tendencies, in session. Clients can also report stopping themselves from revealing or expressing aspects of their emotional experiences in relationships with others. As well, clients can describe suppressing parts of self that inhabit their primary emotions. However, AESI often appears in more subtle ways, such as the abrupt disappearance of an emotion that was about to emerge or had emerged, or lack of congruence between content of speech and non-verbal expression. AESI may involve a non-verbal bodily aspect, such as a headache, tightness or constriction. Another potential indicator is the presence of resignation or hopelessness, which are secondary emotional states often in response to the suppression of primary emotions and repeatedly unmet needs. Clients' efforts to interrupt their emotional experience or expression can be conscious and deliberate or automatic and outside of their awareness.

In EFT, AESI is conceptualized as one of several transdiagnostic process markers called "conflict splits," which refer to "problems that arise when one part of the self attacks or blocks the full expression of a more adaptive and fundamental aspect of the self" (Elliott, Watson et al., 2004, p.220). EFT is grounded in a dialectical constructivist view of dysfunction, in which people are believed to be made up of a collection of complex, ever-changing parts of self. These parts express particular emotion schemes and continually interact with one another to form people's experiences and actions. Dysfunction occurs when these different self aspects are in a conflict that is marked by hostility or by the oppression of one part by another. In the case of

AESI, a coercive or dominant part of self, “the interrupter,” oppresses the authentic, adaptive part of self, “the experiencer,” in which the primary emotions arise. When AESI occurs, the experiencer’s primary emotions are cut off, disavowed, or over-controlled by the interrupter. This prevents clients from being able to access important information about themselves or their situations and stifles their ability to act toward meeting their needs. The result of AESI is often a sense of depletion, limited emotional awareness, or physical discomfort in the client (Greenberg, 2011; Weston, 2018).

EFT’s conceptualization of AESI is compatible with the Assimilation Model of therapeutic change (Brinegar et al., 2006; Osatuke et al., 2004; Stiles, 1999, 2002). This transtheoretical model holds that individuals are comprised of “multiple internal centers of experience, described metaphorically as voices” (Stiles, 2011, p. 368). When voices represent conflicting perspectives, they are experienced as problematic by clients, resulting in emotional distress (Stiles et al., 2004). To cope with this distress, subdominant voices may be warded off, suppressed, dissociated, or rejected by more dominant ones. This perpetuates continued separation and conflict between voices. Within this model, therapeutic change is facilitated through the building of meaning bridges (e.g., words, phrases, stories, theories, gestures, or other expressions) between separated, conflicting voices, in order to connect them “through their common understanding, allowing them to empathize and communicate with one another and engage in joint action” (Brinegar et al., 2006, p. 167).

Weston (2018) utilized grounded theory (Rennie, 2006) and task analytic methodologies (Greenberg, 2007) to study clients’ subjective experiences of and their performances during in-session events of AESI during emotion-focused and client-centered therapy for depression. The

results of her study shed light on the multifaced nature of this emotional processing problem. The emotions interrupted by clients in Weston's study were anger, fear, sadness, emotional pain/hurt, or inchoate emotions. Clients' interruption of these emotions emerged in response to specific emotion triggers, such as clients' memories, vivid imagery, or to therapists' empathic responses, use of metaphor, or direction to attend to and/or express their emotional experience.

Subsequently, clients made explicit statements reflecting their internal opposition to their experience or expression of their emotions and related urges and/or needs. In doing so, some clients described a sense of internal conflict between a part of self that was aware of or expressed the emotional experience, versus another part that opposed it. Others stated a desire or intention to stop the flow of the emotion. Cognitions that functioned to oppose their emotional experience included negative evaluations of the experience of emotion, or hopeless beliefs about expressing the emotion. Paralinguistic behaviors in the form of sighing, silence, or shaking the head from side to side to communicate lack of agreement were also observed.

All clients in Weston's (2018) study displayed what the author referred to as behaviors of control and/or avoidance, which served to stop or shut down the initial emotional experience. Control could be either cognitive and/or physiological in nature. With cognitive control, clients invalidated their emotional experiences, criticized themselves, or expressed hopeless beliefs or prohibitions against allowing their emotions due to the belief that doing so would have a negative impact. Physiological control could involve swallowing, sighing, choking, or clenching muscles. In contrast to control behaviors, some clients engaged in avoidant actions. These included the explicit expression of a desire to avoid the experience or expression of the emotion, or a desire to hide or flee the session. They also included behavior such as self-injunctions

against expression, laughter, statements indicating an internal sense of disconnection from the experience of the emotion, pushing away the emotion, or expressions of hopelessness or helplessness.

The majority of clients in Weston's (2018) study also expressed secondary reactive emotions, which served to inhibit or block the flow of an initial emotional experience and/or its expression. Fear was the most common reactive emotion observed in the study and took the form of fear of loss of control, of the unknown, of expression of emotion, and of dying. Others expressed shame or embarrassment about admitting or showing emotion, because of a belief that it would negatively impact a relationship, or that they could be judged or found wanting by others. Beliefs about not living up to expectations or being ungrateful to another and related feelings of guilt were expressed by some. Anger toward the self was also observed in the form of harsh self-criticism for allowing the emotion. Weston found that the resulting effects of self-interruption in these sessions were most commonly negative, such as feeling depleted, weak, numb, fatigued, feeling bad, resignation, sadness, or low self-worth. However, a few clients described positive effects of feeling less vulnerable, stronger, relieved, and more in control.

In addition to examining in-session client behaviors during self-interruptive events, Weston (2018) also conducted Interpersonal Process Recall Interviews (Rennie, 1992) to better understand clients' subjective experiences of self-interruption and subsequently analyzed clients' responses using a grounded theory approach (Rennie, 2006). All clients interviewed described experiencing a deep sense of vulnerability in relation to their emotional experience, due to a perception of threat to physical self-integrity, psychological self-cohesion, and/or existence. This vulnerability was a catalyst for clients' need for protection via self-interruption. Some clients

noted feeling vulnerable in the face of a visceral experience of emotion, such as an intense, deep, painful, and/or sudden feeling in the body, or in the face of expressing or showing their emotion or related needs to another person. Other clients explained how they experienced emotional conflict involving opposing parts of self with respect to allowing emotion or a threatened identity. Others still reported a hazy emotional experience marked by lack of clarity, confusion about the experience, and/or difficulty symbolizing and/or expressing it. As well, some clients identified a weakened sense of self which could include feeling overwhelmed, a sense of losing control, or being stuck in a black hole, hopelessness, or lacking self-protection.

Another finding from Weston's (2018) interviews was that all clients described how their sense of vulnerability was rooted in a history of negative experiences of emotion. Clients shared stories of emotion that were marked by themes of a long-standing sense of danger, the need to engage in ways of coping that were learned to stay safe, difficulty allowing or expressing feelings, and/or outright invalidation of emotion. These historical experiences left them feeling vulnerable to negative consequences of allowing or expressing their emotions or related urges/needs, which included being physically or verbally attacked, feeling intense fear, loss of control, physical symptoms or illness, depression, feeling unsupported, invalidated and/or unaccepted by others or themselves when they expressed emotions or related needs. The chronic absence of validation and acceptance led some clients to internalize a negative perception of themselves as unacceptable, weak, or crazy, or to feel a sense of alienation and isolation from others. These findings from Weston's study elucidate the range of ways in which AESI can present in psychotherapy, as well as the underlying subjective experiences contributing to its etiology and resulting impact on clients.

Also using a grounded theory approach, Bolger's (1999) earlier analysis of interviews with adult children of alcoholics sheds further light on the subjective experience of emotional pain and its interruption. Bolger defined emotional pain as a sense of woundedness, disconnection, or loss of self and/or awareness of self. Participants in the study described covering or disallowing their emotional pain when they were unable to tolerate or remain present with it. They reported interrupting their pain by refusing to admit it, focusing their attention on external activities or other people, avoiding showing their pain to others, and blocking painful experiences from their memory. Moreover, participants shared that they interrupted their pain in response to feelings of loss of control and alarm about their capacity to cope with the experience. Loss of control involved feeling powerless to regulate or stop their pain, as well as helplessness and hopelessness. Alarm was related to fear of loss of control, breaking down, getting stuck, or exposing negative features about themselves. Alarm could also be in response to intense anxiety, fear, shame, and overwhelm in relation to their pain. Participants who accepted and stayed with these experiences went on to attain emotional transformation through the processing of other primary emotions, whereas participants who continued to struggle with fighting for control over their pain and related emotions, were unable to attain this transformation. Accordingly, it is important for therapists to understand how to help clients overcome aversion to and interruption of their emotional experiences.

**Resolution of AESI.** While the client processes involved in the resolution of Aversion to Emotion/Self-Interruption (AESI) have not been systematically investigated in previous research, Greenberg and colleagues (Greenberg et al., 1993; Elliott, Watson et al., 2004) proposed a sequence of such processes based on their clinical observations. The authors suggest that the

therapist's main goal is to help clients heighten their awareness of their interruptive processes and help them access and allow their blocked emotional experiences. They recommend two-chair enactment as the best intervention for facilitating this. This intervention was drawn from gestalt therapy (Perls, 1969; Perls et al., 1951) and adapted for working with a variety of internal conflicts in EFT, including self-interruption, self-criticism, and worry/anxiety (e.g., Greenberg, 1979, 1980, 1984, 1986; Greenberg et al., 1993; Timulak & McElvaney, 2016; Watson & Greenberg, 2017). Two-chair enactment is beneficial for resolving conflicts between two parts of self, or when one part of self dominates over another part that is disowned or disclaimed (Elliott, Watson et al., 2004; Greenberg, 1979; Greenberg & Dompierre, 1981; Greenberg & Rice, 1981; Greenberg & Webster, 1982). The enactment is set-up by having two chairs facing each other, in order to distinguish between the two parts in opposition (Elliott, Watson et al., 2004). Clients are guided to enact each part, as they engage in a dialogue with the other part of self. Thoughts, feelings, and needs are explored and expressed from each part (Greenberg, 2011). Resolution of the conflict split involves a softening of the dominant voice, which sometimes involves a negotiation between the two parts (Greenberg et al., 1993, Elliott, Watson et al., 2004). Instead of conflict or coercion, the end result is integration between the two sides, along with self-acceptance.

When working on AESI using two-chair enactments, “the interrupter” (i.e., the part of self that blocks primary emotions) is differentiated from the “the experiencer” (i.e., the part within which primary emotions arise; Greenberg et al., 1993; Elliott, Watson et al., 2004; Vrana & Greenberg, 2018). In order to facilitate this differentiation, the interrupter is put in a chair facing the client. The client is then encouraged to sit in this facing chair to enact the interrupter

suppressing or stopping them. The purpose of this enactment is to increase the client's awareness of how they block their emotions or hold themselves back, and to increase the client's sense of agency and control over this process. This helps the client become aware of what they say to themselves to stop feeling, including how they contribute to their own anxiety about the emotion by imagining catastrophic fears as coming true in the future. Since AESI is likely to involve a physical component, the therapist can also encourage the client to enact and exaggerate the physical expressions of their attempts to stop themselves. Elliott and colleagues suggest that this physical enactment is most effective in stimulating associated emotion schemes and facilitating the full expression of emotions. As a result of this enactment, the client comes to understand that, just as they can produce emotional and physical discomfort in themselves, they themselves can change these feelings.

After having enacted the interrupter, the client is asked to return to the original chair as the experiencer and is directed to attend to their internal experience of being interrupted (Greenberg et al., 1993, Elliott, Watson et al., 2004). Common resulting experiences include physical discomfort, passivity, or resignation. The client may also realize how their self-interruption can lead to and perpetuate negative states such as depression, guilt, anxiety, physical tension, or pain. The client's acknowledgement of these negative experiences and states increases their awareness of their inherent desire or need to allow and express the emotion, which is supported and encouraged by the therapist. The client may need to switch between chairs several times, as thoughts, feelings, and needs of each part are more deeply explored, until an agreement or integration is reached between the two parts of self. The task is considered to be resolved when the interrupter no longer opposes the experiencer's primary emotions, including

related needs and action tendencies, and the experiencer can fully experience, own, and express them.

Research has shown that the benefits of chair-based dialogue interventions include increased self-awareness (Greenberg & Higgins, 1980), decisional conflict resolution and behavior change (Greenberg & Dompierre, 1981), as well as reduction in distress (Greenberg & Webster, 1982). One study also found that, compared with empathic reflections alone (Gendlin, 1996), a chair-based dialogue intervention led to deeper levels of client experiential engagement (Klein et al., 1986; Greenberg & Clarke, 1979), an indicator of productive emotional processing shown to predict therapeutic change (Warwar, 2003). However, another study on the application of EFT for treating complex relational trauma showed that, when levels of client experiential engagement during an empathic exploration procedure were similar to those of clients in a chair-based dialogue procedure, therapeutic outcomes were comparable across both intervention groups (Paivio & Pascual-Leone, 2010; Ralston, 2006). This suggests that it is possible for clients to undergo transformative emotional processing both with and without the use of chair-based dialogue interventions, and that the quality of clients' emotional processing may have more of an impact on outcomes than the specific intervention used to facilitate it. Accordingly, process-guided empathic exploration that supports clients' experiential engagement may be an alternative means of facilitating the resolution of AESI.

In EFT, the resolution of AESI is viewed as critical to clients' recovery and growth (Greenberg & Watson, 2006). Previously interrupted primary adaptive emotions (e.g., such as sadness, anger) can now be accessed in order to draw on the adaptive information they contain, so that they can be used in problem solving. In addition, previously interrupted primary

maladaptive emotions (e.g., shame, sadness, and fear) can now be allowed, so that they can be brought into contact with primary adaptive emotional responses (e.g., such as sadness, anger, pride, self-compassion) for the purpose of transformation. Moreover, the resolution of AESI opens clients up to the possibility of living more authentically with greater self-acceptance and cohesion between parts of self previously in conflict. Clients can begin to access a fuller range of emotions and they can feel more empowered to take new actions in the world to meet corresponding needs (Elliott, Watson et al., 2004), including communicating them in relationships with others, which can contribute to improved interpersonal functioning.

Greenberg and Paivio (1998) suggest that once clients act on their decision to approach, allow, and tolerate painful emotions that were previously avoided, clients are left feeling stronger and relieved from having survived them. This also results in a change in clients' internal relationships as they re-own their pain with acceptance and agency. This is supported by the positive transformative effects of allowing and staying with (instead of interrupting) emotional pain found in Bolger's (1999) qualitative research. In her study, participants reported that allowing emotional pain involved a conscious decision to welcome it. For some, the fear or shame associated with their pain was absent, while for others these emotions were sufficiently tolerated in such a way that they did not interfere with clients staying with their pain. Allowing pain also involved non-verbal expressions, such as crying, the symbolization of the felt experience in words, and the re-experiencing of a painful event from the past. Participants further described a sense of "moving through" something or experiencing shifts associated with personal growth, as a result of allowing and staying with their pain. Some noted becoming more focused on their needs and goals, seeing themselves as more independent, worthwhile, having a better

sense of themselves, and being more self-accepting. Others described taking responsibility for their choices and making changes in their lives. As well, others reported a new capacity to allow feelings that emerged in response to what happened in the past, along with greater acceptance. Some clients further disclosed having more realistic views of others and greater desire for closer relationships. These benefits of accessing emotional pain and primary emotions are supported by psychotherapy process research demonstrating that the extent to which clients productively access their emotions in therapy positively predicts outcome. This body of research is reviewed next.

### ***Relationship between In-Session Emotional Processing and Outcome in Psychotherapy***

**Psychotherapy Process Research.** While studies evaluating the efficacy of treatment protocols for specific psychiatric diagnoses were once considered the gold standard of psychotherapy research, there is a growing consensus that such diagnosis-led treatment models lack utility in clinical practice and research (e.g., Bullis et al., 2019; Dalgleish et al., 2020). Several issues with diagnosis-led treatment models have been identified, including evidence that the underlying biopsychosocial processes contributing to the onset and maintenance of many mental disorders are transdiagnostic (i.e., present across several distinct diagnostic categories; Dalgleish et al., 2020), that there is significant heterogeneity in clinical presentation within diagnostic categories (Fried & Nesse, 2015; Galatzer-Levy & Bryant, 2013), and that there is high incidence of comorbidity among diagnoses (Kessler et al., 2005). Diagnosis-led treatment protocols have also been criticized for failing to take into account the complex needs of individual clients, the contexts of interventions, the specificity of treatment strategies or

problems, or their links to processes or mechanisms that bring about therapeutic change (Hofmann & Hayes, 2019). Accordingly, there has been an increased focus in psychotherapy research on answering the question: “What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances, and how does it come about?” (Paul, 1969). In an attempt to answer this question, a large body of psychotherapy research has emerged on the delineation of evidence-based transdiagnostic change processes, or mechanisms of therapeutic change (for reviews see: Hardy & Llewelyn, 2015; Orlinsky et al., 2015).

One transdiagnostic mechanism of therapeutic change that has been widely studied is the degree to which clients access and express their emotions in therapy. A meta-analysis examining the relationship between client emotional expression and outcomes across 44 studies representing a range of therapeutic approaches revealed a significant medium-to-large effect size (Peluso & Freund, 2018). In addition, higher observer ratings of clients’ in-session emotional arousal in the middle phase of EFT predict greater improvement at the end of therapy (Warwar, 2003). Likewise, in intensive short-term dynamic psychotherapy, the facilitation of client in-session bodily arousal and visceral experiencing of affect have been identified as contributing to therapeutic improvement (Town et al., 2017).

Despite the established relationship between emotional arousal and outcome, other research suggests that emotional arousal alone is not sufficient for facilitating therapeutic change. Moderate levels of emotional arousal have been shown to be optimal, whereas too much or too little emotional arousal is less facilitative (Carryer & Greenberg, 2010). Likewise, other studies have indicated that clients who sufficiently regulate their emotions have better outcomes

(Watson et al., 2011; Toukmanian & Dunbar, 1991). When arousal is too low, clients are not able to access the valuable information that their emotions provide. Conversely, when arousal is too high, it is difficult for clients to reflect on and make meaning of their emotional experience. Accordingly, emotions need to be moderately aroused so that the cognitive processes involved in narrative construction can be integrated with affective experiences (Greenberg, 2002; Greenberg, 2008; Greenberg & Pascual-Leone, 1995; Levenson et al., 2020). This is supported by research demonstrating that emotional arousal in conjunction with clients' ability to use their internal experience to make meaning and solve problems, also referred to as client "experiencing" or "experiential engagement" (Klein et al., 1986), is a better predictor of outcome compared to emotional arousal alone (Missirlan et al., 2005; Warwar, 2003; Warwar & Greenberg, 2000). A meta-analysis of 10 studies revealed that clients' levels of experiencing is a significant predictor of therapeutic change across a range of approaches, including EFT, cognitive behavioral, psychodynamic, and interpersonal models (Pascual-Leone & Yeryomenko, 2016). Moreover, clients' levels of experiencing have been shown to mediate the relationship between arousal and outcome, suggesting that arousal may promote therapeutic progress by facilitating client experiencing (Paolone & Pos, 2013).

Research on clients' levels of experiencing over the course of emotion-focused therapy suggests that it is not a static trait, but a skill that that can be improved over time (Pos & Choi, 2019). Pos and colleagues (2003) showed that clients can increase their levels of experiencing during emotion narratives over the course of therapy, and that this increase better predicts outcome than clients' pre-therapy dispositions to emotional processing and experiencing. Another study revealed that clients' steady improvements over the course of EFT coincided with

measurable increases in their emotional range and degree of productive emotional processing (Pascual-Leone, 2009). Moreover, Adams (2010) demonstrated that therapists' higher levels of experiencing during sessions contributed to increases in clients' levels of experiencing, which in turn positively predicted treatment outcome. Thus, therapists' efforts to deepen clients' experiential engagement over the course of therapy can contribute to improved outcomes.

These findings point to the need for therapists to not only promote clients' emotional arousal in therapy, but to also support clients' regulation of and reflection on their aroused experience, in order to enable productive meaning construction. When contact with emotion is established, clients must also cognitively orient to that experience as information, in order to explore, reflect on, and make sense of the experience (Greenberg, 2011). Clients need to be supported in accessing their needs and in making meaning of these emotional experiences, in order to access their adaptive internal emotional resources. This new information can then be integrated into existing schemes, allowing for holistic emotional and narrative transformation (Angus & Greenberg, 2011).

With the aim of providing a map to guide therapists, Greenberg and colleagues (2007) developed criteria for identifying productive client emotional processing. The authors defined productive emotional expression as "a client experiencing a primary emotion in such a way that a) [the client] can extract the useful information inherent in an adaptive emotion in the service of problem resolution, or b) [the client] shows the potential to be able to transform a maladaptive emotion into a more adaptive emotional experience" (Auszra & Greenberg, 2007, p. 142). This definition is supported by research demonstrating that clients who resolve their self-critical depressive tendencies over the course of EFT exhibit more emotion sequences in accordance

with the transformation of secondary and primary maladaptive emotions to primary adaptive emotions (Choi et al., 2016). Similarly, clients' expression of more primary adaptive emotions and less secondary emotions predicted better outcomes at termination and long-term follow-up in EFT for depression (Rinaldi, 2015; Wong, 2016).

Greenberg and colleagues (2007) further proposed that, for productive emotional processing to occur, all elements of a primary emotion scheme, including bodily-felt aspects, need to be activated and experienced in the present moment, and processed in a manner consistent with the following seven features: i) attending, ii) symbolization, iii) congruence, iv) regulation, v) acceptance, vi) agency, and vii) differentiation. The authors explain that clients need to attend to, allow, and tolerate their primary emotions. They need to label and describe their emotional responses in words, so that they can fully comprehend their meaning. There needs to be congruence between clients' verbally symbolized emotional experiences and nonverbal emotional expressions; in contrast, discrepancy can indicate that clients are not fully allowing emotions by blocking their experience. Activated emotional experiences also need to be sufficiently regulated so that they are not overwhelming; clients need to be able to develop and maintain a working distance from their emotional experience, so that they can cognitively orient toward it as information, in order to allow for an integration of cognition and affect. As well, clients need to adopt an accepting stance toward their feelings, valuing them for the information they provide, without negatively judging themselves for having them or trying to stop or over-control them. Moreover, clients need to experience themselves as active agents, rather than passive victims of their emotions, by taking responsibility for their role in generating and changing their emotions, as opposed to focusing on external factors, resigning themselves to

their emotions, or treating them as symptoms to be rid of. Lastly, clients' primary emotional expressions have to become differentiated over time, moving from more general and global emotional reactions (e.g., "feeling bad") to more complex, nuanced feelings or meanings (e.g., "feeling small and unloved"). In applying this criteria to clients undergoing EFT, Greenberg and colleagues found that emotional productivity increased from the beginning to the working and termination phases of therapy. Moreover, productive emotional expression during the working phase was found to account for 66% of treatment outcome, over and above other variables, including high emotional arousal during the working phase (Greenberg et al., 2007).

***Task Analytic Research.*** The importance of differentiating between various forms of emotional expression has also been demonstrated through task analytic research on client change processes in EFT. Task analysis is a discovery-oriented method developed specifically for the study of actual in-session client performance (Greenberg, 2007). Studies using task analytic methodology show that allowing and expressing primary emotions is a key ingredient of therapeutic change, whereas the interruption, inhibition or avoidance of primary emotions contributes to the maintenance of distress and symptoms.

Using task analytic methodology, Pascual-Leone and Greenberg (2007) found that, early in therapy, individuals commonly present with undifferentiated and insufficiently processed secondary emotions, referred to as "global distress." In their study, individuals who successfully resolved their depression were more likely to elaborate on and differentiate their thoughts and feelings related to their global distress and to subsequently move into primary maladaptive states of fear or shame. Once these underlying primary maladaptive states are activated, clients can

obtain information about their core needs and negative self-evaluations, which is a critical step in activating alternate adaptive emotions, such as assertive anger, self-soothing, and hurt/grief.

Moreover, the authors also found that clients' progression through this sequence is positively predicted by their degree of experiential engagement during sessions.

Also using task analytic methodology, Sicoli (2005) developed and validated a model to explain how clients resolve hopelessness over the course of EFT for depression. The author observed that self-interruption contributed to the maintenance of clients' hopelessness. However, the acknowledgement and acceptance of primary emotions, along with the expression of related needs and meaning, was essential to resolving hopelessness, which in turn predicted reduction in symptoms of depression. Likewise, Malcolm (1999; Greenberg & Malcolm, 2002) developed and verified a model of resolution of unfinished business, which identified self-interruption as an obstacle that needed to be worked through before unfinished business could be resolved. On the other hand, the intense expression of primary emotions and corresponding previously unmet interpersonal needs was a critical prerequisite to resolving unfinished business. The value in productively expressing primary emotions was similarly highlighted in models of resolving arrested (or inhibited) anger (Tarba, 2007; 2015), core maladaptive shame (Miller, 2019), attachment insecurity (Sharbanee et al., 2015), and vulnerability (Keating & Goldman, 2003) in depressed clients, as well as worry in clients with generalized anxiety disorder (Murphy et al., 2017; Watson & Greenberg, 2017). The findings of these task analytic studies, along with the process research reviewed above, lend support to the notion that the quality of clients' emotional processing is a transdiagnostic mechanism of therapeutic change and that the interruption of

emotion is a transdiagnostic indicator of problematic processing in therapy that demands intervention.

### **The Current Study**

Given the role of avoidance and inhibition of emotions in the development and maintenance of a range of psychopathology, as well as the importance of the productive processing of primary emotions in effecting therapeutic change, it is imperative that Emotion-focused therapists know how to intervene when Aversion to Emotion/Self Interruption (AESI) emerges in sessions. The nature and experience of AESI has been the subject of a comprehensive investigation by Weston (2018); however, the resolution of this problematic process has received less attention. While Greenberg and colleagues (Greenberg et al., 1993; Elliott, Watson et al., 2004) proposed a sequence of client processes involved in the resolution of AESI, based on clinical observations, there has not been any in-depth systematic investigation into these processes. The current study aims to address this gap in the literature. It is guided by the question, “How do clients move from interrupting their emotions to allowing them in EFT?” with the goal of developing a transdiagnostic model of client processes involved in this change. This will be achieved using a task analytic approach (Greenberg, 1991, 2007; Pascual-Leone et al., 2009; Rice & Greenberg, 1984).

Task analysis is particularly well-suited for studying client processes involved in the resolution of AESI in EFT. This method for studying actual in-session client-therapist performance “recognizes the complexity of the psychotherapeutic process and attempts to analyze the complex unfolding of moment-by-moment performance of people in specific states

and contexts” (Greenberg, 1991, p. 8). Task analysis assumes that clients in therapy engage in central, meaningful “tasks” that they strive to complete (Greenberg, 2007). The completion of these tasks is assumed to be represented by clinically meaningful client-therapist interactional sequences, which are comprised of a beginning point, a working through process, and an end point (Rice & Greenberg, 1984). Through intensive, moment-by-moment “analysis” of client processes, researchers can uncover the specific mechanisms involved in the successful or non-successful resolution of problematic tasks, as they occur within therapy sessions.

The current task analytic study consists of two phases: a Discovery Phase to develop a model of the resolution of AESI and a Validation Phase to verify the model.

### ***Discovery Phase Objectives***

The general objective of the Discovery Phase is to identify how clients resolve AESI. The primary goal is to identify observable shifts in client processes as they move from interrupting to allowing their emotions, and to create a model of the components involved. A secondary goal of this phase is to develop measures suitable for testing this model of resolution. The method and results of the Discovery Phase are presented in Chapter 2.

### ***Validation Phase Objectives***

The general objective of the Validation Phase is to conduct preliminary empirical testing on the model of resolution derived in the Discovery Phase. The primary goal is to demonstrate that the components of the model can be discerned in a different sample than was used in the Discovery phase, and to confirm that their presence is associated with clients’ resolution of AESI. The secondary goal is to examine whether the Validation Phase data support the structure of the derived model. The method of the Validation Phase is presented in Chapter 3, while the

results are reported in Chapter 4. Lastly, the findings from both Phases are discussed in the context of existing literature and implications for clinical practice and future research in Chapter 5.

## **Chapter 2:**

### **Method and Results of the Discovery Phase of the Task Analysis of the Resolution of AESI**

The overarching aim of the Discovery Phase was to identify how clients resolve Aversion to Emotion/Self-Interruption (AESI). The primary goal was to create a model of the component processes involved in clients' progression from AESI to resolution. The secondary goal was to develop measures suitable for testing this model.

#### **Clients**

A total of five clients were analyzed for this first phase of the study. They were selected from clinical trials of emotion-focused therapy (EFT). More specifically, four clients were from the combined York I & II Depression Studies (Goldman et al., 2006; Greenberg & Watson, 1998), and one was from the York Unfinished Business Study (Paivio, 1993; Paivio & Greenberg, 1995). The client selection procedure is described in more detail under the heading Selection of Sessions with AESI Events in the Procedures and Results section below.

Clients from the York I and II Depression Studies met the criteria for a formal diagnosis of major depressive disorder, based on the Structured Clinical Interview for the DSM-IV (SCID; Spitzer et al., 1995), as an inclusion criterion for the original study (Goldman et al., 2006; Greenberg & Watson, 1998). Exclusion criteria consisted of the following: current diagnosis of psychosis, bipolar I disorder, substance dependence, eating disorder, two or more features of schizotypal, paranoid, borderline, or antisocial personality disorder, recent bereavement, current physically abusive relationship, and/or current acute suicidality. Only cases from the emotion-focused therapy (EFT) condition (versus client-centered therapy condition) of the original studies

were selected, in order to examine how clients overcome Aversion to Emotion/Self-Interruption in EFT specifically.

Clients from the Unfinished Business Study (Paivio, 1993; Paivio & Greenberg, 1995) needed to identify a circumscribed area of unfinished business with a significant other that they were motivated to work on in therapy. Exclusion criteria included the following: severe psychological disturbance, psychosis or deep-rooted characterological problems, organic or neurological impairment, major intellectual deficit, complicating illness, substance dependence, current and/or acute suicidality, or current involvement in another form of therapy.

### ***Client Demographics***

The average pre-therapy Global Assessment of Functioning Score (GAF) on the SCID for the clients in the current study was 64.40 ( $SD = 7.83$ ,  $range = 51-70$ ). Clients ranged in age from 26 to 55 years ( $M = 39.40$ ,  $SD = 12.52$ ). Three were female and two were male. Two of the clients were single, 2 were married/common law, and 1 client was separated/divorced. Two clients completed high school, 2 completed post-secondary education, and 1 client completed some post-graduate education.

### **Therapists**

A total of four therapists worked with the five clients in this phase. One of the therapists worked with two clients. The three therapists from the York I and II Depression Studies had at least one year of supervised training in emotion-focused therapy and an additional 48 hours of training over the course of 24 weeks. Training was based on the manualized treatment protocol for the emotion-focused therapy for depression (Greenberg et al., 1993).

The therapist in the Unfinished Business Study had a minimum of three years of clinical experience as an intern and a professional, including a minimum of one year of supervised training in emotion-focused therapy and the gestalt empty-chair method, the main intervention used in the study (Greenberg & Minden, 1988; Greenberg et al., 1993).

In all studies, therapists attended weekly supervision sessions led by experienced clinicians. Therapists were monitored for adherence to the treatment protocol. Non-registered therapists were supervised weekly by a registered psychologist.

## **Procedures and Results**

Each procedural step in the task analytic methodology builds on the one preceding it. To facilitate ease of understanding of how this methodology was implemented, the reporting of the results of the various steps is integrated with the reporting of the procedures below.

### ***Step I: Description of the Task***

**Defining the Marker of Aversion to Emotion/Self-Interruption (AESI).** The first step in approaching a task analysis is to clearly specify and describe the client task of interest (Greenberg, 1984, 2007; Greenberg & Foerster, 1996a, 1996b). For this project, the essential features of Aversion to Emotion/Self-Interruption (AESI) as reflected in theory and research were identified and a precise operational definition was devised.

The *Marker of AESI* was defined as the client explicitly communicating or displaying the following:

- A dislike for or disinclination toward experiencing or expressing a primary emotion (or a related need, action tendency or part of self), and/or
- Efforts to prevent, stop, or over-control the experience or expression of a primary emotion (or a related need, action tendency or part of self). These efforts may be deliberate or automatic. They can manifest as the suppression of one part of self by another.

The Marker could emerge in response to the therapist's attempts to facilitate the client's experience or expression of emotion during a therapy session, or in the context of the client's interactions with self or others outside of therapy sessions.

**Defining the Resolution of AESI.** Once the beginning point of the task, the Marker of AESI, was identified, the investigator proceeded to specify the endpoint of the task, the state of Resolution of AESI.

The *Resolution of AESI* was defined as the client no longer opposing the emotion (or a related need, action tendency or part of self). There is an absence of efforts to stop, prevent, or over-control the emotion. The client may be seen either: (a) reporting that the part of themselves that previously interrupted the emotion (i.e., the interrupter) is now open to the allowing of the emotion, or (b) allowing the previously interrupted emotion in the session.

### *Step II: Explicating the Investigator's Cognitive Map*

Once a clear definition of the task to be examined was developed, it was crucial to identify the perspectives, assumptions, and preconceived ideas with which the investigator entered the task analytic process. This was done to acknowledge the inherent subjectivity, including biases and influences, that all investigators bring to their research. This investigator's views on AESI were informed by her reading on EFT theory (as described in the literature review in Chapter 1 above), as well as her clinical experience as an EFT therapist. Explicit statements of assumptions that the investigator held at the outset of this study included the following:

- a) Emotions involve action tendencies that are adaptive in nature, providing meaning and organizing action. They are individuals' primary sources of information and motivators for action.
- b) Emotions result from appraisals of situations in relation to one's needs.
- c) Emotions can be either adaptive or maladaptive.
- d) Emotions can be changed through the accessing of alternate, adaptive emotions ("changing emotion with emotion").
- e) The degree to which clients are able to draw on their internal experience to make meaning and solve problems, also referred to as experiencing, is related to positive outcome in EFT for depression.
- f) The interruption of naturally-occurring, adaptive emotional processes contributes to the development of depression and unfinished business.

- g) Aversion to Emotion/Self-Interruption is a process that clients engage in to prevent or stop themselves from productively experiencing or expressing an emotion or related need.
- h) In order to overcome their self-interruption, clients need to turn their passive, automatic process of self-interruption into an active one. They need to become aware of how they interrupt themselves, such as through two-chair enactment of their interruptive process. This helps to evoke the interrupted emotion and access the unmet need.
- i) Accessing and allowing previously disowned emotions, in the presence of a safe, therapeutic relationship, can promote adaptive emotional functioning, and in turn facilitate the resolution of distress and symptoms.

### ***Step III: Specifying the Task Environment***

Therapists involved in both the York I and II Depression projects adhered to a manualized protocol for emotion-focused therapy (EFT) for depression. The following manual was utilized:

Greenberg, L.S., Rice, L., & Elliott, R. (1993). *Facilitating emotional change: The moment-by-moment process*. New York: Guilford.

The therapist involved in the unfinished business study adhered to the aforementioned treatment manual, along with the following additional manual more specific to unfinished business:

Greenberg, L. S., & Minden, R. R. (1988). *Manual for three specific marker-driven interventions drawn from gestalt therapy*. Unpublished manuscript. York University, Toronto, Ontario, Canada.

Although the unfinished business study included an additional treatment manual that emphasized the empty-chair intervention more specific to unfinished business, the depression treatment manual also includes this intervention, since unfinished business is common among depressed clients. While the training of therapists in the York I and II Depression projects emphasized the emotional change processes involved in the resolution of depression, the training of therapists in the Unfinished Business study emphasized the emotional change processes involved in the resolution of unfinished business. However, therapists in all three studies were trained on the same general treatment model, along with the same specific interventions for self-interruption. As stated earlier, therapists were monitored for adherence.

At a general level, the EFT treatment protocol for each study instructed therapists to develop positive therapeutic relationships with their clients by means of empathic attunement using client-centered relational conditions (Rogers, 1957), nurturing a therapeutic bond (i.e., communicating empathy, caring, and presence), and developing task collaboration. They were also coached to attend to, empathize with, and validate their clients' moment-to-moment emotional processing in sessions. They were further taught to facilitate clients' emotional awareness, expression, regulation, reflection, and transformation.

At a more specific level, therapists in both studies were trained on the same protocols for working with self-interruption. Therapists were required to identify markers of interruption, including emotional constriction, resignation, or hopelessness. Manualized self-interruption resolution strategies instructed therapists to: 1) help clients turn their passive, automatic process of self-interruption into an active one; 2) heighten clients' awareness of how they interrupt themselves and transform these interruptive processes so that their emotions could be accessed

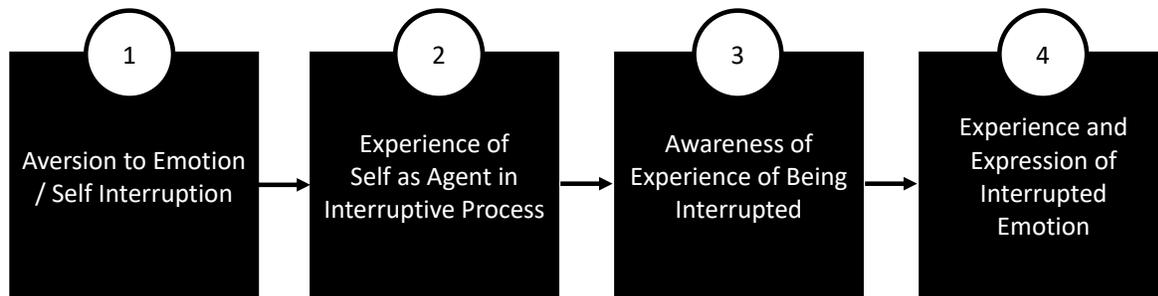
and processed, in order to facilitate the resolution of depression and unfinished business; and 3) use the two-chair dialogue technique for internal splits to facilitate the resolution of self-interruption. For more information about the EFT treatment models for depression and unfinished business, including interventions for self-interruption, refer to Greenberg, and colleagues (1993), as well as Greenberg and Minden (1988).

#### ***Step IV: Rational Analysis and Model***

The next step of the task analytic method involves conducting a rational analysis with the goal of forming hypotheses about client performance in the process of resolving Aversion to Emotion/Self-Interruption (AESI) in emotion-focused therapy (EFT). The investigator drew on her own clinical knowledge, that of her supervisor, and that of other clinicians, along with examining various theoretical views on this subject (see literature review in Chapter 1). The investigator and her supervisor reflected on the process of previous clients with whom they had worked who experienced AESI. The purpose was to elucidate a sequence of the essential components of client performance that were believed to be representative of how clients resolve AESI in emotion-focused therapy. This rational description of client performance served as a reference point with which to compare the actual AESI segments to be empirically examined in subsequent steps of the task analysis.

For the process of AESI resolution, an attempt was made to answer the question, “How do clients resolve their Aversion to Emotion/ Self-Interruption within a session of emotion-focused therapy?” Using the process described above, the rational model of the resolution of AESI was constructed as follows (see Figure 1).

**Figure 1.** *Rational Model of Resolution of Aversion to Emotion/Self-Interruption*



**Rational model of Resolution of Aversion to Emotion/Self-Interruption.**

1. *Aversion to Emotion/ Self-Interruption.* The client communicates or displays: a) a dislike for or disinclination toward experiencing or expressing a primary emotion, and/or b) efforts to prevent, stop, or over-control the experience or expression of a primary emotion, or related need or action tendency. Clients' efforts may be deliberate or automatic. They can manifest as the suppression of one part of self by another. This marker could emerge in response to the therapist's attempts to facilitate the client's experience or expression of emotion during a therapy session, or in the context of the client's interactions with self or others outside of therapy sessions.

2. *Experience of Self as Agent in Interruptive Process.* The client becomes aware of their efforts to stop, prevent, or control their experience or expression of the emotion. This often unfolds in a two-chair dialogue, wherein the interruptive part of the self is differentiated from the experiencing self. The purpose of this enactment is to increase the client's awareness of how they block their emotions and to increase the client's sense of agency and control over this process.

3. *Awareness of Experience of Being Interrupted.* The client becomes aware of the feeling of being stopped, which can include the experience of physical discomfort, passivity or resignation. The client may also realize how their self-interruption can lead to and perpetuate negative states such as depression, guilt, anxiety, physical tension, or pain. The client's acknowledgement of these feelings and states increases their awareness of their desire to allow the emotion.

4. *Experience and Expression of Interrupted Emotion.* The client no longer opposes the emotion, or associated need or action tendency. There is an absence of efforts to stop, prevent, or over-control the emotion. The client may be seen either: (a) reporting that the part of themselves that previously interrupted the emotion (i.e., the interrupter) is now open to the allowing of the emotion, or (b) allowing the previously interrupted emotion in the session.

### ***Step V: Empirical Analysis***

Once the rational model was developed, the empirical portion of the Discovery Phase of the task analysis was carried out, which involved an intensive analysis of actual therapy sessions with Aversion to Emotion/ Self-Interruption (AESI) events. The goal was to formulate a description, based on actual in-session client performance, of what constitutes a state of AESI, the resolution of AESI, along with the delineation of the processes clients engage in as they work toward resolution.

**Selection of Sessions with AESI Events.** To select sessions for inclusion in the study, the investigator started by reviewing therapist post-session reports from the York II Depression Study (Goldman et al., 2006), in order to identify clients noted by their therapists as presenting

with self-interruption. Additionally, the investigator asked colleagues concurrently conducting research using the York Depression I (Greenberg & Watson, 1998), York Depression II (Goldman et al., 2006), and the Unfinished Business Study (Paivio, 1993; Paivio & Greenberg, 1995) datasets to identify cases where Aversion to Emotion/Self-Interruption may have been present. Publicly available videos recorded for the purpose of therapist training in emotion-focused therapy were also reviewed. From these sources, a total of 43 cases were short-listed for closer examination.

Research assistants were trained in identifying the Marker of Aversion to Emotion/Self-Interruption (AESI) based on the definition generated in Step I: Description of the Task. These research assistants reviewed video- and/or audio-recordings of sessions of these cases and took detailed notes of their observations. Subsequently, the investigator reviewed these notes and the session recordings to confirm the presence or absence of the Marker of AESI. Twenty-nine of the short-listed cases were confirmed as having the Marker. Once a Marker was confirmed to be present for a given client, the investigator reviewed session transcripts and/or recordings until the client, in the investigator's judgement, either attained resolution or terminated therapy, whichever came first. From the 29 confirmed cases, 16 were found to resolve AESI, while 13 remained unresolved at the time of termination.

One session was chosen from each case for inclusion in the study. The session selected from each resolved case contained the both the Marker of AESI and its Resolution. If there was more than one session that met these criteria for a resolved client, the investigator selected the session with the greatest amount of AESI-related dialogue. The session selected from each unresolved case contained the Marker of AESI, and if there was more than one session with this

criterion, the investigator selected the session with the greatest proportion of AESI-related dialogue. An expert judge (the investigator’s supervisor) also reviewed these sessions to confirm the investigator’s observations regarding the presence of the Marker of AESI and the classification of cases into Resolved versus Unresolved subgroups.

Of the 16 Resolved cases, the investigator selected 3 “pure gold” examples for the empirical analysis, while the remaining 13 were set aside to be analyzed later in the Validation Phase of this study. Of the 13 Unresolved cases, 2 “pure gold” examples of AESI were used for the empirical analysis, while the remaining 11 were set aside for later analysis in the Validation Phase.

In the end, 5 cases were included in the Discovery Phase empirical analysis, 3 of which represented clients who successfully resolved their AESI, while 2 reflected clients who did not resolve. The Resolved sessions provided examples of the desired endpoint of resolving AESI, while the Unresolved sessions added breadth to the description of AESI resolution by elucidating what resolution is not. An expert clinician (the investigator’s supervisor) confirmed the presence of AESI and whether resolution occurred for each case. Refer to Table 1 for an overview of the cases selected for the empirical analysis.

**Table 1. Overview of Cases Selected for the Empirical Analysis**

<b>Client No.</b>	<b>Session No.</b>	<b>Emotion Interrupted</b>	<b>Resolution State</b>	<b>Dataset</b>
001	08	Sadness	Resolved	Unfinished Business
002	10	Sadness/Pain	Resolved	York II
003	07	Anger/Needs in Relationships	Resolved	York I
004	19	Sadness/Pain	Unresolved	York I
005	18	Anger	Unresolved	York II

**Analytic Procedure.** For the empirical analysis, session recordings and transcripts were examined in detail to clarify the component processes the clients engaged in on the path toward resolving their AESI. The investigator strived to use video-recordings and transcripts of therapy sessions. However, in instances where video-recordings were unavailable or had poor sound quality, these were supplemented or supplanted with audio-recordings of the sessions. The investigator studied the transcripts and recordings in depth numerous times so that attention could be given to different aspects of the process and to ensure that valuable information was not missed. In the initial stage of the analysis, non-verbal behaviours were noted, along with vocal and speech patterns to add depth to the content of the transcripts. Subsequently, the transcripts were examined several additional times, in an effort to extrapolate any shifts or points of change and describe what was observed during those moments. Eventually, detailed lower-order observations were grouped into higher-order categories that better captured the essence of the discrete component processes that clients went through.

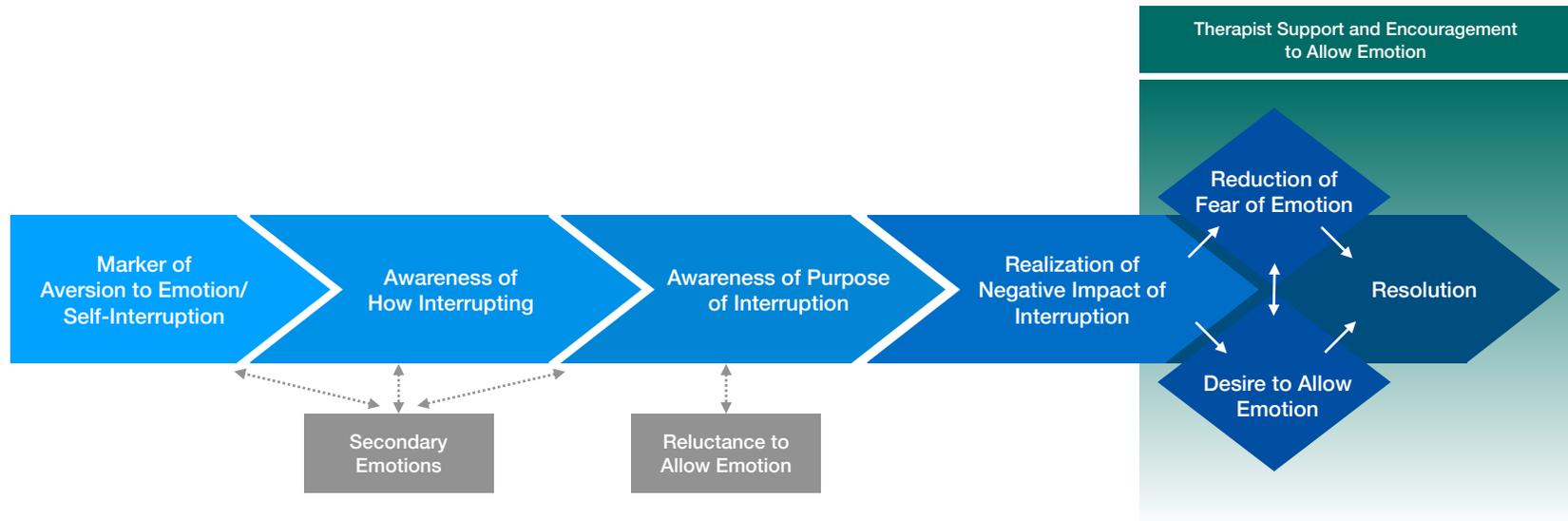
Using the aforementioned procedure, the investigator initially analyzed the three Resolved sessions followed by the two Unresolved sessions. Once all of the three Resolved sessions were analyzed, a preliminary empirical model was drawn which combined the common elements of each performance. Subsequently, the investigator analyzed the two Unresolved sessions, one at a time. While doing so, the investigator considered how processes differed between the Resolved and Unresolved clients, and where Unresolved clients appeared to become stuck. Differences between the Resolved and Unresolved cases in regard to the type and quality of client responses were also considered. Furthermore, examining the Unresolved cases helped to

clarify the components of the model that appeared to be essential to the process of resolution. The findings obtained by comparing Unresolved to Resolved cases led to further refinement of the empirical model. The investigator observed that the information garnered from the analysis of the second Unresolved case did not further the development of new model components or the refinement of existing ones. Accordingly, it was determined that saturation was reached, and the empirical analysis was concluded.

### ***Step VI: Construction of the Rational-Empirical Model***

After engaging in the empirical analysis described above, the model derived from actual client performances was compared to the rational model and both were integrated. Where there were differences, observed performances were given precedence. The integrated rational-empirical model is depicted below in Figure 2. The components in the rational-empirical model that were found to facilitate the process of resolving AESI are represented by blue arrows in the diagram. In contrast, the components represented by grey boxes signify the states in which Unresolved clients tended to become stuck and unable to progress any further toward resolution. Additionally, the green element highlights the importance of the therapists' support and encouragement in clients' progression through later stages in the model.

**Figure 2.** *Synthesized Rational-Empirical Model of Resolution of Aversion to Emotion/Self-Interruption*



When viewing this depiction of the model, one should keep in mind that it assumes that the process of resolving AESI occurs in a single therapy session. Although clients in this sample did resolve AESI in a single session, for some clients in therapy, resolution may not occur in a single session and several sessions may be needed to address AESI before resolution is attained. Additionally, the model outlines a sequence of linear, progressive steps that may precede the resolution of AESI; nevertheless, the process of resolving AESI is believed to occur in a cyclical manner wherein components occurring earlier in the session may be repeated later in a similar or more complete form.

**Description of the Rational-Empirical Model.** The rational-empirical model begins with the *Marker of Aversion to Emotion/ Self-Interruption (AESI)*, which occurs when clients communicate a dislike for or disinclination toward experiencing or expressing an emotion (including a related need, action tendency, or part of self), or when they display efforts to prevent, stop, or over-control their experience or expression of an emotion (including a related need, action tendency, or part of self). Then, clients become *Aware of How they Interrupt* the emotion, such as through avoidance or escape, physical control, cognitive control, or movement to a secondary emotion. Next, clients also become *Aware of the Purpose of their Interruption*, which is to protect them from feared consequences of allowing the emotion – more specifically, fear of damage to identity or attachment, or of becoming overwhelmed.

Subsequently, clients realize that their interruption has a negative impact on them (*Realization of Negative Impact of Interruption*). Negative impacts can take the form of physical discomfort or painful emotions experienced during the session, or longer-term negative consequences. For some clients, this realization facilitates the emergence of a *Desire to Allow the*

*Emotion*, followed by a *Reduction of their Fear of the Emotion*, by way of internalizing validation of their emotional experience and/or a sense of safety in relation to allowing the emotion. For other clients, their *Realization that their Interruption has a Negative Impact* on them is followed by a *Reduction in their Fear of the Emotion* – the latter being an important step that they need to complete before their *Desire to Allow the Emotion* can emerge. These client processes, along with *Therapists' Support and Encouragement to Allow the Emotion* at later stages of the model, are what ultimately facilitate the resolution of AESI. Resolution involves the client no longer opposing the emotion, as evidenced by the absence of efforts to stop, prevent, or over-control the emotion, or associated needs or action tendencies. The client may be seen either reporting that the part of themselves that previously interrupted the emotion (i.e., the interrupter) is now open to the allowing of the emotion or may be observed allowing the previously interrupted emotion in the session.

On the other hand, clients who do not resolve their AESI are unable to progress beyond the first three steps in the model (namely, the *Marker of AESI*, *Awareness of How Interrupting*, and *Awareness of Purpose of Interruption*). They may become stuck in *secondary emotions*, such as shame/guilt, hopelessness, or anxiety/fear, and remain *reluctant to allow* the interrupted emotion.

**Contrasting the Rational-Empirical Model with the Rational Model.** In comparing the rational-empirical model with the initial rational model, it became evident that the rational-empirical model provided more in-depth and nuanced accounts of the client processes involved in the resolution of AESI. The rational model accommodated the observed performances in the following ways.

The empirical analysis revealed the importance of clients experiencing agency in the creation of their self-interruption. However, the component Experience of Self as an Agent in Interruptive Process from the rational model was renamed *Awareness of How Interrupting* in the rational-empirical model, to better capture what clients were observed doing at that point in the process of resolution.

One important discovery was that, along the path toward resolution, clients developed *Awareness of the Purpose of their Interruption*; more specifically, they acknowledged that their interruption offered protection from the potential feared consequences of allowing the emotion. As clients came to understand the fears that held them back, this opened them up to the possibility of working toward a *Reduction of their Fear of the Emotion*.

Moreover, similar to the rational model, the empirical analysis showed that clients' awareness of their experience of having interrupted the emotion was an important step along the path toward resolution. However, the component Awareness of Experience of Being Interrupted was replaced with *Realization of Negative Impact of Interruption* in the rational-empirical model. This was done to reflect the observation that, although some clients may describe positive experiences resulting from the interruption, such as a temporary feeling of relief that comes from having stopped themselves from allowing the feared emotion, it is clients' acknowledgement of the *negative* short-term and long-term consequences of their interruption that helps them become aware of their *Desire to Allow the Emotion*.

Furthermore, the rational-empirical model includes two additional changes. It illustrates that Unresolved clients can become stuck in unproductive *Secondary Emotions*, as well as in a

*Reluctance to Allow* the emotion. It also highlights the importance of *Therapist Support and Encouragement to Allow the Emotion* in clients' progression through later stages in the model.

### ***Components in the Model of Resolution of Aversion to Emotion/Self-Interruption***

The components in the rational-empirical model of the resolution of AESI are described in greater detail below, along with examples from client transcripts to illustrate how they manifested in actual client sessions. Components occurred either while clients engaged in a dialogue with their therapists or during a two-chair enactment. Rating scales were developed to measure each of the components, so that they could be used to validate the model in the next phase of the study. The reader can refer to Appendices A, B, and C for the Marker of AESI Rating Scale (MARS), the Components of Resolution of AESI Rating Scale (CRARS), and the Resolution of AESI Rating Scale (RARS), respectively. The psychometric properties of these scales are reported in Chapter 4: Results of the Validation Phase.

**Marker of Aversion to Emotion/Self-Interruption.** The Marker of Aversion to Emotion/Self-Interruption (AESI) is the starting point in the rational-empirical model. All clients in the present study experienced this step, as this was the phenomenon under investigation. For four of the five clients (2 Resolved, 2 Unresolved) in this study, AESI emerged in response to the therapist's attempt to facilitate the client's experience or expression of an emotion during the therapy session. However, the fifth client (Resolved) reported the emergence of AESI during interactions with a significant other, which was successfully worked through during the session with the therapist.

*Description of the Marker.* The Marker of Aversion to Emotion/ Self-Interruption (AESI) is observed when clients explicitly communicate *a dislike for or disinclination toward experiencing or expressing a primary emotion (or a related need, action tendency, or part of self)*, or when they explicitly report or display *efforts to prevent, stop, or over-control their experience or expression of a primary emotion (or a related need, action tendency, or part of self)*. The Marker can emerge in response to therapists' attempts to facilitate clients' emotional exploration during therapy sessions, or in the context of clients' interactions with self or others outside of therapy sessions.

The manner in which clients convey *a dislike or disinclination* toward experiencing or expressing an emotion can range from cautious hesitation to direct refusal to do so. *Efforts made toward the end of preventing, over-controlling, or stopping* the experience or expression of the emotion can include: (a) attempts to avoid or escape the emotion (e.g., difficulty attending to or staying with the emotion, keeping it hidden or buried, struggling to get away from it, distraction, deflection), (b) attempts to physically control the emotion (e.g., holding back, constricting, squeezing), (c) attempts to cognitively control the emotion (e.g., self-injunctions reflecting negative evaluations, expectations, or beliefs about the emotion), and/or (d) movement to a secondary emotion (e.g., choosing to express anger instead of hurt because it feels less threatening). The aforementioned efforts can be either automatic or deliberate.

*Examples of the Marker of AESI from transcripts:*

Case 002

*Description:* During an empty-chair dialogue for unfinished business, the therapist attempts to explore the client's emotional pain caused by his father's abuse. The client is observed taking long pauses and sighing, and his emotional expression is constricted. When the therapist notices that he is shaking, she directs his attention toward this behaviour. The client then explains that he is expending a great deal of effort to hold back what he is feeling.

*Excerpt:\**

T: mm hm. (p:00:00:12) mm-hm. so you're seeing how it was him that was scared.

C: (deep sigh)

T: how he made you feel so terrified. (p:00:00:22) mm hm.

C: (sigh)

T: mm hm, mm hm, it was so awful for you.

C: (sigh) (*visibly shaking*)

T: (p:00:00:16) mm, *what's the shaking* here? what happens when you do that?

C: I don't know, it just takes *so much strength to hold it all back*.

T: mm hm.

C: *but I can't let it come out*.

(\*Note: In order to facilitate ease of reading this document, key phrases in transcript excerpts have been italicized. However, this italicization is not an indicator of emphasis by the speaker or of any shifts in the quality, manner, tone, or volume of speech.)

Client 004

*Description:* As the therapist attempts to facilitate the client's exploration of emotional pain, the client describes expending effort to distance herself from the pain.

*Excerpt:*

T: what, what's it like right now? can you tell me about it? can you describe what you feel?

C: (p:00:00:07) (sigh) (clear throat) (sigh)

T: it's ok.

C: oh, it just seems like it, it seems to me as like the most, *struggling to get away from the pain*.

### Client 001

*Description:* The therapist attempts to facilitate the client's re-processing of a traumatic memory from childhood involving his abusive father. As the therapist encourages him to attend to his bodily-felt experience of the fear associated with the memory, his secondary anger emerges and serves the function of distancing him from the underlying fear and sadness.

*Excerpt:*

T: mm hm, mm hm, so where do you keep that feeling in your body then? do you feel it, is it-

C: well, I don't know, it's kind of everywhere (T: yeah.), it's in my upper body.

T: is it a shaky feeling or is it, what's-

C: no, it's just a clenched teeth kind of something.

T: waiting something, waiting to be attacked sort of thing, just-

C: really stiffened up kind of.

T: just, just notice it through any words or images that come up and show you, when you felt this way before, or any images or memories of feeling that way specifically

C: (p:00:00:06) *well, you know I start to feel anger (T: mm-hm.) and then to some extent that tension is relieved (T: yeah, yeah.) (chuckle)*

T: right now you feel angry, is that it?

### Client 003

*Description:* The client reports a disinclination toward expressing her emotions and needs during interactions with husband. She stops herself from expressing them by silencing herself in his presence. She describes fearing conflict, if she were to confront him.

*Excerpt:*

T: so what have you been thinking about?

C: (p:00:00:04) um, one of the things I noticed that I still, if I have a disagreement with my husband, because he's so verbal, and he can outspoke me, ah, ou-outtalk me or whatever I um, and he's very you know, he's been under a lot of pressure, because everything he's gone through. (T: mm hm.) I suggested that maybe he should go for, counselling to speak to somebody about it but he sort of, ah let it go, and um, *I don't to bring it up again because I don't want him to think that I'm putting pressure on him* (T: mm hm.) *and that he's going to act defensive and we're going to get into an argument but I notice that when we get into a disagreement whatever, I'm so fast to apologize, even though I feel that I'm right* (T: mm hm.), *I'll apologize just to you know not to fight.*

**Awareness of How Interrupting.** The next step in the model of the resolution of AESI involves clients becoming aware of their efforts to prevent, stop, or over-control their experience or expression of the emotion (or a related need, action tendency, or part of self). These efforts can fall into any of the following categories: (a) avoidance or escape, (b) physical control, (c) cognitive control, or (d) movement to a secondary emotion that circumvents their experience of the primary emotion. Clients may become aware of these efforts as they engage in dialogue with their therapists. Alternatively, clients may develop this awareness over the course of a chair dialogue, in which they are asked to enact the part of themselves or another individual from their past that interrupts the emotion (i.e., the interrupter). As clients enact how their interrupter holds them back, they experience themselves as agents in their self-interruptive process.

Clients can *avoid or escape* the emotion in a number of ways. For instance, they may do so by keeping the target feeling hidden or buried, struggling to get away from it, intentionally distracting themselves, deflecting, becoming numb, or losing contact with the emotion. Additionally, clients can report *physically (muscularly or physiologically) controlling,*

restricting, or constricting the emotion in various ways. These can include shutting it down, holding it back, squeezing it, sucking it back, or making it smaller.

Moreover, clients can also exert *cognitive control* in the form of self-injunctions against experiencing or expressing the emotion. These self-injunctions can generate other painful affect, such as a guilt/shame, anxiety, or hopelessness, and they reflect clients' negative evaluations, expectations, or beliefs about allowing the emotion. Injunctions that induce guilt or shame involve admonishment or derision of the self for allowing the emotion. Statements can range from making oneself feel unentitled to the emotion and associated needs (i.e., self-invalidation) to expressing contemptuous anger toward oneself for experiencing the emotion. Additionally, injunctions that induce anxiety involve scaring oneself about the potential dangers of allowing the emotion. As well, injunctions that induce hopelessness convey hopeless beliefs about outcomes of experiencing or expressing the emotion, which serve to overwhelm and demotivate the self.

Furthermore, clients can also be observed stopping or preventing the emotion via the *movement to secondary emotions*. These secondary emotions reflect clients' inclination or willingness to allow and expressing an emotion that they perceive to be less threatening. For instance, clients can express secondary anger toward another person as a way of avoiding the vulnerability inherent in expressing their primary sadness and hurt.

*Examples of Awareness of How Interrupting from transcripts:*

Client 003

*Description:* During the two-chair intervention, the client enacts how she physically holds herself back (physical control) from experiencing her sadness/pain.

*Excerpt:*

T: mm hm, and what do you do to her? squish her down or?  
 C (as interrupter): *yea that's exactly what you do, squish her.*  
 T: mm hm.  
 C (as interrupter): into the wood.  
 T: with your hands like this.  
 C (as interrupter): no, with my feet.  
 T: with your feet, do it.  
 C (as interrupter): (stomping feet on ground) *push down, down, down, down.*

### Client 005

*Description:* The client's self-critical injunctions (cognitive control) against expressing anger toward his father induce secondary guilt.

*Excerpt:*

T: mm hm and yet you feel, so I mean, part of you does wish for him to be dead.  
 C: mm hm.  
 T: and you're actually very angry.  
 C: *I am actually very angry, I really am.*  
 T: tell him, sometimes I wished for you to be dead, it's hard for you to say, I'm sure  
 C: *the little child does that.*  
 [...]  
 C: a little boy said you know, I wish you were dead.  
 T: *so be a little boy, tell him.*  
 C: (p:00:00:15) *I can't.*  
 T: who's stopping you? what stops you? come over here (gesturing to other chair).  
 [Client changes to an opposite-facing chair to enact interrupter]  
 C (as guilt-inducing interrupter): you're hurting him, insulting him.

### Client 004

*Description:* The client describes how she distracts herself (avoid/escape) and takes a deep breath (physical control) to stop herself from attending to her sadness. Her self-injunctions (cognitive control) against allowing the sadness leave her feeling hopeless.

*Excerpt:*

T: yeah but, since it's there // and it kind of always, it won't go, I mean it won't go away // how do you do that? I want you to do that here

C (as interrupter): how what?

T: you push it away.

C (as interrupter): *well, I just tell myself to, think of something else and take a deep breath and*

T: (+) mm hm

C (as interrupter): *then (+) its just gone.*

T: tell her, tell her why she should you know.

C (as interrupter): what?

T: stay there? what do you say? it's not ever going to get better so don't, don't dwell on it?

C (as interrupter): um. (p:00:00:49)

T: what's happening now?

C (as interrupter): I'm just trying to think //

T: try that.

C (as interrupter): *well, I, I guess you don't, don't - don't think about it.*

T: mm hm.

C (as hopeless-interrupter): *it makes you feel bad and, um, you won't be able to do anything, might as well just, and not really, you can't really do anything about it.*

T: mm hm.

C (as interrupter): *so at least sort of (p:00:00:07) uhm, you can't really*

T: mm hm

C (as interrupter): *change anything so.*

T: hm, you can't, you can't, nothing will ever change, so there's no point in dwelling on it.

C (as hopeless-interrupter): *maybe, I just can't, you can't change it, it's just there sort of.*

T: *mm hm. so don't feel, don't go into it.*

C (as interrupter): *right.*

Client 002

*Description:* The client explains to the therapist how she hides her sadness from herself and others (avoid/escape), and how she expresses secondary anger in its place (emergence of a secondary emotion).

*Excerpt:*

T: right, but if you were to try to describe what, what do you need when you are sad, do you need to be?

C: *alone.*

T: so you feel you need to be alone.

C: usually.

T: right not a need to be held (C: no.) or comforted.

C: *no. (T: hm.) that just makes me angry, I just don't like that, I don't like to be coddled.*

T: uh huh, hm, *so somehow in your, so then it must be hard when you are sad with me, in a way you want to push me away.*

C: *or just not show that I'm sad.*

[...]

T: and when you're angry, I know, I know you're angry and I'm sure underneath, you're hurt.

C: but *the anger makes me feel strong.*

T: yeah, but and

C: *so I choose to*

T: go with that.

C: *go with that.*

### **Awareness of Purpose of Interruption: Protection Against Feared Consequences.**

For this component, clients become aware of and articulate their motivation for interrupting the emotion (or a related need, action tendency, or part of self). Clients realize that their interruption serves to protect them against feared consequences of fully experiencing or expressing the emotion. These feared consequences can be categorized as either: (a) fear of damage to identity and/or attachment, or (b) fear of overwhelm.

*Fear of damage to identity or attachment* can be communicated by clients in a number of ways. Clients can describe believing that experiencing or expressing the emotion will reflect negatively on who they are. They may fear being embarrassed, humiliated, criticized, or negatively judged by others for expressing the emotion (or a related need, action tendency, or part of self). This is often accompanied by a fear of loss of social connection, rejection, or

abandonment. Some clients may anticipate physical or verbal attacks, or a lack of understanding and support from others. Still, other clients may express a fear of losing control or harming others by expressing the emotion.

*Fear of overwhelm* can also be observed in various ways. Clients may exhibit a lack of confidence in their ability to cope with the emotion. They may describe a fear of being unable to regulate or modulate the emotion (e.g., the emotion being too intense or unending). They may also fear dis-integration, falling apart, or losing their ability to cope and resume normal functioning if they were to fully allow the emotion.

As clients describe their feared consequences, they may elaborate on the historical contexts from which these fears emerged. These contexts involve clients' previous experiences with the emotion, including how others in their lives expressed the emotion in question (e.g., parents who never argued, or a caregiver with explosive anger), how others responded to them for expressing the emotion (e.g., punishment, rejection, invalidation), or the internal and external resources they had to cope with the emotion at a time when it was experienced in the past (e.g., a child left to cope with an overwhelming emotion without adequate support from caregivers). Clients' historical contexts may also reflect socially or culturally prescribed rules and expectations about emotional expression (e.g., "children should always respect and obey their parents").

*Examples of Awareness of Purpose of Interruption from transcripts:*

Client 001

*Description:* The client interrupts his experience of emotional pain to protect against being criticized and verbally attacked (damage to identity).

*Excerpt:*

C (as interrupter): *tell the bruised part why it can't come out?* it's just better over here, far better chair more sunlight its better air conditioning, tell the bruised part why it can't come out? well, I guess, why can't it come out? *I guess uh maybe it can't take a chance or something.*

T: tell him don't come out you're going to you're going to get into trouble.

C (as interrupter): yeah well somebody

T: too risky.

C (as interrupter): *somebody else will shout at you and say you're stupid.*

#### Client 004

*Description:* The client interrupts her experience of sadness resulting from unfinished business with her parents because she is afraid of becoming overwhelmed. She also reports a previous experience of intense sadness that left her overwhelmed (i.e., historical context).

*Excerpt:*

T: by being able to make, put words to it to make meaning of it, it really does become less frightening, that's, that's my experience, anyway in dealing with it in that, there's such a sense of relief that comes with being able to deal with it, I know it's hard when you're not (+)

C: no, intellectually I understand (T: yeah.) but, uh, emotionally (giggle) (T: yeah, yeah.) *scares the hell out of me.*

T: for sure.

C: yup. (T: mm hm.) *it's about* (T: yeah.) *the size of it* (T: yeah, yeah.) *so I don't know how much we can do.*

T: I mean, I don't know, how much, how much do you feel I could help you and try to attempt this and sort of, yeah, but if you say that you don't want to then I'm not going to, I'm not going to push you (+)

C: *I'm scared to, right* (+)

[...]

T: yeah, uh *so tell me* (C: yeah.) *about your fear.*

C: uh, it was like uh, *when I was grieving for my granddaughter, that lasted for a long time, more than a year, I mean, really, really crying every day, my whole body was seized in pain and, and in such hurt.* it was okay because I knew I had to go through it, and it was natural, it was normal, I was, it was the right thing to do, it came naturally.

[...]

C: with this [unfinished business with my parents], it's like something like stuff from my childhood (+) (T: yeah.) and it's been like a lifetime, been locked up and (+) (T: right, right.) I don't know, *I don't know what monster is going to come out.*

Client 003

*Description:* The client interrupts her anger during interactions with her husband because she is afraid that he will abandon her if she expresses herself (i.e., damage to attachment).

*Excerpt:*

T: wh-what are you afraid? what do you think is going, going to happen? can you tell me?

C: ah I guess by giving an ultimatum that, you know, if it's not going to ah, if you back down, then you, I think you're, even in a worse off position (T: mm hm.) you lost more ground (T: mm hm.) (sniff) *and if you stick by it, then it can mean that you know, you might end up separating.* (crying)

T: mm hm, okay can you tell here that you're afraid that if you, if you confront him, and, and you tell him how you feel that it, it might lead to a separation? can you tell her that?

C: (sigh) *I'm afraid that if I give him an ultimatum, it might end up being a separation, and at this point I feel like I've put in so much, you know the last twenty years* (T: mm hm.) (sniff) that maybe what I'm complaining about is too trivial.

Client 002

*Description:* The client reports that she interrupts her sadness to protect herself from damage to her identity.

*Excerpt:*

C: see I just don't like getting sad about that (T: yeah.) 'cause *I don't want to like pity myself, do you know what I'm saying? like* (T: yeah.) whatever like you said we had you know, you had a, like certain things happen like (T: yeah.) that don't happen to other people (T: yeah.) but that's, that's all I know, and I don't want, I don't know what I want, I'm not (T: yeah and I'm -) *I just don't want to feel sorry for myself.*

Client 005

*Description:* The client reports fear of losing control and harming his father if he were to express his anger toward him.

*Excerpt:*

C: I am, because *I don't want to hurt him, because when I lash out I go for the jugular verbally.*

[...]

T: what, what do you say, what would happen to you if you express the anger? what's your feeling //?

C: *that I'm doing wrong, that's not the right thing to do, you don't put your father down, you don't.*

**Realization of Negative Impact of Interruption.** In this component process, clients communicate the realization that their self-interruption has a negative impact on them. Negative impacts can fall into one of two categories: (a) physical discomfort and painful emotions experienced by clients during the session or (b) long-term consequences of continued self-interruption.

After interrupting the emotion in the session, clients can verbalize their experience of the *physical discomfort and painful emotions caused by their self-interruption*. They may become aware of feeling tired, resigned, depleted, trapped, tense, squeezed, or of experiencing physical pain, such as a headache. During a two-chair intervention, clients can further express sadness or anger toward the interrupter as they reflect on the negative impact the interruption has on their well-being.

The *negative long-term consequences* of continued interruption can include maintaining the status quo of feeling depressed and stuck, being unable to move forward from their unfinished business, or remaining unable to form close relationships or have their needs met by others. While some clients may self-generate these negative long-term consequences, other

clients come to this insight with the help of conjectures and explanations provided by their therapists.

Although two-chair dialogues can facilitate clients' heightened awareness of the negative impacts of their self-interruption, these interventions are not necessary for every client. For some resolved clients in this study, it was sufficient to explore the negative impact in a dialogue with their therapists. Regardless of the intervention, the end result was that clients internalized the notion that their interruption was problematic, rather than denying or minimizing its negative impact.

*Examples of Realization of Negative Impact of Interruption from transcripts:*

Client 003

*Description:* During the two-chair intervention, the client describes the physical discomfort she experiences as the result of being controlled and constricted by her interrupter.

*Excerpt:*

C (as self, to interrupter): *it feels impossible, it feels painful, my head and my heart. it's almost like I can feel, imagine walls coming up around me.*

Client 001

*Description:* During the two-chair intervention, the client describes how, although his self-interruption helps him feel safe, it also leaves him feeling too confined and constricted.

*Excerpt:*

T: right, right, mm hm can you tell, it's almost like there's a part of yourself that's sort of represents the voice and another part that keeps it inside and you'll be happy too, it's like the other part, like could you tell the other part of you what it's like to be inside, to be kept hidden?

C: (sigh) I feel safe.

T: mm hm.

C: but I *feel confined*.

T: right.

C: *I think there's too much of me in here now too, it hurts, it's too constricting.*

T: mm hm, can you tell him about the hurt, are you in touch with the hurt? can you say how it hurts to be inside?

C (as self, to interrupter): *it's too tight, it's too confining.*

T: mm hm.

C (as self, to interrupter): *it's too, I mean yes I'm safe but*

T: like I can't breathe?

C (as self, to interrupter): *I can't breathe, I have trouble taking a breath.*

### Client 002

*Description:* The therapist explains how the client's interruption of her sadness leaves her feeling resigned and unhappy. The therapist also suggests that even though she tries to ignore the sadness, this unprocessed emotion will continue to be activated in new situations. The client's responses indicate that she has internalized this insight.

### *Excerpt:*

T: but it's also important to be kind to yourself, you know, not just to sort of push those, that sadness away, cause then *I think it leaves you feeling kind of resigned, you know not as happy as you can be.*

C: that makes sense.

[...]

T: one way is to try to just, put [the sadness] aside and say it's, you know, I don't want to pay attention to it, *but somehow it keeps knocking on your door.*

C: yeah.

**Reduction of Fear of Emotion.** Clients' fears associated with allowing the interrupted emotion (or a related need, action tendency, or part of self) are reduced as they internalize (a) validation of and/or (b) a sense of safety in relation to allowing the emotion. As their fears decrease, so does their need to protect themselves via self-interruption.

Clients' *internalization of validation* can be observed when they communicate that their emotions are justifiable and understandable, or when they accept such messages about their emotions from their therapists. Clients come to view themselves as being entitled to their emotions and associated needs. Adaptive emotions are commonly displayed in conjunction with this component. For instance, clients can demonstrate pride or positive self-regard, as well as compassion, kindness, or acceptance toward themselves and their emotional experience. Clients can also express adaptive anger as they hold others accountable for past transgressions, and assert their needs and boundaries in relationships with others. In contrast, clients not able to successfully complete this component continue to relate to their emotional experience in a manner that is controlling, rejecting, critical, or dismissive.

Additionally, clients internalize a *sense of safety* as they come to believe that they can cope with allowing the emotion and any potential consequences of doing so (e.g., possible rejection by significant other). This can involve clients accepting (as opposed to rejecting) statements from their therapists that convey support (e.g., that they were not alone), encouragement (e.g., that they were strong enough), or reassurance/soothing (e.g., that they would be okay). It can also involve clients generating their own supportive, encouraging, or reassuring self-statements. Clients' internalization of a sense of safety, alongside validation of their emotional experience, facilitates their confidence in their ability to allow the emotions that they have been interrupting.

*Examples of Reduction of Fear of Emotion from transcripts:*

Client 001

*Description:* The client demonstrates validation of his sadness. He also displays self-compassion and positive self-regard. (Internalize validation: self-compassion, positive self-regard)

*Excerpt:*

C: well, I don't know, *right now I'm just telling myself that it's okay to be sad.*

T: yeah, mm hm, it's okay to be sad, you deserve, I mean you're entitled to feel that way given what happened to you.

C: yeah.

T: mm hm, mm hm, yeah, what else would you say, almost like to that little boy that had, was hurt, it's okay to be sad, and what else?

C: (p:00:00:10), *well I'm telling that it's (T: mm-hm.), well I'm telling myself that it wasn't, it wasn't me really, it was his problems that um (T: right, right.) surfaced, his problem or whatever, I mean it*

T: wasn't your fault?

C: *it wasn't my fault (T: yeah, yeah, mm hm, mm hm.), so I can be saddened without being responsible.*

Client 002

*Description:* The client is able to internalize support from her therapist, thereby increasing her sense of safety. (Internalize safety: support from therapist)

*Excerpt:*

T: do you want to sort of, stay with the anger and see what comes from there and?

C: yeah.

T: *but if there's any other stuff that comes up, I'll try to guide you through it and you can just tell me if it's not comfortable.*

C: yeah, I think so.

Client 003

*Description 1:* In the first excerpt, the client validates her need to express her anger to her husband about his behavior toward her. Her pride/anger is evident.

*Excerpt 1 (Internalize validation: self-validation, pride-anger):*

C (speaking to self in two-chair dialogue): I think [you] should stand your ground and tell him *you expect it, you deserve it, and he has to give it to you!*

*Description 2:* Later in the session, the client is seen internalizing a greater sense of safety with respect to expressing herself to her husband. She is observed reassuring herself that the consequence she fears (i.e., being abandoned by her husband) is unlikely to occur.

*Excerpt 2 (Internalize safety: reassurance from self):*

C: just think back, on everything that's always happened, and no matter how bad things seem (T: mm hm.) (sniff) *you've never actually split up over twenty years* (T: mm hm.), *I think you know that he loves you just as much as you love him*, so if he hasn't, he doesn't have to give in to you (T: mm hm.), so maybe this time you should stand your ground.

**Desire to Allow Emotion.** In this step, clients express a desire and readiness to allow the emotion (or a related need, action tendency, or part of self). Clients can make statements indicating that they want to allow the emotion, or that they are making attempts to approach or stay with the emotion. Some clients further describe expectations of positive outcomes of allowing the emotion, such as hope for relief from the negative impact of the interruption (e.g., feeling tired, stuck, depressed, etc.). Clients who successfully complete this component express their desire to allow the emotion with a sense of responsibility or ownership over doing so. They view themselves as agents in their interruption and in their allowing of the emotion, rather than passively wishing that they were able to allow the emotion. They acknowledge that their interruption is of their own personal construction and they are motivated to actively try to work with the emotion.

*Examples of Desire to Allow Emotion from transcripts:*

Client 001

*Description:* During trauma processing, the client communicates that he is trying to connect with his bodily felt experience of his emotional pain.

*Excerpt:*

T: so why don't you draw your attention inside your body? 'cause I understand the shock, but I think there is a way that you hold that trauma in your body, that's sometimes hard to, and it's just, if you just try to be really caring and accepting, what's this feeling in your body, you feel as he is hitting you? I think you know in the moment it's really hard, to be there, it's almost like you want to disconnect from it and then just not be there, but it's almost like, I think that's where the pain is trapped inside of you.

C: (p:00:00:08)

T: what's happening M.? looks like there is a lot going on.

C: well, um, *I'm trying to feel it in my body*, but I -

Client 003

*Description:* During the two-chair intervention, the client tells the interrupter that she needs to confront her husband about her feelings and needs, rather than silencing herself during their interactions.

*Excerpt:*

T: mm hm, so she should bring this up again?

C: yes.

T: and deal with it, with her husband?

C: yes.

T: okay, can you say that to her? tell her she has to deal with it? she she should, she should what?

C (as self, to interrupter): *you have to deal with it and, confront him with it*, ah, you don't have to do it in a threatening way but confront with it, confront him with it that, he should go speak to somebody else so because he has, a lot of things that he's, you know, dealt with, (sniff) and I don't think he knows how to cope.

Client 002

*Description:* The client expresses excitement about getting to know a part of himself that he has kept hidden (the interrupted emotion). He refers to the season of spring as a metaphor to describe a feeling of hope for positive change and growth.

*Excerpt:*

C: you know I don't know if it's the fog you know all week I've been feeling like uh there's *something !inside me that's waiting to come out and sometimes I get so excited I can hardly even breathe.* (sigh)

T: so it's like something that's waiting to be !born?

C: mm yeah probably I uh

T: you sort of

C: *someone I'm looking forward to meeting* too I would think, sometimes it's hard to know why all the why all the//?

T: you speak to //?

C: yeah anytime, it's funny all the things are happening it's *it's almost like spring it's almost like the garden's running abloom, all sorts of little things that seem to want to grow up all over the place.*

T: mm hm it's exciting.

[...]

C: *that's why I was saying it's like transforming the burden the, the burden the burden can either dissolve or grow into something.*

*Examples of reluctance to allow emotion from transcripts:*

In contrast to the Resolved clients, Unresolved clients maintained a *reluctance* to allow the emotion. Below are excerpts from transcripts to illustrate this.

Client 004

*Description:* The therapist encourages the client to not push away the emotion, but the client states that she would rather do that. She then goes on to explain why she prefers to push it away rather than to allow it.

*Excerpt:*

T: it's still there?

C: um, yeah, *I start to push it away.*

T: *don't push it away.*

C: *no I'd rather (laugh) (p:00:00:07)*

T: stay with it // that's difficult // you'd rather push it away?

C: // *and yet // like I feel that I'm a pro at that (laugh) pushing it away so (laugh) it's hard to stay with the feeling.*

T: yeah, even if you wanted to it would be very difficult to, right?

C: right.

T: yeah, and yet it seems that those feeling are there and they're, they don't go away so easily, I mean you can, you, you know just like you said, you know, you're a pro, and yet they're kind of just staved off, somehow this process of how you push them away, it seems important to understand it, is that?

C: (p:00:00:10)

T: do you agree, I mean that's?

C: well (sigh), I just push them away, it's pretty easy just to think about something else. (laugh)

T: right, but the how, uh, the how, how you do it, I don't know what seems to me that that's important to understand, what do you think?

C: sure, but, but you know how I do it, you know just think of something else and

T: mm hm.

C: and then it's just (sigh) take a breath and it just seems to be (+) better, slightly better

T: and then what happens when (+) slightly better?

C: yeah it just keeps building until it's all the way forgotten.

### Client 005

*Description:* The client states that he is unable to express his anger toward his father in an empty-chair dialogue. He then asks the therapist if it is possible for him to resolve his unfinished business with his father without having to do so.

*Excerpt:*

T: so are you going to tell him? are you going to express it, or are you going to bottle it and turn him against yourself, I mean, those are the two choices.

C: how do I start to express it? how do I start to let go?

T: well I think you have to, it's something that you have to //

C: yeah I know.

T: I mean, I wish I could do that for you, but I can't so.

C: because every time I sit here and I look at this

T: mm hm.

C: and I've done it a few times, I've got lots of things to say inside

T: right.

C: *but I just can't let them out.*

T: so in some ways you're choosing, I mean, this is true, you're choosing to sacrifice yourself, better to sacrifice yourself than to tell him how you really feel, and so I mean, I take, I ask that question somewhat, you know, I mean, it's metaphor but I mean, I mean it, are you going to carry it with you to your grave? // if you stop and //

C: do you think, that, I'm asking for your opinion, okay?

T: yeah.

C: *do you think I can personally let it go and say whatever he thinks doesn't matter?*

T: *but I think you need to own and express the anger.*

C: *yeah?*

T: *that will help you do it.*

C: *I'm trying to find an easy way out I guess.*

**Resolution: Allowing Emotion.** The final step in the rational-empirical model is the Resolution of AESI, which is observed when the client no longer opposes the previously interrupted emotion (or a related need, action tendency, or part of self). This can manifest in one of two ways. One form of Resolution involves the client displaying verbal and non-verbal behaviours consistent with the activation and expression of the emotion. There is no longer evidence of efforts to prevent, stop, or over-control their experience and expression of the emotion. In the current study, Resolution took this form for the two clients who previously interrupted their emotions in response to therapists' attempts to facilitate their experience and expression of emotion during their respective therapy sessions.

A second form of Resolution can be observed when the client's part of self that previously interrupted the emotion (i.e., the interrupter) is now open to the client allowing the emotion. A synthesis or integration may be reached between the two parts of self that were once in conflict. This may involve having reached a compromise between the parts, in order to resolve

the conflict. These parts become aligned with one another toward the common goal of allowing the emotion. In the current study, Resolution took this form for the client who initially interrupted her experience and expression of emotion during interactions with a significant other. At the start of the subsequent therapy session, the client informed her therapist that she expressed the emotion to her husband for the first time. Her account of the event did not indicate any efforts to stop, prevent, or over-control the emotion at the time of expression.

*Examples of Resolution of AESI from transcripts:*

Client 001

*Description:* The client is tearful as he allows himself to express his sadness and pain in response to the abusive and neglectful treatment he endured at the hands of his father during childhood.

*Excerpt:*

C: (crying) *I feel, you know, sad* (T: mm hm, mm hm.) *like I missed a lot in my life* (T: yeah.) 'cause I didn't have that.

T: yeah, you really missed, missed out and it's not replaceable as you said before, there isn't anything that can make up for not having a father's love, not feeling like you have that, mm hm, mm hm, yeah. what's happening inside?

C: *I don't know, I just feel sad* (T: mm hm.), *empty in kind of* (T: mm hm.) (p:00:00:08) I don't know.

T: can you tell him more about, what I know that you said you father didn't care about love but specifically I just, what would you have imagined the things that you would do with him? like what, I hoped that, things that you sort of dreamed about as a boy?

C: *well I just hoped // anything* (T: yeah.) *a father and a son might do together*

T: yeah, sort of any interest.

C: there's still no warmth no connection.

Client 002

*Description:* During empty-chair work with her parents, the client allows herself to experience the sadness and pain resulting from being emotionally neglected during childhood. (Note:

Although the client uses the word “hopelessness” to refer to her emotional experience – a term commonly associated with a secondary emotional state – her emotional experience is classified as primary adaptive sadness under the EFT treatment model, since she productively accepts and grieves for the first time the fact that her parents will never be able to meet her emotional needs.)

*Excerpt:*

C: *treat me like you love me (starts crying).*

T: I deserve that.

C: I do deserve that, no matter what kind of life you had.

T: hm mm. ‘cause there’s so much pain, of not getting that, it hurts so much.

C: *it’s not fair.*

T: it’s not fair, it’s so hard, mm hm.

C: *it is not fair, how, how, confusing your life is (tearful), you still have to look after me.*

T: mm hm, yeah, I deserved to be looked after.

C: *I deserve love, I deserved to be cared for.*

T: mm hm.

C: both of you have to take responsibility for me.

T: what’s happening inside there?

C: *it’s a hopelessness, it’s not going to happen.*

T: mm hm, yeah, yeah, it looks like it’s going to make me so sad, that I’m not going to get that from you.

C: I knew even from a little child, I know I’m not going to get this.

T: mm hm.

C: it’s just not going to happen.

### Client 003

*Description 1:* During a two-chair dialogue intervention, a compromise is reached between the part of the client that wants to express her emotions to her husband (the experiencer) and the part of her that is afraid to do so (the interrupter). Once the experiencer agrees to be more patient and supportive toward the interrupter, the interrupter feels less vulnerable and is more confident in her ability to express her emotions to her husband. The two parts become integrated and are no longer in conflict; they are now aligned in working toward the same goal.

*Excerpt 1:*

C (as experiencer): (sniff) okay, I'll be there for you and (T: mm hm.) we'll take things, more slowly.

T: so you're kind of listening that she's got to take it a step at a time (C: yeah.) and anything else?

C (as experiencer): (p:00:00:04) and, I guess I'll be your voice within. (T: uh huh.)

T: you're going to still be in there

C (as experiencer): yes, to be supportive (T: uh huh.) start you, you know be more patient (T: mm hm.) I'll be more patient (laugh) (T: mm hm.)

T: so give her a bit of time eh?

C (as experiencer): to get stronger slowly

T: okay, can you come back here?

C: (sigh) (changes chairs) (sniff)

T: anything you want to say to her before we say goodbye?

C (as interrupter): (p:00:00:06) *I think I could [tell him how I feel] with a side of me, with with her help* (T: mm hm.) to, to be there .

T: *so she can help you?*

C (as interrupter): *yes she can, (T: mm hm.) and also with uh R.'s help and with [my therapist]'s help I think I can get to the point, where I can be strong enough (sniff) I feel like I'd be a whole human being, and not feel so vulnerable. (T: mm hm.)*

*Description 2:* In the session following the one in which she addressed her self-interruption, the client tells the therapist that she confronted her husband about how his behaviour has impacted her.

*Excerpt 2:*

C: I had a, a disagreement with my husband on, Sunday, I guess, and for the first time I sort of like

[...]

C: so he didn't have an answer (T: mm hm.) so, you know, he doesn't uh; then he sort of just like goes on to the next, subject, and I was really I guess angry at him for taking that reaction all the time and *I let him know that I was not getting, I was getting, not going to give in to him* (T: mm hm.) *and he has to learn to respect my wishes, + you know.*

T: so you were kind of saying + I want you to respect how I feel.

C: yes and um, *I let him know that, he has done a lot of things to hurt me* (T: mm hm) and uh, you know, he says well for instance what (T: mm hm.), so I brought up some points where I felt that it, you know, really painful things that had happened, not that, well some of them had gone back a couple of years (T: mm hm.) like he's, he says you're still dwelling about things

like that (T: hm.) you know, like you're still carrying that around, and I said well maybe we never dealt with the issues (T: yeah.), I've never let you know how much those things that you said to me are painful. (T: mm hm.)

[...]

T: uh huh, so sometimes he does hurt you with the things that he says

C: yeah, and I said well it's not really um, you know, productive (T: mm hm.) when you say things like that.

T: sounds like you were really able to kind of confront him with how you were really feeling (C: I was.) with a lot of things.

C: I-I was, I was, and, *I did break down and cry but not to the extent that I normally would, like usually when I break down I start crying and I sort of lose it all and I can't continue and I can't discuss it anymore and I + just sort of give in.*

[...]

T: so it sounds like uh, sort of G. has come alive a bit eh a lot.

C: *maybe it's beginning to you know (p:00:00:05), to stand up for myself (T: mm hm.) and things that are important to me. (T: mm hm.)*

**Therapist Support and Encouragement to Allow the Emotion.** Although the development of a model of therapist processes was not an objective of the current investigation, it is worth noting the important role of therapists' support and encouragement in helping clients progress through the later stages of the model. In these stages, therapists were observed working to reduce their clients' fears of their emotions in a number of ways. They were seen validating their clients' emotional experience and associated needs. They related to their clients with compassion and encouraged them to relate to their emotional experience in the same way. Moreover, therapists conveyed support by reassuring their clients that they were safe, that they were not alone and that they were there to guide and help them through the process of allowing the emotion.

Additionally, therapists were observed explicitly encouraging their clients to allow and express the emotion. They directed their clients' attention toward their internal experience, emphasized its importance, and encouraged them to stay with it and symbolize it. They were also

seen using evocative empathic reflections which heightened clients' experience of the emotion. Such interventions by therapists, when appropriately timed in response to clients' progression through the more advanced stages of the model, facilitated clients' desire and ability to stop interrupting and allow the emotion.

*Examples of Therapist Support and Encouragement to Allow from transcripts:*

Client 001

*Description:* The therapist directs the client's attention toward their internal experience, while encouraging acceptance, care, and compassion toward the emotion.

*Excerpt:*

T: so why don't you *draw your attention inside your body?* 'cause I understand the shock, but I think there is a way that you hold that trauma in your body, that's sometimes hard to, and it's just, *if you just try to be really caring and accepting, what's this feeling in your body*, you feel as he is hitting you? I think you know in the moment it's really hard, to be there, it's almost like you want to disconnect from it and then just not be there, but it's almost like, I think that's where the pain is trapped inside of you

C: (p:00:00:8)

T: *what's happening M.?* looks like there is a lot going on.

Client 002

*Description:* The therapist encourages the client to stay with the emerging emotion and emphasizes its importance.

*Excerpt:*

T: *just stay with it.*

C: [giggles and points to therapist]

T: *stay with – no no this is very important.*

### Client 003

*Description:* The therapist directs the client's attention toward their internal experience. She encourages the client to symbolize, elaborate on, and express her experience, while her reflections serve to validate and heighten the client's emotion.

*Excerpt:*

T: mm hm, and *what's happening inside?*

C: I'm angry.

T: mm hm, and *what do you resent?* I resent you

C: I guess I resented, the fact that you made this excuse.

T: mm hm.

C: many, many times, oh you couldn't come into the school because you didn't speak English, you didn't understand, I would have to translate it for you.

T: mm hm, *I resent your excuses. tell her there's no excuse.*

C: there is no excuse, I'm your child. you have to take responsibility for me. you have to look after me.

T: *yeah, yeah.*

C: treat me like you love me (starts crying)

### ***Process Differences Between Resolved and Unresolved Clients***

The presence or absence of model components for each client, along with the total frequencies for each group (Resolved vs. Unresolved) are displayed in Table 2. All components were present in the three Resolved clients, whereas *Realization of Negative Impact of Interruption*, *Reduction of Fear of Emotion*, and *Desire to Allow Emotion* were not present in the Unresolved group.

**Table 2. Frequency Distribution of the Presence of Model Components across Resolved and Unresolved Cases**

Model Components / Clients by Group	Resolved Group (n=3)				Unresolved Group (n=2)		
	001	002	003	Total	004	005	Total
Marker of AESI	√	√	√	3	√	√	2
Awareness of How Interrupting	√	√	√	3	√	√	2
Awareness of Purpose of Interruption	√	√	√	3	√	√	2
Realization of Negative Impact of Interruption	√	√	√	3	X	X	0
Reduction of Fear of Emotion	√	√	√	3	X	X	0
Desire to Allow Emotion	√	√	√	3	X	X	0
Resolution of AESI	√	√	√	3	X	X	0

*Note.* √ = Component is Present. X = Component is Absent.

Over the course of the empirical analysis, the investigator noted how differences between the Resolved and Unresolved clients manifested. Firstly, Unresolved clients exhibited markedly more attempts to interrupt their emotions over the course of their respective sessions, in comparison to the Resolved clients. Although Unresolved clients interrupted their emotions in a variety of ways, they were especially more prone to relying on *cognitive control* to interrupt their emotions, which resulted in their becoming stuck in unproductive *secondary emotions*. More specifically, the Unresolved clients demonstrated more cognitive control in the form of *criticism and invalidation*, which led to their experiencing more *secondary shame or guilt* about having

emotion. Consequently, they were less likely to express entitlement to their emotional experience or needs, and did not display self-compassion, pride, or adaptive anger during their sessions. Similarly, cognitive control via *hopeless* beliefs and expectations about allowing the emotion were strikingly more prominent among Unresolved clients. Their propensity toward secondary *hopelessness* coincided with a limited sense of agency over their change process. Moreover, cognitive control by induction of *anxiety and fear* of the potential dangers of allowing the emotion was also observed. Due to their greater difficulty internalizing *a sense of safety*, along with their inability to internalize *validation* of their emotions as described above, Unresolved clients' *fear of their emotions* did not sufficiently subside for them to feel capable of allowing their emotions.

Secondly, it was observed that the clients in the Unresolved subgroup tended to view the protective benefits of their interruption as more salient than the *negative impact of their interruption*. They were more likely to minimize, rationalize, or dismiss the extent of the negative impact of interrupting their emotions, compared to the Resolved subgroup. This tendency, along with their aforementioned lack of agency, further prevented them from developing a desire to allow their emotions.

In the end, Unresolved clients maintained the view that the potential negative consequences of allowing the emotion outweighed both the negative consequences of interrupting the emotion and the potential positive benefits of allowing the emotion. They remained unmotivated to overcome their self-interruption and to allow the emotion. As a result, they remained disempowered, depleted, and stuck in *secondary emotions*, namely shame/guilt,

hopelessness, and anxiety/fear, and they maintained a *reluctance to allow the emotion*. Thus, they were unable to move forward and resolve the task.

Although the intensive analysis of therapist processes is beyond the scope of this study, the investigator examined therapist interpersonal behaviour among the cases used in the empirical analysis, in order to ensure that this was not a confounding variable contributing to the process differences observed between the Resolved and Unresolved clients. Using the Structural Analysis of Social Behaviour (SASB; Benjamin, 1974), a framework for classifying interpersonal relations, the investigator observed that therapist behaviour was high on the affiliation dimension in each of the sessions analyzed. Therapist behaviour rated as affiliative on the SASB includes warmth and friendliness, affirming and understanding, helping and protecting (as opposed to belittling, blaming, attacking or rejecting). Such therapist behaviour has been shown to be associated with the development of positive therapeutic relationships (e.g., Coady and Marziali, 1994; Henry et al., 1986; Najavits & Strupp, 1994; Wong & Pos, 2014). Although not formally coded, this consistency in therapist interpersonal behaviour across cases suggests that this variable is unlikely to account for the process differences between the Resolved and Unresolved clients.

### **Chapter 3:**

#### **Method of the Validation Phase of the Task Analysis of the Resolution of AESI**

The overarching purpose of the Validation Phase of this study was to conduct preliminary empirical testing of the rational-empirical model of the resolution of Aversion to Emotion/Self-Interruption (AESI) derived in the Discovery Phase (described in Chapter 2). The primary goal was to verify that the components of the rational-empirical model could be discerned in a different sample than was used in the Discovery Phase and to confirm that their presence predicted clients' resolution of their AESI. The secondary goal was to examine whether the data from the Validation Phase supported the structure of the rational-empirical model.

#### **Clients**

Twenty-four clients were analyzed in the Validation Phase of the study. Twenty-one were selected from clinical trials of emotion-focused therapy (EFT). More specifically, twenty clients were selected from the combined York I & II Depression Studies (Goldman et al., 2006; Greenberg & Watson, 1998), and one was selected from the York Unfinished Business Study (Paivio, 1993; Paivio & Greenberg, 1995). Additionally, 3 clients were selected from publicly available videos of sessions of emotion-focused therapy that were recorded for training purposes; these videos were *Emotion-Focused Therapy Over Time: Session 2* (Carlson et al., 2007), *Les Greenberg: Working with Core Emotion* (2019), and *Emotion-Focused Therapy with Empty-Chair Technique* (2016). The client selection procedure is described in greater detail, under *Selection of Sessions with AESI Events* in the Procedures section below.

Inclusion criterion for the York I and II Depression Studies (Goldman et al., 2006; Greenberg & Watson, 1998) involved clients having a formal diagnosis of major depressive disorder, based on the Structured Clinical Interview for the DSM-IV (SCID; Spitzer et al., 1995). Exclusion criteria included: a current diagnosis of psychosis, bipolar I disorder, substance dependence, eating disorder, two or more features of schizotypal, paranoid, borderline, or antisocial personality disorder, recent bereavement, current physically abusive relationship, and/or current acute suicidality. Only cases from the emotion-focused Therapy (EFT) condition (versus client-centered therapy condition) of the original studies were selected, in order to examine how clients overcome Aversion to Emotion/Self-Interruption in EFT specifically.

Inclusion into the Unfinished Business Study (Paivio, 1993; Paivio & Greenberg, 1995) required clients to identify a circumscribed area of unfinished business with a significant other that they were motivated to work on in therapy. Exclusion criteria included: severe psychological disturbance, psychosis or deep-rooted characterological problems, organic or neurological impairment, major intellectual deficit, complicating illness, substance dependence, current and/or acute suicidality, or current involvement in another form of therapy.

Recruitment information and inclusion/exclusion criteria were unavailable for the three clients whose sessions were selected from publicly available training videos.

### ***Client Demographics***

In the overall sample, 14 clients were female and 10 were male. There were 8 single, 10 married/common law, and 6 separated/divorced clients in the study. For the 21 clients selected from the clinical trials of EFT for depression and unfinished business, they ranged in age from

22 to 57 years ( $M = 40.60$ ,  $SD = 10.75$ ). Seven of these clients completed high school, 3 had some post-secondary education, 8 completed their post-secondary education, and 3 clients had some post-graduate education. Their average pre-therapy Global Assessment of Functioning Score (GAF) on the SCID was 61.35 ( $SD = 6.58$ ,  $range = 51 - 70$ ). Information on ethnicity, religion, or other demographic variables was not systematically collected in the original studies. The ages, level of education, GAF scores, and other demographic information were unavailable for the three clients from the publicly available training videos.

### **Therapists**

Thirteen therapists worked with the 24 clients in the Validation Phase sample. Two of these therapists worked with four clients each, two other therapists worked with three clients, while one of the therapists worked with two different clients. The remaining eight therapists worked with one client each. One therapist saw clients in both the York Depression Studies and in publicly available demonstration videos. Another therapist saw clients in both the York Depression and Unfinished Business studies.

Twelve therapists from the York I and II Depression Studies had at least one year of supervised training in emotion-focused therapy and an additional 48 hours of training over the course of 24 weeks. Training was based on the manualized treatment protocol for emotion-focused therapy for depression (Greenberg et al., 1993).

One therapist in the Unfinished Business Study had a minimum of three years of clinical experience as an intern and a professional, including a minimum of one year of supervised

training in emotion-focused therapy and the gestalt empty-chair method, the main intervention used in the study (Greenberg & Minden, 1988; Greenberg et al., 1993).

All studies required therapists to attend weekly supervision sessions led by experienced clinicians. Therapists were monitored for adherence to the treatment protocol. Non-registered therapists were supervised weekly by a registered psychologist.

The therapist of two clients whose sessions were selected from the publicly available training video was a registered psychologist and the founder of the EFT approach. He was the lead researcher, trainer, and clinical supervisor on the York I Depression, York II Depression, and Unfinished Business studies. The therapist in the third publicly available training video was also a registered psychologist considered to be an expert in the practice, training, and supervision of EFT, who also contributed significantly to process research in this therapeutic modality.

## **Process Measures**

### ***Marker of AESI Rating Scale (MARS)***

The Marker of AESI Rating Scale (MARS; see Appendix A) was developed during the Discovery Phase of this study as a means of measuring the presence of the Marker of Aversion to Emotion/Self-Interruption (AESI) in emotion-focused therapy sessions. It is a 5-point Likert-type scale on which raters indicate their level of confidence in the occurrence of the Marker of AESI (1 = definitely not present, 5 = definitely present) in a given segment of a therapy session, on the basis of specified criteria. The criteria for rating stipulate that the Marker occurs when either: (a) the client makes a statement conveying a dislike or disinclination toward experiencing or expressing an emotion, (b) the client reports or displays efforts to prevent, stop, or over-control

their experience or expression of an emotion, including a related need, action tendency, or part of self, or (c) the therapist conjectures about the client's dislike for or disinclination toward the emotion and/or their efforts to prevent, stop or over-control the emotion, in response to which the client communicates agreement. Criteria also stipulate a minimum required level of the client's depth of experiential involvement, as measured using the Experiencing Scale (Klein et al., 1969). Psychometric properties of the MARS are reported under the Results of the Validation Phase in Chapter 4.

### ***Components of Resolution of AESI Rating Scale (CRARS)***

The Components of Resolution of AESI Rating Scale (CRARS; see Appendix B) was developed during the Discovery Phase of this study as a means of measuring the middle component processes in the model of the resolution of Aversion to Emotion/Self-Interruption (AESI) in emotion-focused therapy sessions. These mid-model components are: (i) Awareness of How Interrupting, (ii) Awareness of Purpose of Interruption, (iii) Realization of Negative Impact of Interruption, (iv) Reduction of Fear of Emotion, and (v) Desire to Allow Emotion. Raters treat components as independent from one another. They are asked to indicate their level of confidence in the occurrence of a specified component on a 5-point Likert-type scale (1 = definitely not present, 5 = definitely present) in a given segment of a therapy session. Raters are provided with criteria for identifying the presence of each component. Rating criteria include the presence of specific content in the client's dialogue, along with requirements pertaining to the client's depth of experiential involvement, as measured using the Experiencing Scale (Klein et al., 1969), and the quality of the client's vocal pattern, as measured using the Vocal Quality

Scale (Rice & Kerr, 1986; Rice et al., 1979). Psychometric properties of the CRARS are reported under Procedures in Chapter 3 and the Results of the Validation Phase in Chapter 4.

### ***Resolution of AESI Rating Scale (RARS)***

The Resolution of AESI Rating Scale (RARS; see Appendix C) was also developed during the Discovery Phase of this study as a means of measuring the Resolution of Aversion to Emotion/Self-Interruption (AESI) in emotion-focused therapy sessions. It is a 5-point Likert-type scale on which raters indicate their level of confidence in the occurrence of Resolution (1 = definitely not present, 5 = definitely present) in a given segment of a therapy session, on the basis of specified criteria. The criteria for rating Resolution stipulate that either: (a) there is no longer a part of the client that opposes the experience or expression of the emotion, or (b) the client displays verbal and non-verbal behaviours consistent with the activation and expression of the previously interrupted emotion for a minimum of 20 seconds. The descriptions of verbal and non-verbal emotional behaviours in this measure were drawn from the Client Emotional Productivity Scale – R (Auzra, Greenberg, & Herrmann, 2007). The criteria also specify minimum required levels of the client's depth of experiential involvement, as measured using the Experiencing Scale (Klein et al., 1969), and emotion arousal, as measured using the Client Emotional Arousal Scale – III (Warwar & Greenberg, 1999). Psychometric properties of the RARS are reported under the Results of the Validation Phase in Chapter 4.

### ***Working Alliance Inventory (WAI)***

For cases obtained from the York I and II Depression Study samples, clients' self-reported alliance ratings were obtained using the Working Alliance Inventory (WAI; Horvath,

1981). The WAI is a 36-item inventory rated on a 7-point Likert scale (where 1 = “never,” 7 = “always”) comprised of three alliance subscales assessing bond, task, and goals. This measure has been demonstrated to have good internal consistency and predictive validity (Horvath & Greenberg, 1989). The original 36-item Long Form of the WAI was administered to the 7 clients from the York I sample, while a 12-item Short Form of the WAI (Tracey & Kokotovic, 1989) with comparable psychometric properties was administered to the 13 cases from the York II sample. Although clients from the York I sample were administered the WAI at different intervals from clients from the York II sample, clients from both samples completed the measure at the fourth session. To analyze fourth session responses using both Short and Long forms of the WAI, clients’ mean item scores (out of 7) from that session were calculated.

## **Procedures**

### ***Selection of Sessions with AESI Events***

As described earlier, the investigator selected sessions for inclusion in the Validation Phase sample on the basis of the definitions of the Marker of AESI and of the Resolution of AESI, which were determined in Step I of the Discovery Phase (refer to Step I: Description of the Task in Chapter 2). Sessions were selected prior to the onset of the empirical analysis that established the component processes of the model of resolution. This prevented selection of sessions from being impacted by bias resulting from the investigator’s knowledge of model components.

To select sessions for inclusion in the study, the investigator started by reviewing therapist post-session reports from the York II Depression Study (Goldman et al., 2006), in order

to identify clients noted by their therapists as presenting with self-interruption. Additionally, the investigator asked colleagues concurrently conducting research using the York I Depression (Greenberg & Watson, 1998), the York II Depression (Goldman et al., 2006) and the Unfinished Business Study (Paivio, 1993; Paivio & Greenberg, 1995) datasets to identify cases they had come across where self-interruption may have been present. Publicly available videos recorded for the purpose of therapist training in emotion-focused therapy were also reviewed. From these sources, a total of 43 cases were short-listed for closer examination.

Research assistants, trained in identifying the Marker of Aversion to Emotion/Self-Interruption based on the definition generated in Step I: Description of the Task (see Chapter 2), reviewed video- and/or audio-recordings of sessions of these cases and took detailed notes of their observations. Subsequently, the investigator reviewed these notes and the session recordings to confirm the presence or absence of the Marker of AESI. Twenty-nine cases were confirmed as having the Marker. Once a Marker was confirmed as present for a given client, the investigator reviewed session transcripts until the client, in the investigator's judgement, either attained resolution or terminated therapy, whichever came first. From the 29 confirmed cases, 16 were found to resolve AESI, while 13 remained unresolved at the time of termination. Of the 16 resolved cases, the 13 cases not used in the Discovery Phase were included in the Validation Phase sample. Likewise, of the 13 unresolved cases, the 11 cases not used in the Discovery Phase were included in the Validation Phase sample. In the end, the Validation Phase sample was comprised of a total of 24 clients (13 Resolved and 11 Unresolved).

One session was chosen from each case for inclusion in the study. The session selected from each Resolved case contained the Marker of AESI and its Resolution. If there was more

than one session meeting these criteria for a given client, the investigator selected the session with the greatest amount of AESI-related dialogue. The session selected from each Unresolved case contained the Marker of AESI, and if there was more than one session with the Marker, the investigator selected the session with the greatest proportion of AESI-related dialogue. An expert judge (the investigator's supervisor) also reviewed these sessions to confirm the investigator's observations regarding the presence of the Marker of AESI and the classification of cases into Resolved versus Unresolved subgroups. Sessions not used in the final sample were used to train raters on the rating scales (i.e., MARS, CRARS, and RARS).

### ***Selection of Segments for Rating***

Using her clinical judgement and the criteria in the rating scales (i.e., MARS, CRARS, RARS), the investigator divided the dialogue from each session selected for inclusion in the sample into segments, each segment representing a possible component of the model of resolution (i.e., either the Marker of AESI, the Resolution of AESI, or one of the five mid-model components). It should be noted that the segmenting of sessions was conducted approximately two years after the investigator initially selected cases for inclusion in the study. At the time of segmenting, the list of client sessions was randomized so that the investigator was blind to which sessions represented Resolved versus Unresolved cases. Segmenting began at the first occurrence of the Marker of AESI in a given session and continued until either the Resolution of AESI was attained or the session came to an end, whichever came first. In this way, the investigator selected segments representing all five mid-model components prior to having knowledge of whether a session represented a Resolved case or an Unresolved case.

A rateable segment started with the emergence of a model component and ended when session dialogue no longer represented the component in question. Therapeutic dialogue that did not represent any model components (i.e., non-AESI dialogue) was set aside to be potentially used as a filler, when there were insufficient numbers of rateable segments in a given session (explained in greater detail below). Dialogue not relevant to the therapeutic process (e.g., therapists adjusting microphones, clients asking to leave the room to use the washroom) was removed.

The investigator selected three segments representing each component from every client session (3 segments X 7 components = 21 segments per session; 21 segments X 24 client sessions = total of 504 segments). The rationale behind selecting three segments for each component was to maximize the likelihood that a client's highest level of expression of a specific component was captured, thereby reducing researcher bias in the selection of examples. When there were more than three examples of a specific component within a given session, the investigator drew on her clinical judgement and the criteria from the rating scales to choose the three segments representing the client's highest level of expression of that component, regardless of their order of occurrence in the session.

When there were less than three examples of a component or if a component was not present within a given session, the investigator selected random excerpts from the previously set aside non-AESI dialogue (i.e., therapeutic dialogue in the session that did not reflect client performance on any of the model components), which filled-in for the missing examples. These excerpts of non-AESI dialogue varied in length, to match the range of lengths of actual component examples. This ensured that raters could not distinguish between segments consisting

of non-AESI dialogue versus those representing actual component examples, on the basis of this feature. For the 11 clients that did not resolve AESI, all of their resolution segments and some or all of their late mid-model segments were drawn from non-AESI dialogue. Resolved clients could also have segments comprised of non-AESI dialogue, if they had less than three examples representing certain components. For example, if a client displayed attainment of the component Desire to Allow Emotion only once during the session, the remaining two segments presented to raters under this component were drawn from non-AESI dialogue. All but one Resolved client had a proportion of segments comprised of non-AESI dialogue. Table 3 provides a breakdown of the number of segments comprised of non-AESI dialogue versus the number of segments comprised of dialogue reflecting client performance on model components.

An expert judge (the investigator's supervisor) was given 20 randomly-picked segments of mid-model components and classified them with 95.00% agreement with the investigator's judgement. When disagreement occurred, it was discussed until a consensus on a component was reached.

**Table 3. Frequency Distribution of Segments Comprised of Dialogue Representing Client Performance on Model Components versus Segments Comprised of Non-AESI Dialogue, by Resolution Subgroup**

<b>Model Component</b>	<b>Resolved Subgroup (n=13)</b>			<b>Unresolved Subgroup (n=11)</b>		
	Component Examples <sup>a</sup>	Non-AESI Dialogue <sup>b</sup>	Total <sup>c</sup>	Component Examples <sup>a</sup>	Non-AESI Dialogue <sup>b</sup>	Total <sup>c</sup>
Marker of AESI	33	6	39	30	3	33
Awareness of How Interrupting	34	5	39	32	1	33
Awareness of Purpose of Interruption	36	3	39	31	2	33
Realization of Negative Impact of Interruption	27	12	39	21	12	33
Reduction of Fear of Emotion	29	10	39	23	10	33
Desire to Allow Emotion	27	12	39	20	13	33
Resolution of AESI	26	13	39	7	26	33

*Note.* <sup>a</sup> Number of segments comprised of dialogue representing client performance on each model component. <sup>b</sup> Number of segments comprised of non-AESI dialogue (filling-in for missing examples) for each model component. <sup>c</sup> Total number of segments for each model component.

### *Training Procedure for Raters*

Four raters were involved in completing the rating of segments after participating in training on the use of the process measures. Raters consisted of two master's students in clinical psychology, and two research assistants who had completed their undergraduate degrees in psychology and had previously acted as raters for other psychotherapy process research studies. It should be noted that raters were not involved in the selection of sessions used for the study. Raters were divided into two pairs, each consisting of one graduate student and one research assistant. One pair was trained on rating three of the model components (specifically, Awareness of How Interrupting, Awareness of Purpose of Interruption, and Realization of Negative Impact of Interruption), while the other pair was responsible for rating the remaining four components (specifically, Marker of AESI, Reduction of Fear of Emotion, Desire to Allow Emotion, and Resolution of AESI). Rater pairs did not overlap on components. Each pair was trained separately.

During training, raters received instruction on the rating criteria for the components they were responsible for. This was accompanied by examination of segment transcripts and recordings (not included in the validation sample), to consolidate understanding of the material. Subsequently, raters and the investigator independently rated additional segments (also not included in the validation sample). A discussion between raters and the investigator followed each rating, and discrepancies in ratings were discussed until a consensus was reached. Training and practice continued until adequate interrater agreement was established between the investigator and individual raters, as well as within each pair of raters (i.e., percent agreement >

80% and Cohen's Linear Weighted Kappa  $>.70$ ; Cohen, 1968), on their respective model components (as rated using the Marker of AESI Rating Scale [MARS; Appendix A], the Resolution of AESI Rating Scale [RARS; Appendix C], and the Components of Resolution of AESI Rating Scale [CRARS; Appendix B]). By the end of training and practice, Cohen's Weighted Kappa values ranged from .71 to .84, with a mean of .81, and percent agreement ranged from 85 to 100%, with a mean of 92.3%. The total training period amounted to 20 hours for the rater pair responsible for four model components, and 15 hours for the rater pair responsible for the remaining three components.

### ***Rating Procedure***

Once training was completed, raters were invited to make judgements about the presence of model components that they were responsible for rating in the validation sample. The procedure for rating is explained below. It should be noted that raters were instructed to complete all ratings independently. When disagreements between two raters were identified during data entry, they were taken to an expert judge (the investigator's supervisor) as a "tie-breaker" and the expert judge's coding was used in analyses.

*Rating the Marker of AESI using the MARS.* One pair of raters was asked to rate segments representing the Marker of AESI using the MARS. Transcripts and recordings of the three segments best representing the Marker from each session were provided in random order (Refer to "Selection of Segments for Rating" section above for details on how these segments were chosen). For context, raters were also provided with up to two minutes of session dialogue leading up to each segment to be rated. For each segment that they were presented, raters were

asked to indicate their level of confidence in the presence of the Marker on the MARS. A total of 72 segments (24 clients X 3 examples) were rated using this measure. Each rater in the pair judged 59 segments. Raters overlapped on 46 segments, or 63.9% of the total number of segments rated, so that inter-rater reliability could be calculated.

*Rating the Components of Resolution using the CRARS.* Rater pairs were asked to evaluate the presence of the five mid-model components in session segments, using the CRARS. One pair of raters was responsible for three mid-model components (Awareness of How Interrupting, Awareness of Purpose of Interruption, Realization of Negative Impact of Interruption), while the other pair was responsible for the remaining two (Reduction of Fear of Emotion and Desire to Allow Emotion). For each mid-model component, raters were presented with transcripts and recordings of the three segments from every session that best represented the component. Raters completed all segments pertaining to a given component before moving on to the next component. For each component, session segments were presented in a random order. For context, raters were provided with up to two minutes of session dialogue leading up to each segment to be rated.

For each segment that raters were presented with, they were asked to indicate their level of confidence in the occurrence of the specified mid-model component on the CRARS. A total of 360 (24 clients X 5 components X 3 examples) segments were rated using this measure. Within a given component, each rater in the pair judged 59 segments. Raters overlapped on 46 segments, or 63.9% of the total number of segments rated, so that inter-rater reliability could be calculated.

*Rating Resolution using the RARS.* Lastly, the same pair of raters who rated on the Marker of AESI using MARS was also asked to rate session segments that best represented the

Resolution of AESI using the RARS. Raters were only given segments representing resolution once they had submitted their ratings for all other model components. This ensured that raters were blind to whether clients resolved the task while they rated the other components.

Transcripts and video- and/or audio-recordings of the three segments from each session were provided in random order. For context, raters were provided with up to two minutes of session dialogue leading up to each segment to be rated. Raters were also provided with segments recordings and transcripts pertaining to the Marker of AESI for every client.

For each segment that raters were presented with, they were asked to indicate their level of confidence in the presence of resolution on the RARS. A total of 72 segments (24 clients X 3 examples) were rated using this measure. Each rater in the pair judged 59 resolution segments. Raters overlapped on 46 segments, or 63.9% of the total number of segments rated, so that inter-rater reliability could be calculated.

### ***Variables from Ratings***

The following variables were generated, based on ratings on the process measures, to be used in the data analyses. These variables served as either independent or dependent variables, depending on the analysis.

*Ratings.* Raters' scores out of 5 for all segments rated on the Marker of AESI Rating Scale (MARS), the Resolution of AESI Rating Scale (RARS), and each of the five mid-model components on the Components of Resolution of AESI Rating Scale (CRARS) were treated as ordinal data.

*Peak Ratings.* The highest (or “peak”) score out of 5 across the three segments for a given component, as rated on the MARS, CRARS, or RARS, was entered for every client. Peak ratings were used so as to not penalize clients who successfully attained certain components, but did so less than three times in their respective sessions.

*Resolution Subgroups.* Clients were divided into Resolved and Unresolved subgroups, on the basis of their RARS scores. Clients with peak scores of 4 or 5 out of 5 were included in the Resolved subgroup, while those with peak scores of 3 or lower were included in the Unresolved subgroup. Subgroup membership (Resolved/Unresolved) was created as a categorical variable in this way.

### **Data Analysis by Hypothesis**

The following are the hypotheses investigated in the Validation Phase and the data analytic procedures implemented to address them.

#### ***Establishing Inter-Rater Reliability of the Process Measures***

**H1:** Raters will attain significant inter-rater reliability on the Marker of AESI Rating Scale (MARS), the Resolution of AESI Rating Scale (RARS), and each of the five mid-model components on the Components of Resolution of AESI Rating Scale (CRARS).

*Analysis:* Percent agreement and Cohen’s Weighted Kappa were used to determine inter-rater reliability between raters on each of the rating scales. It was anticipated that the level of agreement between raters, when accounting for chance agreement, would be significantly greater than zero.

### ***Relating Late Mid-Model Components of the Rational-Empirical Model to Task Resolution***

**H2:** Peak ratings of clients' performance on late mid-model components (i.e., Realization of Negative Impact of Interruption, Reduction of Fear of Emotion, and Desire to Allow Emotion, as rated on the CRARS) will be positively associated with peak ratings of their performance on the Resolution of AESI (as rated on the RARS).

*Analysis:* Frequency distributions and Somers' *D* statistics were generated to determine the strength and direction of bivariate relationships between peak ratings of clients' performance on each late mid-model component and peak ratings of their performance on Resolution of AESI. It was expected that clients with higher peak ratings on late mid-model components would be more likely to also obtain higher peak ratings on Resolution. It was also expected that Somers' *D* values would indicate positive associations between peak ratings on each late mid-model component and on Resolution.

Additionally, direct binary logistic regression analyses were conducted to determine whether regression equations in which peak ratings of clients' performance on late mid-model components, when considered in combination, would be related to Resolution subgroup membership. It was anticipated that the regression models would be positively associated with membership in the Resolution subgroup and that the odds ratio for each late mid-model component (i.e., the ratio of the likelihood of Resolved clients attaining a given component compared to Unresolved clients) would be greater than 1.

### ***Investigating the Structure of the Rational-Empirical Model***

**H3:** *Number of Late Mid-Model Components:* The total number of late mid-model components attained by each client (as rated on the CRARS) will be positively associated with their Resolution of AESI (as rated on the RARS).

*Analysis:* The relationship between the number of late mid-model components on which clients obtained peak ratings of 4 or 5 (out of 5) and their peak ratings on Resolution of AESI was examined using Somers' *D* statistics and a binary logistic regression analysis. It was anticipated that Somers' *D* values would indicate a positive association between number of late mid-model components completed and peak ratings on Resolution. It was also anticipated that higher numbers of late mid-model components attained would increase the odds of membership in the Resolved subgroup (i.e., odds ratios greater than 1), while lower numbers would increase the odds of membership in the Unresolved subgroup (i.e., odds ratios less than 1).

**H4:** *Sequentiality of Mid-Model Components:* The sequence of mid-model components among clients from the Resolved subgroup will follow the sequence predicted by the rational-empirical model.

*Analysis:* Descriptive analyses and Fisher's exact tests were used to identify the number of clients from the Resolved subgroup who followed the predicted sequence. It was expected that, among Resolved clients, a greater proportion would follow the predicted sequence than not.

## Chapter 4:

### Results of the Validation Phase of the Task Analysis of the Resolution of AESI

#### Sample Characteristics

Twenty-four clients were included in the Validation Phase. Clients were divided into Resolved and Unresolved subgroups, on the basis of their scores on the Resolution of AESI Rating Scale (RARS). Thirteen clients had peak ratings of 5 (“definitely present”) on the RARS and comprised the Resolved subgroup. The remaining 11 clients all had peak ratings of 1 (“definitely not present”) and comprised the Unresolved subgroup. These peak ratings confirmed the investigator’s initial classification of clients into these subgroups, at the time of session selection (see Chapter 3: Selection of Sessions with AESI Events).

Fisher’s (1934) exact tests did not reveal significant differences between the two subgroups with respect to gender (Fisher’s exact  $p = .473$ ), marital status (Fisher’s exact  $p = .396$ ), or level of education (Fisher’s exact  $p = .809$ ). Independent samples t-tests (Student, 1908) also did not show significant differences between the two subgroups on age ( $t(21) = -.190, p = .851$ ) or pre-therapy Global Assessment of Functioning Scores (GAF) on the SCID ( $t(17) = -.972, p = .345$ ). These results indicate Resolved and Unresolved clients belong to the same general population with respect to demographics.

The experiences that clients interrupted were found to vary. Seven clients (4 Resolved and 3 Unresolved) described interrupting sadness, while 2 clients (1 Resolved and 1 Unresolved) interrupted anger. Four clients (3 Resolved and 1 Unresolved) described their interrupted experience as pain or hurt. Three clients (2 Resolved and 1 Unresolved) struggled with neglect or

overcontrol of their emotions or behaviour more generally. Moreover, 7 clients (5 Resolved and 2 Unresolved) noted self-silencing or difficulty expressing their emotions and needs in relationships with others. Finally, 1 Unresolved client expressed difficulty finding the words to describe the emotional experience that he was interrupting.

Sixteen clients (8 Resolved and 8 Unresolved) engaged in a two-chair dialogue specifically addressing their self-interruption, whereas 8 clients (5 Resolved and 3 Unresolved) did not. The difference between the two Resolution subgroups in the proportion of clients who engaged in chair dialogue for self-interruption was not statistically significant (Fisher's exact  $p = .679$ ).

### **Establishing Inter-Rater Reliability of the Process Measures (H1)**

Percent agreement within rater pairs on each model component, as measured on the MARS (Marker of AESI Rating Scale), CRARS (Components of Resolution of AESI Rating Scale), and RARS (Resolution of AESI Rating Scale), ranged from 87% to 94%, with a mean of 89%. Inter-rater reliability was calculated using Cohen's Linear Weighted Kappa (Cohen, 1968). This test allows the use of weighting schemes to take into account the closeness of agreement between categories in ordinal data; in this case, a linear weighting scheme was applied as a more conservative approach. Weighted Kappa values ranged from .68 to .82 with a mean of .77. All Kappa coefficients were statistically significant ( $p < .001$ ), indicating that rater agreement was significantly greater than what one would expect based on chance alone. Refer to Table 4 for a breakdown of percent agreement, Weighted Kappa coefficients, along with their significance levels and 95% confidence intervals.

**Table 4. Inter-Rater Agreement on Process Measures, by Model Component.**

<b>Process Measure</b>	<b>Component</b>	<b>Percent Agreement</b>	<b>Weighted<sup>1</sup> Kappa</b>	<b>95% Confidence Interval<sup>2</sup></b>
Marker of AESI Rating Scale (MARS)	Marker of AESI	94%	.81*	.59 - 1.04
Components of Resolution of AESI Rating Scale (CRARS)	Awareness of How Interrupting	87%	.68*	.42 - .94
	Awareness of Purpose of Interruption	93%	.82*	.66 - .98
	Realization of Negative Impact of Interruption	86%	.78*	.62 - .94
	Reduction of Fear of Emotion	87%	.79*	.62 - .97
	Desire to Allow Emotion	91%	.76*	.55 - .97
Resolution of AESI Rating Scale (RARS)	Resolution of AESI	89%	.74*	.55 - .92

*Note.* <sup>1</sup> linear weights applied. <sup>2</sup> 95% confidence interval around the Weighted Kappa statistic

\*  $p < .001$  (testing the Null Hypothesis that Kappa = 0).

### **Relating Late Mid-Model Components to Task Resolution (H2)**

Given the relatively small size of the Validation Phase sample, greater emphasis should be placed on the estimates of parameters or effect sizes, when interpreting the reported results that follow, rather than  $p$ -values from tests of significance. According to Wasserstein and Lazar (2016),  $p$ -values are impacted by sample sizes and cannot be relied on to make decisions about importance of effects without additional context. The authors note that:

Statistical significance is not equivalent to scientific, human, or economic significance. Smaller  $p$ -values do not necessarily imply the presence of larger or more important effects, and larger  $p$ -values do not imply lack of importance or even lack of effect. Any effect, no matter how tiny, can produce a small  $p$ -value if the sample size or measurement precision is high enough, and large effects may produce unimpressive  $p$ -values if the same sample size is small or measurements are imprecise. (p. 132)

Accordingly, it has been suggested that careful and accurate interpretation of the results of statistical analyses involves consideration of the full context, which includes examination of estimates of effect sizes alongside  $p$ -values (Cumming, 2014; Greenland et al., 2016; Sullivan & Feinn, 2012).

### ***Preliminary Analyses***

**Frequency Distributions for Components of the Rational Empirical Model.** The peak (or highest) rating out of 5 for each component on the MARS, CRARS, and RARS was entered for every client. In the end, all peak ratings were either values of 1 (“definitely not present”) or 5 (“definitely present”). Refer to Table 5 for the frequency distribution of the presence of model components in the overall sample and by Resolution subgroup (Resolved vs. Unresolved).

The distribution of mid-model components across Resolved and Unresolved subgroups was similar to the distribution observed during the Discovery Phase (see Table 2 in Chapter 2). The two early mid-model components of Awareness of How Interrupting and Awareness of Purpose of Interruption were present among all clients in both subgroups. Conversely, there was more variability between the subgroups on the presence of the three late mid-model components. Realization of Negative Impact of Interruption was observed in both subgroups, but occurred more frequently in the Resolved subgroup. Reduction of Fear of Emotion was present among all clients in the Resolved subgroup, but was not present among any clients in the Unresolved

subgroup. Desire to Allow Emotion was present in most, but not all Resolved clients, and was not present among Unresolved clients. Overall, Resolved clients completed either all or all but one late mid-model components from the rational-empirical model. In contrast, Unresolved clients completed one or none of the late mid-model components.

**Table 5. Frequency Distribution of the Presence of Model Components for Resolution**

*Subgroups and the Overall Sample*

Component	Resolved Subgroup ( <i>n</i> = 13)		Unresolved Subgroup ( <i>n</i> = 11)		Overall Sample ( <i>N</i> = 24)	
	<i>n</i> (%) Present <sup>a</sup>	<i>n</i> (%) Not Present <sup>b</sup>	<i>n</i> (%) Present	<i>n</i> (%) Not Present	<i>n</i> (%) Present	<i>n</i> (%) Not Present
Marker of AESI	<b>13</b> <b>(100%)</b>	<b>0</b> <b>(0%)</b>	<b>11</b> <b>(100%)</b>	<b>0</b> <b>(0%)</b>	<b>24</b> <b>(100%)</b>	<b>0</b> <b>(0%)</b>
Awareness of How Interrupting	<b>13</b> <b>(100%)</b>	<b>0</b> <b>(0%)</b>	<b>11</b> <b>(100%)</b>	<b>0</b> <b>(0%)</b>	<b>24</b> <b>(100%)</b>	<b>0</b> <b>(0%)</b>
Awareness of Purpose of Interruption	<b>13</b> <b>(100%)</b>	<b>0</b> <b>(0%)</b>	<b>11</b> <b>(100%)</b>	<b>0</b> <b>(0%)</b>	<b>24</b> <b>(100%)</b>	<b>0</b> <b>(0%)</b>
Realization of Negative Impact of Interruption	<b>12</b> <b>(91.31%)</b>	<b>1</b> <b>(7.69%)</b>	<b>6</b> <b>(54.54%)</b>	<b>5</b> <b>(45.45%)</b>	<b>18</b> <b>(75.00%)</b>	<b>6</b> <b>(25.00%)</b>
Reduction of Fear of Emotion	<b>13</b> <b>(100%)</b>	<b>0</b> <b>(0%)</b>	<b>0</b> <b>(0%)</b>	<b>11</b> <b>(100%)</b>	<b>13</b> <b>(54.17%)</b>	<b>11</b> <b>(45.83%)</b>
Desire to Allow Emotion	<b>10</b> <b>(76.92%)</b>	<b>3</b> <b>(23.08%)</b>	<b>0</b> <b>(0%)</b>	<b>11</b> <b>(100%)</b>	<b>10</b> <b>(41.67%)</b>	<b>14</b> <b>(58.33%)</b>

*Note.* <sup>a</sup> Number (and percentage) of clients who obtained a peak score of 5 (“definitely present”).

<sup>b</sup> Number (and percentage) of clients who obtained a peak score of 1 (“definitely not present”).

To illustrate the relationships between late mid-model components, two-way frequency distributions were generated. Table 6 shows that, among clients who attained Realization of Negative Impact of Interruption, more clients attained a Reduction of Fear of Emotion than not. Conversely, most clients who did *not* attain Realization of Negative Impact of Interruption also did *not* attain Reduction of Fear of Emotion. Interestingly, while most clients who attained Reduction of Fear of Emotion also attained Realization of Negative Impact of Interruption, the clients who did *not* attain Reduction of Fear of Emotion were almost equally as likely to attain Realization of Negative Impact of Interruption as not.

**Table 6. *Frequency Distribution of the Presence of Realization of Negative Impact of Interruption and Reduction of Fear of Emotion***

		Reduction of Fear of Emotion		
		Present <sup>a</sup>	Not Present <sup>b</sup>	Total
Realization of Negative Impact of Interruption	Present <sup>a</sup>	12	6	18
	Not Present <sup>b</sup>	1	5	6
	Total	13	11	24

*Note.* <sup>a</sup> Number of clients who obtained a peak score of 5 (“definitely present”). <sup>b</sup> Number of clients who obtained a peak score of 1 (“definitely not present”).

Table 7 demonstrates that, while clients who attained Realization of Negative Impact of Interruption had an equal likelihood of attaining vs. not attaining Desire to Allow Emotion, those clients who did *not* attain Realization of Negative Impact of Interruption were less likely to attain Desire to Allow Emotion. Among clients who did attain Desire to Allow Emotion, almost all had

attained Realization of Negative Impact of Interruption. Conversely, clients who did *not* attain Desire to Allow Emotion were less likely to attain Realization of Negative Impact of Interruption.

**Table 7. Frequency Distribution of the Presence of Realization of Negative Impact of Interruption and Desire to Allow Emotion**

		Desire to Allow Emotion		
		Present <sup>a</sup>	Not Present <sup>b</sup>	Total
Realization of Negative Impact of Interruption	Present <sup>a</sup>	9	9	18
	Not Present <sup>b</sup>	1	5	6
	Total	10	14	24

*Note.* <sup>a</sup> Number of clients who obtained a peak score of 5 (“definitely present”). <sup>b</sup> Number of clients who obtained a peak score of 1 (“definitely not present”).

Last, Table 8 indicates that, among clients who attained Reduction of Fear of Emotion, more clients attained Desire to Allow Emotion than not. In contrast, all clients who did *not* attain a Reduction of Fear of Emotion also did *not* attain Desire to Allow Emotion. Moreover, all clients who attained Desire to Allow Emotion also attained Reduction of Fear of Emotion, while those who did *not* attain Desire to Allow Emotion were less likely to attain Reduction of Fear of Emotion.

**Table 8. Frequency Distribution of the Presence of Reduction of Fear of Emotion and Desire to Allow Emotion**

		Desire to Allow Emotion		
		Present <sup>a</sup>	Not Present <sup>b</sup>	Total
Reduction of Fear of Emotion	Present <sup>a</sup>	10	3	13
	Not Present <sup>b</sup>	0	11	11
	Total	10	14	24

Note. <sup>a</sup> Number of clients who obtained a peak score of 5 (“definitely present”). <sup>b</sup> Number of clients who obtained a peak score of 1 (“definitely not present”).

**Bivariate Relationships Between Late Mid-Model Components.** The strength and direction of associations between peak ratings on late mid-model components on the CRARS were quantified using the Somers’ *D* statistic (Somers, 1962). Values generated by this rank-based non-parametric test range between -1 and 1, where values close to an absolute value of 1 indicate a strong relationship between variables and values close to 0 indicate little or no relationship. The symmetric approach to Somers’ *D* was used for measuring associations between mid-model components, because it does not distinguish between a dependent/outcome variable vs. an independent/predictor variable. Symmetric Somers’ *D* values in Table 9 indicate that Reduction of Fear of Emotion had a fairly strong positive relationship with Desire to Allow Emotion (Somers’  $D = .770, p < .05$ ), and a moderate positive relationship (Somers’  $D = .430, p < .05$ ) with Negative Impact of Interruption. In contrast, the relationship between Negative Impact of Interruption and Desire to Allow emotion was small and not statistically significant (Somers’  $D = .290, p = .109$ ). (The asymmetric approach to Somers’ *D* was used to quantify

relationships between Resolution of AESI and mid-model components, which is described in detail in a later section.)

**Table 9. Matrix of Association Between Late Mid-Model Components and Resolution.**

	<b>Realization of Negative Impact of Interruption</b>	<b>Reduction of Fear of Emotion</b>	<b>Desire to Allow Emotion</b>	<b>Resolution of AESI</b>
<b>Realization of Negative Impact of Interruption</b>	-	.430 <sup>a</sup> *	.290 <sup>a</sup>	.500 <sup>b</sup> *
<b>Reduction of Fear of Emotion</b>	.430 <sup>a</sup> *	-	.770 <sup>a</sup> **	1.00 <sup>b</sup> **
<b>Desire to Allow Emotion</b>	.290 <sup>a</sup>	.770 <sup>a</sup> **	-	.786 <sup>b</sup> **
<b>Resolution of AESI</b>	.500 <sup>b</sup> *	1.00 <sup>b</sup> **	.786 <sup>b</sup> **	-

*Note.* <sup>a</sup> Symmetric Somers' D was used to measure associations between mid-model components (two-tailed, where neither variable is treated as independent or dependent).

<sup>b</sup> Asymmetric Somers' D was used to measure associations between Resolution of AESI and mid-model components (one-tailed, where Resolution of AESI is treated as the dependent variable, and the late mid-model component is treated as the independent variable).

\*  $p < .05$ , \*\*  $p < .001$ .

### **Relationship Between Working Alliance and Resolution, Late Mid-Model**

**Components.** In order to eliminate the possibility that it could have been the alliance rather than the model components that determined resolution, the investigator checked to see if the working alliance between clients and therapists differed between the Resolved and Unresolved subgroups. Working Alliance Inventory (WAI) scores were available for clients obtained from the York I and II Depression Study samples ( $N = 20$  [Resolved subgroup  $n = 9$ , Unresolved subgroup  $n = 11$ ]). Although clients from the York I sample were administered the Long Form of the WAI at different intervals than clients from the York II sample who were administered the Short Form of the WAI, clients from both samples completed the measure at the fourth session. To analyze fourth session responses using both Short and Long Forms of the WAI, clients' mean item scores (out of 7) from that session were calculated. These values comprised the Averaged WAI Item Scores variable, descriptive statistics for which are presented in Table 10. The means of the Averaged WAI Items Scores in Resolved ( $M = 5.52$ ) and Unresolved subgroups ( $M=5.22$ ) were similar and both comprised of values above 5. This indicates that the difference between Resolution subgroups is marginal and that the average client in each subgroup had a strong therapeutic alliance with their therapist.

**Table 10. Descriptive Statistics for Averaged WAI Item Scores for the Resolved Subgroup, Unresolved Subgroup, and Overall Sample (N=20)**

	<i>n</i>	<i>M</i>	<i>SD</i>	Range	Skewness	<i>SE</i>	Kurtosis	<i>SE</i>
Resolved Subgroup	<i>n</i> = 9	5.52	0.49	4.33 – 6.17	-1.81	0.72	5.20	1.40
Unresolved Subgroup	<i>n</i> = 11	5.22	0.82	3.56 – 6.58	-0.57	0.66	0.75	1.28
Overall Sample	<i>N</i> = 20	5.34	0.69	3.56 – 6.58	-0.99	0.52	1.44	0.99

*Note.* *n* = subgroup sample size. *N* = overall sample size. *M* = Mean. *SD* = Standard Deviation. *SE* = Standard Error (of Skewness or of Kurtosis).

With respect to the distribution of Averaged WAI Item Scores across the two subgroups, Table 10 shows that there was a wider range of Averaged WAI Item Scores in the Unresolved subgroup, compared to the Resolved subgroup; however, the Levene's Test of Equality of Variances did not indicate that the variances were significantly different,  $F(1,18)=2.609, p=.124$ . The distribution of scores in the Resolved subgroup was slightly negatively skewed (i.e., more scores at the high-end of the range of values), as well as leptokurtic (i.e., shape of distribution has a high peak). In order to improve normality, a logarithmic transformation was applied. An independent samples t-test did not show significant differences between the two subgroups on Averaged WAI Item Scores,  $t(18) = -.703, p = .491$ .

Point-Biserial Correlations (Kornbrot, 2014) were also generated to determine the strength and direction of the bivariate relationships between the Averaged WAI Item Scores and peak ratings on late mid-model components on the CRARS, as well as on Resolution of AESI on

the RARS. Point-Biserial Correlations are a specific case of Pearson Product-Moment Correlations for associations between dichotomous and continuous variables. Since all clients in the overall sample completed the two early mid-model components, relationships between WAI scores and these components were not analysed. Correlational analyses revealed that Averaged WAI Item Scores had only a minimal association with Resolution ( $r_{pb}=.218$ ). Additionally, it had no association with Desire to Allow Emotion ( $r_{pb}=.032$ ), a minimal association with Reduction of Fear of Emotion ( $r_{pb}=.218$ ), and a small association with Realization of Negative Impact of Interruption ( $r_{pb}=.316$ ). None of these relationships were statistically significant.

Self-reported alliance ratings were not available for the 1 client from the Unfinished Business sample or for the 3 clients from the publicly available session recordings. However, no remarkable differences in bond or in collaboration on tasks or goals were observed by the investigator between these sessions and the ones from the York I and II Depression Study samples. Therefore, the alliance did not appear to be associated with Resolution of AESI to a strong degree.

**Bivariate Relationships Between Late Mid-Model Components and Resolution.** The strength and direction of bivariate associations between peak ratings on late mid-model components on the CRARS and resolution on the RARS were calculated using the Somers' *D* statistic (Somers, 1962). Values generated by this rank-based non-parametric test range between -1 and 1, where values close to an absolute value of 1 indicate a strong relationship between variables and values close to 0 indicate little or no relationship. The asymmetric approach to this statistic was used, because it treats one variable as a dependent/outcome variable (i.e., Resolution) and the other as an independent/predictor variable. It is important to note that,

although the investigator uses the terms “predictor” and “outcome” to describe variables analyzed using the Somers’  $D$  statistic throughout this paper, these statistics do not measure accuracy of prediction, but rather strength and direction of association (Feng, 2010; Shmueli, 2010).

Asymmetric Somers’  $D$  values in Table 10 show that Resolution had a moderate positive association with Realization of Negative Impact of Interruption (Somers’  $D = .50, p < .05$ ), a fairly strong positive relationship with Desire to Allow Emotion (Somers’  $D = .79, p < .001$ ), and a perfect positive relationship with Reduction of Fear of Emotion (Somers’  $D = 1.00, p < .001$ ). These relationships between late mid-model components and Resolution are stronger in magnitude compared to their relationships with Averaged WAI Item Scores.

### ***Main Analyses: Logistic Regression Models of Resolution as a Function of Late Mid-Model Components***

A series of direct binary multiple logistic regression analyses were performed to determine the relationship between attainment of mid-model components (using peak ratings on the CRARS) and Resolution of AESI (using peak ratings on the RARS). Since the two early mid-model components (i.e., Awareness of How Interruption and Awareness of Purpose of Interruption) were present among all clients in the overall sample, they were excluded from these analyses. Peak ratings for the three late mid-model components (i.e., Realization of Negative Impact of Interruption, Reduction of Fear of Emotion, and Desire to Allow Emotion) and Resolution were recoded so that ratings of 5 (“definitely present”) were changed to values of 1, and ratings of 1 (“definitely not present”) were changed to values of 0. The new binary variables

representing the three late mid-model components were entered into the regression equations as predictors. The new binary Resolution variable was entered as the outcome. It is important to note that, although the investigator uses the terms “predictor” and “outcome” to describe the variables analyzed using regression models throughout this paper, these analyses do not assess accuracy of prediction, but rather strength and direction of association (Feng, 2010; Shmueli, 2010).

Due to complete and quasi-complete separation in the data (i.e., late mid-model components’ perfect or near-perfect associations with Resolution; refer to Table 5 for distributions of the presence of each component by Resolution subgroup), there was failure of convergence of the maximum likelihood algorithm (i.e., the maximum likelihood estimate did not exist). Consequently, standard logistic regression models could not be generated. To address this problem, penalized maximum likelihood estimation was applied to the models. This method was initially suggested by Firth (1993) to reduce bias in logistic regression in small samples. Simulation studies have shown that this method produces finite estimates of parameters, even when there is complete or quasi-complete separation, with relatively little bias (Heinze & Schemper, 2002; Puhr et al., 2017). Accordingly, the results reported below are based on penalized likelihood ratio tests and confidence intervals, instead of the Wald tests and confidence intervals that are typically used in standard logistic regression (Heinze & Schemper, 2002).

**Full Model of Resolution as a Function of Realization of Negative Impact of Interruption, Reduction of Fear of Emotion, and Desire to Allow Emotion.** A test of the late mid-model components’ association with Resolution subgroup membership was performed. The three binary variables representing peak ratings on each late mid-model component (as described

above) were entered into the regression equation as predictors simultaneously. When compared against an intercept-only model, this regression model was reliably better fitting, Penalized Likelihood Ratio Test  $\chi^2(3, N = 24) = 24.47, p < .001$ , Nagelkerke *pseudo-R*<sup>2</sup> = 1.00. It correctly classified clients as either Resolved versus Unresolved with 100 % accuracy.

Table 11 shows regression coefficients, their standard errors and 95% confidence intervals, odds ratios and their 95% confidence intervals, and Likelihood Ratio test chi-square values for each predictor. Reduction of Fear of Emotion was the only statistically significant independent predictor in this model of Resolution, Penalized Likelihood Ratio Test  $\chi^2(1) = 7.79, p < .001$ . The odds ratio of 84.32 for Reduction of Fear of Emotion is considerably greater than 1. It signifies that, if a client successfully completes the component of Reduction of Fear of Emotion, their odds of Resolution is 84.32 times that of a client who did not complete this component. This is not surprising considering this component has a perfect relationship with Resolution, as shown in Table 9. Comparatively, Desire to Allow Emotion had small odds ratio of 2.51; however, it may still be clinically meaningful for therapists to know that attainment of this component more than doubles their clients' chances of attaining Resolution. Lastly, the odds ratio of 1.33 for Realization of Negative Impact of Interruption was only marginal above 1.

**Table 11. Binary Multiple Logistic Regression Model of Resolution as a Function of Realization of Negative Impact of Interruption, Reduction of Fear of Emotion, and Desire to Allow Emotion (N=24)**

	<i>B</i>	<i>SE</i>	95% C.I.		Odds Ratio	95% C.I.		$\chi^2$
			<i>Lower</i>	<i>Upper</i>		<i>Lower</i>	<i>Upper</i>	
(Intercept)	-2.77	1.75	-10.05	-0.27	0.06	0.00	0.76	5.08*
<b>Realization of Negative Impact of Interruption</b>	0.283	2.11	-5.29	6.67	1.33	0.01	793.60	0.01
<b>Reduction of Fear of Emotion</b>	4.43	2.28	1.15	10.22	84.32	3.16	27577.20	7.79**
<b>Desire to Allow Emotion</b>	0.92	2.24	-4.36	6.20	2.51	0.01	491.75	0.19

*Note.* Model fitted by penalized maximum likelihood.

*B* = Regression Coefficient; *SE* = Standard Error of *B*; 95 % C.I. = 95% Confidence Interval (of *B* or of Odds Ratio);  $\chi^2$  = Penalized Likelihood Ratio Test Chi Square.

\* $p < .05$ . \*\* $p < .001$ .

**Model of Resolution as a Function of Realization of Negative Impact of Interruption and Desire to Allow Emotion.** Because Reduction of Fear of Emotion had a strong relationship with Desire to Allow Emotion and a moderate relationship with Realization of Negative Impact, as indicated by the Somers' *D* values in Table 9, the inclusion of Reduction of Fear of Emotion in the regression equation could potentially suppress the relationships between Resolution and the other two components. As such, a direct model of Resolution where Realization of Negative Impact of Interruption and Desire to Allow Emotion were simultaneously entered as predictors,

without Reduction of Fear of Emotion, was tested for comparison. Not surprisingly, when compared to the full model, this model was reliably less well-fitting,  $\chi^2(1, N = 24) = 7.789$ ,  $p < .01$ . Nevertheless, it was still significantly different from the intercept-only model, Penalized Likelihood Ratio Test  $\chi^2(2, N = 24) = 16.78$ ,  $p < .001$ , Nagelkerke *pseudo-R*<sup>2</sup> = .79. This model correctly classified 10 out of 13 (76.92%) of the Resolved Cases. Three Resolved cases (23.08%) were incorrectly classified as Unresolved. The model correctly classified 100% of the Unresolved cases.

Desire to Allow Emotion was the only significant independent predictor in this model of Resolution, Penalized Likelihood Ratio Test  $\chi^2(1) = 12.71$ ,  $p < .001$ . Table 12 shows regression coefficients, their standard errors and 95% confidence intervals, odds ratios and their 95% confidence intervals, and Penalized Maximum Likelihood Ratio test chi-square values for each predictor. The odds ratio of 52.67 for Desire to Allow Emotion is considerably greater than 1. Realization of Negative Impact of Interruption had an odds ratio of 6.67. Although this component was not a statistically significant independent predictor based on the Penalized Likelihood Ratio Test, it may be clinically meaningful for therapists to know that attainment of this component increases their clients' chances of attaining Resolution more than sixfold.

**Table 12. Binary Multiple Logistic Regression Model of Resolution as a Function of Realization of Negative Impact of Interruption and Desire to Allow Emotion (N=24)**

	<i>B</i>	<i>SE</i>	95% C.I.		Odds Ratio	95% C.I.		$\chi^2$
			<i>Lower</i>	<i>Upper</i>		<i>Lower</i>	<i>Upper</i>	
<b>(Intercept)</b>	-2.53	1.51	-7.61	-0.26	0.08	0.00	0.77	5.05*
<b>Realization of Negative Impact of Interruption</b>	1.90	1.59	1.59	6.95	6.67	0.45	1039.39	1.75
<b>Desire to Allow Emotion</b>	3.96	1.64	1.54	1.54	52.67	4.71	7293.95	12.71**

Note: Model fitted by penalized maximum likelihood.

*B* = Regression Coefficient; *SE* = Standard Error of *B*; 95 % C.I. = 95% Confidence Interval (of *B* or of Odds Ratio);  $\chi^2$  = Penalized Likelihood Ratio Test Chi Square.

\* $p < .05$ . \*\* $p < .001$ .

**Model of Resolution as a Function of Negative Impact of Interruption.** Lastly, a model of Resolution where Realization of Negative Impact of Emotion was the only predictor was tested, to examine how the odds ratio of this component would change once the influence of the other two late mid-model components was removed. This model was reliably less well-fitting than the full model (shown in Table 11),  $\chi^2(2, N = 24) = 20.50, p < .001$ , as well as the model without Reduction of Fear of Emotion (shown in Table 12),  $\chi^2(1, N = 24) = 12.72, p < .001$ . Nevertheless, it was statistically significantly different from the intercept-only model, Penalized Likelihood Ratio Test  $\chi^2(1, N = 24) = 4.20, p < .05$ , Nagelkerke *pseudo-R*<sup>2</sup> = .24. This model correctly classified 12 out of 13 (92.31%) Resolved cases. Only 1 (7.69%) of the Resolved cases was incorrectly classified as Unresolved. However, this model only correctly classified 5 out of

11 (45.45%) Unresolved cases. Six (54.54%) of the Unresolved cases were incorrectly classified as Resolved.

Table 13 shows regression coefficients, their standard errors and 95% confidence intervals, odds ratios and their 95% confidence intervals, and Penalized Likelihood Ratio test chi-square values. Realization of Negative Impact of Interruption had an odds ratio of 7.05, which is only a marginal increase from the previous model.

**Table 13. Binary Multiple Logistic Regression Model of Resolution as a Function of Realization of Negative Impact of Interruption (N=24)**

	<i>B</i>	<i>SE</i>	95% C.I.		Odds Ratio	95% C.I.		$\chi^2$
			<i>Lower</i>	<i>Upper</i>		<i>Lower</i>	<i>Upper</i>	
<b>(Intercept)</b>	-1.30	0.99	-3.58	0.31	0.27	0.03	1.36	2.43
<b>Realization of Negative Impact of Interruption</b>	1.95	1.11	0.08	4.38	7.05	1.08	80.42	4.20*

*Note: Model fitted by penalized maximum likelihood.*

*B = Regression Coefficient; SE = Standard Error of B; 95 % C.I. = 95% Confidence Interval (of B or of Odds Ratio);  $\chi^2$  = Penalized Likelihood Ratio Test Chi Square.*

*\*p<.05.*

## Investigating the Structure of the Rational-Empirical Model (H3 & H4)

### *Number of Mid-Model Components (H3)*

#### **Frequency Distribution of Number of Late Mid-Model Components Completed.**

Since the two early mid-model components were present among all clients, these were not included in this analysis. The total number of late mid-model components on which each client obtained a peak rating of 5 out of 5 (“definitely present”) was counted. The resulting Number of Late Mid-Model Components Completed (NLMMCC) variable had values ranging from 0 to 3, with 0 signifying that a client did not complete any late mid-model components, and 3 signifying that a client completed all three late mid-model components. The frequency of each value of the NLMMCC variable by Resolution is presented in Table 14.

**Table 14. *Frequency Distribution of Number of Late Mid-Model Components Completed and Resolution (N=24)***

		Resolution Subgroup		
		Resolved	Unresolved	Total
	0 <sup>a</sup>	0	5	5
<b>Number of Late Mid-Model Components Completed</b>	1 <sup>a</sup>	0	6	6
	2 <sup>a</sup>	4	0	4
	3 <sup>a</sup>	9	0	9
	Total	13	11	24

*Note.* <sup>a</sup> The number of Late Mid-Model Components with a rating score of 5 (“definitely present”).

### **Bivariate Relationships between Numbers of Late Mid-Model Components**

**Completed and Resolution.** The strength and degree of the bivariate relationships between Resolution and the Number of Late Mid-Model Components Completed (NLMMCC) was calculated using the asymmetric Somers'  $D$ , where Resolution was treated as the dependent/outcome variable. When all values of NLMMCC (ranging from 0 to 3) were considered together as one continuous variable, they were shown to have a strong positive relationship with Resolution (Somers'  $D = .68, p < .001$ ). To allow for comparison of the 4 discrete values of NLMMCC (i.e., 0 through 3), the variable was transformed into dummy variables. The completion of 0 or 1 component was shown to have a strong negative relationship with Resolution (Somers'  $D = -.684, p < .01$ , and Somers'  $D = -.722, p < .001$ , respectively). In contrast, the completion of 2 components had a moderate positive relationship (Somers'  $D = .550, p < .05$ ), while the completion of 3 components had a fairly strong positive relationship (Somers'  $D = .733, p < .001$ ), with Resolution. These results indicate that the greater number of components completed by clients, the more likely they are to attain Resolution, lending support to the structure of the rational-empirical model.

### **Model of Resolution as a Function of Number of Late Mid-Model Components**

**Completed.** A direct binary logistic regression was conducted to test the model of Resolution as a function of Number of Late Mid-Model Components Completed (NLMMCC). Due to the small sample size and complete separation of the NLMMCC variable by the Resolution variable (see Table 14 above), Firth's (1993) penalized maximum likelihood estimation was utilized to fit the model. To allow for comparison of the 4 discrete values of NLMMCC (i.e., 0 through 3), the

variable was transformed into 3 dummy variables, which were entered simultaneously into the regression equation as predictors. The intercept represented 0 late mid-model components completed, while the dummy variables represented values of 1, 2, or 3 late mid-model components completed, respectively. Resolution (1 = Resolved, 0 = Unresolved) was entered as the outcome variable.

The model of Resolution as a function of the 3 NLMMCC dummy predictors entered simultaneously was found reliably different from the intercept-only model, Penalized Likelihood Ratio Test  $\chi^2(3, N = 24) = 24.41, p < .001$ , Nagelkerke *pseudo-R*<sup>2</sup> = 1.00. The model correctly classified 100% of Resolved and Unresolved cases. Table 15 shows regression coefficients, their standard errors and 95% confidence intervals, odds ratios and their 95% confidence intervals, and Penalized Likelihood Ratio Test chi-square values for each dummy variable. Results show that the completion of 2 or 3 out of 3 late mid-model components was significantly positively associated with Resolution, Penalized Likelihood Ratio Test  $\chi^2(1) = 8.47, p < .01$  and Penalized Likelihood Ratio Test  $\chi^2(1) = 13.76, p < .001$ , respectively. The odds ratios show that clients who completed 2 or 3 components were more likely to achieve Resolution compared to those who did not complete any components, by factors of 99 and 209, respectively. Conversely, the completion of 0 components was associated with membership in the Unresolved subgroup, Penalized Likelihood Ratio Test  $\chi^2(1) = 4.88, p < .01$ . The odds ratio for completing 0 components is 0.09, which is considerably less than 1. The completion of 1 component was not associated with subgroup membership.

**Table 15. Binary Multiple Logistic Regression Model of Resolution as a Function of Number of Late Mid-Model Components Completed (N=24)**

	<i>B</i>	<i>SE</i>	95% C.I.		Odds Ratio	95% C.I.		$\chi^2$
			<i>Lower</i>	<i>Upper</i>		<i>Lower</i>	<i>Upper</i>	
<b>(Intercept - 0 Components<sup>a</sup>)</b>	-2.39	1.62	-7.28	-0.22	0.09	0.00	0.80	4.88*
<b>1 Component</b>	-0.17	2.27	-5.47	5.13	0.85	0.00	169.45	0.01
<b>2 Components</b>	4.60	2.32	1.29	10.41	99.00	3.62	33344.92	8.47**
<b>3 Components</b>	5.34	2.23	2.13	11.14	209.00	8.43	68576.76	13.76***

*Note: Model fitted by penalized maximum likelihood.*

<sup>a</sup>*Intercept-only model reflects clients who completed 0 Mid-Model Components.*

*B = Regression Coefficient; SE = Standard Error of B; 95 % C.I. = 95% Confidence Interval (of B or of Odds Ratio);  $\chi^2$  = Penalized Likelihood Ratio Test Chi Square.*

*\*p<.05. \*\*p<.01. \*\*\*p<.001.*

#### ***Sequentiality of Mid-Model Components (H4)***

Descriptive analyses and Fisher's exact tests were used to determine whether mid-model components occurred in the expected sequence delineated in the rational-empirical model (see Figure 2 in Chapter 2) among clients from the Resolved subgroup ( $n = 13$ ). For each client, the earliest instance of each mid-model component with a rating of either 4 ("likely present") or 5 ("definitely present") was recorded, and the chronological order in which these appeared was examined. Only 3 Resolved clients followed the exact sequence laid out in the rational-empirical model. However, all 13 clients displayed the two early mid-model components followed by a combination of two or three late mid-model components, a sequence which occurred

significantly more frequently than expected by chance alone (Fisher's exact  $p = .003$ ). Patterns observed among early and late mid-model components are described below.

**Early mid-model components.** The two early mid-model components in the rational-empirical model are Awareness of How Interrupting and Awareness of Purpose of Interruption. While they appeared earlier in sequence than the remaining mid-model components for all clients in the Resolved subgroup ( $n = 13$ ), only 7 clients displayed them in the exact predicted sequence (i.e., Awareness of How Interrupting -> Awareness of Purpose of Interruption). For the remaining 6 clients, the sequence was reversed (i.e., Awareness of Purpose of Interruption -> Awareness of How Interrupting). One order did not occur more frequently than the other at a statistically significant level (Fisher's exact  $p = .149$ ).

**Late mid-model components.** The predicted sequence of the three mid-model components was expected to be either: (a) Realization of Negative Impact of Interruption -> Reduction of Fear of Emotion -> Desire to Allow Emotion *or* (b) Realization of Negative Impact of Interruption -> Desire to Allow Emotion -> Reduction of Fear of Emotion. A total of 9 clients in the Resolved subgroup ( $n=13$ ) displayed all three of these late mid-model components. The presence of all three did not occur statistically significantly more often than the presence of only two of these components (Fisher's exact  $p = .581$ ), among resolved clients. Six of the 9 clients who presented with all three late mid-model components followed one of the predicted sequences, specifically sequence (b). However, the other 3 clients who completed all three late mid-model components did so in different orders, with Reduction of Fear of Emotion occurring first. For two such clients, the pathway to resolution was: Reduction of Fear of Emotion ->

Realization of Negative Impact of Interruption -> Desire to Allow Emotion. Another client's pathway involved: Reduction of Fear of Emotion -> Desire to Allow Emotion -> Realization of Negative Impact of Interruption.

The sequence of late mid-model components was further examined for the 4 Resolved clients who only attained two out of three of these components. Three clients did not express a Desire to Allow Emotion. These 3 clients followed the pathway of: Realization of Negative Impact of Interruption -> Reduction of Fear of Emotion. Closer examination of the session transcripts of these clients revealed that, once their fear of allowing the emotion was sufficiently reduced, they spontaneously began to allow their emotions with high intensity, in contrast to other clients, who took a more gradual approach. One possible explanation is that their previous interruption strategies were less effective at distancing them from their emotions, which meant their interrupted emotions were more easily accessible. Equally, they may have experienced a desire to allow the emotion, without having explicitly stated it.

As well, Realization of Negative Impact of Interruption was not rated as present among 1 client, who followed the pathway of: Reduction of Fear of Emotion -> Desire to Allow Emotion. Closer examination of his session transcript showed that, although he and his therapist did not discuss negative impacts of his interruption, the client conveyed the belief that overcoming his interruption was a necessary part of relieving an emotional burden he had carried since childhood. While such statements did not meet rating criteria for Realization of Negative Impact of Interruption on the CRARS, they imply that he viewed his self-interruption as impeding his ability to relieve himself of his emotional burden. As a result, his therapist may not have felt the need to help guide him toward better understanding the negative impact of continuing to

interrupt his emotion. This suggests that, for this client's session, his barrier to resolving his AESI was not lack of awareness of its negative impacts, a component he may have already attained in a previous session of therapy. Rather, his therapist focused her efforts on reducing his fear of the emotion, which appeared to be a bigger obstacle to him allowing the emotion.

## **Chapter 5: Discussion**

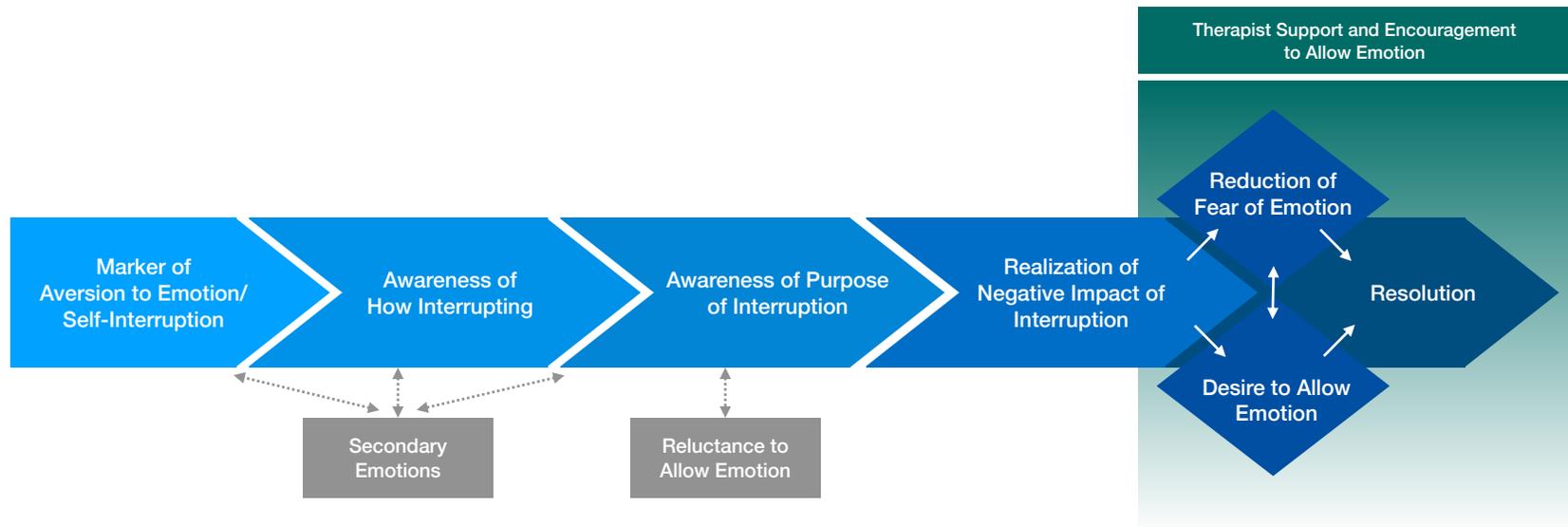
The aim of this study was to develop and preliminarily validate a transdiagnostic model of how clients overcome Aversion to Emotion/ Self-Interruption (AESI) over the course of a session of emotion-focused therapy (EFT; Greenberg et al., 1993). AESI is regarded as an indicator of problematic emotional processing, because it prevents clients from accessing their primary emotions, utilizing them for the information they provide, and taking action to meet related needs (Greenberg et al., 1993; Elliott, Watson et al., 2004). As such, it was of interest to investigate the in-session client processes facilitative of the resolution of AESI. Using task analytic methodology (Greenberg, 2007), a model of the component processes involved in clients' progression from a Marker of AESI to its Resolution was developed (Discovery Phase), and preliminary support for the validity of the model was established (Validation Phase). In this chapter, results of the study in the context of existing literature on EFT and psychotherapy research are discussed, along with their implications for clinical practice. Limitations of the study and directions for future research are also considered.

### **A Model of Resolution of Aversion to Emotion/Self-Interruption (AESI)**

In the Discovery Phase of this study, a model of the resolution of AESI was developed through the intensive analysis of 5 cases (3 Resolved, 2 Unresolved). The model is displayed in Figure 2, which is repeated below for ease of reference. The model identified 7 component processes involved in this task, which are represented by blue arrows in the diagram. These components are the Marker of AESI, Awareness of How Interrupting, Awareness of Purpose of Interruption, Realization of Negative Impact of Interruption, Reduction of Fear of Emotion,

Desire to Allow Emotion, and Resolution of AESI. In the Discovery Phase sample, the first three components were observed as present among all clients, while the last four components were only observed among Resolved clients. Rating scales were developed to measure each component, so that they could be used to verify the model in the Validation Phase of the study. These rating scales consist of the Marker of AESI Rating Scale (MARS; Appendix A), the Components of Resolution of AESI Rating Scale (CRARS; Appendix B), and the Resolution of AESI Rating Scale (RARS; Appendix C).

**Figure 2.** *Rational-Empirical Model of Resolution of Aversion to Emotion/Self-Interruption*



When viewing this depiction of the model, one should keep in mind that it assumes that the process of resolving AESI occurs in a single therapy session. Although clients in this sample did resolve AESI in a single session, for some clients in therapy, resolution may not occur in a single session and several sessions may be needed to address AESI before resolution is attained. Additionally, the model outlines a sequence of linear, progressive steps that may precede the resolution of AESI; however, the process of resolving AESI is believed to occur in a cyclical manner wherein components occurring earlier in the session may be repeated later in a similar or more complete form.

Figure 2 also displays the states in which Unresolved clients tend to become stuck and unable to progress any further toward resolution, namely Secondary Emotions and Reluctance to Allow Emotion, which are represented by grey boxes. In addition, the green element highlights the importance of Therapists' Support and Encouragement to Allow Emotion in clients' progression through later stages in the model.

The above model of the resolution of AESI developed in the Discovery Phase refines our understanding of the client processes involved in this task. It builds on a model previously proposed by Greenberg and colleagues (Greenberg et al., 1993; Elliott, Watson et al., 2004; See Figure 1 in Chapter 2) by offering a more in-depth and nuanced description of known processes, along with the identification of new processes. Findings from the Discovery Phase, in the context of their contributions to existing literature and their implications, are discussed below.

### *Awareness of How Interrupting*

The finding of the component Awareness of How Interrupting supports the existing perspective in emotion-focused therapy (EFT) literature that a critical initial step in the process of overcoming AESI involves clients becoming aware of their efforts to prevent, stop, or over-control their experience or expression of their emotions (Greenberg et al., 1993; Elliott, Watson, et al., 2004). As clients identify how they hold themselves back, they experience themselves as active agents in their self-interruptive process. The importance of clients becoming aware of how they contribute to their difficulties has also been highlighted in a Principle-Based approach to psychotherapy integration (Eubanks & Goldfried, 2019; Goldfried et al., 2021). This method of integration emphasizes empirically supported change principles that are common across different therapeutic orientations and diagnostic categories. Eubanks and Goldfried (2019) describe how clients often start therapy in a state of “unconscious incompetence” (p. 7) being unaware of the ways in which they contribute to their difficulties, and that one of the main goals of therapy is to help clients move toward a state of increased awareness, referred to as “conscious incompetence” (p. 7). As clients gain more insight, they can start to recognize opportunities for making positive changes and develop “conscious competence” (Eubanks & Goldfried, 2019, p. 8).

While it has been suggested that the best intervention for facilitating clients’ awareness of how they interrupt themselves is through the enactment of their interruption in a two-chair dialogue (Elliott, Watson et al., 2004), not all Resolved clients in the Discovery Phase sample engaged in this intervention. One out of three Resolved clients demonstrated awareness of their interruption during empathic exploration with their therapists. This suggests that some clients

can develop a sense of agency over their self-interruptive process by simply acknowledging how they stop themselves, without needing to enact this process in a two-chair dialogue. Accordingly, the component Experience of Self as Agent in Self-Interruptive Process from the proposed model was renamed Awareness of How Interrupting to better reflect what clients were observed doing at this point in the process of resolution.

### *Awareness of Purpose of Interruption*

Another discovery of this study is that, along with clients becoming aware of how they interrupt themselves, clients also need to become aware of the purpose of their interruption. This involves realizing that their interruption serves to protect them from the feared consequences of allowing their emotions. During this component, some clients may share accounts of personal memories of earlier negative experiences with emotions that they perceive as underlying their AESI in the present. This component represents a new addition to the original model of the resolution of AESI (Greenberg et al., 1993; Elliott, Watson et al., 2004).

This discovery is in line with findings from Weston's (2018) qualitative interviews with clients who interrupted their emotions during therapy, which she analyzed using a grounded theory approach (Rennie, 2006). Interview responses revealed that clients interrupted their emotions in an attempt to protect themselves, in response to a feeling of vulnerability associated with having their emotions. Weston explained that this vulnerability "encompassed a sense or feeling of a threat to physical self-integrity, psychological self-cohesion, and/or existence" (p. 162), which was rooted in clients' personal memories with emotion.

The discovery of this component is also in line with Greenberg & Watson's (2006) recommendation that part of helping clients overcome their self-interruption involves facilitating their awareness of and identification with its positive, protective function. As clients become aware of and articulate their specific feared consequences of allowing their emotions, their agency over their self-interruptive process is further heightened. Moreover, therapists' insight into clients' fears can enhance their case formulation and inform subsequent interventions aimed at alleviating these fears.

### ***Realization of Negative Impact of Interruption***

Consistent with the initial model (Greenberg et al., 1993; Elliott, Watson et al., 2004), it was observed that clients' awareness of the resulting impact of their interruption was an important step toward the resolution of AESI. However, the component Awareness of Experience of Being Interrupted from the initial model was replaced with Realization of Negative Impact of Interruption in the current model, in order to reflect two critical observations. First, although some clients may describe positive experiences resulting from their self-interruption, such as a temporary feeling of relief that comes from having stopped themselves from allowing the feared emotion, it is clients' acknowledgement of the negative consequences of their interruption that helps them become aware of their inherent adaptive desire to allow the emotion. In contrast to Resolved clients, Unresolved clients were more likely to view the positive impacts of their self-interruption as outweighing the negative impacts, which they sometimes dismissed or minimized. Accordingly, it is clients' realization of *negative* impacts that distinguishes between those who go on to resolve AESI and those who do not.

Second, although the previous model posits that clients need to experience the immediate effects of their self-interruption during the session, not all Resolved clients in the current study were observed doing so. Some Resolved clients did not describe their experience of these immediate effects, but nevertheless, demonstrated insight into the negative long-term consequences of continued self-interruption (e.g., maintaining the status quo of feeling depressed and stuck, being unable to move forward from their unfinished business, or remaining unable to form close relationships or have their needs met by others). These clients came to understand that, while their interruption had a protective function, it also held them back from attaining their goals or living the kind of life that they desired. Reflecting on and amplifying the discrepancy between clients' behaviour and their desires or values has been implicated in enhancing motivation for change (Miller & Rollnick, 2002). This suggests that clients' innate desire to allow their emotions may be accessed through not only their experience of immediate negative effects during the session, but also their realization of negative long-term effects of continued self-interruption. These observations further enhance our understanding of the client processes involved in the resolution of AESI.

### ***Reduction of Fear of Emotion***

A significant discovery is the finding that clients' Reduction of Fear of Emotion is an essential step toward their resolution of AESI. Although the role of therapists in supporting clients in facing, accepting, and tolerating aversive emotions has been widely cited in EFT literature (e.g., Greenberg & Watson, 2006; Paivio & Pascual-Leone, 2010; Watson & Greenberg, 2017), the internalization of this support as a client process was not included in the

original model of the resolution of AESI (Greenberg et al., 1993; Elliott, Watson et al., 2004). In the Discovery Phase, it was observed that clients' relationship toward their aversive emotions, along with related needs, action tendencies, and/or parts of self, shifted prior to their attainment of resolution. Their fears associated with allowing their emotions were reduced as they internalized validation and/or a sense of safety provided by their therapists. As clients' fears decreased, so did their need for self-protection through self-interruption. The observation that the component Reduction of Fear of Emotion was attained by all Resolved clients, while it was not attained by any Unresolved clients, suggests that it is a crucial pre-requisite to clients allowing their aversive emotions and that it differentiates clients who go on to allow from those who do not. Thus, it is essential that therapists support their clients in reducing their fears associated with experiencing and expressing their emotions.

In EFT, the therapeutic relationship is regarded as a primary vehicle for helping clients develop more positive ways of relating to themselves and their emotional experiences (Watson & Greenberg, 2017; Paivio & Pascual-Leone, 2010). Research has shown that interactions with significant others play a vital role in the development of structural right brain neurobiological systems that are involved in the processing, modulation, and regulation of emotions, as well as in the development of one's sense of self (Chambers, 2017; Schore, 1994, 2021). These interactions have also been implicated in individuals' development of confidence to explore their external and internal worlds (Benjamin, 1993; Bowlby, 1988; Feeny & Thrush, 2010; Pine, 1986). Similarly, clients' interactions with their therapists can facilitate their internalization of more positive ways of relating to themselves and their emotional experiences (Alexander & French, 1946; Riess, 2012; Schore & Schore, 2008; Travis et al., 2001). Therapists' soothing presence,

empathic affirmations, and validation of emotions and needs can help reduce clients' isolation and distress, as well as mistrust in and fear of their internal experience. Over time, the interpersonal validation and safety provided by therapists turns into clients' self-validation, self-compassion, and self-soothing (Sroufe, 1996; Stern, 1985).

The discovery of this component also lends support to Greenberg and colleagues' (Auszra & Greenberg, 2007; Greenberg et al., 2007; Herrmann & Auszra, 2019) position that, for emotional expression to be productive in therapy, clients need to relate to their emotions from a stance of acceptance. In other words, clients need to accept their emotions, as well as themselves for having them. When Greenberg and colleagues rated sessions of EFT for depression using this criterion, along with other criteria for identifying productive emotional expression, productive expression was found to significantly predict reduction in symptoms at the end of therapy over and above the contribution of other factors, such as emotional arousal and working alliance (Greenberg et al., 2007). Thus, the cultivation of a positive relationship with one's emotions, including a stance of acceptance, has implications for therapeutic outcome, and should be supported and encouraged within the therapeutic relationship.

### ***Desire to Allow Emotion***

Last, the finding of the component Desire to Allow Emotion further enriches our understanding of the client processes involved in the resolution of AESI. In the Discovery Phase, clients who resolved this task were observed conveying that they wanted to allow, or that they were making attempts to try to approach or stay with, their emotions. Their statements conveyed a sense of agency over their resolution of their AESI, in that they made a conscious decision to

try to allow their emotions with a sense of responsibility or ownership over doing so. The attainment of this component differentiated Resolved from Unresolved clients in the current study. Clients who were unable to resolve their AESI maintained a reluctance to allow and conveyed that allowing their emotions felt impossible, elusive, or too frightening. This finding supports Greenberg and Paivio's (1998) assertion that approaching previously avoided painful emotions for the first time is a decision that requires intentionality on the part of clients. It also represents a new addition to the initial model of the resolution of AESI put forth by Greenberg and colleagues (Greenberg et al., 1993; Elliott, Watson et al., 2004), and offers insight into another process that may be observed in clients on the path toward resolution.

### **Preliminary Evidence for the Validity of the Model**

In the Validation Phase of the study, ratings of the seven components of the model of the resolution of AESI in a sample of 24 clients (13 Resolved, 11 Unresolved) were made by two pairs of independent, blind-to-outcome raters on the three rating scales (i.e., MARS, CRARS, RARS). As tested in Hypothesis 1, significant inter-rater reliability was obtained on each rating scale. Findings pertaining to Hypotheses 2 through 4, along with their implications, are discussed below.

### ***Resolution is Positively Associated with Realization of Negative Impact of Interruption, Reduction of Fear of Emotion, and Desire to Allow Emotion***

Associations between attainment of mid-model components and Resolution of AESI were investigated in Hypothesis 2. Consistent with observations in the Discovery Phase sample, the two early mid-model components (Awareness of How Interrupting and Awareness of Purpose of

Interruption) were present among all clients, while the three late mid-model components (Realization of Negative Impact of Interruption, Reduction of Fear of Emotion, Desire to Allow Emotion) occurred more frequently among clients in the Resolved subgroup than the Unresolved subgroup. All three late mid-model components were positively associated with Resolution subgroup membership. This lends preliminary support to the validity of the model of the resolution of AESI developed during the Discovery Phase of this study.

### ***Realizing the Negative Impact of Interruption is Important but not Sufficient***

An unexpected finding was that Resolution of AESI had a perfect positive relationship with Reduction of Fear of Emotion and a fairly strong positive relationship with Desire to Allow Emotion, while, in contrast, it only had a moderate positive relationship with Realization of Negative Impact of Interruption. Although Realization of Negative Impact of Interruption occurred more frequently among Resolved clients, it was still observed in 6 out of 11 (54.54%) Unresolved cases. This was not anticipated by the investigator, since in the initial model of the resolution of AESI (See Figure 1 in Chapter 2; Greenberg et al., 1993; Elliott, Watson et al., 2004), clients' experience of being interrupted was proposed as the primary catalyst for clients becoming aware of their desire to allow their emotions. Closer examination of Unresolved clients who conveyed a Realization of Negative Impact of Interruption revealed that, despite attainment of this component, they were unable to attain Reduction of Fear of Emotion or Desire to Allow Emotion. This suggests that realizing the negative impact of self-interruption on its own may not be sufficient in facilitating clients' access to their desire to allow their emotions, and that other processes (described next) need to accompany this realization.

### ***Reduction of Fear of Emotion is Essential***

Along with realizing the negative impact of their interruption, clients also need to experience a shift in their relationship toward their aversive emotions, before they can attain resolution. The perfect relationship between Resolution of AESI and Reduction of Fear of Emotion demonstrates that this component is essential to successful completion of this task. If clients are unable to attain Reduction of Fear of Emotion, their perception of threat posed by the potential negative consequences of allowing their emotions remains a barrier. Several clients described how they perceived their feared consequences of allowing as posing a greater threat to them than the negative impacts of their interruption. As a result, they maintained their aversion and continued to express reluctance to allow their emotions.

Clients who were unable to attain Reduction of Fear of Emotion may have had more entrenched negative beliefs about their emotions, related needs, or about themselves for having them. This is reflected in the observation that, among Unresolved clients, cognitive control through injunctions against having their emotions was more prominent. The resulting effect was the induction of secondary emotions that lacked adaptive value and obstructed their ability to access their inherently adaptive Desire to Allow Emotion. More specifically, Unresolved clients demonstrated more cognitive control in the form of criticism and invalidation, which led them to experience more secondary shame or guilt about having their emotions. Consequently, they were less likely to view themselves as entitled to their emotional experience or needs, and they did not display self-compassion, pride, or adaptive anger during their sessions. Similarly, cognitive control via hopeless beliefs and expectations about allowing their emotions was also observed

more frequently. Their propensity toward secondary hopelessness coincided with a limited sense of agency over their change process. Moreover, cognitive control by induction of anxiety and fear of the potential dangers of allowing was observed, as well. Unresolved clients became stuck in these secondary emotions, unable to experience a shift in how they treat themselves and their primary (interrupted) emotions. They may have benefited from more time and support from their therapists to internalize validation and safety, in order to reduce their sense of vulnerability in relation to their emotions, before being ready to allow them.

### ***Mixed Support for the Structure of the Model***

The overall structure of the model of the resolution of AESI was also investigated during the Validation Phase of this study. As tested in Hypothesis 3, the completion of all three late mid-model components was most strongly associated with Resolution, compared to the completion of fewer components. This lends further support to the contribution of each late mid-model component. Nevertheless, the completion of all but one late mid-model components was also associated with membership in the Resolved subgroup. This suggests that there is individual variability in the paths that clients take toward attaining resolution.

The varied nature of these paths was explored in greater depth, as the sequence of mid-model components among Resolved clients was examined in Hypothesis 4. While only 3 (out of  $n=13$ ) Resolved clients followed the exact sequence identified by the model of resolution (see Figure 2), all clients displayed the two early mid-model components (i.e., Awareness of How Interruption, Awareness of Purpose of Interruption) followed by a combination of two or three late mid-model components (i.e., Realization of Negative Impact of Interruption, Reduction of

Fear of Emotion, Desire to Allow Emotion), a sequence which occurred significantly more often than expected by chance alone. The two early mid-model components, Awareness of How Interrupting and Awareness of Purpose of Interruption, occurred first and in immediate proximity to one another among all Resolved clients. However, in contrast to the proposed model, their order in relation to one another was interchangeable. Subsequently, all Resolved clients exhibited the late mid-model component of Reduction of Fear of Emotion, along with *one or both* of the remaining mid-model components: Realization of Negative Impact of Interruption and/or Desire to Allow Emotion. The order in which these two or three late mid-model components occurred varied across clients, as well. Despite this variability in sequence within early mid-model components and within late mid-model components, these findings lend support for the overall structure of the rational-empirical model. They enrich our understanding of the ways in which clients can successfully progress through the model of the resolution of AESI.

### ***Additional Findings***

In order to eliminate the possibility that the therapeutic relationship, rather than the model components, determined clients' resolution of AESI, the investigator checked if the working alliance differed between the Resolved and Unresolved subgroups. The therapeutic relationship, or working alliance, has been defined as the "holistic collaborative aspects of the therapist-client relationship" (Flückiger, et al., 2018, p. 317) and is one of the most researched factors contributing to psychotherapy outcome. A meta-analysis of 295 independent studies revealed that the strength of the alliance is a consistently robust predictor of outcome irrespective of the treatment approach used, patient characteristics, the measures used to assess alliance and

outcome, and the countries in which the studies were carried out (Flückiger et al., 2018). Results from the current study indicate that the average client in both the Resolved and Unresolved subgroups had a strong therapeutic alliance with their therapist, as measured by the Working Alliance Inventory (Horvath, 1981; Horvath & Greenberg, 1989; Tracey & Kokotovic, 1989). A marginally higher working alliance was found in the Resolved subgroup; however, this was not statistically significant. Moreover, the magnitude of the relationship between working alliance and resolution was considerably smaller than the magnitude of the relationships between late mid-model components and Resolution. Accordingly, the process differences found between the Resolution subgroups cannot be attributed to differences in working alliance alone.

Moreover, clients' ability to resolve their AESI was not dependent on whether therapists' support and encouragement to allow their emotions was provided over the course of a two-chair enactment or during empathic exploration. This suggests that process-guided empathic exploration that supports client emotional processing is an alternative means of facilitating resolution of AESI. This is consistent with research on EFT for complex interpersonal trauma, which demonstrated that, when levels of client experiential engagement during an empathic exploration procedure were similar to those of clients in a chair-based dialogue procedure, therapeutic outcomes were comparable across both intervention groups (Paivio & Pascual-Leone, 2010; Ralston, 2006).

### **Clinical Implications**

This is the first study to systematically investigate the client processes involved in the resolution of Aversion to Emotion/Self-Interruption (AESI) in emotion-focused therapy (EFT).

Through this investigation, a model of client processes was developed and preliminarily validated. The model provides therapists with a guide for working with clients who present with the Marker of AESI in EFT. The model specifies which client performances are most likely to lead to resolution. By keeping the model in mind, therapists can assess where clients are along the path to resolution. For instance, therapists can ask themselves whether their clients need help becoming aware of aspects of their AESI as specified by the early mid-model components, or whether their clients have this awareness but need more support to progress through some of the late mid-model components. Moreover, although a model of therapist processes was not developed as part of this study, observations were made pertaining to therapist interventions that appeared to facilitate clients' progression through the three late mid-model components.

The results also offer preliminary evidence of the model's validity as a transdiagnostic model. Rather than selecting a sample of clients on the basis of a specific diagnostic category from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V; American Psychiatric Association, 2013), this sample was selected based on the presence of the Marker of AESI in clients from clinical trials of EFT for depression and unfinished business, as well as from publicly available training videos for various presenting concerns including complex relational trauma. As such, this model can apply to clients with range of presenting problems who exhibit the AESI in therapy.

### **Limitations of the Study and Directions for Future Research**

Despite its contributions to our understanding of the resolution of AESI, the current study is not without its methodological and procedural limitations. These will now be described, along

with suggestions as to how future research could address them. The nature of task analyses of psychotherapy processes poses several challenges. Because this method involves both exploratory and qualitative components, some findings are vulnerable to biases by the investigator and observer-raters. Another challenge is the reduced number of cases and sessions that can be selected for analysis and empirical study. Identifying and selecting sessions, as well as segments within these sessions, is laborious and time-consuming. Thus, the 5 cases from the Discovery Phase sample and the 24 cases from the Validation Phase sample represent a limited number. The power of statistical tests can be greatly reduced by sample size (Wasserstein & Lazar, 2016), thereby possibly reducing the chance of detecting a true effect in tests of statistical significance. However, it can also reduce the likelihood that statically significant results reflect a true effect and diminish the reproducibility of the results (Button et al., 2013). Additional studies need to be conducted to determine the reproducibility of the results of the current study.

Moreover, while the current study aimed to preliminarily validate this model of the resolution of AESI, additional steps need to be taken to further establish its validity. A process-outcome study can be conducted to relate the mid-model components and resolution to session and treatment outcome (Greenberg, 2007). These outcomes can take the form of standardized self-report measures completed by clients pertaining to their subjective experiences of their distress, symptoms (e.g., depression, anxiety) or target complaints. Such measures can be completed by clients at the start and end of treatment, at regular intervals during treatment, as well as at treatment follow-up (e.g., 18 months after termination). For instance, Greenberg and Malcolm (2002) related the process of resolution of unfinished business with a significant other to therapeutic outcome, and found that those who expressed previously unmet interpersonal

needs and experienced a shift in their view of the other, had significantly better outcomes at termination, including reductions in symptom distress, interpersonal patterns, and degree of task resolution.

Prospective research should also involve a greater proportion of clients from varying diagnostic and demographic groups, as well as from other treatment approaches, in order to expand the generalizability of the results. While the current sample included clients from two clinical trials of EFT for depression, one trial of EFT for unfinished business, and several publicly available EFT training videos, the majority of the clients in this study were from the depression trials. As well, information related to ethnicity, religion, and other potentially relevant demographic variables was not systematically collected at the time of the original clinical trials, so it is unknown to what extent these results generalize to diverse client populations. Moreover, as these findings were developed within the context of individual EFT with adult clients, they may not accurately describe the process by which clients overcome AESI in other treatment approaches or modalities.

Furthermore, since the current study only examined the resolution of AESI in a single session, subsequent research could expand the method used in this investigation to include the study of the development of the model components over a series of AESI events across multiple therapy sessions. Such an approach was illustrated by Tarba (2015), who studied the resolution of arrested anger among depressed clients over their entire course of EFT. Pascual-Leone and Greenberg (2007) and Greenberg and Malcolm (2002) also developed and validated models of how clients overcome global distress and unfinished business with a significant other, respectively, over the course of EFT. Accordingly, examination of AESI events throughout

clients' entire course of treatment may provide a more comprehensive illustration of how the process of resolution of this task unfolds over time.

Another limitation of this study is that the process measures developed and used are based on ratings made by external observers. This does not take into account clients' perspectives of their experiences in therapy. Discrepancies have been found between the intensity of clients' expressed emotions, as determined by observers, and clients' reports of their subjective experience of the intensity of their emotions (Warwar et al., 2003). Additional information can be obtained when combining ratings completed by external raters and clients' accounts of their experiences in session. This was exemplified by Weston (2018), who integrated results from the Discovery Phase of a task analysis of the nature of clients' self-interruption with results from qualitative interviews conducted with participants about their subjective experiences of these sessions. Weston's use of grounded theory analysis (Rennie, 2006) on participants' responses in Interpersonal Process Recall Interviews (Rennie, 1992) led to a richer and more complete picture of the nature of self-interruption. Future research on the resolution of AESI could involve such analyses of qualitative interviews, to obtain a more complex and thorough representation of the processes involved in this task.

An additional direction that warrants further exploration is the therapist processes that facilitate clients' resolution of AESI. The current study revealed that certain therapist interventions appeared to coincide with clients' progression through the late mid-model components to resolution, as described under Therapist Support and Encouragement to Allow Emotion in Chapter 2. A more systematic investigation into therapist actions would provide a richer and more detailed picture. One way of approaching this could involve conducting a task

analysis of therapist actions or processes. Alternatively, as previously suggested by Kramer and Stiles (2015), interactional sequences between therapist and client processes, and their relationship to client resolution or outcome, could be investigated.

Lastly, future research could examine the relationships between various client characteristics and their attainment of model components. Such characteristics could include the nature of clients' trauma histories (e.g., as assessed by the Childhood Trauma Questionnaire; Pennebaker & Susman, 1988), their attachment styles (e.g., as classified on the Adult Attachment Interview; George et al., 1985), or their propensity toward responding to stressors through intentional use of emotional processing and emotional expression (e.g., as measured by the Emotional Approach Coping Scale; Stanton et al., 2000), at baseline or over the course of treatment. Thus, there are many avenues for future research on the resolution of AESI.

## **Conclusion**

In summary, a model of client processes involved in the resolution of Aversion to Emotion/Self-Interruption (AESI) in sessions of emotion-focused therapy (EFT) was developed and preliminarily validated. The model adds to the literature as it provides a more differentiated understanding of the processes that clients move through as they resolve AESI and it can serve as a map for therapists as they guide clients through this task. Additionally, preliminary evidence of the validity of the model was obtained, as relationships between three late mid-model components (i.e., Realization of Negative Impact of Interruption, Reduction of Fear of Emotion, Desire to Allow Emotion) and task resolution were established and the overall structure of the model was supported. Moreover, instruments were created for identifying the presence of the

marker of AESI, mid-model components, and task resolution, which can be used in future studies.

## References

- Adams, K.E. (2010). *Therapist influence on depressed clients' therapeutic experiencing and outcome* [Unpublished doctoral dissertation]. York University, Toronto, Canada.
- Alexander, F., & French, T. M. (1946). *Psychoanalytic therapy: Principles and application*. Ronald Press.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>
- Angus, L. (2012) Toward an integrative understanding of narrative and emotion processes in emotion-focused therapy of depression: Implications for theory, research and practice. *Psychotherapy Research*, 22, 4, 367-380.  
<https://doi.org/10.1080/10503307.2012.683988>
- Angus, L., Boritz, T., Bryntwick, E., Carpenter, N., Macaulay, C. & Khattra, J. (2017). The Narrative-Emotion Process Coding System 2.0: A multi-methodological approach to identifying and assessing narrative-emotion process markers in psychotherapy. *Psychotherapy Research*, 27, 253-269.  
<https://doi.org/10.1080/10503307.2016.1238525>
- Angus, L. & Greenberg, L. (2011) *Working with narrative in emotion-focussed therapy: Changing stories, healing lives*. American Psychological Association Press.  
<https://doi.org/10.1037/12325-000>
- Angus, L. E., Lewin, J., Bouffard, B., & Rotondi-Trevisan, D. (2004). "What's the story?" working with narrative in experiential psychotherapy. In L. E. Angus & J. McLeod

- (Eds.), *The handbook of narrative and psychotherapy: Practice, theory and research* (pp. 87–101). SAGE. <https://doi.org/10.4135/9781412973496>
- Auszra, L., & Greenberg, L. S. (2007). Client emotional productivity. *European Psychotherapy*, 7, 137-152.
- Auszra, L., Greenberg, L. S., & Herrmann, I. R. (2007). *Client Emotional Productivity Scale Revised* [Unpublished manuscript], York University, Toronto, Ontario, Canada.
- Barlow, D. H. (1991). Disorders of emotion. *Psychological Inquiry*, 2, 58–71.  
[https://doi.org/10.1207/s15327965pli0201\\_15s](https://doi.org/10.1207/s15327965pli0201_15s)
- Barlow, D. H., Sauer-Zavala, S., Carl, J. R., Bullis, J. R., & Ellard, K. K. (2014). The nature, diagnosis, and treatment of neuroticism: Back to the future. *Clinical Psychological Science*, 2, 344–365. <https://doi.org/10.1177/2167702613505532>
- Batten, S. V. (2001). Testing the effects of a written disclosure task with sexual abuse survivors. [Unpublished doctoral dissertation]. *Dissertation Abstracts International*, 61, 4970.
- Beblo, T., Fernndo, S., Klocke, S., Griepenstroh, J., Aschenbrenner, S., & Driessen, M. (2012). Increased suppression of negative and positive emotions in major depression. *Journal of Affective Disorders*, 141, 474-479.  
<https://doi.org/10.1016/j.jad.2012.03.019>
- Begotka, A. M., Woods, D. W., & Wetterneck, C. T. (2004). The relationship between experiential avoidance and the severity of trichotillomania in a nonreferred sample. *Journal of Behavior Therapy*, 35, 17–24. <https://doi.org/10.1016/j.jbtep.2004.02.001>
- Benjamin, L. S. (1974). Structural analysis of social behavior. *Psychological Review*, 81, 392-425. <https://doi.org/10.1037/h0037024>

- Benjamin, L.S. (1993). *Interpersonal diagnosis and treatment of personality disorders*. Guilford Press.
- Bolger, E.A. (1999). Grounded theory analysis of emotional pain. *Psychotherapy Research, 9*, 342-362. <https://doi.org/10.1093/ptr/9.3.342>
- Boritz, T., Angus, L., Monette, G., & Hollis-Walker, L. (2011). Narrative and emotion integration in psychotherapy: Investigating the relationship between autobiographical memory specificity and expressed emotional arousal in brief emotion-focused and client-centred treatments of depression. *Psychotherapy Research, 21*, 16–26. <https://doi.org/10.1080/10503307.2010.504240>
- Bowlby, J. (1988). A secure base: Parent-child attachment and healthy human development. *Basic Books*. <https://doi.org/10.1176/ps.41.6.684-a>
- Breuer J. & Freud S. (1893). Studies on Hysteria. In Strachey, J. (Ed.), *The standard edition of the complete psychological works of Sigmund Freud (Vol. 2)*. The Hogarth Press Limited.
- Brinegar, M.G., Salvi, L.M., Stiles, W.B., & Greenberg, L.S. (2006). Building a meaning bridge: Therapeutic progress from problem formulation to understanding. *Journal of Counseling Psychology, 53*, 165-180. <https://doi.org/10.1037/0022-0167.53.2.165>
- Bullis, J.R., Boettcher, H., Sauer-Zavala, S., Farchione, T.J., & Barlow, D.H. (2019). What is an emotional disorder? Transdiagnostic mechanistic definition with implications for assessment, treatment, and prevention. *Clinical Psychology: Science and Practice, 26*, 1-19. <http://dx.doi.org/10.1037/h0101755>

- Button, K.S., Ioannidis, J.P.A, Mokrysz, C., Nosek, B.A., Flint., J., Robinson, E.S.J., & Munafò, M.R. (2013). Power failure: Why small sample size undermines the reliability of neuroscience. *Nature Reviews: Neuroscience*, *14*, 365-376.  
<https://doi.org/10.1038/nrn3475>
- Campbell-Sills, L., Barlow, D. H., Brown, T. A., & Hofmann, S. G. (2006a). Acceptability and suppression of negative emotion in anxiety and mood disorders. *Emotion*, *6*, 587–595. <https://doi.org/10.1037/1528-3542.6.4.587>
- Campbell-Sills, L., Barlow, D. H., Brown, T. A., & Hofmann, S. G. (2006b). Effects of suppression and acceptance on emotional responses of individuals with anxiety and mood disorders. *Behaviour Research and Therapy*, *44*, 1251–1263.  
<https://doi.org/10.1016/j.brat.2005.10.001>
- Carlson, J. (Director). (2007). *Emotion-focused therapy over time* [DVD]. American Psychological Association.
- Carryer, J.R., & Greenberg, L.S. (2010). Optimal levels of emotional arousal in experiential therapy for depression. *Journal of Consulting and Clinical Psychology*, *78*, 190-199.  
<https://doi.org/10.1037/a0018401>
- Chambers, J. (2017). Neurobiology of attachment: From infancy to clinical outcomes. *Psychodynamic Psychiatry*, *45*, 542-563. <https://doi.org/10.1521/pdps.2017.45.4.542>
- Chapman, A. L., Gratz, K. L., & Brown, M. Z. (2006). Solving the puzzle of deliberate self-harm: The experiential avoidance model. *Behavior Research and Therapy*, *44*, 371–394. <https://doi.org/10.1016/j.brat.2005.03.005>

- Chapman, A. L., Specht, M. W., & Cellucci, T. (2005). Borderline personality disorder and self-harm: Does experiential avoidance play a role? *Suicide and Life Threatening Behavior, 35*, 388–399. <https://doi.org/10.1521/suli.2005.35.4.388>
- Choi, B.H., Pos, A.E., & Magnusson, M.S. (2016). Emotional change process in resolving self-criticism during experiential treatment of depression. *Psychotherapy Research, 26*, 484-499. <https://doi.org/10.1080/10503307.2015.1041433>
- Clark, D. M., Ball, S., & Pape, D. (1991). An experimental investigation of thought suppression. *Behavior Research and Therapy, 29*, 253–257. [https://doi.org/10.1016/0005-7967\(91\)90115-J](https://doi.org/10.1016/0005-7967(91)90115-J)
- Coady, N. F., & Marziali, E. (1994). The association between global and specific measures of the therapeutic relationship. *Psychotherapy, 31*, 17–27. <https://doi.org/10.1037/0033-3204.31.1.17>
- Cohen, J. (1968). Weighted kappa: Nominal scale agreement provision for scaled disagreement or partial credit. *Psychological Bulletin, 70*, 213-220.  
<https://doi.org/10.1037/h0026256>
- Cumming, G. (2014). The new statistics: Why and how. *Psychological Science, 25*, 7-29.  
<https://doi.org/10.1177/0956797613504966>
- Dalgleish, T., Black, M., Johnston, D., & Bevan, A. (2020). Transdiagnostic approaches to mental health problems. Current status and future directions. *Journal of Consulting and Clinical Psychology, 88*, 179-195. <http://dx.doi.org/10.1037/ccp0000482>
- Damasio A. (1999). *The feeling of what happens*. Harcourt-Brace.

- Damasio, A. (2003). *Looking for Spinoza: Joy, sorrow and the feeling brain*. Harcourt Brace Jovanovich.
- Elliott, R. & Greenberg, L. (2017) Humanistic-experiential psychotherapy in practice. In A. Consoli, L. Beutler & B. Bongar (Eds.) *Comprehensive textbook of psychotherapy: Theory and practice* (pp. 106-120). Oxford University Press.
- Elliott, R., Greenberg, L., & Lietaer, G. (2004). Research on experiential psychotherapy, In M. Lambert (Ed.) *Bergin and Garfield's handbook of psychotherapy and behavior change* (pp. 493–539). John Wiley & Sons.
- Elliott, R., Watson, J.C., Goldman, R.N., & Greenberg, L.S. (2004). *Learning emotion-focused therapy: The process-experiential approach to change*. American Psychological Association. <https://doi.org/10.1037/10725-000>
- Emotion focused therapy with empty chair technique* [Film]. (2016). psycTherapy. Retrieved from: <https://psyctherapy.apa.org/Title/7777700544-001>. doi: 10.1037/v00544-001.
- Eubanks, C.F. & Goldfried, M.R. (2019). A principle-based approach to psychotherapy integration. In J.C. Norcross and M.R. Goldfried (Eds). *Handbook of psychotherapy integration (3 ed.)* (pp. 88-108). Oxford University Press. <https://doi.org/10.1093/med-psych/9780190690465.001.0001>
- Feeny, B.C., & Thrush, R.L. (2010). Relationship influences on exploration in adulthood: The characteristics and function of a secure base. *Journal of Personality and Social Psychology*, 98, 57-76. <https://doi.org/10.1037/a0016961>

- Feng, Z. (2010). Classification versus association models: Should the same methods apply? *Scandinavian Journal of Clinical and Laboratory Investigation*, *242*, 53-58.  
<https://doi.org/10.3109/00365513.2010.493387>
- Firth, D. (1993). Bias reduction of maximum likelihood estimates. *Biometrika*, *80*, 27-38.  
<https://doi.org/10.1093/biomet/80.1.27>
- Fisher, R.A. (1934). *Statistical methods for research workers* (5th ed). Oliver & Boyd.
- Flückiger, C., Del Re, A.C., Wampold, B.E., & Horvath, A.O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy*, *55*, 316-340.  
<http://dx.doi.org/10.1037/pst0000172>
- Foroughe, M., Stillar, A., Goldstein, L., Dolhanty, J., Goodcase, E., & Lafrance, A. (2019). Brief emotion focused family therapy: An intervention for parents of children and adolescents with mental health issues. *Journal of Marital and Family Therapy*, *45*, 410-430. <https://doi.org/10.1111/jmft.12351>
- Frankl, V. (1959). *Man's search for meaning*. Beacon.
- Frederickson, B., Mancuso, R., Branigan, C., & Tugade, M. (2000). The undoing effect of positive emotions. *Motivation and Emotion*, *24*, 237-258.  
<https://doi.org/10.1023/A:1010796329158>
- Freud, S. (1914). Remembering, repeating, and working through. *Standard Edition*, *12*, 145-156.
- Fried, E. I., & Nesse, R. M. (2015). Depression is not a consistent syndrome: An investigation of unique symptom patterns in the STAR\*D study. *Journal of Affective Disorders*, *172*, 96-102. <http://dx.doi.org/10.1016/j.jad.2014.10.010>

- Frijda, N.H. (1986). *The emotions: Studies in emotion and social interaction*. Cambridge University Press. <https://doi.org/10.1017/CBO9780511659904.010>
- Galatzer-Levy, I. R., & Bryant, R. A. (2013). 636,120 ways to have posttraumatic stress disorder. *Perspectives on Psychological Science*, 8, 651–662. <https://doi.org/10.1177/1745691613504115>
- Gendlin, E. T. (1996). *Focusing-oriented psychotherapy: A manual of the experiential method*. Guilford Press.
- George, C., Kaplan, N., & Main, M. (1985). *The Adult Attachment Interview* [Unpublished manuscript]. University of California at Berkeley. Retrieved from: [http://www.psychology.sunysb.edu/attachment/measures/content/aai\\_interview.pdf](http://www.psychology.sunysb.edu/attachment/measures/content/aai_interview.pdf)
- Girz, L., Lafrance Robinson, A., Foroughe, M., Jasper, K., & Boachie, A. (2013). Adaptive family-based therapy to a day hospital programme for adolescents with eating disorders: Preliminary outcomes and trajectories of change. *Journal of Family Therapy*, 35, 102-120. <https://doi.org/10.1111/j.1467-6427.2012.00618.x>
- Gold, D. B., & Wegner, D. M. (1995). Origins of ruminative thought: Trauma, incompleteness, non-disclosure and suppression. *Journal of Applied Social Psychology*, 25, 1245–1261. <https://doi.org/10.1111/j.1559-1816.1995.tb02617.x>
- Goldfried, M.R., Smith, J., & Henriques, G. (2021, May). *SEPI webinar: Advancing psychotherapy integration by creating common ground* [Video file, 11m:24s]. Retrieved from [https://youtu.be/nbHO\\_nuxfIY](https://youtu.be/nbHO_nuxfIY)

- Goldman, R., & Greenberg, L. (2015). *Case formulation in emotion-focused therapy: Co-creating clinical maps for change*. American Psychological Association.  
<https://doi.org/10.1037/14523-000>
- Goldman, R. N., Greenberg, L. S., & Angus, L. E. (2006). The effects of adding emotion focused interventions to the client-centered relationship conditions in the treatment of depression. *Psychotherapy Research, 16*, 537-549.  
<https://doi.org/10.1080/10503300600589456>
- Greenberg, L. S. (1979). Resolving splits: The two-chair technique. *Psychotherapy: Theory, Research and Practice, 16*, 310-318. <https://doi.org/10.1037/h0085895>
- Greenberg, L. S. (1980). The intensive analysis of recurring events from the practice of gestalt therapy. *Psychotherapy: Theory, Research & Practice, 17*, 143–152.  
<https://doi.org/10.1037/h0085904>
- Greenberg, L. S. (1984). Task analysis: The general approach. In L. Rice & L. Greenberg (Eds.), *Patterns of change: Intensive analyses of psychotherapy process* (pp. 124-148). The Guilford Press.
- Greenberg, L. S. (1986). Change process research. *Journal of Consulting and Clinical Psychology, 54*, 4–9. <https://doi.org/10.1037/0022-006X.54.1.4>
- Greenberg, L. S. (1991). Research on the process of change. *Psychotherapy Research, 1*, 14-24.  
<https://doi.org/10.1080/10503309112331334011>
- Greenberg, L.S. (2002). *Emotion-focused therapy: Coaching clients to work through their feelings*. American Psychological Association. <https://doi.org/10.1037/14692-000>

- Greenberg, L. S. (2007). A guide to conducting a task analysis of psychotherapeutic change. *Psychotherapy Research, 17*, 15-30. <https://doi.org/10.1080/10503300600720390>
- Greenberg, L. S. (2008). Emotion and cognition in psychotherapy: The transforming power of affect. *Canadian Psychology/ Psychologie Canadienne, 49*, 49–59. <https://doi.org/10.1037/0708-5591.49.1.49>
- Greenberg, L. S. (2010). Emotion-focused therapy: A clinical synthesis. *Focus, 8*, 1-11. <https://doi.org/10.1176/foc.8.1.foc32>
- Greenberg, L. S. (2011). *Emotion-focused therapy*. American Psychological Association. <https://doi.org/10.1037/15971-000>
- Greenberg, L. S. (2021). *Changing emotion with emotion: A practitioner's guide*. American Psychological Association. <https://doi.org/10.1037/0000248-000>
- Greenberg, L. S. & Angus, L. (2004). The contributions of emotion processes to narrative change in psychotherapy: A dialectical constructivist approach. In L. Angus & J. McLeod (Eds.) *Handbook of Narrative Psychotherapy: Practice, Theory, and Research* (pp. 331–349). SAGE. <https://doi.org/10.4135/9781412973496>
- Greenberg, L.S., Auszra, L., Herrmann, I. (2007). The relationship among emotional productivity, emotional arousal and outcome in experiential therapy of depression. *Psychotherapy Research, 17*, 482-493. <https://doi.org/10.1080/10503300600977800>
- Greenberg, L. S., & Clarke, K. M. (1979). Differential effects of the two-chair experiment and empathic reflections at a conflict marker. *Journal of Counseling Psychology, 26*, 1–8. <https://doi.org/10.1037/0022-0167.26.1.1>

- Greenberg, L. & Dompiere, L. (1981). Specific effects of gestalt two-chair dialogue on intrapsychic conflict in counseling. *Journal of Counseling Psychology, 28*, 288-294.  
<https://doi.org/10.1037/0022-0167.28.4.288>
- Greenberg, L. S., & Foerster, F. (1996a). *A manual on task analysis* [Unpublished manuscript]. York University, Toronto, Canada.
- Greenberg, L. S., & Foerster, F. (1996b). Task analysis exemplified: The process of resolving unfinished business. *Journal of Consulting and Clinical Psychology, 64*, 439-446.  
<https://doi.org/10.1037/0022-006X.64.3.439>
- Greenberg, L. S., & Higgins, H. M. (1980). Effects of two-chair dialogue and focusing on conflict resolution. *Journal of Counseling Psychology, 27*, 221–224.  
<https://doi.org/10.1037/0022-0167.27.3.221>
- Greenberg, L.S., & Malcolm, W. (2002). Resolving unfinished business: Relating process to outcome. *Journal of Consulting and Clinical Psychology, 70*, 406-416.  
<https://doi.org/10.1037/0022-006X.70.2.406>
- Greenberg, L. S., & Minden, R. R. (1988). *Manual for three specific marker-driven interventions drawn from gestalt therapy* [Unpublished manuscript]. York University, Toronto, Canada.
- Greenberg, L.S., & Paivio, S. (1997). *Working with emotions in psychotherapy*. Guilford Press.
- Greenberg, L.S., & Paivio, S.C. (1998). Allowing and accepting painful emotional experiences. *The International Journal of Action Methods, 51*, 47-61.
- Greenberg, L.S., & Pascual-Leone, J. (1995). A dialectical constructivist approach to experiential change. In R. A. Neimeyer & M. J. Mahoney (Eds.), *Constructivism in*

*psychotherapy* (pp. 169–191). American Psychological Association.

<https://doi.org/10.1037/10170-000>

Greenberg L.S., & Pascual-Leone, J. (2001). A dialectical constructivist view of the creation of personal meaning. *Journal of Constructivist Psychology, 14*, 165–186.

<https://doi.org/10.1080/10720530151143539>

Greenberg, L.S. & Rice, L. (1981). The specific effects of a gestalt intervention. *Psychotherapy: Theory, research, and practice, 18*, 31-37. <https://doi.org/10.1037/h0085958>

Greenberg, L.S., Rice, L., & Elliott, R. (1993). *Facilitating emotional change: The moment-by-moment process*. Guilford Press.

Greenberg, L. S., & Safran, J. (1987). *Emotion in psychotherapy: Affect, cognition and the process of change*. Guilford Press.

Greenberg, L.S., Warwar, S., & Malcolm, W. (2008). Differential effects of emotion-focused therapy and psychoeducation in facilitating forgiveness and letting go of emotional injuries. *Journal of Counselling Psychology, 55*, 185–196. <https://doi.org/10.1037/0022-0167.55.2.185>

Greenberg, L. S., & Watson, J. C. (1998). Experiential therapy of depression: Differential effects of client-centered relationship conditions and active experiential interventions.

*Psychotherapy Research, 8*, 210-224.

<https://doi.org/10.1080/10503309812331332317>

Greenberg, L. S., & Watson, J. C. (2006). *Emotion-focused therapy for depression*. American Psychological Association. <https://doi.org/10.1037/11286-000>

- Greenberg, L. S., Watson, J., & Goldman, R. (1998). Process-experiential therapy of depression. In L. S. Greenberg, J. C. Watson & G. Lietaer (Eds.), *Handbook of experiential therapy* (pp. 227-248). Guilford Press.
- Greenberg, L.S. & Webster, M. (1982). Resolving decisional conflict by gestalt two-chair dialogue: Relating process to outcome. *Journal of Counseling Psychology*, 29, 468-477.  
<https://doi.org/10.1037/0022-0167.29.5.468>
- Greenland, S., Senn, S.J., Rothman, K.J., Carlin, J.B., Poole, C., Goodman, S.N., & Altman, D.G. (2016). Statistical tests, *P* values, confidence intervals, and power: A guide to misinterpretations. *European Journal of Epidemiology*, 31, 337-350.  
<https://doi.org/10.1007/s10654-016-0149-3>
- Gross, J. (1989). Emotional expression in cancer onset and progression. *Social Science and Medicine*, 28, 1239–1248. [https://doi.org/10.1016/0277-9536\(89\)90342-0](https://doi.org/10.1016/0277-9536(89)90342-0)
- Gross, J. J., & John, O. P. (2003). Individual differences in two emotion regulation processes: Implications for affect, relationships, and well-being. *Journal of Personality and Social Psychology*, 85, 348-362. <https://doi.org/10.1037/0022-3514.85.2.348>
- Gross, J. J., & Levenson, R. W. (1993). Emotional suppression: Physiology, self-report, and expressive behavior. *Journal of Personality and Social Psychology*, 64, 970- 986.  
<https://doi.org/10.1037/0022-3514.64.6.970>
- Gross, J. J., & Levenson, R. W. (1997). Hiding feelings: The acute effects of inhibiting negative and positive emotion. *Journal of Abnormal Psychology*, 106, 95- 103.  
<https://doi.org/10.1037/0021-843X.106.1.95>
- Guidano, V.F. (1991). *The Self in Process*. Guilford Press.

- Hardy, G. E., & Llewelyn, S. (2015). Introduction to psychotherapy process research. In O. C. G. Gelo, A. Pritz, & B. Rieken (Eds.), *Psychotherapy research: Foundations, process, and outcome* (pp. 183–194). Springer-Verlag Publishing.  
[https://doi.org/10.1007/978-3-7091-1382-0\\_9](https://doi.org/10.1007/978-3-7091-1382-0_9)
- Hayes, S.C., Pistorello, J., & Levin, M.E. (2012). Acceptance and commitment therapy as a unified model of behavior change. *The Counseling Psychologist, 40*, 976-1002.  
<https://doi.org/10.1177/0011000012460836>
- Hayes, S. C., Strosahl, K., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. Guilford Press.
- Heinze, G. & Schemper, M. (2002). A solution to the problem of separation in logistic regression. *Statistics in Medicine, 21*, 2409-2419. <https://doi.org/10.1002/sim.1047>
- Henry, W. P., Schacht, T. E., & Strupp, H. H. (1986). Structural analysis of social behaviour: Application to a study of interpersonal process in differential therapeutic outcome. *Journal of Consulting and Clinical Psychology, 54*, 27-31.  
<https://doi.org/10.1037/0022-006X.54.1.27>
- Herrmann, I., & Auszra, L. (2019). Facilitating optimal emotional processing. In L. S. Greenberg & R. N. Goldman (Eds.), *Clinical handbook of emotion-focused therapy* (pp. 193–216). American Psychological Association. <https://doi.org/10.1037/0000112-000>
- Hofmann, S.G., & Hayes, S.C. (2019). Process-based therapy. *Clinical Psychological Science, 7*, 37-50. <https://doi.org/10.1177/2167702618772296>

- Horvath, A. O. (1981). *An exploratory study of the working alliance: Its measurement and relationship to therapy outcome* [Unpublished doctoral dissertation]. University of British Columbia, Vancouver, Canada. <https://dx.doi.org/10.14288/1.0054327>
- Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*, 222-233.  
<https://doi.org/10.1037/0022-0167.36.2.223>
- Izard, C. E. (2002). Translating emotion theory and research into preventative interventions. *Psychological Bulletin, 128*, 796–824. <https://doi.org/10.1037/0033-2909.128.5.796>
- Johnson, S. M. (2004). *The practice of emotionally focused couple therapy: Creating connection*. Brunner-Routledge. <https://doi.org/10.4324/9780203017999>
- Johnson, S. M., & Greenberg, L. S. (1985a). The differential effectiveness of experiential and problem-solving interventions in resolving marital conflict. *Journal of Consulting & Clinical Psychology, 53*, 175–184. <https://doi.org/10.1037/0022-006X.53.2.175>
- Johnson, S. M., & Greenberg, L. S. (1985b). Emotionally focused couples therapy: An outcome study. *Journal of Marital and Family Therapy, 11*, 313–317.  
<https://doi.org/10.1111/j.1752-0606.1985.tb00624.x>
- Kashdan, T. B., Barrios, V., Forsyth, J. P., & Steger, M. F. (2006). Experiential avoidance as a generalized psychological vulnerability: Comparisons with coping and emotion regulation strategies. *Behaviour Research and Therapy, 9*, 1301–1320.  
[10.1016/j.brat.2005.10.003](https://doi.org/10.1016/j.brat.2005.10.003)
- Keating, E., & Goldman, R. (2003, July). *A task analytic study of vulnerability and shame in emotion-focused therapy*. Paper presented at the Conference of the World

Association for Person-Centered and Experiential Psychotherapy and Counseling,  
Egmond Aan Zee, the Netherlands.

Kessler, R. C., Chiu, W. T., Demler, O., Merikangas, K. R., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM–IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *62*, 617– 627.

<http://dx.doi.org/10.1001/archpsyc.62.6.617>

Klein, M. H., Mathieu, P. L., Gendlin, E. T., & Kiesler, D. J. (1969). *The Experiencing Scale: A research training manual*. University of Wisconsin Extension Bureau of Audiovisual Instruction.

Klein, M. H., Mathieu-Coughlan, P., & Kiesler, D. J. (1986). The Experiencing Scales. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 21–71). Guilford Press.

Kornbrot, D. (2014). Point Biserial Correlation. In N. Balakrishnan, T. Colton, B. Everitt, W. Piegorisch, F. Ruggeri and J.L. Teugels (Eds.), *Wiley StatsRef: Statistics reference online*. <https://doi.org/10.1002/9781118445112.stat06227>

Kramer, U., & Stiles, W.B. (2015). The responsiveness problem in psychotherapy: A review of proposed solutions. *Clinical Psychology: Science and Practice*, *22*, 277-295.  
<https://doi.org/10.1111/cpsp.12107>

Le Doux, J. (1996). *The emotional brain: The mysterious underpinnings of emotional life*. Simon and Schuster.

- Leijssen, M. (1998). Focusing: Interpersonal and intrapersonal conditions of growth. In E. Lambers & B. Thorne (Eds.), *Person-centered therapy: A European perspective* (pp. 131–158). SAGE.
- Les Greenberg: Working with core emotion* [Film]. (2019). Counselling Channel Limited.
- Levenson, H., Angus, L. & Pool, E. (2020) Viewing psychodynamic/interpersonal psychotherapy through the lens of memory reconsolidation. In R. Lane & L. Nadel (Eds.) *Neuroscience of enduring change: Implications for psychotherapy* (pp. 300-327). Oxford University Press. <https://doi.org/10.1093/oso/9780190881511.001.0001>
- Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. Guilford Press.
- Linehan, M. M., Cochran, B. N., & Kehrer, C. A. (2001). Dialectical behavior therapy for borderline personality disorder. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual* (pp. 470–522). Guilford Press.
- MacLeod, R., Elliott, R., & Rodgers, B. (2012). Process-experiential/emotion-focused therapy for social anxiety: A hermeneutic single-case efficacy design study. *Psychotherapy Research, 22*, 67-81. <https://doi.org/10.1080/10503307.2011.626805>
- Mahoney, M. (1991). *Human Change Processes*. Basic Books.
- Malcolm, W.M. (1999). *Relating process to outcome in the resolution of unfinished business in process experiential psychotherapy* [Unpublished Doctoral Dissertation]. York University, Toronto, Canada.

- Marx, B. P., & Sloan, D. M. (2003). Peritraumatic dissociation and experiential avoidance as predictors of posttraumatic stress symptomatology. *Behavior Research and Therapy*, *43*, 569–583. <https://doi.org/10.1016/j.brat.2004.04.004>
- May, R. (1977). *The meaning of anxiety*. Norton.
- Miller, S. (2019). *Testing a psychotherapy change process in a sample of depressed clients with underlying maladaptive shame* [Unpublished Doctoral Dissertation]. York University, Toronto, Canada.
- Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). Guilford Press. <https://doi.org/10.1097/01445442-200305000-00013>
- Minuchin, S. (1974). *Families and Family Therapy*. Harvard University Press.
- Missirlian, T.M., Toukmanian, S.G., Warwar, S. H., & Greenberg, L.S. (2005). Emotional arousal, client perceptual processing, and the working alliance in experiential psychotherapy for depression. *Journal of Consulting and Clinical Psychology*, *73*, 861-871. <https://doi.org/10.1037/0022-006X.73.5.861>
- Murphy, J., Rowell, L., McQuaid, A., Timulak, L., O’Flynn, R., & McElvaney, J. (2017). Developing a model of working with worry in emotion-focused therapy: A discovery-phase task analytic study. *Counselling and Psychotherapy Research*, *17*, 56-70. <https://doi.org/10.1002/capr.12089>
- Nadel, L., & Bohbot, V. (2001). Consolidation of memory. *Hippocampus*, *11*, 56-60. [https://doi.org/10.1002/1098-1063\(2001\)11:1<56::AID-HIPO1020>3.0.CO;2-O](https://doi.org/10.1002/1098-1063(2001)11:1<56::AID-HIPO1020>3.0.CO;2-O)

- Najavits, L. M., & Strupp, H. H. (1994). Differences in the effectiveness of psychodynamic therapists: A process–outcome study. *Psychotherapy, 31*, 114–123.  
<https://doi.org/10.1037/0033-3204.31.1.114>
- Neimeyer, R., & Mahoney, M. (1995). *Constructivism in psychotherapy*. American Psychological Association. <https://doi.org/10.1037/10170-000>
- Oatley, K. (1992). *Best laid schemes*. Cambridge University Press
- Orcutt, H. K., Pickett, S., & Pope, E. (2005). Experiential avoidance and forgiveness as mediators in the relation between traumatic life events and PTSD symptoms. *Journal of Social and Clinical Psychology, 24*, 1003–1029. <https://doi.org/10.1521/jscp.2005.24.7.1003>
- Orlinsky, D., Heinonen, E., & Hartmann, A. (2015). Psychotherapy process research. In J.D. Wright (Ed.), *International encyclopedia of social and behavioral sciences (2ed)* (pp. 515-520). Elsevier. Retrieved from:  
<https://www.sciencedirect.com/science/article/pii/B0080430767013346>
- Osatuke, K., Glick, M.J., Gray, M.A., Reynolds, D.J., Jr., Humphreys, C.L., Salvi, L.M., & Stiles, W.B. (2004). Assimilation and narrative: Stories as meaning bridges. In L. Angus & J. McLeod (Eds.), *Handbook of narrative and psychotherapy: Practice, theory, and research* (pp. 193-210). SAGE. <https://doi.org/10.4135/9781412973496>
- Paivio, S. C. (1993). *Comparative efficacy of experiential therapy using empty chair dialogue and psychoeducational group treatment for resolving unfinished business* [Unpublished doctoral dissertation]. York University, Toronto, Canada.

- Paivio, S.C. & Angus, L. (2017) *Narrative processes in emotion-focused therapy for complex trauma*. American Psychological Association. <http://dx.doi.org/10.1037/0000041-001>
- Paivio, S. C., & Greenberg, L. S. (1995). Resolving “unfinished business”: Efficacy of experiential therapy using empty-chair dialogue. *Journal of Consulting and Clinical Psychology, 63*, 419-425. <https://doi.org/10.1037/0022-006X.63.3.419>
- Paivio, S.C., & Nieuwenhuis, J. (2001) Efficacy of emotion focused therapy for adult survivors of child abuse: A preliminary study. *Journal of Traumatic Stress, 14*, 115-133. <https://doi.org/10.1023/A:1007891716593>
- Paivio, S.C., & Pascual-Leone, A. (2010). *Emotion-focused therapy for complex trauma: An integrative approach*. American Psychological Association. <https://doi.org/10.1037/12077-000>
- Pascual-Leone, A. (2009). Dynamic emotional processing in experiential therapy: Two steps forward, one step back. *Journal of Consulting and Clinical Psychology, 77*, 113–126. <https://doi.org/10.1037/a0014488>
- Pascual-Leone, A., & Greenberg, L. S. (2007). Emotional processing in experiential therapy: Why "the only way out is through." *Journal of Consulting and Clinical Psychology, 75*, 875–887. <https://doi.org/10.1037/0022-006X.75.6.875>
- Pascual-Leone, A., Greenberg, L., & Pascual-Leone, J. (2009). Developments in task analysis: New methods to study change. *Psychotherapy Research, 19*, 527-542. <https://doi.org/10.1080/10503300902897797>

- Pascual-Leone, A., & Yeryomenko, N. (2016). The client “experiencing” scale as a predictor of treatment outcomes: A meta-analysis on psychotherapy process. *Psychotherapy Research, 6*, 653-665. <https://doi.org/10.1080/10503307.2016.1152409>
- Pascual-Leone, J. (1991). Emotions, development and psychotherapy: A dialectical constructivist perspective. In J. Safran & L. Greenberg (Eds). *Emotion, Psychotherapy and Change* (pp. 302–335). Guilford Press.
- Paul, G. L. (1969). Behavior modification research: Design and tactics. In C. M. Franks (Ed.), *Behavior therapy: Appraisal and status* (pp. 29–62). McGraw-Hill.
- Peluso, P.R., & Freund, R.R. (2018). Therapist and client emotional expression and psychotherapy outcomes: A meta-analysis. *Psychotherapy, 55*, 462-472. <https://doi.org/10.1037/pst0000165>
- Penley, J. A., Tomaka, J., & Wiebe, J. S. (2002). The association of coping to physical and psychological health outcomes: A meta-analytic review. *Journal of Behavioral Medicine, 25*, 551–603. <https://doi.org/10.1023/a:1020641400589>
- Pennebaker, J.W. (1989). Confession, inhibition, and disease. In L. Berkovitz (Ed.). *Advances in experimental social psychology* (Vol. 22, pp. 221-244). Academic Press. [https://doi.org/10.1016/S0065-2601\(08\)60309-3](https://doi.org/10.1016/S0065-2601(08)60309-3)
- Pennebaker, J.W. & Susman, J.R. (1988). Disclosure of traumas and psychosomatic processes. *Social Science and Medicine, 26*, 327-332. [https://doi.org/10.1016/0277-9536\(88\)90397-8](https://doi.org/10.1016/0277-9536(88)90397-8)
- Perls, F.S. (1969) *Gestalt therapy verbatim*. Real People Press.
- Perls, R., Hefferline, R. R., & Goodman, P. (1951). *Gestalt therapy*. Dell.

- Pine, F. (1986). On the development of the “borderline-child-to-be.” *American Journal of Orthopsychiatry*, 53, 450-457. <https://doi.org/10.1111/j.1939-0025.1986.tb03476.x>
- Paolone, D., & Pos, A.E. (2013, October). *Clients’ expressed emotional arousal in therapy: Does it help resolve depression?* Poster session presented at the Annual Meeting of the North American Chapter of the Society for Psychotherapy Research, Memphis, TN.
- Pos, A. E. (2006). *Experiential treatment for depression: A test of the experiential theory of change, differential effectiveness, and predictors of maintenance of gains* [Unpublished doctoral dissertation]. York University, Toronto, Canada.
- Pos, A.E., & Choi, B. (2019). Relating process to outcome in emotion-focused therapy. In L. Greenberg & R. Goldman (Eds.), *Clinical handbook of emotion-focused therapy* (pp. 171-191). American Psychological Association. <https://doi.org/10.1037/0000112-000>
- Pos, A.E., Greenberg, L.S., Goldman, R.N., & Korman, L.M. (2003). Emotional processing during experiential treatment of depression. *Journal of Consulting and Clinical Psychology*, 71, 1007-1016. <https://doi.org/10.1037/0022-006X.71.6.1007>
- Pos, A.E., Greenberg, L.S., & Warwar, S.H. (2009). Testing a model of change in the experiential treatment of depression. *Journal of Consulting and Clinical Psychology*, 77, 1055-1066. <https://doi.org/10.1037/a0017059>
- Purh, R., Heinze, G., Nold, M., Lusa, L., & Geroldinger, A. (2017). Firth’s logistic regression with rare events: Accurate effect estimates and predictions? *Statistics in Medicine*, 26, 2302-2317. <https://doi.org/10.1002/sim.7273>

- Ralston, M.B. (2006). *Imaginal confrontation versus evocative empathy in emotion-focused trauma therapy* [Unpublished doctoral dissertation]. University of Windsor, Windsor, Canada.
- Rennie, D. L. (1992). Qualitative analysis of client's experience of psychotherapy: The unfolding of reflexivity. In Toukmanian, S. G. and Rennie, D. L. (Eds.), *Psychotherapy process research: Paradigmatic and narrative approaches*, (pp. 211- 233). SAGE.
- Rennie, D. L. (2006). The grounded theory method: Application of a variant of its procedure of constant comparative analysis to psychotherapy research. In C. T. Fischer (Ed.), *Qualitative research methods for psychologists: Introduction through empirical studies* (pp. 59–78). Elsevier.
- Rice, L. & Greenberg, L. (Eds) (1984). *Patterns of change: An intensive analysis of psychotherapeutic process*. Guilford Press.
- Rice, L. N., & Kerr, G. (1986). Measures of client and therapist vocal quality. In L. Greenberg & W. Pinsoff (Eds.), *The psychotherapeutic process: A research handbook* (pp. 73–105). Guilford Press.
- Rice, L. N., Koke, C. J., Greenberg, L. S., & Wagstaff, A. K. (1979). *Manual for Client Vocal Quality* [Unpublished manuscript]. Counselling and Development Centre, York University, Toronto, Ontario, Canada.
- Riess, H. (2012). Neurobiological correlates of the psychotherapy relationship and E.M.P.A.T.H.Y.: The role of biomarkers in psychotherapy. In R. A. Levy, J. S. Ablon, & H. Kächele (Eds.), *Psychodynamic psychotherapy research: Evidence-*

*based practice and practice-based evidence* (pp. 283–300). Humana Press - Springer.

[https://doi.org/10.1007/978-1-60761-792-1\\_17](https://doi.org/10.1007/978-1-60761-792-1_17)

Rinaldi, G. (2015). *Markers of termination readiness during experiential treatment of depression* [Unpublished honors thesis]. York University, Toronto, Canada.

Robinson, A.L., Dolhanty, J., & Greenberg, L. (2015). Emotion-focused family therapy for eating disorders in children and adolescents. *Clinical Psychology and Psychotherapy*, 22, 75-82. <https://doi.org/10.1002/cpp.1861>

Robinson, A.L., Dolhanty, J., Stillar, A., Henderson, K., & Mayan, S. (2014). Emotion-focused family therapy for eating disorders across the lifespan: A pilot study of a 2-day transdiagnostic intervention for parents. *Clinical Psychology and Psychotherapy*, 23, 14-23. <https://doi.org/10.1002/cpp.1933>

Roemer, L., Salters, K., Raffa, S. D., & Orsillo, S. M. (2005). Fear and avoidance of internal experiences in GAD: Preliminary tests of a conceptual model. *Cognitive Therapy and Research*, 29, 71–88. <https://doi.org/10.1007/s10608-005-1650-2>

Rogers, C. R. (1957). A theory of therapy, personality and interpersonal relationships, as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A study of a science* (Vol. 3, pp. 184-256). McGraw Hill.

Scherer, A., Boecker, M., Pawelzik, M., Gauggel, S., & Formann, T. (2017). Emotion suppression, not reappraisal, predicts psychotherapy outcome. *Psychotherapy Research*, 27, 143-153. <https://doi.org/10.1080/10503307.2015.1080875>

Schore, A. N. (1994). *Affect regulation and the origin of the self*. Erlbaum.

<https://doi.org/10.4324/9781315680019>

- Schore, A.N. (2021). The interpersonal neurobiology of intersubjectivity. *Frontiers in Psychology: Developmental Psychology, 12*, 1366-1385.  
<https://doi.org/10.3389/fpsyg.2021.648616>
- Schore, J.R., & Schore, A.N. (2008). Modern attachment theory: The central role of affect regulation in development and treatment. *Clinical Social Work, 36*, 9-20.  
<https://doi.org/10.1007/s10615-007-0111-7>
- Shahar, B., Bar-Kalifa, E., & Alon, E. (2017). Emotion-focused therapy for social anxiety disorder: Results from a multiple baseline study. *Journal of Consulting and Clinical Psychology, 85*, 238-249. <https://doi.org/10.1037/ccp0000166>
- Sharbanee, J. M., Greenberg, L., & Watson, J. (2015, June). *Emotional processing of anxious insecurity*. Paper presented at the annual meeting of the Society for Psychotherapy Research, Philadelphia, PA.
- Shmueli, G. (2010). To explain or to predict? *Statistical Science, 25*, 289-310.  
<https://doi.org/10.1214/10-STS330>
- Sicoli, L.S. (2005). *Development and verification of a model of resolving hopelessness in process-experiential therapy of depression* [Unpublished doctoral dissertation]. York University, Toronto, Canada.
- Somers, R. H. (1962). A new asymmetric measure of association for ordinal variables. *American Sociological Review, 27*, 799–811. <https://doi.org/10.2307/2090408>
- Spitzer, R., Williams, J., Gibbon, M., & First, M. (1995). *Structured Clinical Interview for DSM-IV*. American Psychiatric Press.

- Sroufe, L.A. (1996). *Emotional development: The organization of emotional life in the early years*. Cambridge studies in social and emotional development. Cambridge University Press. <https://doi.org/10.1017/CBO9780511527661>
- Stanton, A. L., Kirk, S. B., Cameron, C. L., & Danoff-Burg, S. (2000). Coping through emotional approach: Scale construction and validation. *Journal of Personality and Social Psychology*, 78, 1150–1169. <https://doi.org/10.1037/0022-3514.78.6.1150>
- Stern D. (1985). *The interpersonal world of the infant*. Basic Books.  
<https://doi.org/10.4324/9780429482137>
- Stewart, S. H., Zvolensky, M. J., & Eifert, G. H. (2002). The relations of anxiety sensitivity, experiential avoidance, and alexithymic coping to young adults' motivations for drinking. *Behavior Modification*, 26, 274–296.  
<https://doi.org/10.1177/0145445502026002007>
- Stiles, W.B. (1999). Signs and voices in psychotherapy. *Psychotherapy Research*, 9, 1-21.  
<https://doi.org/10.1093/ptr/9.1.1>
- Stiles, W.B. (2002). Assimilation of problematic experiences. In J.C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (p. 357-365). Oxford University Press. <https://doi.org/10.1093/ptr/kpg044>
- Stiles, W.B. (2011). Coming to terms: Senior Career Award paper. *Psychotherapy Research*, 21, 367-384. <https://doi.org/10.1080/10503307.2011.582186>
- Stiles, W.B., Osatuke, K., Glick, M.J., & Mackay, H.C. (2004). Encounters between internal voices generate emotion: An elaboration of the assimilation model. In H.H. Hermans

& G. Dimaggio (Eds.), *The dialogical self in psychotherapy* (pp. 91-107). Brunner-Routledge. <https://doi.org/10.4324/9780203314616>

"Student" Gosset, W. S. (1908). The probable error of a mean. *Biometrika*, 6, 1–25.  
<https://doi.org/10.2307/2331554>

Sullivan, G.M., & Feinn, R. (2012). Using effect size – or why the *p* value is not enough. *Journal of Graduate Medical Education*, 4, 279–282. <https://doi.org/10.4300/JGME-D-12-00156.1>

Tamietto, M., & de Gelder, B. (2010). Neural bases of the non-conscious perception of emotional signals. *Nature Reviews. Neuroscience*, 11, 697–709.  
<https://doi.org/10.1038/nrn2889>

Tarba, L.R. (2007). *A task analysis of the expression of arrested anger in the resolution of depression in emotion-focused therapy* [Unpublished master's thesis], York University, Toronto, Canada.

Tarba, L.R. (2015). *A task analysis of the expression of arrested anger in the resolution of depression in emotion-focused therapy* [Unpublished doctoral dissertation], York University, Toronto, Canada.

Thompson, S., & Girz, L. (2019). Overcoming shame and aloneness: Emotion-focused group therapy for self-criticism. *Person-Centered and Experiential Psychotherapies*.  
<https://doi.org/10.1080/14779757.2019.1618370>

Timulak, L., & McElvaney, J. (2016). Emotion-focused therapy for generalized anxiety disorder: An overview of the model. *Journal of Contemporary Psychotherapy: On the Cutting*

*Edge of Modern Developments in Psychotherapy*, 46, 41–52.

<https://doi.org/10.1007/s10879-015-9310-7>

Tomkins, S. (1962). *Affect, imagery and consciousness: The negative affects*. Springer.

Toukmanian, S.G., & Dunbar, C.A. (1991). *Client perceptual processing in gestalt two-chair resolution and non-resolution performances* [Technical Report No. 193]. York University, Toronto, Canada.

Town, J. M., Salvadori, A., Falkenström, F., Bradley, S., & Hardy, G. (2017). Is affect experiencing therapeutic in major depressive disorder? Examining associations between affect experiencing and changes to the alliance and outcome in intensive short-term dynamic psychotherapy. *Psychotherapy*, 54, 148–158.

<http://dx.doi.org/10.1037/pst0000108>

Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, 1, 207–210. <https://doi.org/10.1037/1040-3590.1.3.207>

Travis, L. A., Bliwise, N. G., Binder, J. L., & Horne-Moyer, H. L. (2001). Changes in clients' attachment styles over the course of time-limited dynamic psychotherapy.

*Psychotherapy: Theory, Research, Practice, Training*, 38, 149–159.

<https://doi.org/10.1037/0033-3204.38.2.149>

Tull, M. T., Gratz, K. L., Salters, K., & Roemer, L. (2004). The role of experiential avoidance in posttraumatic stress symptoms and symptoms of depression, anxiety, and somatization. *The Journal of Nervous and Mental Disease*, 192, 754–761.

<https://doi.org/10.1097/01.nmd.0000144694.30121.89>

- Vrana, G., & Greenberg, L. (2018) Overview of emotion-focused therapy. In M. Foroughe (Ed.), *Emotion focused family therapy with children and caregivers: A trauma-informed approach* (pp. 1-22). Routledge. <https://doi.org/10.4324/9781315161105>
- Warwar, S.H. (2003). *Relating emotional processes to outcome in experiential psychotherapy of depression* [Unpublished doctoral dissertation]. York University, Toronto, Canada.
- Warwar, S. H., & Greenberg, L. S. (1999). *Client Emotional Arousal Scale-III* [Unpublished manuscript]. York University, Toronto, Ontario, Canada.
- Warwar, S., & Greenberg, L. S. (2000, June). *Catharsis is not enough: Changes in emotional processing related to psychotherapy outcome*. Paper presented at the annual meeting of the International Society for Psychotherapy Research, Indian Hills, Chicago.
- Warwar, S. H., Greenberg, L. S., & Perepeluk, D. (2003). *Reported in-session emotional experience in therapy*. Paper presented at the annual meeting of the International Society for Psychotherapy Research. Weimar, Germany.
- Wasserstein, R.L., & Lazar, N.A. (2016). The ASA statement on *p*-values: Context, process, and purpose. *The American Statistician*, *70*, 129-133.  
<https://doi.org/10.1080/00031305.2016.1154108>
- Watson, J., Gordon, L., Stermac, L., Kalogerakos, F., & Steckley, P. (2003). Comparing the effectiveness of process-experiential with cognitive-behavioral psychotherapy in the treatment of depression. *Journal of Consulting and Clinical Psychology*, *71*, 773–781.  
<https://doi.org/10.1037/0022-006X.71.4.773>
- Watson, J. C. & Greenberg, L.S. (2017). *Emotion-focused therapy for generalized anxiety*. American Psychological Association. <https://doi.org/10.1037/0000018-000>

- Watson, J.C., McMullen, E.J., Prosser, M.C., & Bedard, D.L. (2011). An examination of the relationships among clients' affect regulation, in-session emotional processing, the working alliance, and outcome. *Psychotherapy Research, 21*, 86-96.  
<https://doi.org/10.1080/10503307.2010.518637>
- Wegner, D. M., Schneider, D. J., Carter, S. R., & White, T. L. (1987). Paradoxical effects of thought suppression. *Journal of Personality and Social Psychology, 53*, 5–13.  
<https://doi.org/10.1037/0022-3514.53.1.5>
- Wegner, D. M., Schneider, D. J., Knutson, B., & McMahon, S. R. (1991). Polluting the stream of consciousness: The effect of thought suppression on the mind's environment. *Cognitive Therapy and Research, 15*, 141–152. <https://doi.org/10.1007/BF01173204>
- Weston, J. L. (2018). *Protection from dangerous emotions: Interruption of emotional experience in psychotherapy* [Unpublished doctoral dissertation]. York University, Toronto, Canada.
- Westrup, D.A. (1999). Experiential avoidance and alcohol dependence relapse (3171) [Doctoral dissertation, Elbeny College of Arts and Science]. *Graduate Theses, Dissertations, and Problem Reports*. Retrieved from: <https://researchrepository.wvu.edu/etd/3171>
- Wiebe, S.A., & Johnson, S.M. (2016). A review of the research in emotionally focused therapy for couples. *Family Process, 55*, 390-407. <https://doi.org/10.1111/famp.12229>
- Wnuk, S.M., Greenberg, L., & Dolhanty, J. (2015). Emotion-focused group therapy for women with symptoms of bulimia nervosa. *Journal of Treatment and Prevention, 23*, 253-261.  
<https://doi.org/10.1080/10640266.2014.964612>

Wong, K. (2016). *Examining processes of change for experientially distant and non-distant client subgroups in experiential therapy for depression* [Unpublished doctoral dissertation]. York University, Toronto, Canada.

Wong, K. & Pos, A. E. (2014). Interpersonal processes affecting early alliance formation in experiential therapy for depression. *Psychotherapy Research, 24*, 1-11.

<https://doi.org/10.1080/10503307.2012.708794>

Yalom, I. D. (1980). *Existential psychotherapy*. Basic Books.

## Appendices

### Appendix A: Marker of AESI Rating Scale (MARS)

#### **Marker of Aversion to Emotion/ Self-Interruption (AESI) Rating Scale**

This rating scale was developed to identify the occurrence of aversion to emotion /self-interruption (AESI) within video- and/or audio-recordings and transcripts of sessions of emotion-focused therapy. It is based on findings from the first phase of a task analysis conducted by Vrana (2020).

This rating scale incorporates elements of the following previously developed rating scale:

- Experiencing Scale (Klein, Mathieu, Gendlin, & Kiesler, 1969)

#### **I. Description, Rating Criteria, and Examples of the Marker of AESI**

The Marker of AESI is observed when a client communicates a dislike for or disinclination toward experiencing or expressing an emotion (or a related need, action tendency, or part of self), or when they report efforts to prevent, stop, or over-control the emotion. AESI can occur in response to the therapist's attempts to facilitate the client's experience or expression of an emotion during a therapy session, or in the context of the client's interactions with others outside of therapy sessions.

#### **Criteria for Rating:**

**The Marker of AESI is present when both of the following criteria are met:**

**Criterion 1.** Any one or more of the following are observed:

- The client makes a statement conveying a dislike or disinclination toward experiencing or expressing an emotion (or a related need, action tendency, or part of self).
- The client reports efforts to prevent, stop, or over-control their experience or expression of an emotion (or a related need, action tendency, or part of self). These efforts can either be automatic or deliberate. They can take any of the following forms:
  - Attempts to avoid or escape the emotion
  - Attempts to physically control or contain the emotion
  - Attempts to cognitively control the emotion
  - Movement to secondary emotions
- The therapist conjectures about the client's dislike for or disinclination toward the emotion and/or their efforts to prevent, stop, or over-control the emotion, in response to which the client provides verbal or non-verbal agreement. The client does not respond in a way that suggests disagreement.

*(cont'd on next page)*

**Criterion 2.** Depth of experiencing must take one of the two following forms:

A. The client's statement under Criterion 1(A or B) reflects a depth of experiential involvement at a level 3 or higher, as measured by the Experiencing Scale (Klein, Mathieu, Gendlin, & Kiesler, 1969). At the very least, the content of the client's speech reflects limited self-descriptions, behavioural descriptions of feelings, or personal reactions to events. The client may also share their feelings and personal experiences in a self-descriptive and associative manner.

OR

B. The therapist's statement under Criterion 1 (C) involves a description of the client's personal reaction or emotional experience.

*Note:* The client can be engaged in a dialogue with their therapist or in a chair dialogue at the time that the marker is observed.

**Examples:**

➤ **Examples of (1A) a dislike or disinclination toward experiencing or expressing the emotion:**

- This can involve a statement ranging anywhere from cautious hesitation to direct refusal to allow or express the emotion. For example,
  - T: I imagine the pain starts to come up again, and it feels really overwhelming.  
C: Yeah. I don't –I don't want to deal with it.
  - C: I don't want to be sad. I don't know... I guess I just don't like feeling sorry for myself.
  - T: Can you speak from the pain?  
C: No. I can't go there right now. It's too hard.
- The client may describe a preference for experiencing or expressing a different emotion instead. For example,
  - T: Stay with the anger  
C: (shakes head) But, I don't like feeling angry. It's easier to stay with the sadness.
- The client may report reluctance to express their emotions and needs in a relationship with another person (e.g., not speaking up or apologizing prematurely to avoid conflict). For example,
  - C: I don't want to tell him how I feel. I'm afraid he will get upset. I don't want to start another argument.

➤ **Examples of (1B-i) *avoiding or escaping* the emotion:**

- The client may have difficulty attending to or staying with the emotion. For example,
  - C: It's funny. I'm finding it hard to stay with it. My mind keeps running off in different directions. I seem to get easily distracted whenever we get onto this topic.
- The client is aware of the automatic loss of emotional experience. They may describe feeling numb or having lost connection or contact with the emotion. Some clients may be dissociated, disconnected or withdrawn from the outside world. For example,
  - T: Mhm, it was so scary for you when he would get mad and shout at you. What's happening for you right now, as you remember this?  
C: (pauses for 20 seconds) (sighs) I don't know. I think I lost the feeling. I don't feel anything right now.  
T: Okay. Just take a moment to check inside. What's happening in your body?  
C: (pauses for 30 seconds) I feel numb... like there's nothing there.
- The client describes the emotion as something kept hidden or buried, a part of themselves that they disown, block or wall off from, something they are struggling to move away from or protecting themselves from. For example,
  - T: What's happening inside right now?  
C: I can feel myself struggling to keep the feeling down.  
T: So it's hard for you to stay with the feeling – to let it come out?  
C: Yeah.  
T: What's the hardest part about doing that?  
C: I'm so used to burying it, that it just comes naturally to me. It's easier to just keep doing that.
  - T: Can you speak from this part?  
C: I don't know if I can. It's a part of myself that I don't like to indulge. I usually keep it tucked away, out of sight. It's really hard for me to let this part of myself come out.

➤ **Examples of (1B-ii) *physically (muscularly or physiologically) controlling or containing* the emotion:**

- The client describes attempts to constrict, restrict, or control the emotion or a part of themselves. They may use descriptors such as shutting it down, holding it back, packing it down, sucking it in, or making it smaller. They may also describe trying to make themselves smaller or silencing themselves. For example,
  - T: Can you tell your father about how much you miss him? How do you do that?  
C: I miss ... (pauses 00:00:10)  
T: What happens when you try to tell him?

C: I can't say it. It's like there's a big lump in my throat and I can't seem to get the words out. I feel small.

○ T: What's happening for you right now?

C: I guess I'm noticing the feeling coming back and I'm trying to keep it contained so that it doesn't take over.

- Non-verbal behaviours that serve to interrupt the continuation of or prevent the emotion may also be present. This can include physical constriction, tension, shaking, squeezing, tightening, swallowing, or sighing. They can also include acting opposite to the emotion (e.g., smiling when sad, laughing or using humour when angry). For example,

○ T: What's happening with your hands?

C: I didn't even realize I'm holding them in fists.

T: Do that some more. Can you put words to that?

C: I'm squeezing, trying to hold it together – to not let my anger take over.

○ T: What's the sigh?

C: (pauses 00:00:08) I'm trying to keep my feelings under control.

○ T: In our last session you told me that when you feel sad, it's hard for you to let others know – that you tend to smile in front of them so they can't tell that you're sad. I just wanted to check-in to see if that might be happening with me right now?

C: Probably.

➤ **Examples of (1B-iii) *cognitively controlling the emotion*:**

- Self-injunctions against experiencing or expressing the emotion may be communicated. Negative evaluations, expectations, or beliefs about the emotion or about the self for having the emotion may be verbalized. For example,
  - C: A part of me is mad. But another part of me says I'm being selfish. I should think more about what he is going through, rather than putting more demands on him. I know it's been hard for him and he is trying his best. I'm asking for too much. I should just let it go.
  - C: Sometimes I feel sad when I think about the past, but then I tell myself that lots of people have it much worse and that I should stop feeling sorry for myself. In the grand scheme of things, it's not that big of a deal.

➤ **Examples of (1B-iv) movement to a secondary emotion:**

- The secondary emotion reflects the client's inclination toward allowing and expressing an emotion that they perceive to be less threatening.
  - *Example where the client moves to secondary anger (also example of 1A – dislike/disinclination to allowing sadness)*

T: How do you feel about all the ways that he's let you down?  
 C: I'm angry. I don't even want to look at him or have anything to do with him.  
 T: Yeah, you're really angry with him, because what he did was !so unfair. And I also think there might be some sadness there too, underneath the anger.  
 C: I'm sure there is.  
 T: Can you speak from the sadness?  
 C: Why? The anger feels so much better. I'd rather stay with that.

∅ **Examples of statements that are excluded, because they do not meet Criterion 2.**  
*Client Experiencing (EXP) is < level 3.*

- ∅ T: Anger is an emotion that is difficult for some people to express. (*EXP 1 – not specific to client's internal world*)  
 C: Yeah.
- ∅ C: My dad always used to tease my brother, because he cried easily. He used to say that crying is a sign of weakness. (*EXP 2*)

Raters can refer to Experiencing Scale manual (Klein, Mathieu, Gendlin, & Kiesler, 1969) for additional examples and more detailed descriptions of different levels of EXP.

## II. Rating Process

For each client, there will be three segments to be rated. Segments will be presented in random order. Raters will be provided with up to two minutes of session dialogue prior to every segment to be rated for context.

For each segment, raters will assign a value on an ordinal scale from 1-5, representing the degree to which they are confident that the marker of AESI is present, on the basis of the criteria outlined in this manual. Refer to the table below for a breakdown of the rating scale. Higher ratings reflect greater levels of confidence in the presence the marker.

Rating	Description
1	A marker of AESI is <b>definitely not</b> present.
2	A marker of AESI <b>unlikely</b> to be present.
3	I am <b>uncertain</b> whether a marker of AESI is present or not.
4	A marker of AESI is <b>likely</b> present.
5	A marker of AESI is <b>definitely</b> present.

### References

Klein, M. H., Mathieu, P. L., Gendlin, E. T., & Kiesler, D. J. (1969). *The Experiencing Scale: A research training manual*. Madison: University of Wisconsin Extension Bureau of Audiovisual Instruction.

**Appendix B: Components of Resolution of AESI Rating Scale (CRARS)**

**Components of Resolution of Aversion to Emotion/  
Self-Interruption (AESI) Rating Scale**

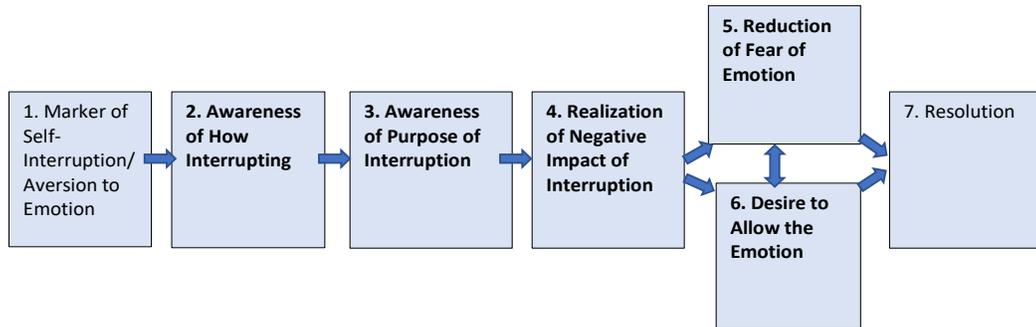
This rating scale was developed to identify the mid-model component processes involved in the resolution of aversion to emotion/self-interruption (AESI) within video- and/or audio-recordings and transcripts of sessions of emotion-focused therapy. It is based on a rational-empirical model of client performance from the first phase of a task analysis conducted by Vrana (2020). This manual provides descriptions of these component processes and instructions on how to rate them.

This rating scale incorporates elements of the following previously developed rating systems:

- Experiencing Scale (Klein, Mathieu, Gendlin, & Kiesler, 1969)
- Vocal Quality Scale (Rice & Kerr, 1986; Rice, Koke, Greenberg & Wagstaff, 1979)

**I. Diagram of Client Processes Involved in the Resolution of  
Aversion to Emotion/Self-Interruption (AESI)**

(Vrana, 2020)



**II. Model Components to be Rated**

Only Components 2 through 6 from the model diagram above are included in this rating scale. For rating components 1 and 7, please refer to the Marker of AESI Rating Scale (MARS) and the Resolution of AESI Rating Scale (RARS), respectively.

### III. Rating Process

For the purpose of rating using this scale, each model component is treated as a separate and mutually exclusive task. The goal is to determine which components were completed by clients.

For each component of this scale, there will be three session segments to be rated per client. Segments will be presented in random order. Raters will be provided with up to two minutes of session dialogue prior to every segment to be rated for context.

For each segment, raters will assign a value on an ordinal scale from 1-5, representing the degree to which they are confident that the specified component is present, on the basis of the criteria outlined in this manual. Refer to the table below for a breakdown of the rating scale. Higher ratings reflect greater levels of confidence in the presence of a given component.

<b>Rating</b>	<b>Description</b>
1	This component is <b>definitely not</b> present.
2	This component is <b>unlikely</b> to be present.
3	I am <b>uncertain</b> whether this component is present or not.
4	This component is <b>likely</b> present.
5	This component is <b>definitely</b> present.

## **IV. Descriptions, Rating Criteria, and Examples of Mid-Model Components**

### **2. Awareness of How Interrupting**

For this component, clients become aware of how they prevent, stop, or over-control their experience or expression of the emotion (or a related need, action tendency, or part of self). This can include avoidance or escape, physical control, cognitive control, or movement to a secondary emotion. These efforts can be either deliberate or automatic.

Clients may become aware of how they interrupt as they engage in a dialogue with their therapists, or they may come to this awareness over the course of a chair dialogue. For instance, during a two-chair intervention, clients may be asked to enact the part of themselves that interrupts the emotion (i.e., the interrupter). In some cases, the client may engage in an empty-chair intervention, wherein they enact how a significant other or attachment figure interrupted them or negatively responded to their expression of the emotion (i.e., the internalized interruptive other).

#### **Criterion for Rating**

**This component occurs when one or more of the following are observed:**

1. The client makes a statement describing the way(s) in which they attempt to prevent, over-control or stop the emotion (or a related need, action tendency, or part of self).
2. The client enacts the way(s) in which they attempt to prevent, over-control, or stop the emotion (or a related need, action tendency, or part of self).
3. The therapist makes a conjecture about the way(s) in which the client is attempting to prevent, over-control, or stop the emotion (or a related need, action tendency, or part of self), and the client shows verbal or non-verbal agreement. The client's response does not suggest disagreement.

*Note:* For the purpose of this rating scale, descriptions or enactments of *how significant others/attachment figures interrupted* the client's expression of an emotion (or a related need, action tendency, or part of self) are considered to reflect the client's awareness of how they interrupt themselves. The interruption is assumed to have been internalized by the client.

#### **Examples:**

Clients can demonstrate awareness into their use of one or more of the following ways of interrupting the emotion, which can either be done automatically or deliberately:

- a. Attempts to avoid or escape the emotion
- b. Attempts to physically control or contain the emotion
- c. Attempts to cognitively control the emotion
- d. Movement to secondary emotions

➤ **Examples of awareness of (a) avoiding or escaping the emotion:**

- The client may be aware of having difficulty attending to or staying with the emotion. They may realize that they are distracting or stopping themselves from attending to the emotion.

*For example:*

- C: It's funny. I'm finding it hard to stay with it. My mind keeps running off in different directions. I seem to get easily distracted whenever we get onto this topic.

- The client might be aware of the automatic loss of emotional experience. They may describe feeling numb or having lost connection or contact with the emotion. Some clients may be dissociated, disconnected or withdrawn from the outside world.

*For example:*

- T: Mhm, it was so scary for you when he would get mad and shout at you. What's happening for you right now, as you remember this?  
C: (pauses for 20 seconds) (sighs) I don't know. I think I lost the feeling. I don't feel anything right now.  
T: Okay. Just take a moment to check inside. What's happening in your body?  
C: (pauses for 30 seconds) I feel numb... like there's nothing there.

- The client may become aware of trying to keep the emotion hidden or buried. They may describe it as a part of themselves that they disown, block or wall off from, something they are struggling to move away from or protecting themselves from.

*For example:*

- T: What's happening inside right now?  
C: I can feel myself struggling to keep the feeling down.  
T: So it's hard for you to stay with the feeling – to let it come out?  
C: Yeah.  
T: What's the hardest part about doing that?  
C: I'm so used to burying it, that it just comes naturally to me. It's easier to just keep doing that.
- T: Can you speak from this part?  
C: I don't know if I can. It's a part of myself that I don't like to indulge. I usually keep it tucked away, out of sight. It's really hard for me to let this part of myself come out.

➤ **Examples of awareness of (b) physically (muscularly or physiologically) controlling or containing the emotion:**

- The client may demonstrate awareness into their attempts to constrict, restrict, or control the emotion or a part of themselves. They may use descriptors such as packing or shutting it down, holding it back, sucking it in, bottling it up, or making it smaller. They may also describe trying to make themselves smaller or silencing themselves.

*For example:*

- T: Can you tell your father about how much you miss him? How do you do that?  
C: I miss ... (pauses 00:00:10)  
T: What happens when you try to tell him?  
C: I can't say it. It's like there's a big lump in my throat and I can't seem to get the words out. I feel small.
- T: What's happening for you right now?  
C: I guess I'm noticing the feeling coming back and I'm trying to keep it under control so that it doesn't take over.
- T: How do you hold yourself back from feeling? Can you do it to him?  
C: (as interrupter, to experiencer): Push it down. Keep it contained. Stuff it down. It's safer this way.
- T: How do you stop her?  
C (as interrupter, to experiencer): Hold still. Don't move. Don't make a sound.

- Clients may also be aware of non-verbal behaviours that serve to interrupt the continuation of or prevent the emotion. These can include physical constriction, tension, shaking, squeezing, tightening, swallowing, or sighing. They can also include acting opposite to the emotion (e.g., smiling when sad, laughing or using humour when angry).

*For example:*

- T: What's happening with your hands?  
C: I didn't even realize - I'm holding them in fists.  
T: Do that some more. Can you put words to that?  
C: I'm squeezing, trying to hold it together, not let my anger take over.
- T: What's the sigh?  
C: (pauses 00:00:08) I'm trying to keep my feelings under control.
- T: I remember in our last session, you told me that when you feel sad, it's hard for you to let others know – that you tend to smile in front of them so they can't

tell that you're sad. I just wanted to check-in to see if that's happening with me right now?

C: Probably.

➤ **Examples of awareness of (c) cognitively controlling the emotion:**

Cognitive control involves self-injunctions against experiencing or expressing the emotion, such as:

- talking oneself out of allowing the emotion
- forbidding oneself from expressing it
- stopping oneself from attending to it

*For example:*

- C (as interrupter, to experiencer): Stop it. I'm not going to let you out. You have to stay inside the cage. It's better this way.
- C (as interrupter, to experiencer): Don't go there. Don't think about it. Just sweep it aside.

Though not always the case, injunctions can take on a *guilt/shame, anxiety, or hopelessness* inducing quality. Such self-injunctions reflect clients' negative evaluations, expectations, or beliefs about the emotion.

- ***Injunctions that induce guilt or shame*** can take the form of admonishment or derision of the self for having or wanting to allow the emotion, including:
  - Making oneself feel unentitled to the emotion or associated need
  - Telling oneself they are over-reacting or undermining or dismissing the validity of the emotion and associated need
  - Negatively judging, criticizing, or ridiculing oneself for having the emotion or associated need
  - Telling oneself that one is weak, childish, immature, selfish, bad or needy for experiencing or expressing the emotion.
  - Expressing contemptuous anger or disgust toward oneself for experiencing the emotion
  - Overpowering, threatening, or bullying the self into not feeling the emotion

*For example:*

- C: I get angry. But then I tell myself that I'm being selfish. I should think more about what he is going through. I know it's been hard for him and he is trying his best. I'm asking for too much.

- C (as interrupter, to experiencer): Only ungrateful children are still upset with their parents after this much time. Grow up and get over it.
  - C (as interrupter, to experiencer): Don't be so needy. You will turn other people away. No one wants to be around someone so clingy.
  - C (as other, to self): Quit your whining. You're being annoying. You're too much. I can't deal with you right now. I don't want to hear it.
  - C (as interrupter/other, to experiencer): Stop it! Shut up! Be quiet and behave yourself.
  - C: Sometimes I feel sad when I think about the past, but then I tell myself that lots of people have it much worse and that I should stop feeling sorry for myself. In the grand scheme of things, it's not that big of a deal.
- ***Injunctions that induce anxiety*** take the form of scaring oneself about the potential dangers of allowing the emotion, including:
    - Telling oneself that one would become overwhelmed, fall apart, or be unable to cope with or handle the emotion
    - Telling oneself that one would be rejected or abandoned, or be judged negatively for allowing the emotion
    - Listing everything that could "go wrong" if the emotion is allowed
    - Telling oneself it is safer to not allow the emotion

*For example:*

- C (as interrupter, to experiencer): Don't go there. Don't think about it. It's too big. You won't be able to handle it.
- C (as interrupter, to experiencer): If you let it out, you may not be able to close it back up. You will be overwhelmed and may never be able to put yourself back together.
- C (as interrupter, to experiencer): If they see you getting emotional, they will see how messed up you are. People will be turned off from you. You'll end up all alone.
- C (as interrupter, to experiencer): I'm scared of how much anger is inside of you. If you let it out – you don't want to lose control and hurt someone.

- ***Injunctions that induce hopelessness*** take the form of conveying hopeless beliefs or expectations about the emotion, which serve to overwhelm or demotivate the self, including:
  - Telling oneself nothing will change if the emotion is allowed.
  - Telling oneself there is no point to allowing the emotion.
  - Making oneself feel heavy, defeated, tired, and overburdened.

*For example:*

- C (as interrupter, to experiencer): There's no point in letting that feeling out. Nothing can change the past. You'll just feel worse. Nothing can be done.
  - C: Every time I think about confronting him, I stop myself. I think to myself, he's never going to change. He won't take my feelings seriously. No good is going to come out of speaking up. I just have to accept that this is who he is and learn to live with it.
  - C (as interrupter, to experiencer): You can't deal with it. It's too much. It's heavy and overwhelming. It's just too big. You're not strong enough.
- **Example of awareness of (d) movement to a secondary emotion:**  
The secondary emotion reflects the client's inclination toward allowing an emotion that they perceive to be less threatening.
- *Example where the client moves to secondary anger to interrupt primary sadness:*  
T: How do you feel about all the ways that he's let you down?  
C: I'm angry. I don't even want to look at him or have anything to do with him.  
T: Yeah, you're really angry with him, because what he did was !so unfair. And I also think there might be some sadness there too, underneath the anger.  
C: I'm sure there is.  
T: Can you speak from the sadness?  
C: Why? The anger feels so much better. I'd rather stay with that.

### 3. Awareness of Purpose of Interruption: Protection Against Feared Consequences

For this component, clients become aware of and articulate the purpose of their interruption of the emotion (or a related need, action tendency, or part of self). Clients realize that their interruption serves to protect them against feared consequences of experiencing or expressing the emotion.

This component process can be observed while clients engage in a dialogue with their therapists or during a chair dialogue.

#### Criterion for Rating

This component occurs when either one of the following are observed:

1. The client makes a statement identifying one or more feared consequences of allowing the emotion (or a related need, action tendency, or part of self). (It is not enough for the client to be aware of a fear or a desire to protect themselves; they must articulate what they are afraid of or protecting themselves from.)
2. The therapist makes a conjecture about the client's feared consequence(s) of allowing the emotion (or a related need, action tendency, or part of self), and the client shows verbal or non-verbal agreement. The client's response does not suggest disagreement.

*Note:* Though not a criterion for rating, clients often cite the historical context in which the self-interruption emerged, when describing their feared consequences.

#### Examples:

- Clients' feared consequences of allowing the emotion can be conceptualized as falling into one of two categories: (a) *fear of damage to identity or attachment*, or (b) *fear of overwhelm*.

#### **a) Feared consequences related to Damage to Identity or Attachment can include:**

- Experiencing or expressing the emotion will reflect negatively on who they are
- Embarrassment, humiliation, shame, criticism, negative judgement, or rejection by others if they experience or express the emotion or associated need
- Acting against personal values or expectations of self in social role
- Vulnerability or exposure, loss of power, or interpersonal safety
- Loss of social connection, rejection, or abandonment
- Physical, verbal, or emotional harm from others
- Lack of understanding and support from others
- Loss of control
- Harm toward others

*For example:*

- T: Can you tell that part why it can't come out?  
C (as interrupter, to experiencer): It's too risky.  
T: What could happen?  
C: I guess that they'll judge you and see you differently. It'll be so embarrassing.
- T: So it's really hard to ask others for help and let others in.  
C: Yeah. It's easier to not count on anyone, because then I don't get disappointed when they let me down. That's inevitably what always ends up happening.  
T: Mmhmm, so by shutting people out, you protect yourself from getting disappointed and hurt by them.  
C: Yeah.
- C: I'm scared he will leave if I push too hard for what I need.  
T: It's scary to think about the possibility of him leaving.  
C: Yeah. I don't know if I can survive on my own.
- T: What's the hardest part about telling her how you feel?  
C: I don't want to add to her stress or burden her. She has her own things that she's dealing with.  
T: Right. You care about her and worry about burdening her with more.  
C: Yeah. She is barely coping as it is. I want to be a husband who makes her happy, not more stressed.
- C: I'm scared to let my anger out.  
T: What's the scariest part about doing that?  
C: Well, I just keep going back to memories of my dad taking his anger out on us. I don't ever want to do that to someone else. I'm scared of losing control and saying something I can't take back.
- C: I don't know if I can get angry at my parents.  
T: What the hardest part about that for you?  
C: It's been drilled into me that kids are supposed to respect and obey their parents, and be grateful for their sacrifices.  
T: Uh-uh, so it would make you a bad daughter.  
C: Yeah the worst.

**b) Feared consequences related to Overwhelm can include:**

- Inability to cope with the emotion
- Inability to regulate or modulate emotion (e.g., it will be too intense or unending)
- Dis-integration, falling apart
- Loss of ability to cope or resume normal functioning after emotion fully allowed

*For example:*

- T: Come here. How do you scare her? Can you do that to her now?  
C (as interrupter, to experiencer): If you open that up, it's like you are opening the floodgates. Who knows if you will ever be able to close them back up again? And who knows what will come out? Whatever is there has been stored behind that barrier for so long, it's just better left there.
- T: What's the scariest part about staying with the pain?  
C: Well, there's a lot there. The last time I felt intense grief, it was when I lost my mother. I could barely make it out of bed or function. But with this pain, it's been building up for so long that, it's like, what if this is like that but worse and doesn't go away?  
T: It feels like this big scary thing that could be overwhelming and never-ending.  
C: I'll be drowning all alone, and there will be no end in sight.
- T: What happens in your body when I ask you to stay with the sadness?  
C: I can feel myself getting tense. My chest feels tight. I guess a bit anxious.  
T: That makes sense. It can feel really scary to stay with a feeling that you've kept locked up inside of you for so long. Almost like it could explode if you were to let it out.  
C: (nods head)

#### 4. Realization of Negative Impact of Interruption

For this component, clients come to realize that their self-interruption has a negative impact on them. The negative impact can take the form of physical discomfort or painful emotions experienced in response to the client's self-interruption during the session, or long-term negative consequences of continued self-interruption. While some clients can self-generate the negative long-term consequences, many come to this understanding with the help of conjecture and explanation provided by their therapists.

This component process can be observed while clients engage in a dialogue with their therapists or during a chair dialogue.

##### Criteria for Rating

**Clients are considered to have successfully satisfied this component when all three of the following criteria are met:**

**Criterion 1.** The client communicates that they are aware of the negative impact of their self-interruption in one of the two following ways:

- a. The client makes a statement identifying one or more negative impacts.
- b. The therapist describes one or more negative impacts, and the client shows verbal or non-verbal agreement.

**Criterion 2.** The client's statement under 1(a) or the client's agreement with the therapist's statement under 1(b) is not followed by a client statement that minimizes or denies the negative impact(s), or that describes the positive impact(s) of the interruption.

**Criterion 3.** Depth of experiencing must take one of the two following forms:

- a. The client's statement under Criterion 1(a) reflects a depth of experiential involvement at a level 4 or higher, as measured by the Experiencing Scale (Klein et al., 1969). The client may share their feelings and personal experiences in a self-descriptive and associative manner. The client may also pose problems or propositions about their feelings and personal experiences, in an exploratory, elaborative, or hypothetical manner.
- b. The therapist's statement under Criterion 1(b) involves a description of the client's personal reaction or emotional experience, or poses problems or propositions related to same.

*Note:* For the purpose of this rating scale, descriptions or enactments of *how significant others/attachment figures interrupted* a client's expression of an emotion (or a related need, action tendency, or part of self) are considered to reflect the client's awareness of how they interrupt themselves. The interruption is assumed to have been internalized by the client. Accordingly, the client's realization of the negative impact of the significant other/attachment figure's interruptive behaviour is considered a reflection of the client's realization of the negative impact of their own self-interruption.

**Examples:**

The negative impact(s) which clients become aware of can take the form of (i) *physical discomfort or painful emotions experienced in response to the client's self-interruption during the session*, or (ii) *long-term negative consequences of continued self-interruption*.

➤ **Examples of statements depicting awareness of (i) *physical discomfort or painful emotions experienced in response to self-interruption during the session*:**

- tired, depleted
- squeezed
- physical pain (e.g., in back, shoulders, head)
- resigned
- trapped
- tense
- sadness toward interrupter for not allowing them to experience or express the emotion
- anger toward interrupter for not allowing them to experience or express the emotion

*For example:*

- T: So, what you're saying is that you start to notice the sadness coming up and as you remember what it was like and how difficult it was not to be loved. All of that pain feels - it feels like it's just too much. Then you say, "I don't want to be me, I don't want to feel it." What happens when you say that?  
C: Well, I get a headache, I get . . . my eyes become really foggy.
- C (as interrupter, to experiencer): Stop, hold it in, suck it down. Don't let it out.  
T: Okay, switch, come back here. What happens for you when you hear her say that?  
C (as experiencer): I feel really tense. My chest feels tight; I'm holding my breath.
- T: What is it like to hear her say that you have to stay small and not speak up?  
C (tearing up): I feel so trapped. It's not fair. I should be allowed to take up space have a voice just like everyone else!

➤ **Examples of statements depicting awareness of (ii) *negative long-term consequences of continued self-interruption*:**

- maintenance of status quo of feeling depressed or unhappy
- feeling stuck and unable to move forward
- difficulty forming close relationships or being authentic
- inability to have needs met by others
- interrupted emotion will eventually become more intense and overwhelming

*For example:*

- T: I know it's really hard for you to talk about the grief. At the same time, I see that this unfinished business leaves you feeling depleted and weighed down.  
C: Yeah.  
T: It keeps coming up. And it takes a lot of energy from you to keep it pushed down.  
C: I think you're right.
- C: It's been the same for the past 10 years. This isn't working for me. And if I continue to keep it inside, then it will just be more of the same. I have to tell him how I feel.
- C: This sadness inside isn't going away. No matter how hard I try to move on, I end up back here again. It's just going to keep building unless I deal with what happened to me.
- T: It's so hard to open up to others, but I imagine there's also a part of you that is tired of always doing it all alone.  
C: (sighs) I'm so tired.

⊘ **Examples of statements that are excluded because they do not meet Criterion 2. They are followed by a client statement that minimizes or denies the negative impact(s), or that describes positive impact(s) of the interruption:**

- ⊘ T: It's so hard to open up to others, but there's also a part of you that is tired of always doing it all alone.  
C: (sighs) Yeah. It's tiring. But I'm sort of used to it. It's better than risking disappointment.
- ⊘ T: You can put the feeling away, but it eventually comes back.  
C: You're right. It does come back. But then I just have to push it away again and I feel better again.
- ⊘ C (as experiencer, to interrupter): I feel so trapped. It's not fair. I need to be allowed to let these feelings out.  
T: Okay switch. What do you say to that?

C (as interrupter, to experiencer): No way. You're over-reacting. It's not that bad. It's better than the alternative. This is safer. I know what's good for you and I'm not letting you do that.

∅ **Examples of statements that are excluded because they do not meet Criterion 3.**

*Client Experiencing (EXP) is < level 4.*

- ∅ T: In this type of therapy, we try to figure out which emotions clients are avoiding, because this is where they get stuck, so that we can know how to help them be able to move forward. *(EXP 1 – not specific to client's internal world)*  
C: I see.
- ∅ C: I went to the movies last night. We watched – oh I forget the name of the movie. But anyways, the main character in the movie stayed in an unhappy marriage because she was too scared of being alone. She was sad a lot of the time. *(EXP 2)*
- ∅ C: He got under my skin. I didn't want him to see how mad I was. I kept my mouth shut the whole time. I was so tired I had to have a nap afterward. *(EXP 3)*

Raters can refer to the Experiencing Scale manual (Klein, Mathieu, Gendlin, & Kiesler, 1969) for additional examples and more detailed descriptions of different levels of EXP.

## 5. Reduction of Fear of Emotion

In this component, clients' fears associated with allowing the interrupted emotion (or a related need, action tendency, or part of self) are reduced as they internalize validation of their emotional experience and a sense of safety in relation to allowing the emotion.

This component process can be observed while clients engage in a dialogue with their therapists or during a chair dialogue.

### Criteria for Rating

**Clients are considered to have successfully completed this component when all three of the following criteria are met:**

**Criterion 1.** The client must display **A) Internalization of validation** of their emotional experience **AND/OR B) Internalization of a sense of safety** in relation to allowing (experiencing and expressing) the (interrupted) emotion.

- A)** The client internalizes validation of their interrupted emotional experience, which is observed when either:
- i. The client makes a statement communicating that their emotion (or a related need, action tendency, or part of self) is valid,  
*OR*
  - ii. The therapist makes a statement communicating that the client's emotion (or a related need, action tendency, or part of self) is valid, and the client's response does not suggest disagreement or rejection of the therapist's statement.

**AND/OR**

- B)** The client internalizes a sense of safety in relation to allowing (experiencing and expressing) the interrupted emotion, which is observed when either:
- i. The client makes a statement communicating that they can cope with allowing the emotion (or a related need, action tendency, or part of self) and/or any potential consequences of doing so,  
*OR*
  - ii. The therapist makes a statement communicating that the client is able to cope with allowing the emotion (or a related need, action tendency, or part of self) and/or any potential consequences of doing so, and the client's response does not suggest disagreement or rejection of the therapist's statement.

*(cont'd on next page)*

**Criterion 2.** The client's or therapist's statement under Criterion 1 is not followed by the client conveying that the emotion (or a related need, action tendency, or part of self) is invalid or unsafe (e.g., "I should be over this by now," "I should find a way to be happy with what I have," "It's too risky," "It's too scary"). The client may believe that the emotion is valid but lack a sense of safety, or vice versa. If there is evidence that the client still is *unable to either internalize validation or a sense of safety*, then they are not considered to have attained completion of this component.

**Criterion 3.** Depth of experiencing must take one of the two following forms:

- i. The client's statement under (1A) or (1B) reflects a depth of experiencing at a level 3 or higher, as measured by the Experiencing Scale (Klein et al., 1969). At the very least, the content of the client's speech reflects limited self-descriptions, behavioural descriptions of feelings, or personal reactions to events. The client may also share their feelings and personal experiences in a self-descriptive and associative manner.
- ii. The therapist's statement under (1A) or (1B) is focused on the client's internal reaction or experience. The therapist communicates validation of or sense of safety in relation to the *client's* emotion (e.g., a therapist's statement specific to the client's experience such as "there is strength in *your* sadness," rather than a general statement about the emotion such as "sadness is an important emotion").

*Note:* Although not a required criterion for this component, the statements made by clients under (1A) and (1B) are commonly observed alongside Adaptive Emotions, such as:

- Pride or positive self-regard, as well as compassion, kindness or acceptance toward themselves and their emotional experience
- Adaptive anger as they hold others accountable for past transgressions and they assert their needs and boundaries in relationships with others

**Examples:**

- **Examples of statements that convey (1A) validation of the client's emotional experience:**  
 (Note: statements must be either: (i) made by client, or (ii) if made by therapist, must not be rejected by client)

Such statements can convey any of the following:

- The client's emotional experience and associated needs are justifiable and understandable
- The client is entitled to having and expressing the emotion and associated needs
- The client is entitled to having their needs met by themselves and by others
- The client is seen expressing their needs or boundaries assertively, thereby conveying that they are valid.
- The client or therapist are observed relating to the client's emotional experience, or a part of the client, with acceptance, compassion, and/or valuing, thereby conveying that it is valid.

For example:

- (i) Client – Validation of emotional experience  
C: I'm telling myself that it wasn't my fault and that I'm allowed to be sad.
- (i) Client – Validation of unmet need  
C (to father in empty chair): Dad, you really let me down. I deserved a dad who loved me. Everyone deserves that.
- (i) Client – Validation of unmet need through self-assertion  
C (to other chair): Stop! How dare you? Stop criticizing and nagging me.
- (i) Client and (ii) therapist – Valuing of self, validation of unmet need through self-assertion  
T: So you're saying it was him who was wrong. He was the sick one.  
C: Yeah, I was just being a kid. Who does that to a kid?  
T: It was not okay  
C: No it wasn't okay.
- (ii) Therapist – Acceptance/compassion/valuing of part of self, emotion (no evidence of disagreement or rejection by client)  
T: Try as much as you can to be caring and compassionate to this part of yourself that has been hurt. Just be patient and curious with it. See what this part has to say.  
C: Okay, I can try to do that.
- (ii) Therapist – Valuing emotion (no evidence of disagreement or rejection by client)  
T: These tears are important. Stay with this.  
C: (crying) okay

- *(ii) Therapist – Valuing part of self, emotion (no evidence of disagreement or rejection by client)*

T: I think there is also a lot of strength in your tears, in being vulnerable. I don't think it's necessarily a sign of weakness. It takes a lot of guts to open yourself up, especially when it wasn't safe to do so in the past.

C: That's true. It's really hard.

➤ **Examples of statements that convey (1B) safety in relation to the emotion:**

*(Note: statements must be either: (i) made by client, or (ii) if made by therapist, must not be rejected by client)*

Such statements can involve any of the following:

- Reassurance (e.g., that the client will be okay, that the potential negative consequences are unlikely to occur or that the client will be able to cope with them)
- Encouragement (e.g., that the client is strong enough to allow the emotion, that the client can cope with the emotion)
- Support (e.g., that the client is not alone and has support of the therapist and others)

*For example:*

- *(i) Client – support*

C (as critic-interrupter, to experiencer): Okay, I'll support you from now on. I'll try to be more patient and less hard on you.

T: okay, switch back. What happens when you hear her say that?

C: (as experiencer, to critic-interrupter): I accept your support.

- *(i) Client – reassurance*

C: Come to think of it, when I look back on our relationship, even when we have had big blowouts, he never walked out the door. We've been together for 15 years. He loves me and I don't think he would throw in the towel just because of one disagreement. We've worked things out before. I need to trust that he will stick around to work through this too.

- *(ii) Therapist – reassurance and support (no evidence of disagreement or rejection by client)*

C: I want to try to do it, but I'm scared of what else could come out in the process.

T: That makes sense. Because this is new for you, it feels scary. But I'm right here with you and, if anything else does come up, I'll be here to help you through it every step of the way. Do you think you can let me know if anything gets to be too much or uncomfortable for you?

C: I think so.

- (ii) *Therapist – encouragement (no evidence of disagreement or rejection by client)*  
T: I think processing this emotion could really help you. We don't have to go there if you don't want to, but I do think that you are strong enough to do it.  
C: Right.
- (ii) *Therapist – reassurance, support (no evidence of disagreement or rejection by client)*  
C: I don't know how to even start to let this feeling out. I'm so used to keeping it inside.  
T: You are already starting to do it. This is a process that takes time. We will get there together.  
C: (sighs)

∅ **Examples of statements that are excluded because they do not meet Criterion 2.**

*They are followed by the client conveying that the emotion or associated need is invalid or unsafe.*

A client may believe that the emotion is valid but lack a sense of safety, or vice versa. If there is evidence that the client still is *unable to either internalize validation or a sense of safety*, then they are *not* considered to have attained completion of this component.

*For example:*

- ∅ C: Sometimes I wonder if I'm just making a big deal out of nothing, you know?  
Was it really emotional abuse? Like did I really have it that bad when I was a kid?  
T: My sense is that this is very real. From what you've told me, it sounds like what you went through was really brutal. It was emotional abuse.  
C: (pauses) Ugh. It feels too overwhelming to think about. I'd rather not.
- ∅ C (as experiencer, to interrupter): You need to let me have my feelings. We have [therapist's name] who said she can help us through it and that we are strong enough to handle it. I believe her.  
T: Switch; come over here. What do you say to that?  
C (as interrupter, to experiencer): It doesn't matter how you feel. You have to hold it together. Keep it locked up inside.
- ∅ C (to father in empty chair): I hate you. My life would be easier without you.  
T: What happens for you when you say that?  
C: I feel like a horrible son. It's the worst thing I could say to him. It's disrespectful.

- Ø C (as experiencer, to interrupter): I'm so tired of working non-stop. I need a break.
- T: I deserve a break. Let me breathe.
- C: Yeah, let me breathe.
- T: Okay, come here now.
- C (as interrupter, to experiencer): I know you're tired. I wish it didn't have to be this way. But there's no time for breaks. If you're not productive enough, you may not make partner at the firm. If the quality of your work slides, then people will notice, you won't get promoted, or you could even get fired.

Ø **Examples of statements that are excluded because they do not meet Criterion 3.**  
*Client Experiencing (EXP) is < level 3.*

*For example:*

- Ø T: I think there can be a lot of strength in vulnerability. I don't think it's necessarily a sign of weakness. It takes a lot of guts to open up, especially when it wasn't safe to do so in the past. (*EXP 1 – not specific to client's internal world*)
- C: That's true.
- Ø C: You know, I was watching that Ted Talk about the power of vulnerability. The speaker described how something that is often thought of as a sign of weakness can actually be a good thing sometimes. (*EXP 2*)

Raters can refer to the Experiencing Scale manual (Klein, Mathieu, Gendlin, & Kiesler, 1969) for additional examples and more detailed descriptions of different levels of EXP.

## 6. Desire to Allow

For this component, clients are observed expressing a desire to try to allow the interrupted emotion (or a related need, action tendency, or part of self). This component process can be observed while clients engage in a dialogue with their therapists or during a chair dialogue.

### Criteria for Rating

**Clients are considered to have successfully completed this component when all four of the following criteria are met:**

**Criterion 1.** The client makes one or more statements communicating their desire or intention to allow the interrupted emotion (or a related need, action tendency, or part of self) (e.g., “I want to do it” “I’m trying to do it”).

**Criterion 2.** There is no indication that the client is unready to imminently try to allow the emotion (or a related need, action tendency, or part of self). The client’s statement under Criterion 1 does not convey that their desire is to allow in the distant future (e.g., “I know I need to let it out at some point”). The client’s statement under Criterion 1 is not accompanied by a statement conveying that allowing the emotion is not possible or a lack of willingness to try to allow it (e.g., “It feels elusive” “I need someone else to force it out of me” “I can’t do it” “It’s too risky”).

**Criterion 3.** The client’s speech is characterized by a focused vocal pattern on the Vocal Quality Scale (Rice et al., 1979; Rice & Kerr, 1986).

- In a *focused vocal pattern*, the client directs their attention inward with a concentrated use of energy. They track their internal experiences and find a way to symbolize it into words. The client’s production of accents is achieved with loudness or drawl, accentuation is irregular, the pacing is uneven, terminal contours are ragged and unexpected, perceived energy is moderate to high, but there is no disruption of ordinary speech pattern.
- In other words, the client’s statement does not sound rehearsed or have a “speaking at” or lecturing quality that characterizes an externalizing vocal pattern; rather there is a sense that the dialogue is “coming from inside” the client.

**Criterion 4.** The client’s depth of experiencing must be at a level 4 or higher, as measured by the Experiencing Scale (Klein et al., 1969). The client’s statement must describe their own sincere, internal desire or willingness to try to allow the emotion (or a related need, action tendency, or part of self), rather than an abstract understanding of the value of allowing the emotion. There is no evidence of lack of conviction in the client’s statement. The statement is not made for the sole purpose of appeasing or deferring to the therapist.

**Examples:**➤ **Client statements expressing a desire or intention to allow the emotion can include any of the following:**

- "I want to do it"
- "I want to work through it and get to the other side"
- "I'm trying to do it"
- "I'm trying to stay with it"
- "Okay, I'll try and see how far I can get today"
- expressing the need to be allowed to feel/express emotion/part of oneself: e.g., "Stop holding me back. I need to be allowed out of this box," Or "I need to be able to say how I'm feeling"

*For example:*

- T: What's happening for you right now? It looks like there's a lot going on inside.  
C: I'm trying to stay with the feeling as much as possible.
- T: What do you think he should do?  
C (as experiencer, to interrupter): You need to let me deal with this. I need you to trust that I can handle it, that our relationship can handle it. We need to confront him. We can't keep burying our heads in the sand.
- C: I'm looking forward to meeting this part of myself that has been hidden for so long. I'm excited to see what life will be like on the other side of this process.
- T: It's up to you. We don't have to do this today if you don't want to. But I think you can handle it.  
C: I'd like to try to do it.  
T: Okay, let's see how far we can get today. But you let me know if it's too much.  
C: I can do that.
- C (as experiencer, to interrupter): Stop! This isn't a way to live. I can't keep going on like this. You have to let me out of this box. I want to be free. I want to feel like a whole person.

∅ **Examples of statements that are excluded, because Criterion 2 is not met.**

*Statements expressing a desire to allow the emotion may be accompanied by the client conveying that they are not ready to imminently try to allow the emotion or that allowing the emotion is not possible for them to achieve. The client can lack a sense of agency or they can express a sense of hopelessness with respect to allowing it. For instance, they may convey:*

- That they are unable to do it
- That it is too risky to do it
- That there is no point to doing it
- That they *wish* to be able to allow the emotion or stop interrupting it
- They want to allow the emotion *later in the future*
- That they need someone else to force them to feel the emotion
- That allowing the emotion feels elusive or impossible.

*For example:*

- ∅ C: I agree with you. I think it would be a good idea for me to work through this and get to the other side of it. But I think I need someone to really push me to get there, because I don't think I can get myself there.
- ∅ C: It'd probably be good for me to process this so I can move on. (pauses 00:00:10) (sighs) It just feels impossible.
- ∅ C: I know I should do it, but it's too scary. I can't (shakes head).
- ∅ C: I know I should say something to him, but I can't. There's no point. He won't change (sighs).
- ∅ C (as experiencer, to interrupter): Let me feel. I deserve to be allowed to feel my feelings just like everybody else.  
T: Okay, good, switch back here now.  
C: (as interrupter, to experiencer): No way! You don't know what's good for you. I don't have any proof that you could handle me letting you do that.
- ∅ C: I *should be able* to do this. I have to get it out of me somehow.
- ∅ C: I think it would be good if I could get to the point of being able to let this out.

∅ **Examples of client statements that are excluded because they do not meet Criterion 3 or 4.**

*The client's Vocal Pattern is externalizing, instead of focused (does not meet criteria 3) and Client Experiencing (EXP) is < level 4 (does not meet criteria 4)*

- Ø In an *externalizing vocal pattern*, the client’s attentional energy is directed outward in an effort to produce some effect in the outside world. Accentuation is extremely regular and is achieved with pitch more than loudness or drawl. The pace is even and terminal contours are highly expected in relation to the structure of what is said. There is no disruption of speech pattern. The content is not newly experienced and symbolized. It has a pre-monitored quality of recounting, rather than exploring. The client’s statement sounds rehearsed or has a “speaking at” or lecturing quality.

*For Example:*

- Ø C: You know, people always say that honesty is the key to a healthy relationship. (*EXP 1 + externalizing voice*)
- Ø C: I know that it’s not healthy to keep things inside. You have to feel it to get over it. (*EXP 1 + externalizing voice*)
- Ø C: I read a book that said that being authentic and sharing feelings openly, even if it leads to disagreement, is the key to a long-lasting marriage. (*EXP 2 + externalizing voice*)
- Ø T: I think that this sadness inside of you keeps coming up. It needs our attention and is asking to be let out. If we can make space for your sadness today, then it’s something that we can start to work through together.  
C: (sighs) I guess you’re right. That’s probably a good idea. (*EXP 2 + externalizing voice*)  
T: As you’re saying that, I get the sense that a part of you isn’t totally sure.  
C: Well, I guess I don’t really have any guarantees that letting out this feeling will be helpful.  
(*Note: The client’s first statement in this example is marked by a lack of conviction. It does not reflect the client’s own, sincere desire to allow the emotion. The client is agreeing with the therapist out of deference.*)
- Ø C: My friend M. told me that therapy helped her get in touch with her feelings. I felt really happy for her that she was able to do that. It seems like this has made a positive difference for her. She encouraged me to do that same. (*EXP 3 + externalizing voice*)

Raters can refer to the Experiencing Scale manual (Klein, Mathieu, Gendlin, & Kiesler, 1969) and the Vocal Quality Scale manual (Rice & Kerr, 1986; Rice, Koke, Greenberg & Wagstaff, 1979) for additional examples and more detailed descriptions of different levels of EXP and categories of vocal patterns, respectively.

### References

- Klein, M. H., Mathieu, P. L., Gendlin, E. T., & Kiesler, D. J. (1969). *The Experiencing Scale: A research training manual*. Madison: University of Wisconsin Extension Bureau of Audiovisual Instruction.
- Rice, L. N., & Kerr, G. (1986). Measures of client and therapist vocal quality. In L. Greenberg & W. Pinsoff (Eds.), *The psychotherapeutic process: A research handbook* (pp. 73–105). New York, NY: Guilford Press.
- Rice, L. N., Koke, C. J., Greenberg, L. S., & Wagstaff, A. K. (1979). *Manual for client vocal quality*. Unpublished manuscript, Counselling and Development Centre, York University, Toronto, Ontario, Canada.

## Appendix C: Resolution of AESI Rating Scale (RARS)

### **Resolution of Aversion to Emotion/Self-Interruption (AESI) Rating Scale**

This rating scale was developed to identify the occurrence of the Resolution of aversion to emotion/self-interruption (AESI) within video- and/or audio-recordings and transcripts of sessions of emotion-focused therapy. It is based on the findings from the first phase of a task analysis conducted by Vrana (2020).

This rating scale incorporates elements of the following previously developed rating systems:

- Client Emotional Productivity Scale - Revised (Auszra, Greenberg, & Herrmann, 2007)
- Emotional Arousal Scale- III (Warwar & Greenberg, 1999)
- Experiencing Scale (Klein, Mathieu, Gendlin, & Kiesler, 1969)

#### **I. Description, Rating Criteria and Examples of Resolution of AESI**

The Resolution of AESI occurs when the client no longer opposes the emotion (or a related need, action tendency, or part of self). In other words, there is an absence of efforts to stop, prevent, or over-control the emotion. The client may be seen either: (a) reporting that the part of themselves that previously interrupted the emotion (i.e., the interrupter) is now open to the allowing of the emotion, or (b) allowing the previously interrupted emotion in the session.

Resolution can occur either while the client engages in a dialogue with the therapist or during a chair dialogue.

#### **Criteria for Rating:**

Either **all criteria under A OR all criteria under B** must be present:

**A) The client reports that the part of them that previously interrupted the emotion (or a related need, action tendency, or part of self) is now open to the allowing of the emotion. Both of the following criteria must be present:**

1. The client communicates that the part of them that previously interrupted the emotion (i.e., the interrupter) is now open to the client allowing the emotion. A synthesis or integration may be reached between the part of the self that experiences the emotion (i.e., the experiencing self) and the part of the self that previously wanted to interrupt the emotion (i.e., the interrupter). This may involve having reached a compromise between the parts of the self in order to resolve the conflict. The two parts are now aligned with one another.

*(cont'd on next page)*

2. The client's depth of experiential involvement is at a level 4 or higher, as measured by the Experiencing Scale (Klein, Mathieu, Gendlin, & Kiesler, 1969). At the very least, the client shares their feelings and personal experiences in a self-descriptive and associative manner.

**OR**

**B) When the client is seen allowing the previously interrupted emotion (including a related need, action tendency, or part of self) in the session, the client displays verbal and non-verbal behaviours consistent with the activation and expression of this emotion. All 5 of the following criteria must be present:**

1. Verbal behaviour indicating activation and expression of the previously interrupted emotion, as described in the Client Emotional Productivity Scale – R (Auzra, Greenberg, & Herrmann, 2007): The client provides descriptions of emotional reactions (e.g., “It hurts”) or action tendencies (e.g., “I want to hit him”). If the therapist provides the label, the client has to express agreement either verbally or non-verbally.
2. Non-verbal behaviour indicating activation and expression of the previously interrupted emotion: The emotion is not merely talked about; there is clear evidence of activation and expression of the emotion. Non-verbal emotional behavior must be present.  
As defined in the Client Emotional Productivity Scale – R (Auzra et al., 2007, p. 5), “the client must clearly express emotion in voice and/or body, i.e. a clear emotional expressive/action tendency is present. It must deviate markedly from the client’s individual baseline. The client shows an *expressive/action tendency* such as clenching his or her fists (such as in anger), shrugging (such as in resignation), shrinking back (such as in shame or fear), or crying (such as in sadness or pain).” *The non-verbal behavior must be congruent with, or consistent with, the verbal expression of the emotion.*
3. The client’s emotional arousal is at a Level 5 or higher on the Client Emotional Arousal Scale – III (Warwar & Greenberg, 1999). Arousal is fairly intense and fully present in voice and body. The emotion flows into speech pattern to a great extent; speech patterns deviate markedly from the client’s baseline and are fragmented or broken. There is elevated loudness and volume. Arousal appears fairly unrestricted.
4. The client's depth of experiential involvement is at a level 4 or higher, as measured by the Experiencing Scale (Klein, Mathieu, Gendlin, & Kiesler, 1969). At the very least, the client shares their feelings and personal experiences in a self-descriptive and associative manner.
5. There is no indication that the client is attempting to prevent, stop, or over-control their emotion for a minimum of 20 seconds.

**Examples:**

➤ **Examples of Resolution A: when the client reports having achieved agreement or integration between the parts of themselves that were previously conflicted:**

- C (as interrupter, to experiencer): Okay. Maybe I have been a bit over-protective. I guess I can try loosening up a bit from time to time. I will try to let you come out more often.  
T: Do you need anything from her to be able to do that?  
C: I need you to be patient with me. It will take a bit of time for me to get used to doing that. This is new for me.  
T: okay, switch come back here. What do you say to that?  
C (as experiencer, to interrupter): Okay, I will be more patient with you. I know this is new and not easy for you.  
T: What happens for you as you say that?  
C: I feel hopeful. I feel like maybe for the first time, we can work together, her and I, as a team.
  
- C (as experiencer, to interrupter): I need you to let me be honest with him. I can't keep hiding how I feel. It's not fair to me. I can't keep living this way.  
T: Okay switch. What is it like for you to hear her say that?  
C (as interrupter, to experiencer): You're right. This is something I need to let you do. I didn't realize that my holding you back was hurting you so much. I don't want to stand in your way anymore.... I only wanted to keep you safe. Now I see that I don't need to keep you safe anymore. You are able to do that for yourself. You are not a little girl anymore. You are a capable, grown adult now. I see that.

∅ **Examples where one or more criteria for Resolution A are not met, indicating that the client has not attained completion of this component:**

- ∅ C (as interrupter, to experiencer): Okay. Maybe I have been a bit over-protective. But I don't know if I can loosen the reins yet. It's just too risky.  
T: What do you need from her?  
C: Keep doing what I tell you to do in order to stay safe. It's the only way to survive.  
T: okay, switch come back here. What do you say to that?  
C (as experiencer, to interrupter): There's no give with her. She won't even meet me halfway, or even one percent of the way.  
*Reasons why criteria not met:*
  - The interrupter is not open to the client allowing the emotion and is unwilling to compromise. The two sides remain at an impasse.
  
- ∅ C (as experiencer, to interrupter): I need you to let me be honest with him. I can't keep hiding how I feel. It's not fair to me. I can't keep living this way.

T: Okay switch. What is it like for you to hear her say that?

C (as interrupter, to experiencer): I'm sorry this is not fair to you. But he won't be able to handle you telling him the truth. He could become suicidal again.

*Reasons why criteria not met:*

- The interrupter is not open to the client allowing the emotion and is unwilling to compromise. The two sides remain at an impasse.

➤ **Examples of Resolution B: when the client is seen allowing the previously interrupted emotion in the session:**

○ *Expressing adaptive sadness/grief:*

T: There's been so much loss. Tell her what it's been like for you.

C (speaking to parent in empty chair): (crying) I feel sad. I missed out on so much because of you.

T: Tell her what you missed.

C: (crying) A chance at a normal childhood. I never felt safe or got to be a kid.

○ *Expressing adaptive anger:*

T: Right, so he's the one who was sick.

C (speaking to parent in empty chair): (in an assertive tone) Yes, you were the one who was sick. You were disturbed. You didn't know how to be a parent. You were incapable of showing love. I was just being a kid. I didn't do anything bad. You were the one who was messed up.

⊘ **Examples where one or more criteria for Resolution B are not met, indicating that the client has not attained completion of this component:**

⊘ *Expressing adaptive sadness/grief:*

T: There's been so much loss. Tell her what it's been like for you.

C (in empty-chair task with parent): It's sad. (pauses 00:00:08)

T: What's happening for you right now?

C: I don't know what else to say. I feel blank

*Reasons why criteria not met:*

- Client verbal behavior is not consistent with non-verbal behavior: he is not crying and his emotional expression is constricted
- Client Emotional Arousal (EA) < 5: emotion not overflowing into speech
- Client experiencing (EXP) < 4: client not elaborating on experience of sadness.
- If client experienced sadness initially, it has now become interrupted, as he has lost contact with the emotion.
- No evidence of client experiencing sadness for > 20 seconds.

Ø *Expressing adaptive anger:*

T: Right, so he's the one who was sick.

C (in empty-chair task with parent): (speaking softly and gazing at the ground) Yeah. You were sick.

T: Tell him what you resent the most.

C: (pauses 00:00:05) (sighs) How you treated me all those years.

T: I'm angry at you. It wasn't fair.

C: (still speaking softly and gazing at the ground) Yeah, I'm angry. It wasn't fair

*Reasons why criteria not met:*

- Client verbal behavior is not consistent with non-verbal behavior: she says she is angry, but her tone and body language do not convey assertiveness; she appears small and disempowered
- EA < 5: emotion not overflowing into speech
- EXP < 4: no spontaneous elaboration on emotional experience

Raters can refer to the Emotional Arousal Scale – III manual (Warwar & Greenberg, 1999) and the Experiencing Scale manual (Klein, Mathieu, Gendlin, & Kiesler, 1969) for additional examples and more detailed descriptions of different levels of EA and EXP, respectively.

## II. Rating Process

For each client, there will be three segments to be rated. Segments will be presented in random order. For context, raters will be provided with session dialogue pertaining to the marker of AESI for every client, along with up to two minutes of session dialogue prior to every segment to be rated.

For each segment to be rated, raters will assign a value on an ordinal scale from 1-5, representing the degree to which they are confident that resolution is present, on the basis of the criteria outlined in this manual. Refer to the table below for a breakdown of the rating scale. Higher ratings reflect greater levels of confidence in the presence of resolution.

Rating	Description
1	The resolution of AESI is <b>definitely not</b> present.
2	The resolution of AESI is <b>unlikely</b> to be present.
3	I am <b>uncertain</b> whether the resolution of AESI is present or not.
4	The resolution of AESI is <b>likely</b> present.
5	The resolution of AESI is <b>definitely</b> present.

### References

- Auszra, L., Greenberg, L. S., & Herrmann, I. R. (2007). *Client Emotional Productivity Scale Revised*. Unpublished manuscript, York University, Toronto, Ontario, Canada.
- Klein, M. H., Mathieu, P. L., Gendlin, E. T., & Kiesler, D. J. (1969). *The Experiencing Scale: A research training manual*. Madison: University of Wisconsin Extension Bureau of Audiovisual Instruction.
- Warwar, S. H., & Greenberg, L. S. (1999). *Client Emotional Arousal Scale-III*. Unpublished manuscript, York University, Toronto, Ontario, Canada.