

EXAMINING PROCESSES OF CHANGE FOR EXPERIENTIALLY DISTANT AND
EXPERIENTIALLY ENGAGED CLIENT SUBGROUPS IN EXPERIENTIAL THERAPY FOR
DEPRESSION

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Abstract

This study examined whether different client subgroups, identified as either experientially distant or experientially engaged based on their early tendency to approach inner experience, undergo distinct emotional change processes during experiential therapy for depression. It was hypothesized that these distinct emotional change processes would be best captured using different process measures, which were the Experiencing Scale (EXP) and the Classification of Affective Meaning States (CAMS), respectively. As experientially distant clients were hypothesized to experience depression related to being estranged from the adaptive information within emotional experience, increasing general access to emotional experience was presumed to be the change process most likely to relieve their depression, and optimally captured by the EXP scale. Experientially engaged clients were hypothesized to experience depression related to activation of maladaptive emotion schemes, and it was assumed that alleviation of their depression would occur through accessing primary adaptive emotions, which would be measured by the CAMS. A second purpose of this investigation was to examine whether these different change processes would differentially predict long-term resilient gains in addition to outcome at treatment termination.

Results opposite to the hypotheses were found. Emotion scheme typology as measured by the CAMS was a better predictor of outcome for the experientially distant subgroup, and depth of experiencing as captured by the EXP scale a better predictor of outcome for the experientially engaged subgroup. While unexpected, these results support the original hypothesis concerning the existence of distinct

subtypes of depressed clients who undergo separate paths to change. They also supported experiential therapy change principles, indicating that both depth of experiencing and emotion scheme typology are powerfully related to termination and long-term outcome in this psychotherapy model.

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Chapter 1: Introduction

This study investigates emotional processing predictors of outcome at treatment termination and 18-month follow up. It examines whether different indicators of emotional processing (depth of experiencing or emotion scheme typology) will differentially predict outcome for two subtypes of depressed clients. With depressed clients representing a heterogeneous population, the core aim was to investigate whether early differences in the tendency to approach inner emotional experience affect which emotional processing measure best captures clients' change processes and predicts their ability to benefit from experiential treatment for depression or their long-term gains in this therapy model.

Treatment of Depression: The importance of longer-term treatment gains

Depression is a highly prevalent and debilitating mental disorder affecting 350 million people worldwide (World Health Organization, 2012). Internationally, it is the leading cause of disability when measured by years lost to illness (Marcus, Yasamy, van Ommeren, Chisholm, & Saxena, 2012), and is projected to become the worldwide leading disease burden by 2030 (World Health Organization). In Canada, over one million individuals experience a depressive episode annually, with one in ten Canadians expected to experience depression at some point during their lifetime (Patten & Juby, 2008). Sufferers experience marked impairment in major areas of life such as employment, physical health, and relationships (Kessler et al., 2003), which incur significant personal, social, and economic costs (Lin, Jacobs, Ohinmaa, Schopflocher, & Dewa, 2008). In fact, depression is the fastest growing category of disability costs for Canadian employers (Mood Disorders Society of Canada, 2009).

Clearly, effective treatment of depression needs to be a priority.

Several short-term psychotherapies (i.e., cognitive-behavioural therapy, interpersonal therapy, and experiential therapy) have been shown to be equally effective treatments of depression (Elkin et al, 1989; Greenberg & Watson, 1998; Goldman, Greenberg, & Angus, 2006; Shea, Elkin, Imber, & Sotsky, 1992; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003). However, despite this demonstrated therapeutic efficacy depressive relapse is quite common (Westen & Morrison, 2001). In fact, depression is now considered to be a largely recurrent disorder (Hollon, Stewart, & Strunk, 2006), with over 75% of depressed individuals experiencing an additional depressive episode in naturalistic follow-ups (Blatt, 2004; Judd, 1997; Nierenberg et al., 2003). The average depressed individual experiences four major depressive episodes in his or her lifetime. Moreover, notwithstanding the efficaciousness of therapeutic treatment, clients who respond to psychotherapy are not exempt from experiencing depressive recurrences. In a meta-analysis examining relapse rates following cognitive-behavioural therapy for depression, it was found that among those clients who responded to intervention, 29% and 54% of these individuals experienced relapse-recurrence by one and two years, respectively (Hollon et al., 2006). Maintenance of treatment gains has also been studied in experiential therapies, with Emotion-focused therapy (EFT) appearing to demonstrate greater protection against depressive relapse when compared to client-centered therapy (CCT; Ellison, Greenberg, Goldman & Angus, 2009). Ellison et al. reported that at the end of an 18-month follow-up period, approximately 52% of client responders to CCT, and 23% of client responders to

EFT, defined as those with minimal or no depressive symptoms for a minimum of eight consecutive weeks following treatment termination, had experienced depressive relapse. Thus, as Westen, Novotny & Thompson-Brenner (2004) argue, most current psychotherapies for depression are not adequately long lasting. One conclusion drawn from these troubling research findings is that the efficacy of all empirically supported treatments for depression, and in particular their long-term effectiveness, should be much improved.

The frequency of depressive relapse and recurrence has raised the concern that current and common short-term treatment protocols may alleviate depressive symptoms but either leave underlying causes of depression unaddressed, or fail to eliminate them fully, thus leaving clients vulnerable to reoccurring depression (Luyten, Blatt, & Coveleyn, 2005; Teasdale, 1999; Westen & Morrison, 2001). As such, one clear goal for improving treatments for depression is to develop treatments that lead clients to full recovery, and the prevention of future depressive episodes. Some researchers (Teasdale, 1999) have suggested that to evaluate the true impact of treatments on depressive resolution requires measuring client outcome not at treatment termination (when the client has yet to experience the loss of the therapy relationship), but instead at a follow-up time point. Only then can treatment gains be best evaluated, when one can better demonstrate that resilient change in the client has actually occurred.

Another important way to achieve the goal of lasting client recovery is to identify the essential therapeutic processes required for resilient change. One must demonstrate both that these occur during therapy and that they predict clients'

resilient gains at treatment follow-up. One focus of the proposed study is to examine a change process theorized across most empirically supported approaches to treating depression, emotion-schematic change (Greenberg & Paivio, 1997; Greenberg & Safran, 1986; Teasdale, 1999). One aim of this study is to demonstrate that changes in emotion scheme typology both occur during experiential therapy and also predicts long-term resilient gains in this treatment model.

Experiential Therapy for Depression

Experiential therapy is an empirically validated approach for treating depression (Goldman et al., 2006; Greenberg & Watson, 1998; Watson et al., 2003). In experiential theory, emotion is a core process of interest. Emotion is viewed as holding potential adaptive value to help inform adaptive action and to facilitate growth and change (Greenberg & Watson, 2006). Clients are consequently helped in experiential treatment to make sense of their emotional experience through emotional processing.

Emotional Processing

Emotional processing is a complex construct that encompasses a variety of therapeutic tasks. It has long been emphasized and empirically examined in humanistic-experiential therapies, but despite differences in theory and offered interventions emotional processing may in fact be a common factor in all treatments (see Whelton, 2004 for a review).

The term 'emotional processing' incorporates a number of associated activities under its umbrella. This includes: developing and deepening awareness of and attention to inner emotional experience (Gendlin, 1964); expressing

appropriate emotions skillfully (Goleman, 1995); regulating overwhelming emotions (Linehan, 1993); reflecting on the meaning of emotional experience (Klein, Mathieu-Coughlan & Kiesler 1986); and, if necessary, transforming maladaptive emotion schemes (Greenberg, 2010). All of these emotional processing tasks occur within the context of an empathic therapeutic relationship, which additionally provides a corrective experience of emotion (Alexander & French, 1946).

While some therapy models (e.g., behavioural therapy, elaborated below) focus more narrowly on addressing specific aspects of emotional processing, such as reducing emotional arousal or increasing emotion regulation, in experiential therapy, the importance of all of these emotional processing tasks (awareness, expression, regulation, meaning-making, and transformation) is emphasized. Emotional processing enables clients to gain access to and make use of the potentially meaningful information implicit within their emotional experience. It also facilitates emotion schematic change, or the transformation of maladaptive emotion through the access of alternative, adaptive emotions. Emotional processing is theorized to lead to new emotional reactions, new self-experiences, alternative and adaptive ways of meaning making (Greenberg & Watson, 2006; Pos, 2006), and to personal story reconstruction as well (Angus & Greenberg, 2011).

Emotional Processing in Other Treatment Models

Behaviour Therapy

In the behavioral therapy tradition emotional processing has been extensively researched. Its impact on outcome for the treatment of various disorders is well established, particularly for anxiety disorders (e.g., OCD, PTSD; Foa,

Riggs, Massie & Yarczower, 1995a; Kozak, Foa & Steketee, 1988). Traditional behaviorists have viewed emotional processing as occurring through the extinction of an unwanted emotional reaction through a habituation process, or through extinguishing links between stimulus and response (Rachman, 1980). For example, an individual with a spider phobia is presented repeatedly with a spider, until he or she has habituated to the stimulus and the fear response is extinguished. When the presentation of a spider no longer elicits fear, it is assumed at this point that emotional processing has occurred. Later behavioral theory addressing emotional processing asserts that it occurs when a dysfunctional memory structure connected to a problematic emotional reaction is activated and then subsequently modified through the provision of new, corrective information (Foa & Kozak, 1986). In this scenario, it is believed that presenting the spider-phobic individual with an arachnid activates a maladaptive fear structure in the brain, in which the problematic meaning of the stimulus ('Spiders are dangerous') is altered through incompatible information (i.e., the spider does not attack). A newer, alternate theory suggests that through the development of new outcome expectancies (Arch & Craske, 2009; Craske & Barlow, 2008), emotional reactions are also changed (e.g., the individual develops an awareness of alternative consequences to being attacked when faced with a spider, including the most probable result of not being harmed).

Cognitive-Behavioural Therapy

In purer cognitive therapies, interest in the productive role of emotion has been a relatively recent development. Negative emotions in particular have been historically viewed as symptoms that mark the operation of irrational beliefs or

schemas that need to be altered, after which such emotions will dissipate. However, a growing number of cognitive theorists are taking an increased interest in emotion, and recognizing that emotion can be a source of valuable information and tacit meaning (Samoilov & Goldfried, 2000). This change in emphasis is due in part to empirical and clinical evidence demonstrating that clients often experience continued emotional distress despite changes in self-understanding and insight (Greenberg & Safran, 1984). This unexpected finding led cognitive theorists to hypothesize and research the existence of two levels of information processing and meaning construction, one at the rational/logical level and the other at a higher-order, implicational level (Teasdale, 1999; Teasdale & Barnard, 1993). Implicational meaning structures include affective and sensory connotations that extend beyond the conceptual definition and are linked with emotion. While traditional CBT techniques such as cognitive restructuring may be effectively targeting meaning structures at the logical level, the emotional context at the implicational level may be left unchanged, increasing the chances of depressive relapse (Teasdale, 1999; Teasdale, 1993). It has been subsequently proposed that cognitive therapists should target 'hot cognitions' (emotionally charged beliefs) in order to alter both explicit meanings and reorganize implicit meaning structures, and which require the client to experience in-session emotional arousal (Samoilov & Goldfried, 2000).

Psychoanalytic and Psychodynamic Therapies

In psychoanalytic and psychodynamic therapies emotional processing has also been articulated as important. In classic psychoanalysis it was considered essential for clients to become consciously aware of painful early affective

experiences that had since been repressed. These traumatic incidents and their associated painful emotions need to be re-experienced and expressed in order to release their psychic energy and lead to patient improvement (abreaction; Breuer & Freud, 1893). This change process is thought to be mediated by the gaining of insight, in which the client becomes aware of the original conflict or trauma that is the source of the unresolved emotional energy (Freud, 1906). As such, a rational understanding of one's emotions and their origins is considered a necessary precursor to change.

An extension of this theory of change in psychoanalysis has also now been articulated. In addition to experiencing abreaction or catharsis, a client also needs to engage in a corrective emotional experience (CEE; Alexander & French, 1946). The CEE is an interpersonal relationship (typically with the therapist) in which the client's re-experience and re-expression of emotions from the original conflict are transformed. This transformation is due to the therapist's response to the client being contradictory to the manner of response in the source trauma. This psychodynamic view of emotional change shares elements with both the cognitive-behavioural and experiential models. Shared with the cognitive-behavioural perspective is the emphasis on achieving greater understanding and insight. Congruent with an experiential perspective is the importance placed upon having new emotional experiences that are discordant with old, problematic ones. This incongruence then leads to transformation.

Despite historical differences between therapeutic modalities on the importance of emotional processing in treatment, there is growing consensus

regarding the value of understanding and making use of emotion in therapy (Pos, 2006). This heightened interest necessitates that emotional processing as a construct be accurately defined and measured in order for its contribution to outcome to be fully understood and demonstrated.

Operationalizing Emotional Processing

Evaluating the relationship between emotional processing and outcome has required researchers to operationalize this construct. There are a number of measures that address specific aspects of emotional processing, such as assessing a client's level of emotional awareness (Levels of Emotional Awareness Scale [LEAS]; Lane, Quinlan, Schwartz, & Walker, 1990) or ability to regulate affect (Observer-rated Measure of Affect Regulation [O-MAR]; Watson & Prosser, 2004). However, one of the earliest and most robust operationalizations of emotional processing is to use a client's depth of experiencing as measured by the Experiencing Scale (the EXP; Klein, Mathieu-Coughlan & Kiesler, 1986).

Depth of Experiencing

A distinction between experiencing as a general process and the EXP scale as a measure of emotional processing is briefly touched on here. Experiencing as a general phenomenon refers to all of what is occurring within us that is potentially available to awareness, and the EXP scale is a measure of how an individual relates to that inner experience. The EXP scale captures the extent to which an individual is able to become aware of, orient to, and use their bodily felt experience as information for problem solving. The relationship between an individual's depth of experiencing, measured using the EXP scale, and outcome has been one of the most

robust findings in psychotherapy process research (Orlinsky & Howard, 1978; also see Hendricks, 2001 for a review).

Deeper client experiencing has been linked to successful outcome as measured by therapist and client reports as well as by independent evaluations. This relationship has been demonstrated not only in humanistic and experiential therapies but in cognitive-behavioural and psychodynamic treatments as well (Castonguay, Goldfried, Wisner, Raue & Hayes, 1996; Silberschatz, Fretter & Curtis, 1986). Depth of client experiencing averaged over the entire therapy process, as well as measured only in the early, middle, or late phases of treatment have all been linked to positive client change. In addition to client experiencing predicting successful therapy outcome, therapist experiencing has been demonstrated to do so as well. Adams (2010) has found that deeper therapist experiencing during therapy sessions is associated with deeper client experiencing levels and better client outcomes.

In experiential treatment of depression, depth of client experiencing has been measured in a number of contexts, including in relation to core therapeutic themes (Goldman & Greenberg & Pos, 2005). Depth of experiencing has also been examined during clients' emotion narratives or emotion episodes in therapy (Korman, 1991) in order to operationalize emotional processing more specifically. When examining emotional processing operationalized as depth of experiencing during emotion episodes (i.e., EE-EXP; applying the EXP scale to emotion narratives in therapy), Pos, Greenberg, Goldman & Korman (2003) found that the depth to which clients process emotions at the end of therapy, and not their capacity to do so

at therapy onset, best predicts client improvement. Pos, Greenberg & Warwar (2009) demonstrated this relationship even more convincingly by examining client experiencing within three phases of therapy and by also controlling for the working alliance across treatment. They found that depth of experiencing during working phases of therapy best predicted client outcomes. Paolone and Pos (2013) more recently have also shown that depth of experiencing during the working phase of experiential therapies mediates the relationship between arousal and outcome, suggesting that arousal promotes emotional processing by facilitating the experiencing process. The EXP scale has therefore shown itself to be a robust operational measure of emotional processing.

However, the EXP scale as an emotional processing measure has limitations that must be considered. First, as a measure of emotional processing, it does not measure the particular emotion states that clients are expressing during therapy. As such, the EXP scale measures emotional processing as a somewhat general phenomenon, measuring in a global way the degree to which clients are referring to and using their emotional experience while solving problems in therapy. It measures clients' general capacity to approach, tolerate and explore emotions. As such, the EXP scale does not appear to make additional clinically relevant distinctions within a client's inner experience (i.e. distinctions among emotion categories such as anger versus fear; or among emotion schematic typology such as adaptive versus maladaptive emotion schemes). This limitation of the EXP scale can make it difficult to identify the particular types of emotional experiences that are necessary or more useful for therapeutic change.

Transformation of Depressogenic Emotion Schemes

All treatments for depression identify depressogenic emotion schemes as a particularly important target for change (see Pos, 2006, for a review). From an Emotion-Focused Therapy (EFT) perspective, emotion schematic typology offers an important consideration for this emotional change process, distinctions not captured by the EXP scale.

In general EFT theory, emotion schemes are viewed as dynamic cognitive-affective structures that rapidly and automatically synthesize a wide variety of information (i.e., memory, perception, conscious appraisals, motivation, and action) to organize one's moment-to-moment experience of oneself and the world. However, emotion schemes are also articulated within this literature as exhibiting distinctive types, not all of which are considered adaptive. Rather, at the heart of depressive vulnerability (Greenberg & Foerster, 1996) are thought to be the operation of secondary and primary maladaptive emotion schemes. So while all emotion states have the intrinsic potential to provide useful information (e.g., while the experience of shame may be negative, it has the potential adaptive value of regulating undesirable behaviour and preserving social relationships), important distinctions are made in EFT to differentiate whether the emotion scheme *type* currently activated has the capacity to transform depressogenic emotion schemes at the heart of a client's depressive vulnerability. The emotion scheme type assumed to be most likely to transform depressogenic emotion schemes in EFT theory is primary adaptive emotion.

Notice, therefore, that primary emotion in EFT is conceptualized as either

adaptive or maladaptive. Either adaptive or maladaptive primary emotion schemes are an individual's initial fundamental reaction to a situation. As such primary emotions are irreducible to other feelings. They can also occur either in or out of awareness. Adaptive primary emotions provide useful information about the current situation and orient the individual experiencing it towards the appropriate action necessary to meet his or her needs. They make coherent situational and biologically adaptive sense. In this way adaptive primary emotions encourage active problem solving, such as setting boundaries in response to anger at a violation, or seeking comfort and support after experiencing sadness at a loss. In contrast, maladaptive primary emotions are often over-learned responses to negative childhood or early adult experiences, often with core attachment figures.

Maladaptive primary feelings are responses that may once have served a useful purpose in the past, but when presently activated in current situations lead to responses that are now inappropriate (e.g., fear in response to affection from a past abuser is now activated in response to a loving other). As such, they do not provide useful information to guide present action for the adult. Because maladaptive primary emotions do not change with changing circumstances, they often leave the individual experiencing them feeling stuck, hopeless, and helpless (i.e., depressed). Present functioning is ruled by the past, and the newness and richness of the present moment is lost (Greenberg, 2010). At the core of maladaptive emotions is often a deep fear, such as fear of abandonment; shame at being unworthy or despicable; or terror in response to lack of physical or psychological safety (Timulak, 2015). The experience of these maladaptive emotions give rise to the

painful familiar feelings of loneliness, sadness, abandonment, insecurity, worthlessness, or inadequacy (Greenberg & Watson, 2006), that are at the core of an individual's depression. An EFT treatment target in depression is therefore to transform primary maladaptive emotion schemes by accessing alternative primary adaptive emotions (i.e., 'changing emotion with emotion'; Greenberg & Paivio, 1997).

Secondary emotions are conceptualized as emotional reactions or learned emotional responses to either adaptive or maladaptive primary emotion schemes. They can be triggered by initially experienced thoughts or feelings. For example, an individual who feels fear at the possibility of danger may subsequently experience the secondary emotion of anger or shame in response to the fear. From an EFT perspective secondary emotions require exploration in order to first, understand their protective function, and then to defuse the oft-irrational appraisals or meanings that trigger these secondary reactions. Even more importantly, the primary emotions underlying these secondary reactions need to be accessed (Greenberg & Watson, 2006); these potentially adaptive emotions can lead to awareness of important unmet needs and can guide effective action.

In summary, emotion schemes in EFT theory are specified as being primary (maladaptive or adaptive) or secondary. An important EFT goal is to help clients access primary *adaptive* emotions in order to transform the other maladaptive or secondary emotion scheme forms. According to the EFT model, the process of transforming depressogenic emotion schemes occurs by first becoming aware of maladaptive emotions (arriving at the pain), fully experiencing them, recognizing

hitherto unmet needs, and finally by experiencing alternative primary adaptive emotions. When clients are able to gain access to alternative, more adaptive emotion schemes and the self-organizations that co-occur with these schemes, this challenges primary or secondary maladaptive emotion states. Over time and with repeated access to adaptive emotion schemes, a more adaptive self-organization will emerge (Greenberg, Rice, & Elliott, 1993; Greenberg & Watson, 2006). Research examining in-session emotional experiences have found support for the EFT change principle of 'changing emotion with emotion', demonstrating that maladaptive emotion states are indeed transformed through the activation of alternative adaptive emotions. Herrmann, Greenberg, & Auszra (2014) found that higher proportions of sequences in which clients moved from primary maladaptive to primary adaptive emotions during the working phase of therapy predicted better outcomes in experiential treatment for depression.

To illustrate this emotional transformation process, we return to the example of the individual with a past history of sexual abuse who experiences maladaptive fear/terror in response to her current partner during moments of intimacy. This individual is guided during treatment to: become aware of these emotions of fear/terror and their origins; recognize how such fear made adaptive sense in the past; identify and access her previously unmet needs for safety and security; and activate the alternative, adaptive emotions of self-compassion or protective anger for having been abused, as well as perhaps sadness for innocence lost. These alternative adaptive emotional experiences are instrumental in the transformation of maladaptive emotion schemes, and result in the emergence of a more emotionally

flexible and resilient self-organization (Timulak, 2015).

How does accessing primary adaptive emotion transform depression? In experiential theory, change in emotion schematic structure is theorized to occur in therapy as new adaptive feelings are integrated into self-experience through the process of memory reconsolidation (Greenberg, 2010). A longstanding and widely accepted view of memory indicates that immediately after any learning experience there is a period of time in which the memory coherent with that learning is labile, after which the memory becomes permanent (Muller & Pilzecker, 1900). During the memory consolidation stage, it is possible to interfere with its formation; however, once this opportunity has passed, a memory can be altered but not eliminated. Recent alternative views of memory challenge this position and suggest that a memory structure is amenable to change each time it is retrieved during the subsequent reconsolidation period (Nader & Hardt, 2009). This suggests that during experiential treatment reprocessing painful maladaptive emotions allows the associated memories to be activated and potentially transformed. As such, the core EFT change principle of 'changing emotion with emotion' (Greenberg, 2002) is consistent with memory reconsolidation theory. Automatic operation of maladaptive primary or secondary emotion schemes can be altered through gaining new learning experiences and accessing alternative adaptive emotions in therapy, which are then consolidated into old existing memory structures. Eventually this can lead to reconsolidated new memories that integrate adaptive experiences into old narratives. Through this process new narratives and self-experiences are constructed.

CAMS Measure of Emotional Processing. A recent, alternative measure of emotional processing based on the emotion-focused theory of change (Greenberg & Paivio, 1997; Greenberg, 2002, 2010) called the Classification of Affective Meaning states (CAMS; Pascual-Leone & Greenberg, 2005) has been used to examine assumptions concerning emotion schematic change in EFT. The CAMS presents an optimal progression of affective meaning states that clients are assumed to take when they have good session and final outcomes in experiential therapy. In a mixed sample of depressed and emotionally injured clients treated with EFT, Pascual-Leone (2009) and Pascual-Leone and Greenberg (2007) showed that clients who achieved positive outcomes engaged in an emotional change process in which they moved from undifferentiated, overwhelming emotion states to more specific, advanced emotion states with greater affective regulation and elaborated meaning. While it has originally been used as a measure of specific categories of affective meaning states such as global distress, assertive anger or self-compassion, it has also recently been used to operationalize the EFT emotion schematic typology. That is, each affective meaning state captured by CAMS can also be classified as belonging to one of the secondary, primary maladaptive or primary adaptive emotion scheme types. By using CAMS as a measure of emotion scheme typology, Choi, Pos, & Magnusson (2015) found that increased access to primary adaptive emotion predicted better outcomes while increased proportions of secondary emotions predicted poorer outcomes in experiential treatment for self-critical depression.

Individual Differences among Depressed Clients

Another factor contributing to depressive relapse, recurrence, and response

variability to treatment (Westen & Morrison, 2001) may be the heterogeneity of the depressed population (Street, Sheeran, & Orbell, 1999). Current treatments may be failing to recognize or fully account for the impact of such client heterogeneity on the efficacy of therapy protocols. Depressive symptoms can be represented across several domains of human functioning: (1) cognitive: decreases in attention, concentration, and decision-making; (2) physiological: disruptions in appetite, sleep, and sexual functioning; (3) motivational: diminished interest in pleasurable activities or achievement of goals; and (4) affective: feelings of hopelessness, worthlessness, and depressed mood (APA, 2000; Greenberg & Watson, 2006). As such, depression is a complex disorder with multiple etiologies (Street et al., 1999), and can consequently be represented in a variety of symptom constellations. It follows that two depressed individuals presenting with different symptoms may require treatments that differ from each other. Moreover, not only are individuals depressed in different ways, they often enter therapy differing from each other on variables demonstrated to affect their ability to form alliances and engage in a treatment model. Such pre-therapy client characteristics include treatment expectations, attachment style, types of interpersonal difficulties, and personality traits (Meyer et al., 2002; Wong & Pos, 2012). Early evidence has demonstrated that treatments that achieve a match between particular clients and particular treatments produce better outcomes. Sotsky and colleagues (1991) investigated patient characteristics predictive of treatment response in a large NIMH clinical trial studying treatment for depression and found that clients with low cognitive dysfunction achieved better outcomes in cognitive-behavioral therapy, and clients

with low social dysfunction achieved better outcomes in interpersonal therapy.

Attention to and evidence for the idea that treatments need to match the clients who are receiving them has been growing steadily (Beutler, Clarkin, & Bongar, 2000). Ma and Teasdale (2004) have argued for example that the number of prior depressive episodes an individual experiences indicates different pathological etiologies, with clients who experience three or more depressive episodes representing a different subgroup from those who have experienced zero to two previous episodes. Wakefield and Schitz (2013) concur with this view, proposing that clients with more recurrent depressions suffer from an underlying pathology, over and above a simple reactivity to life stressors or environmental variables. They hypothesize that individuals with less recurrent depressions are sensitive to both positive and negative interpersonal interactions, and as such, the relationship between the therapeutic alliance and outcome is greater for these clients. Conversely, for individuals with more recurrent depressions, they argue that interpersonal experiences (as measured in treatment by the therapeutic alliance) are less important in predicting outcome in comparison to therapy processes that address the intrapsychic processes that are maintaining their pathology. Findings from a recent study examining the relationship between alliance and outcome support this hypothesis, with the number of previous depressive episodes moderating the positive relationship between alliance and outcome (Lorenzo-Luaces, DeRubeis, & Webb, 2014). The alliance was a predictor of outcome for only those clients who had two or fewer depressive episodes. These findings provide additional evidence that different processes of therapy help different clients.

In the current study the lifetime number of depressive episodes was limited to two or under. Therefore subtypes based on previous depressive experience are not relevant here. In addition to previous episodes of depression, however, there are other potential variables that may helpfully define relevant subgroups in the current sample.

Defining depressive subgroups. Depressive subgroups can be defined on the basis of distinctions in either content or process. Subgroups formed on the basis of content might differentiate individuals based on content distinctions such as shared core themes (i.e., anaclitic versus introjective depression in psychodynamic therapy; Blatt, 1974; Blatt, Shahar & Zuroff, 2001). Subgroups formed on the basis of process might parse individuals using distinctions that relate to common ways in which they relate to their experience, themselves, or to other people (i.e., being generally distant from or engaged with inner emotional experience; high or low social dysfunction). Sotsky and colleagues (1991) found evidence suggesting that clients with pre-therapy strengths in particular areas benefit from treatment models capitalizing on these strengths. As such, identifying clients who have pre-therapy strengths in emotional processing capacity might enhance outcomes in experiential therapy. Given that experiential therapy is a process-oriented therapy whereby the manner in which clients describe or relate to their inner experience is indicative of specific emotional processing difficulties, the focus of the current study will be examining subgroups based on distinctions in process.

Most process and outcome research on treatments for depression obtains information about average relationships among client processes and outcome. Yet

clinicians treat *specific*, not average, clients who may respond *variably* to treatment (Westen & Morrison, 2001). One could argue therefore that one treatment's process of change might be effective for one type of depressed client but be ineffective for another client, one with perhaps a different processing difficulty or depressive etiology. Even within treatments there may be several processes of change at work, with particular clients responding to or engaging in different change processes. It is incumbent on psychotherapy researchers to investigate these issues in order to establish optimal client to treatment process matches. The practice of matching particular clients to particular treatment processes or interventions has demonstrated promise in the field of anxiety. For example, for participants with public speaking anxiety who had emotion regulation deficits at baseline, exposure combined with affect labeling (a form of emotion regulation) was more beneficial in reducing physiological arousal than exposure alone, compared to participants who had pre-existing strengths in emotion regulation (Niles, Craske, Lieberman, & Hur, 2015). In contrast to previous findings in which clients benefited from therapies capitalizing on areas of strength (Sotsky et al., 1991), this study suggests that providing interventions targeting specific areas of deficit or weakness could also lead to improved treatment outcomes.

As such, one potentially useful approach to process research would be to focus on studying mechanisms of change for recognizable subgroups of depressed clients within given treatments, subgroups that may perhaps have different therapeutic needs and engage in different pathways to therapeutic change. In the present study another core aim is to examine whether subgroups of depressed

individuals who presented with early emotional processing differences engage in distinct processes of change in experiential therapy for depression. Initial research in this line of questioning has yielded promising findings. Pos (2006) found that increases in depth of experiencing (measured using the EXP scale) predicted twice the amount of outcome variance for clients who were lower in their early treatment capacity to process emotions (i.e., had lower initial EXP scores) compared to clients who entered therapy with more emotional processing skill (i.e., had higher initial EXP scores). Pos suggested that clients who were demonstrating higher experiencing skills in early therapy may have been engaging in a different change process, one not captured by the EXP measure. Subgroups of clients engaging in potentially different processes of change were thereby suggested.

Depressive Subgroups

At least two depressed subgroups are, in fact, suggested by Emotion-focused theory that relate to two general difficulties thought to lead to pathology (Pos, Greenberg & Elliott, 2008). *Experiential distance* is the tendency to be disconnected from one's internal experience. This leads to having a predominantly external focus on others, and being estranged from the potentially adaptive information found in one's emotional experience. This leads to depression because one is out of touch with one's interpretation of the world, one's personal needs within it, and the appropriate actions that are necessary to meet such needs. At the extreme, individuals of this type may struggle with *alexithymia*, a deficit in functioning in relation to emotion that expresses itself as the inability to access and describe feelings, as well as the tendency to be external in one's focus. Alexithymic

individuals are unable to find words to express their emotions, and such difficulties are associated with a range of psychiatric disorders, including depression (Whelton, 2004).

A second possible road to depression outlined by experiential theory is through the automatic functioning of core depressogenic emotion schemes (Greenberg & Watson, 2006) that were initially formed in response to early painful experiences. This likely leads to frequent unavoidable activation of unwanted and distressing emotional experiences, and then to experiences of helplessness, hopelessness, and subsequent depression. Rather than limited access to their internal worlds, these clients would have problematic access to it. If clients do indeed come into therapy with different emotional processing difficulties, then it is important for clinicians to recognize this and match the therapeutic interventions offered as well as perhaps differentially measure these processes of change (Beutler et al., 2000; Harmon, Hawkins, Lambert, Slade, & Whipple, 2005; Lambert, 1992, 2001; Lambert & Bergin, 1994; Lambert, Whipple, Hawkins, Vermeersch, Nielsen & Smart, 2003).

Overview of Current Study

The aim of the proposed study is to investigate emotional change processes that may be specific to each of the two above-mentioned depressed subgroups that have received short-term experiential treatment. The major hypothesis is that resolution of depression will occur in different ways for these two subtypes of depressed clients: Experientially distant clients will resolve their depressions by approaching, tolerating and internally focusing on their feeling experiences and by

obtaining the ability to articulate deeper adaptive emotions and needs more consistently. Alternatively, clients who are able to approach and articulate their inner experience but are experiencing chronic activation of depressogenic emotion schemes will resolve their depressions by accessing primary adaptive emotions that are assumed to transform the underlying maladaptive emotion schemes at the heart of their pathology.

*The Experiencing Scale: A Potential Best Emotional Processing Measure for
Experientially Distant Clients*

Encouraging the client's capacity to access internal experience has always been an important goal within experiential therapies. It has been a long-held assumption within experiential treatment that increasing awareness and exploration of one's emotions leads to adaptive change (Rogers, 1957). The Experiencing Scale (Klein, Mathieu-Coughlan, & Kiesler, 1986) is a process measure that has been frequently used to operationalize this capacity to access internal experience. The EXP scale measures the degree to which clients orient to, symbolize, and use their internal experiences as information during problem solving and meaning-making. The relationship between an individual's depth of emotional experience and outcome has been most extensively studied in experiential treatment (Greenberg & Korman, 2003; Pos, Greenberg, Goldman & Korman; 2005; Pos; Greenberg & Warwar, 2009), but also demonstrated in dynamic and cognitive treatments as well (Castonguay, Goldfried, Wiser, Raue & Hayes, 1996; Orlinsky & Howard, 1978; Silberschatz, Fretter, & Curtis, 1985). Clients who enter treatment high in experiencing or increase this ability during therapy have been shown to

achieve better outcomes (Seeman, 1996).

However, as suggested by Pos (2006), depth of emotional experience may be a better predictor of outcome for some clients than others, and increasing client experiencing may not be the sole pathway to change. Pos found that the amount of outcome variance explained by experiencing varied depending on clients' depth of experiencing early in therapy; more variance was explained for individuals who were low in early experiencing than for those who were high in early experiencing. Clients whose initial depth of experiencing were low are those that can be viewed as experientially distant, as their early therapy emotion narratives tended to be external in focus and to be devoid of feeling words or reports of internal experiences. These are clients who appear to be estranged from the fundamental adaptive information contained in their emotion experience at the beginning of therapy, and these clients increased their ability to orient to, talk about and explore their deeper adaptive feelings across the therapy process. General deepening of experiencing was therefore the emotional processing indicator that appeared to capture the necessary changes these clients made to resolve their depressions, and the relationship of experiencing to outcome was greater for these clients than for the sample as a whole.

However, for clients who entered therapy already attentive to and able to speak about their feelings, depth of experiencing predicted far less (nearly 50% less) of their improvement in depressive symptoms compared to the variance explained for low early experiencing clients. It can be argued that a possible explanation of this finding relates to a general limitation of the EXP measure - that it

captures the degree to which clients are experiencing emotion but not what specific emotions the client is engaged with. Because the EXP scale as a process measure is an 'emotion-category-free' measure of emotional process it may not have captured the important emotional processing changes that were occurring for early high experiencing clients, which as argued above may be the transformation of their depressogenic emotion schemes. For these clients, another emotional processing measure may be necessary to capture the alternate emotional processing pathway that they take to therapeutic change.

Classification of Affective Meaning States: A Potential Best Emotional Processing Measure for Experientially Engaged Clients

As suggested above, it is possible that for clients who enter therapy with greater capacity to access their emotional experience, their depression may arise due to the activation of problematic and unavoidable maladaptive depressogenic emotion states. For these clients, it may be the transformation of maladaptive emotion states through the accessing of alternative adaptive states that might predict good outcomes, rather than simply enhancing the depth to which they experience emotion. That is, transformation of maladaptive or secondary emotion schemes through the experience of specific adaptive emotion states may be the necessary process of change for these clients who already have the skill to get in touch with their inner experience. For example, a depressed individual who feels maladaptive shame and inadequacy in relation to the self is guided in therapy to articulate his unmet needs for acceptance and validation, and experience the adaptive emotions of grief, self-compassion or protective anger (Timulak, 2015).

Such emotions are hypothesized to transform the individual's depressogenic emotion schemes. The CAMS measure (Pascual-Leone & Greenberg, 2005) can capture such changes in emotion schemes across therapy, and may serve as a better emotional processing measure that could predict outcome for these clients.

Study Hypotheses

The primary goal of this study will be to compare two processes of change related to two client subgroups (experientially distant versus experientially engaged) that received experiential therapy for depression. These change processes will also be examined for their ability to predict long-term resilient gains in this treatment model. The specific hypotheses are:

1. For clients identified as experientially distant, outcome at therapy termination will be best predicted by depth of experiencing, as measured by the EXP scale. These clients are predicted to benefit by engaging in a process of change in which they generally deepen their emotional experience by becoming aware of and getting in touch with their emotions, and using their emotions as useful information for problem-solving.

2. For clients identified as experientially engaged, outcome at therapy termination will be best predicted by emotion scheme typology, as captured by the CAMS measure. These clients are predicted to benefit by engaging in a more specific and alternate change process of accessing adaptive emotions that are assumed to transform depressogenic emotion.

3. For both experientially distant and experientially engaged client subgroups, the relative power of depth of experiencing and emotion scheme typology as

measured by the EXP scale and the CAMS measure, respectively, to predict long-term resilient gains will be compared. It is hypothesized that outcome at 18-month follow-up will be best predicted by access to primary adaptive emotions as measured by the CAMS.

Chapter 2: Method

Participants

Participants were 55 clients who provided 18-month follow-up data after receiving short-term (16-20 sessions) experiential therapy for depression in two clinical trials at York University (Goldman, Greenberg, & Angus, 2006; Greenberg & Watson, 1998). Both trials tested the effectiveness of two experiential treatments for depression: Client-centered therapy (CCT) and Emotion-Focused Therapy (EFT). All clients met criteria for Major Depressive Disorder on the Structured Clinical Interview (SCID; Spitzer, Williams, Gibon & First, 1989) for the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R; APA, 1987) and had a Global Assessment of Functioning (GAF) score of at least 50. Exclusion criteria included: current treatment or medication for depression; three or more episodes of depression; current drug or alcohol abuse; current eating disorder, antisocial or borderline personality disorder; bipolar or psychotic disorder; a past history of incest; recent suicide attempts; loss of a significant other in the past year; or ongoing involvement in a physically abusive relationship. Only clients for whom termination and 18-month follow-up data were available were used in this study. This was to enable examination of the predictive power of the proposed change mechanisms on long-term outcome.

Establishing Depressive Subgroups

Clients were classified as experientially distant or experientially engaged based on their early (session two) modal EXP ratings. These ratings were obtained from archival data (Pos, 2006). An EXP rating of 3 was chosen as the criterion to

demarcate between client subgroups based on a theoretical argument. EXP ratings below Level 3 denote client narratives that are predominantly external and lack emotion vocabulary; in contrast, EXP ratings above 3 indicate that client narratives contain the use of emotion words, signifying that the client can refer to and describe their inner subjective feelings to some degree.

Clients whose early modal EXP rating in session two was below 3 were classified as experientially distant, and those whose modal EXP ratings were 3 or above were classified as experientially engaged. Forty-two clients were classified as belonging to the experientially distant (ED) subgroup, while 13 clients were classified as belonging to the experientially engaged (EE) subgroup.

Client Demographics

Clients in the ED subgroup ($n = 42$) consisted of 28 women and 14 men; the clients in the EE subgroup ($n = 13$) consisted of 7 women and 6 men. The mean age of the ED subgroup was 41.5 years old ($SD = 10.59$), and the mean age of the EE subgroup was 33.9 years old ($SD = 7.63$). Clients in the EE subgroup were significantly younger than those in the ED subgroup ($t = 2.39, p < .05$). However, there was no significant relationship between age and either emotional processing variable ($ps > .05$). No differences between subgroups were found in marital status, educational status, presence or type of personality disorder, or form of therapy received (CCT or EFT) (all $ps > .05$).

Therapists

Twenty-two therapists provided treatment in this study. They were 19 women and 3 men. Twelve of these therapists were advanced clinical psychology

doctoral students, nine had PhDs in Clinical Psychology and one was a psychiatrist. Therapists were trained in both CCT and EFT and provided treatment in both conditions; therapists served as their own controls by seeing an equal number of clients in each condition. Since there was an inadequate client to therapist ratio to support analyses at the level of therapist, the current study does not address therapist effects.

Treatments

Clients in the original two clinical trials were randomly assigned to receive either CCT or EFT. While tasks within the two treatments differ as therapy progresses, in early sessions both CCT and EFT aim to build strong empathically attuned alliances and to deepen clients' emotional process to promote change. As such, in both CCT and EFT treatments the emphasis in the first three sessions is to establish a strong therapeutic bond and an environment within which clients can safely approach and process their emotional experiences (Pos et al., 2008). Active interventions are introduced in EFT only after the third session of therapy when it is assumed that the therapeutic relationship has been established. Adherence to both CCT and EFT were achieved in the original trials (Goldman et al., 2006; Greenberg & Watson, 1998).

Client-centered therapy (CCT). In CCT therapists provide three necessary facilitative relationship conditions: unconditional positive regard, empathy, and congruence. The treatment followed a manual of Client-centered therapy based on Rogers (1957, 1975; Greenberg, Rice, & Watson, 1994). Therapists follow the clients' internal

track, communicate empathy, facilitate exploration, encourage symbolization of core meaning and increase emotional awareness.

Emotion focused therapy (EFT). EFT provides a client-centered relationship while using marker-guided, process directive interventions developed as the result of integrating gestalt and experiential therapies (Greenberg, Rice and Elliott, 1993; Greenberg & Watson, 2006). The first three sessions provide client-centered conditions. Following this and while maintaining a client-centered relationship, specific emotional problem markers are used to determine matched interventions. The six interventions used are: (1) two-chair dialogue for internal splits; (2) empty-chair dialogue for unfinished business with a significant other; (3) focusing on an unclear felt sense; (4) empathic affirmation in response to vulnerability; (5) self-soothing for distress; and (6) systematic evocative unfolding for problematic reactions.

Pre/Post-treatment Measures

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

The BDI is 21-item self-report measure that has been used widely to assess depressive symptomology. Its internal consistency ranges from .73 to .92 with a mean of .86, and has demonstrated good discriminant and concurrent validity (Beck, Steer, & Garbin, 1988). Residual gain scores on the BDI were used to capture client change at both termination and 18-month follow-up. That is, outcome at 18-month follow-up was measured as the client's residual score from a regression of 18-month depression scores on pre-treatment depression scores. As such, this was not a measure of maintenance of gains between termination and follow-up, but of

outcome measured at 18-month follow-up. Outcome of experiential therapy for depression was thus measured in two ways: at termination of treatment and at 18 months after termination that ignored termination scores. For a more detailed description of how residual gain scores were chosen as the measure of outcome, please see Appendix B.

Emotional Processing Measures

The Experiencing Scale (EXP; Klein, Mathieu-Coughlan, & Kiesler, 1986). The EXP scale measures the degree to which clients' orient to, symbolize, and use general internal experience as information when problem-solving. When the EXP scale is applied to emotion episodes (EEs; Korman, 1991), it has been used to operationalize the emotional processing continuum (Pos, Greenberg, Goldman, & Korman, 2003). When applied in this way, experiencing scores in the early, working phase, and late phases of therapy have all been shown to predict outcomes with early phase experiencing's effect on outcome consistently being mediated by later measures (Pos et al., 2003; Pos et al., 2009). Some specific levels of experiencing have also been demonstrated to predict positive outcome in the experiential treatment of depression (Adams, 2010; Pos, 2006). Raters use grammatical, expressive, paralinguistic, and content distinctions to classify segments of client narrative according to a 7-point ordinal rating scale. Ratings 1–4 describe the progressive movement of client orientation from external to internal referents. Ratings 5–7 denote progressive use of inner perspectives in affective problem solving. Inter-rater reliability coefficients have been reported to range from .76 to .91. Segment length does not significantly affect experiencing ratings, and re-rating correlation

coefficients of .80 have been reported (Klein et al., 1986). Experiencing scores in this study reflect the use of the EXP scale applied to emotion episodes. For a detailed description of the Experiencing Scale and information on how distinguish between levels of experiencing, please see Appendix A.

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

The CAMS is an instrument developed for the observation and measurement of specific emotion states demonstrated to be important in the emotional change process. It is applicable during psychotherapy events in which the client is emotionally engaged and aroused. Ten discrete emotional states are captured (in an assumed order of ascending productivity and depth of emotional processing): (1) Global Distress (GD), which describes instances of overwhelming and undifferentiated distress; (2) Rejecting Anger (RA), which captures distancing and destructive anger; (3) Fear/Shame (FS), which captures core maladaptive pain related to inadequacy, worthlessness, or insecurity; (4) Negative Self-Evaluation (NSE), which describes the expression of a specific self-criticism; (5) Need, which captures the articulation of unmet essential needs for healthy functioning; (6) Relief, which captures client expressions of feeling better, lighter, or more hopeful; (7) Assertive Anger (AA), which captures adaptive boundary setting or healthy entitlement to existential needs; (8) Self-Soothing (SS), which describes clients' self-directed compassion or nurturance; (9) Hurt/Grief (HG), which captures client acknowledgement of core pain, sadness, or loss; and (10) Acceptance and Agency (AcAg), which describes client expressions of coming to terms with their circumstances or the development of a new, agentic perspective. The complete

CAMS manual can be accessed online at:

http://www1.uwindsor.ca/people/apl/system/files/Pascual-Leone_and_Greenberg,2005,CAMSmeasure.pdf.

Transforming CAMS Categories to Emotion Scheme Types

Previous research (in consultation with the author of the CAMS) has also used the CAMS to measure emotion schematic types (Choi et al., 2015). In the current study I followed the method of Choi et al. and also classified CAMS codes as belonging to emotion schematic types. The secondary emotion category was comprised of CAMS Global Distress (GD) and Rejecting Anger (RA) codes; the primary maladaptive emotion category was comprised of CAMS Fear/Shame (FS) and Negative Self-Evaluation (NSE) codes; and the category of primary adaptive emotion was comprised of CAMS Relief (RE), Hurt/Grief (HG), Assertive Anger (AA), Self-Soothing (SS), and Acceptance and Agency (ACAG) codes. The CAMS Need code was maintained as a separate category due to its unique significance in EFT theory as being a necessary precursor to accessing primary adaptive emotion (Greenberg & Watson, 2006). Most analyses in this study reflect the use of these emotion schematic types. It will be identified when individual CAMS codes were specifically examined.

Emotion Episodes

The context within which emotional processing was measured using both the EXP scale and the CAMS was during emotion episodes (EEs; Greenberg & Korman, 1993; Korman, 1991). An EE is a segment of psychotherapy narrative in which a client speaks about having experienced emotion in response to a real or imagined

situation. A complete EE contains five components: the situation, an emotional response, an action tendency associated with the emotion, an appraisal of self or situation, and a related concern or need. For an EE to be identified, only the emotional response or action tendency and a reported situation are required (Pos et al., 2009). In the original process research (see Pos et al., 2009), EEs were exhaustively sampled for all 74 York 1 and York 2 clients during five sessions per client: session two (the early phase of treatment); two sessions between session four and the fourth last session that the client identified as the most helpful on session outcome measures (the working phase of treatment); and the second and third last sessions (the late phase of treatment). The EEs in the two working phase sessions were rated for client depth of experiencing and emotion scheme typology using the EXP scale and the CAMS measure, respectively.

Procedure

Emotion Episode Sampling

Emotion episodes in the beginning, working, and termination phases of treatment were initially identified in Pos (2006) by a primary rater. To obtain reliability, two other EE raters identified the emotion episodes for 120 transcripts (70 and 50 sessions, respectively). Agreement was considered to have occurred if there was consensus on the situation identified, as well as the emotional reaction to it. Reliability was then measured as a percentage based hit-rate of accurately identified and agreed-upon emotion episodes. For a full description of EE identification, please see Pos (2006).

Experiencing Ratings

Client experiencing ratings used in this current study were taken from archival data (Pos et al., 2009). In the original research, experiencing ratings were sampled from five sessions during three phases (early, working, and late) of therapy. Three raters were used in the original study; all raters were senior doctoral clinical psychology students. All EEs in each session were rated for client depth of experiencing, with each EE being given a modal as well as a peak experiencing score. Experiencing scores were then averaged across each session. In the working and termination phases the average experiencing rating for each of the two sessions were again averaged to result in an average experiencing rating for that phase of therapy. Since previous research has indicated that the strongest predictor of outcome were experiencing ratings from the working phase of therapy (Pos et al., 2009), only working phase experiencing ratings were examined in the current study in relation to outcome. Beginning and termination phase experiencing ratings were examined to see if how and how experiencing changed across therapy between depressive subgroups. For working phase analyses, both peak and modal experiencing ratings were examined but only the modal analyses will be reported as they represent the most frequent levels of experience, which could be argued likely better reflect clients' stable individual differences. Peak analyses also did not produce differences of note, except for two analyses. This will be noted below in the Results.

CAMS Sampling Procedure

The same EEs within the two working phase sessions for which experiencing ratings had been previously completed (Pos et al., 2009) were coded in the current

study for CAMS. This allowed for the two measures of emotional processing to be compared for their relative power to predict termination and long-term outcomes.

CAMS Ratings

Three raters were used in this study to code CAMS: two senior doctoral students and a professor, all of whom were members of the Clinical Psychology program at York University and who had received extensive training in CAMS coding from the measure's developer, Dr. Antonio Pascual-Leone. The CAMS training was completed over three separate sessions, culminating in 25 hours of training in total.

Out of the 110 sessions included in this study, 100 sessions were coded by two raters (~91%); 10 sessions were coded by one rater after reliability was established (5 sessions each). All coding was conducted independently, and all CAMS-rated EEs that were coded by two raters were included in the reliability calculations. Disagreements in codes were resolved consensually, and original codes were used for reliability analyses. Raters A and B completed ratings for 74 sessions together (1264 CAMS ratings); raters B and C completed ratings for 26 sessions together (558 CAMS ratings). Raters A and B each completed ratings for five sessions individually after reliability between the two coders was established.

Chapter 3: Results

Data Preparation

All variables were examined and found to be normally distributed with no assumptions of normality violated. For depression scores at termination and at 18-month follow-up, one client at each time point was found to be an outlier (scores greater than 2.5 standard deviations above the mean on the BDI) and each was excluded from analyses examining outcome at that time point.

Inter-rater Reliability

Emotion episode sampling. Reliability for emotion episode sampling was established in Pos (2006). A sample of 120 sessions including beginning, working and termination phases was used to establish reliability. Reliability was measured as a percentage based hit-rate of accurately identified and agreed-upon emotion episodes. The average hit rate for identifying emotion episodes was 92%.

Rater-reliability of Experiencing (EXP) ratings. Reliability for EXP ratings was also previously established in Pos (2006). The average weighted Cohen's kappa between a primary and two other reliability raters was .79 for modal experiencing ratings and .82 for peak experiencing ratings.

Rater-reliability of CAMS ratings. Cohen's (1960) kappa (k) was used to measure inter-rater agreement on the CAMS, as it is a nominal scale. For CAMS ratings, Cohen's k was .77 between raters A and B (who rated the majority of EEs), and was .88 between raters B and C. Inter-rater reliability between both pairs of raters were above .75, which is considered excellent beyond chance (Fleiss, 1981).

Differences between Current Study Sample and Overall York 1 & 2 Study

Sample

In order to establish that the current study sample of 55 clients who provided follow-up data was representative of the original 74 clients in the York 1 and 2 clinical trials, differences between those clients who did ($n=55$) and did not ($n=19$) provide 18-month follow-up data were examined. These groups were compared on their pre-treatment and termination depression scores, as well as their modal and peak experiencing scores in the early, working phase, and termination phases of therapy. No differences were found between those clients who did and did not provide 18-month follow-up data on all variables (all $ps > .05$).

Differences between Experientially Distant (ED) and Experientially Engaged (EE) Subgroups on Demographic, Process, and Outcome Variables

In order to establish that the ED and EE subgroups did not differ on variables that might impact the validity of current tests, differences were explored in demographic, process, and outcome variables to ascertain that random assignment had been successful.

Differences between Subgroups in Demographic Variables

As reported above, clients in the EE group were significantly younger than those in the ED group ($t = 2.39, p < .05$). However, no significant relationships between age and either emotional processing variable (EXP and CAMS; $ps > .05$) were found. No differences between subgroups were found on any other demographic variable or treatment assignment ($ps > .05$). For this reason these variables were not further considered in analyses.

Differences between Subgroups in Modal Experiencing across time

That the subgroups were meaningfully different on experiencing scores was first validated using a mixed ANOVA analysis. This examined whether there were differences in experiencing scores between depressive subgroups across the beginning, working, and termination phases of therapy. There was a statistically significant interaction between depressive subgroup and treatment phase on modal experiencing, $F(2, 106) = 8.37, p < .01, \text{partial } \eta^2 = .14$. There was a statistically significant difference in modal experiencing scores between subgroups at the beginning of therapy, $F(1, 53) = 66.71, p < .01, \text{partial } \eta^2 = .56$. As expected, clients in the ED group had experiencing scores ($M = 2.59, SD = .24$) that were significantly lower than clients in the EE group ($M = 3.22, SD = .26$). There was also a statistically significant difference in experiencing scores between subgroups in the working phase of therapy, $F(1, 53) = 4.47, p < .05, \text{partial } \eta^2 = .08$. Experiencing scores for clients in the ED group were again lower ($M = 2.83, SD = .33$) than those in the EE group ($M = 3.05, SD = .35$). Finally, there was a statistically significant difference in experiencing scores between depressive subgroups in the termination phase of therapy, $F(1, 53) = 4.79, p < .05, \text{partial } \eta^2 = .08$. Clients in the ED group had lower experiencing scores ($M = 2.93, SD = .39$) compared to clients in the EE group ($M = 3.19, SD = .37$).

There was also a statistically significant effect of treatment phase on modal experiencing for the ED subgroup, $F(2, 82) = 7.55, p < .01, \text{partial } \eta^2 = .33$. For the ED subgroup, there was a significant increase in modal experiencing scores from the beginning to the working and termination phases of treatment. However, there was

no significant increase in modal experiencing scores between the working and termination phases of treatment.

There was no statistically significant effect of treatment phase on modal experiencing for the EE subgroup, $F(2, 24) = 2.39, p > .05$, partial $\eta^2 = .17$. For the EE subgroup, there were no changes in modal experiencing scores from the beginning to the working and termination phases of treatment. There was also no significant change in modal experiencing scores between the working and termination phases of treatment.

Differences between Subgroups in Peak Experiencing Across Treatment

There was a statistically significant interaction between depressive subgroup and treatment phase on peak experiencing, $F(2, 106) = 6.42, p < .01$, partial $\eta^2 = .108$.

There was a statistically significant difference in peak experiencing scores between subgroups in the beginning phase of therapy, $t(1, 53) = -6.97, p < .01$. Clients in the ED subgroup at the beginning of therapy had lower peak experiencing scores ($M = 3.17, SD = .19$) than those in the EE subgroup ($M = 3.60, SD = .21$). There were no significant differences between depressive subgroups on peak experiencing in either the working or termination phases of therapy (all $ps > .05$).

There was a statistically significant effect of treatment phase on peak experiencing for the ED group, $F(1, 42) = 59.41, p < .001$, partial $\eta^2 = .592$. For the ED subgroup, there was a significant increase in peak experiencing scores from the beginning ($M = 3.17, SD = .19$) to working phase ($M = 3.35, SD = .24$) time points, and also a significant increase from the beginning to the termination ($M = 3.52, SD = .31$)

time points. The increase in peak experiencing scores from the working to termination time points was also significant ($p < .01$).

There was a statistically significant effect of time on peak experiencing for the EE group, $F(2, 24) = 4.17, p < .05$, partial $\eta^2 = .258$. For the EE subgroup, peak experiencing scores were not significantly different between the beginning ($M = 3.60, SD = .21$) and working phase time points ($M = 3.50, SD = .31$), and not statistically different between beginning and termination ($M = 3.69, SD = .33$) time points. However, peak experiencing scores did significantly increase between working and termination phase time points ($p < .01$).

Differences between Subgroups in Depression Across Time

A second mixed ANOVA analysis was completed to examine whether there were differences between ED and EE subgroups in depression scores at pre-treatment, termination and 18-month follow-up. There was no statistically significant interaction between depression scores and subgroup, $F(2, 102) = 1.72, p = .18$, partial $\eta^2 = .03$. Thus, there were no differences between subgroups in their depression scores either before treatment, at treatment termination, or at follow-up.

The main effect of time showed a statistically significant difference in depression scores at the different time points, $F(2, 102) = 97.58, p < .01$, partial $\eta^2 = .66$. There was a statistically significant decrease in depression scores from pre-therapy ($M = 24.96, SD = 6.03$) to the termination ($M = 7.52, SD = 5.89$) and follow-up ($M = 9.51, SD = 8.13$) time points for the entire sample. There was no significant difference in depression scores from the termination to follow-up time points.

Finally, there was no significant main effect of depressive subgroup, indicating that there were no differences in depression scores between the ED and EE subgroups, $F(1, 51) = .42, p > .05$, partial $\eta^2 = .01$. Both depressive subgroups improved in this treatment for depression.

Differences between Subgroups in CAMS Categories and CAMS Emotion Scheme Types

Differences between ED and EE groups in individual CAMS categories during the working phase of therapy are presented in Table 1. Differences between depressive subgroups in mean proportions of CAMS-derived emotion scheme (ES) types during the working phase of therapy are presented in Table 2. No significant differences were found between ED and EE groups (all $ps > .05$) on either individual CAMS categories or ES types.

In preparation for regression analyses, Pearson correlations were conducted to examine the relationships among working phase experiencing, CAMS, and depression scores at termination and 18-month follow-up. These correlations were conducted for the entire sample (Table 3), as well as for experientially distant (Table 4) and experientially engaged (Table 5) subgroups.

Regression Analyses

Although there were no explicit hypotheses concerning the entire sample in relation to termination or 18-month follow up, regression analyses began by examining emotional processing predictors for the entire sample. This is because no previous research had yet compared the relative predictive power of these two emotional processing measures.

For all regression analyses examining depression scores at termination and at 18-month follow-up, experiencing is entered as a predictor of outcome first, due to its established relationship to outcome (Pos, 2006). Following this, CAMS emotion scheme variables are entered into the model. If any CAMS emotion scheme variables were found to be a significant predictor of outcome, then the individual CAMS component variables that contributed to the emotion scheme category were further examined. For example, if the secondary emotion scheme was a significant predictor, then a later analysis examined the unique contribution of the two CAMS categories (Global Distress and Rejecting Anger) that had been summed to create the secondary emotion scheme category.

Emotional processes predicting termination outcome for the entire sample

The results of the first regression analysis examining experiencing and CAMS as predictors of outcome for the full sample are presented in Table 6. The full model was significant, $F(5, 48) = 4.63, p < .01$. The final model indicates that while experiencing is a significant predictor on its own in Step 1, it is no longer significant when the CAMS emotion scheme categories are added to the model. The only significant unique predictor in the full model was secondary emotion, and its relationship to depression was positive, indicating that its occurrence signified higher depression at termination.

Given the strength of secondary emotion as a predictor in the previous regression, and that experiencing drops out as a significant predictor when CAMS is added to the model, a second hierarchical regression examined whether secondary emotion mediates the relationship between experiencing and depression scores at

termination. Insignificant CAMS codes were dropped from the model as well. This model is presented in Table 7. The predictors were only experiencing in Step 1 and CAMS secondary emotion was added in Step 2. Experiencing was still a significant and unique predictor in Step 1. However, when secondary emotion is entered in the final step, experiencing drops out as a significant predictor, supporting the hypothesis that secondary emotion mediates the relationship between experiencing and outcome.

The two previous models appear to demonstrate that for the entire sample in general, CAMS emotion scheme variables (and in particular, secondary emotion schemes) are a better predictor of depression at termination than experiencing.

Since experiencing was never maintained as an independent predictor of termination outcomes, an additional regression model for the entire sample removed experiencing from the model in order to more specifically examine the predictive impact of emotion scheme types on outcome. In particular, it was examined whether secondary emotion mediated the impact of other CAMS emotions scheme types on outcome. This model is presented in Table 8. In this model all CAMS emotion types except secondary emotion were entered in Step 1 and secondary emotion was added in Step 2. The model was not significant in Step 1, although the beta coefficient of primary adaptive emotion was large. The final model was significant in Step 2 with the addition of secondary emotion, which was the only significant unique predictor.

A question remained whether particular components of primary adaptive emotion would be more important to predicting termination outcomes than others.

Since primary maladaptive emotion and need never predicted outcome in previous analyses a final regression model predicting termination outcome was performed with only CAMS primary adaptive emotion components in Step 1 and then adding secondary emotion components in Step 2. Primary adaptive emotion and secondary emotion categories are each broken down into their component types (primary adaptive emotion into hurt/grief and assertive anger; secondary emotion into global distress and rejecting anger). For primary adaptive emotion, only hurt/grief and assertive anger were examined as each of these emotions has EFT theoretical significance to outcome (Greenberg, 2002, 2010; Pascual-Leone & Greenberg, 2007). The results of this analysis are presented in Table 9. Only the final model in Step 2 is significant, $F(4,49) = 7.09, p < .01$. Assertive anger, global distress, and rejecting anger are each *unique* significant predictors of depression at termination. Assertive anger predicted lower depression scores; global distress and rejecting anger predicted higher depression scores at termination. Thirty seven percent of the termination outcome variance is explained by these variables.

Emotional Processes Predicting Termination Outcome for Experientially Distant and Experientially Engaged Client Subgroups

Regression analyses were then conducted to examine the comparative power of CAMS and experiencing to predict termination outcome for experientially distant versus experientially engaged client subgroups.

Experientially Distant Client Subgroup

The results of the first hierarchical regression analysis examining whether experiencing or CAMS better predicts depression at termination for experientially

distant clients is presented in Table 10. Experiencing is entered in Step 1, and CAMS emotion scheme categories entered in Step 2. Both steps yielded significant models. As was found for the entire sample, experiencing is a significant predictor of outcome for experientially distant clients only when considered alone. Among the CAMS emotion scheme predictors, secondary emotion is once again the sole independent predictor of depression at termination in the full model.

As secondary emotion continued to be a strong predictor of outcome for this subgroup, another hierarchical regression model examined whether secondary emotion mediates the relationship both between experiencing and outcome, as well as between other CAMS categories and outcome. The only change from the previous model was that secondary emotion was entered in Step 3. The results are presented in Table 11. For experientially distant clients, experiencing is not a significant predictor in Step 2, even without the inclusion of secondary emotion. Experiencing appears to lose its predictive utility once any CAMS variables are entered into the model. In the full model in Step 3, secondary emotion again appeared as the only CAMS emotion scheme category that independently predicted outcome.

Since experiencing was virtually totally mediated by CAMS categories in the previous model, a final regression model tested the predictive impact of only CAMS emotion schemes on outcome, maintaining a Step 2 entry of secondary emotion. The results of this analysis are presented in Table 12. The model was significant in Step 1, $F(3, 37) = 3.08, p < .05$; primary adaptive emotion was the sole significant and unique predictor. In Step 2, after secondary emotion was entered into the model, the full model was again significant, $F(4, 36) = 5.92, p < .01$. The inclusion of secondary

emotion, however, led to primary adaptive emotion dropping out as a significant predictor. Secondary emotion is the only significant and unique predictor; it mediates the relationship between primary adaptive emotion and depression at termination for this subgroup.

A final hierarchical analysis exclusively examined which specific components of primary adaptive emotion and secondary emotion predict depression at termination for this experientially distant subgroup. Only specific emotion components were examined due to their significance in EFT theory. The results of this analysis are presented in Table 13. In Step 1, the components of primary adaptive emotion (hurt/grief and assertive anger) were entered into the model; in Step 2, the components of secondary emotion (global distress and rejecting anger) were entered to test whether they would again mediate the components of primary adaptive emotion. While both steps in the model were significant, in Step 1 neither hurt/grief nor assertive anger were significant independent predictors. However, in the full model after the addition of secondary emotion components, assertive anger, global distress, and rejecting anger were all found to be significant and unique predictors of depression at termination. Assertive anger again predicted lower depression scores; while global distress and rejecting anger predicted higher depression scores.

Experientially Engaged Subgroup

The first hierarchical regression for the experientially engaged subgroup tested the relationship between experiencing, CAMS categories, and depression at termination. It is presented in Table 14. Only the Step 1 model was significant, and

in that model experiencing significantly predicts termination outcome when it is the sole predictor. However, once the CAMS emotion scheme variables are added in Step 2, the full model is non-significant. When considered together, neither experiencing nor CAMS variables are significant unique predictors of depression at termination for this subgroup.

Given that modal experiencing was not a predictor of outcome once CAMS categories were included in the model for this subgroup I also examined peak experiencing as a predictor with CAMS codes in a two-step hierarchical regression. Results of this regression can be seen in Table 15. Both Step 1 and Step 2 of the models were significant, and peak experiencing is a significant predictor of termination outcome in both steps. In Step 2, CAMS primary adaptive emotion is also a significant predictor, predicting higher depression scores at termination.

Emotional processes predicting 18-month follow-up outcome for the entire sample

In order to examine whether experiencing or CAMS better predicts long-term resilient gains, regression analyses were conducted regressing experiencing and CAMS emotion scheme variables on depression scores at 18-month follow-up for the entire sample. The results of this analysis are presented in Table 16. Following previous analyses, experiencing is entered as the first predictor followed by the CAMS categories in Step 2. Both steps in the model were significant. In Step 1, experiencing is a significant predictor when considered alone. However, in Step 2, experiencing is no longer significant, and primary adaptive emotion emerges as the sole significant and unique predictor for longer-term gains; its inclusion explains an additional 19% of the outcome variance over and above experiencing alone. Higher

proportions of primary adaptive emotion predict lower depression scores at 18-month follow-up.

Given that experiencing was not a significant unique predictor of long-term outcome in the previous full model, a hierarchical regression analysis using only CAMS emotion scheme variables was conducted. The results of this analysis are presented in Table 17. In this regression, secondary emotion, primary maladaptive emotion, and needs are entered into Step 1; primary adaptive emotion is added in Step 2 to examine whether it mediated the impact of other CAMS emotion scheme categories. Both steps of the models were significant. Primary adaptive emotion remained the only unique and significant predictor in the final model; its inclusion explained an additional 12% of the outcome variance and interestingly now mediated the relationship between secondary emotion and depression at 18-month follow-up.

A final hierarchical regression analysis examined whether CAMS contributors to primary adaptive and secondary emotion scheme variables specifically predict depression at 18-month outcome for the entire sample. These results are found in Table 18. The model was significant; global distress predicted higher depression scores and assertive anger uniquely predicted lower depression scores at follow-up.

Emotional Processes Predicting 18-Month Follow-up Outcome for the Experientially Distant Subgroup

A hierarchical analysis regressing experiencing and CAMS on depression at 18-month outcome is displayed in Table 19. As with previous analyses,

experiencing is entered in Step 1, and is followed by the CAMS emotion scheme variables in Step 2. In Step 1, experiencing alone is not a significant predictor of long-term resilient gains. Emotion scheme variables, after being added in Step 2, however, are. The final full model is significant. Once again, as found for the entire sample, primary adaptive emotion was the only significant and unique predictor, indicating that its occurrence in the working phase of treatment predicts lower depression scores 18 months after treatment termination.

A following hierarchical regression examined which specific CAMS emotion components predicted long-term outcome. This is presented in Table 20.

Experiencing was dropped from this model as it was not related to outcome in the previous model. The full model was significant. In contrast to what was found for the full sample, for the experientially distant subgroup, rejecting anger was the only significant unique predictor of long-term depression scores, and assertive anger showed a trend towards significance for predicting long-term depression scores.

Experientially Engaged Client Subgroup

A hierarchical analysis regressing experiencing and CAMS emotion scheme variables onto long-term depression scores for experientially engaged clients is presented in Table 21. As with the experientially distant subgroup analyses, experiencing was entered in Step 1 and the CAMS variables entered in Step 2. In Step 1 the standardized beta coefficient of experiencing appears to indicate that this variable is strongly related to outcome, however the model is not significant. The full model was not significant, despite the standardized beta coefficient for experiencing remaining large.

As with termination analyses for this sub-group, because modal experiencing was not related to outcome, the next regression model used peak experiencing as a predictor. These results are found in Table 22. Peak experiencing was entered in Step 1 of the model; this model was significant and peak experiencing was a significant predictor of long-term outcome on its own. However, in Step 2 with the addition of CAMS emotion scheme categories, the full model was no longer significant.

Due to the original hypothesis that depth of experiencing would predict long-term outcomes (albeit for the other subgroup), a final regression model tested whether peak experiencing at Level 6 would predict outcomes for the experientially engaged subgroup. Level 6 EXP was chosen as the predictor as this category is coded when the client is describing an altered perspective of their problem, or has reached some resolution to it already. Level 6 may be representative of emotion schematic change that has already occurred, upon which the client is reflecting. In this regression model, peak experiencing at Level 6 is the only predictor. This model is presented in Table 23, and it is significant. Peak experiencing at Level 6 explains a large amount of the long-term outcome variance for this EE subgroup ($\beta = -.63$).

Chapter 4: Discussion

This study examined the hypothesis that different client subgroups (identified as either experientially distant or experientially engaged) engage in distinct emotional change processes during experiential therapy for depression. It was also hypothesized that these distinct emotional change processes would be best captured using different emotional processing measures, which would differentially predict outcome for these subgroups. As emotionally distant clients have been shown to benefit from deepening experiencing when outcome is measured at termination (Pos, 2006), the original hypothesis predicted that depth of experiencing, as measured by the EXP scale, would be a better process predictor for this subgroup. This was because experientially distant clients were assumed to experience depression related to a general distance from the adaptive information within their emotional experience. As such, increasing access to emotional experience was presumed to be the change process most likely to relieve their depression. Alternatively, it was predicted that emotion scheme typology, as measured by the CAMS, would be a better process predictor for the experientially engaged subgroup. For these clients, it was assumed that they were suffering depression related to activation of maladaptive emotion schemes. As such, it was hypothesized that the CAMS would better capture the access to primary adaptive emotions from which these clients were expected to benefit. Finally, these two emotional processing measures (the EXP and the CAMS) were compared for their relative power to predict outcome at termination as well as at 18-month follow-up for the entire sample.

Unexpectedly, results opposite to the hypotheses were found. Emotion scheme typology was a better predictor of termination and long-term outcome for the experientially distant subgroup, and depth of experiencing a better predictor of termination and long-term outcome for the experientially engaged subgroup. In particular, depth of experiencing was a better predictor for the experientially engaged subgroup when looking at specific levels of peak as opposed to modal experiencing scores. While these results were opposite of what was originally predicted, they still support the contention that experientially distant and experientially engaged subgroups represent distinct types of depressed clients at pre-treatment who undergo unique pathways to change. However, these results also generate questions as to what the EXP and the CAMS measures truly capture in terms of the work depressed clients are engaging in during experiential treatment.

This study also provided some additional support for experiential (CCT/EFT) therapy change principles, adding to the existing research literature that has already demonstrated that depth of experiencing and emotion schematic change both occur during experiential therapy and are powerfully related to outcome in this psychotherapy model. However, most importantly, this study has demonstrated for the first time that not only are both depth of experiencing and emotion scheme typology linked to outcome at therapy termination, but also that these variables/measures can predict clients' depression scores 18 months after they have finished treatment. In the following sections I discuss these and other findings, as well as the theoretical and clinical implications, limitations, and potential future directions of this study.

Hypothesis One: Experiencing will best predict outcomes for experientially distant clients

Depth of experiencing was originally hypothesized to be the optimal emotional processing predictor for experientially distant clients based on an assumption that this subgroup was initially detached from the potentially adaptive information implicit within their inner experience. This detachment was measured by their average tendency at the beginning of therapy to not use emotion words and to be externally focused in their narratives. Since clients are encouraged in this treatment to gain greater awareness of their emotional experience, and to symbolize the information and meaning held within it, it was assumed that increases in experiencing would best capture the change process that these clients would perhaps most benefit from in treatment (Pos, 2006).

Termination outcomes for experientially distant clients. Experiencing scores did, in fact, increase across treatment for this subgroup, and when considered alone did predict considerable outcome variance (14%). However, once CAMS emotion scheme categories were added into the regression models in later steps, they were better predictors of outcome than experiencing (adding 26% to the explained variance). In fact, when CAMS codes were considered alone they explained 40% of the outcome variance at termination for this group.

In particular, higher proportions of secondary emotion were found to predict higher depression scores at termination, as well as mediate the relationship between primary adaptive emotion and outcome. This means that CAMS is not only a better predictor of outcome for this subgroup than experiencing, but also indicates

that secondary emotion better predicts poorer outcome than primary adaptive emotion predicts better outcome. These results suggest that the CAMS may be particularly useful in capturing clients' overwhelming reaction to, and potential avoidance of, deeper emotional experience (through engagement with secondary emotions), the presence of which appears to be strongly related to depression for this experientially distant subgroup.

Once secondary and primary adaptive emotion schemes had been established as significant predictors of outcome, the specific components of these emotion scheme types were then examined more closely. Both global distress and rejecting anger were found to predict higher depression scores at termination, while only assertive anger was found to independently predict lower depression scores at termination. Expressions of hurt/grief were not significantly related to depression scores for this subgroup.

Long-term outcomes for experientially distant clients. At 18-month follow-up, experiencing did not predict outcome even when considered alone. Rather, primary adaptive emotion alone emerged as the most important predictor of long-term gains. When experiencing was again dropped from the models, and specific components of secondary and primary adaptive emotion schemes examined, it was found that rejecting anger predicted higher depression scores and primary assertive anger showed a trend towards significance in predicting lower depression scores. Global distress, although a significant predictor of termination outcome, was no longer a predictor of follow-up depression scores, although it also showed a trend

towards significance initially. And as was found for termination outcomes, expression of hurt/grief did not directly predict 18-month follow-up.

Specific emotion states and outcome for experientially distant clients.

Rejecting anger. Rejecting anger was found to predict higher depression scores at termination and persisted as a predictor of higher depression scores at 18-month follow-up. Previous research examining the relationship between rejecting anger and either session or therapy outcome has been mixed. One research study found rejecting anger to be a 'stepping stone' to productive assertive anger and could thus be related to good session and overall outcome for depression (Pascual-Leone & Greenberg, 2007). However, in other research rejecting anger was associated with persistent symptomology in relation to borderline personality disorder (Kramer, Pascual-Leone, Berthoud, et al., 2015). The results of the current study align with the latter findings and suggest that anger which serves to attack or distance from another is predictive of poorer outcome.

Several potential reasons for why this might be the case are well articulated in a paper by Pascual-Leone, Gilles, Singh & Andreescu (2013), who assert that problematic anger often reflects self-critical or other-judging, other-blaming processes. While rejecting anger in the current study was coded when clients were expressing an attempt to distance themselves from an external other, it was also coded when clients were directing this anger towards themselves (i.e., during two-chair interventions). Rejecting anger in the latter instance is reflective of self-criticism, or in its extreme, self-hatred. Self-criticism has long been recognized as a characteristic form of depression (Blatt, Quinlan, Chevron, McDonald, & Zuroff,

1982; Greenberg & Watson, 2006), and is now emerging as a predictor in its development (Dunkley, Sanislow, Grilo, & McGlashan, 2010). It is unsurprising then, that if rejecting anger in this study were reflective of clients' engaging in self-criticism or self-hatred, that this would be predictive of poorer treatment outcomes.

Rejecting anger has also been conceptualized as a form of secondary emotion that occurs in reaction to deeper hurt, fear, or shame in relation to the self (Greenberg & Paivio, 1997; Pascual-Leone et al., 2013). In this instance, painful feelings are triggered regarding the self, and the individual attempts to gain distance from them by attacking an external other. For example, a client during therapy may re-experience the terrible pain and shame he felt when his mother abandoned him as a child, and then lash out in rage against his imagined mother. Rather than staying with these difficult core feelings regarding the self, rejecting anger is used in order to gain distance from these painful emotions. Rejecting anger in these circumstances is highly reinforcing, as the individual temporarily escapes his or her pain and experiences activating contempt towards the other. It becomes a way for the individual to self-regulate, although this is ultimately an unproductive long-term strategy as the core painful feelings remain, as do the unmet needs that give rise to them (Korman, 2005; 2008; Pascual-Leone et al., 2013). In addition to reflecting self-criticism, rejecting anger in this study may have also captured its use as a secondary emotion process occurring in response to primary pain.

Future research should make clear distinctions between client expressions of rejecting anger that are self-critical or other-directed, in order to more clearly understand its relationship to outcome. Previous research has demonstrated that

other-directed rejecting anger can be a productive 'stepping stone' to adaptive assertive anger (Pascual-Leone & Greenberg, 2007). It may be that only enduring self-critical rejecting anger is unproductive and detrimental to treatment success.

Assertive Anger. Assertive anger was found to predict lower depression scores at termination. There was also a trend towards significance for its ability to predict lower depression scores at 18-month follow-up. It was an interesting finding that at both termination and at follow-up higher proportions of primary adaptive assertive anger but not hurt/grief predicted lower depression scores for experientially distant clients. This may be pointing to the specific importance of anger in depressive resolution as indicated by many theories of depression (see Choi et al., 2015 for a review). Assertive anger may have been significantly related to depression alleviation for several reasons. First, depression is a disorder generally characterized by feelings of sadness, loss, hopelessness, and helplessness. These are emotions that are associated with the urge to withdraw, to sink down into oneself, and to hide. Assertive anger is an activating emotion associated with the opposite action tendency – to push forward and assert one's own needs and boundaries (Carver & Harmon-Jones, 2009). This feeling of personal control, strength, and entitlement to what one needs and what has hitherto been missing in a client's life is likely a powerful and self-affirming counterbalance to depression's hopelessness and helplessness (Timulak, 2015).

Assertive anger may also be more predictive of outcome due to its potentially particular relevance for this study's clients. It may be that clients in this experientially distant subgroup had depressive themes that were related to loss of

power or control, boundary violations, and being unable to assert him or herself. If so, accessing assertive anger may indeed have been the most appropriate and powerful way to transform depression in these clients. Psychodynamic theory and research have supported the existence of at least two subtypes of depression based on specific vulnerabilities or themes: anaclitic depression is characterized by difficulties related to attachment concerns, and feelings of helplessness, abandonment, and weakness; while introjective depression is characterized by difficulties related to achievement, and feelings of inferiority, self-criticism, and shame (Blatt, 1974; Blatt, Shahar & Zuroff, 2001). Treatment of the anaclitic individual focuses on addressing issues of dependence and autonomy, and possibly encouraging the experience and expression of anger; for the introjective individual, therapy is more likely to address issues of identity and self-definition (Pos, 2006). Further research is necessary to examine clients' core depressive themes in therapy and link them to the primary adaptive emotions most useful in transforming those maladaptive schemes at the heart of a client's particular depression.

Finally, as an activating, energizing, and other-directed emotion, depressed clients may be more willing to initially access and engage with anger before experiencing hurt or sadness. Once clients experience the affirming power of anger against the other, and feel entitled to obtaining unmet needs, attention may then turn to grieving what was lost and could never be. As such, it may be that because hurt/grief and mourning is more difficult to access, it may be experienced later in treatment after the self has first been strengthened through the anger experience.

Further research examining emotion schemes later in treatment would be helpful to clarify this issue.

Global distress. Global distress was a strong predictor of depression at termination and persisted as a predictor (with a trend towards significance) for 18-month follow-up. As a form of secondary emotion, global distress most often occurs in reaction to and obscures deeper emotion at the heart of a client's distress. Although painful and overwhelming to experience, global distress is in effect describing avoidance of still deeper emotional experiences. Also, as the global distress category encompasses feelings of hopelessness, helplessness, and resignation, it perhaps captures some of the affective symptoms of depression itself. It is unsurprising then that the experience of global distress would predict continued depressive symptoms.

Hypothesis Two: Emotion scheme typology will best predict outcomes for experientially engaged clients

Termination outcomes for experientially engaged clients. While this subgroup improved from treatment to the same degree as the experientially distant clients, contrary to the original hypothesis, emotion scheme typology as measured by the CAMS was not a successful emotional processing predictor for this subgroup. This was true in spite of both subgroups evidencing equal proportions of all CAMS emotion scheme categories expressed. However, both modal and peak experiencing scores during the working phase of treatment did predict significant outcome variance for these clients when considered alone.

Long-term outcomes for experientially engaged clients. The CAMS emotion scheme variables persisted in being unrelated to outcome at 18-month follow-up for this subgroup. While modal experiencing showed a trend towards significance in predicting 18-month follow-up for this group, peak experiencing alone (and at Level 6 specifically) did significantly predict 18-month follow-up depression scores.

The EXP Scale as a measure of emotion schematic change. How and why did Level 6 EXP predict outcome for experientially engaged clients? At Level 6 EXP clients are aware of previously implicit feelings and the meanings associated with them (Klein et al., 1969), and is bringing them forth with acceptance. It is possible that Level 6 EXP actually captures a client who is storying emotion schematic change. Experiencing at this level indicates clients are accessing “a synthesis of readily accessible, newly recognized, or more fully realized feelings and experiences [which] produce personally-meaningful structures or resolve issues” (page 59, Klein et al, 1986). Put more simply, it indicates that the client is functioning in a manner that represents a change or shift from their previous way of relating to inner experience. This is an argument for Level 6 EXP being a measure of positive change. As such, this level likely indicates when a client has achieved the very emotional change that they have been seeking in therapy and are reflecting on it in order to make sense of it. It is not surprising then that this would relate to reduced depressive symptomology.

Previous research examining the relationship between depth of experiencing and outcome in experiential therapy has found that Level 5 or 6 EXP is significantly associated with minimal depression scores at long-term follow-up (Pos, 2006). If

deeper levels of experiencing are indeed capturing emotion schematic change, and doing so better than CAMS for particular subgroups of clients, than identifying the processes that predict these levels of the EXP scale become important questions for future research. Additional research might examine whether particular CAMS emotion categories predict deeper levels of experiencing.

Hypothesis Three: Accessing primary adaptive emotions as measured by CAMS will best predict 18-month follow-up for all depressed clients

Although not hypothesized, the comparative ability of depth of experiencing and emotion scheme typology to predict outcome had not been previously tested, so for the entire sample the relationship between the two emotional processing variables and both termination and 18-month outcomes was examined. In both sets of analyses the results were largely coherent with that found for the experientially distant subgroup. While experiencing was able to predict both termination and 18-month follow-up outcomes when considered alone, CAMS-derived emotion scheme categories were better predictors once added to the models. And when examining the specific components of CAMS emotion scheme categories, global distress and rejecting anger emerged as predictors of higher depression at termination, while primary adaptive anger emerged as the most important independent predictor of lower depression at 18-month follow-up. However, less variance was explained in these regression models examining the entire sample than was explained in analyses observing the experientially distant subgroup alone. These results can be easily justified by the inclusion of the experientially engaged subgroup in the full sample analyses, for which as discussed above, the CAMS-derived emotion scheme

types did not appear to capture their change process. As the association between primary adaptive emotion, secondary emotion, and outcome has already been discussed above in relation to the first two hypotheses, the following discussion will examine the provocative finding that only primary adaptive emotion independently predicts long-term follow-up, as well as the role maladaptive emotions and unmet needs might play in the emotional change process of experiential therapy.

Primary adaptive emotion and long-term outcome. The finding that primary adaptive emotion is the best predictor of depression 18 months after clients have completed treatment supports the EFT theory of change. As discussed above, knowing that clients are emotionally engaged with and actively processing their inner experience is useful, but more helpful in predicting long-term outcome is whether clients are accessing primary adaptive emotions. Specifically, having assertive anger experiences by the working phase of treatment appears to be most important in heralding positive long-term client change in depression. That only particular advanced meaning states (primary adaptive emotion) reliably discriminated clients who were able to achieve lasting positive change lends additional support as well to the EFT change principle of ‘changing emotion with emotion’ (emotional transformation) – it is not enough to simply arrive at and explore the symptoms (secondary emotion) of or core pain underlying (primary maladaptive emotion) depression, but the pain must be transformed through accessing alternative, adaptive emotions in order for deep change to occur.

Maladaptive emotions and unmet needs: what role do they play? This study has demonstrated the importance of secondary and primary adaptive emotions in

either hindering or helping the emotional change process. However, in this study neither access to needs nor exploration of maladaptive emotion during the working phase was associated with outcome. This was despite maladaptive fear and shame being the emotion category most often engaged in by both client subgroups. These results are in line with previous research examining emotion schematic change using the CAMS (Choi et al., 2015; Pascual-Leone & Greenberg, 2007), in which maladaptive emotion and unmet needs failed to independently predict outcome.

Overall, it appears that accessing maladaptive primary emotions and unmet needs may be necessary but insufficient in the emotional change process, and are useful only if their experience subsequently leads to primary adaptive emotion. Future research might identify which clients are able to make productive use of maladaptive emotions and unmet needs, in that they are subsequently followed by the expression of primary adaptive emotion. It should be also examined in future studies whether the presence of primary adaptive emotion during the termination phase of therapy predict follow-up depression scores. Perhaps there are clients who are primarily engaging with the experience of maladaptive emotion and their associated unmet needs in the working phase of treatment but are then able to access adaptive emotions by therapy termination. These clients potentially have alternate but equally positive trajectories of change.

Another possibility for why maladaptive emotion was not an independent predictor of outcomes is that the majority of clients in the current sample may have been able to quickly access primary adaptive emotion following expression of maladaptive emotion, rather than getting 'stuck' in them or retreating into

secondary emotion. As such, they may be particularly suited to this treatment model because they have either a 'head start' or a more straightforward route towards achieving the essential change process of this therapy. These are also likely those clients who can readily benefit from the traditional 16 to 20-session course of treatment. Some clients who are primarily focused on exploring their maladaptive emotions or accessing needs during the working phase of therapy may perhaps still 'catch up' to clients who experience primary adaptive emotion earlier. These are clients who perhaps need a longer course of treatment. For clients who are still primarily engaging with primary maladaptive emotion or unmet needs during the working phase of treatment, but are able to access primary adaptive emotion by treatment termination, several additional sessions to consolidate transformative changes might be helpful, as it is accessing adaptive emotion that appears to be most beneficial for all clients. Future research should examine how many additional sessions such clients might need in order to experience long-term alleviation of their depression.

What do the EXP scale and CAMS capture? Comparing their utility as emotional processing measures

Results found in the current study were in direct opposition to the original hypotheses. While these findings do provide support for the hypothesis that the two depressive subgroups are indeed distinct from one another and undergo separate change pathways, this raises questions as to how opposite results could have occurred and what this might represent. Upon further reflection of both the EXP scale and the CAMS, it is the author's belief that there is some, perhaps significant,

degree of overlap between the two measures. Both measures are viewed as capturing depth of experiencing and as well as some elements consistent with emotion schematic change.

First, regarding the EXP scale, it is the author's contention that at its higher levels, this measure captures elements of emotion schematic change in addition to depth of experiencing. In its earlier stages, from 1-4, the EXP scale is capturing clients' increasing engagement with their inner experience. However, as noted earlier, not all inner experiences are therapeutically productive. Increased awareness of and access to secondary emotion is unlikely to be helpful. If some increases in experiencing, as reflected by higher scores on the EXP scale are reflecting greater access to secondary emotion this might explain why some research studies examining experiencing have found mixed results with respect to its ability to predict treatment success (Orlinksy, Ronnestad, & Wilutzki, 2004).

Clients who are at mid-high levels of the EXP scale (e.g., Stage 3, 4, and perhaps 5) are aware of, describing, and processing inner experiences that also may or may not contain adaptive information. This, again, is because the EXP scale is an emotion-category-free measure. It is not possible to determine from experiencing ratings alone, particularly at lower levels, whether feelings being explored are secondary, primary maladaptive, or primary adaptive emotion.

However, at higher levels of experiencing (Levels 6 and 7 of the EXP), this measure captures client narratives describing the emergence of new meaning, the resolution of personally significant problems, and shifts or changes in personal experience. These are all potential indicators of emotion schematic change. This

attention to and elaboration of novel aspects of experience is perhaps also signaling the creation of a new personal narrative that is contradictory to the previous, problematic one (Gonçalves, Mendes, Ribeiro, Angus, & Greenberg, 2010). While lower levels of the EXP scale seem to focus almost exclusively on the presence or absence of attention to emotional experience, higher stages appear to incorporate more cognitive factors, capturing the client's ability to reflect on and make meaning from their emotional experience (Wexler, 1974). At these advanced stages, clients are emotionally regulated, able to flexibly respond to their inner experience, as well as reflect on its meaning. These abilities are in fact, in experiential therapies, indicative of an individual who is functioning optimally – an individual who is not responding in the 'same old' way to experience by refusing to acknowledge emotions or feeling stuck in them, but one who is aware of, open to, and accepting of his or her changing inner experience. At Levels 6 and 7 of the EXP scale, clients are demonstrating this capacity to function at a complex and optimal level of functioning, and reaching such levels could be considered markers of emotional transformation or productive cognitive-affective meaning making. Reaching these highest levels of experiencing may be indicative of someone who is not only experiencing adaptive emotion (as would be captured by CAMS) but is actively integrating this new emotional experience into existing self-organizations, deriving new meaning from their emerging experiences, or is articulating transformative shifts at both the cognitive and implicational levels of information processing (Teasdale, 1999).

While Levels 6 and 7 of the EXP scale have been previously used as measures of good session process (small 'o' outcomes; Greenberg, 1986), reaching these specific levels of the EXP scale may in fact be better conceptualized as process proxies of symptom outcome measures (large 'O' outcomes).

As for the CAMS, it is also contended that this measure does not only capture specific emotion states that are important for emotion schematic change, but that the emotion scheme typology captured with the CAMS also implicitly represents the depth of client experiencing. When clients are expressing secondary emotion, this indicates that they are working with more superficial (although still painful) forms of distress. In secondary emotion, clients are aware that they are upset, but the idiosyncratic meaning of their core pain is not available to them. As such, the finding that secondary emotion is predictive of higher depression at termination for experientially distant clients can potentially be interpreted as confirmation that lower levels of experiencing are, in fact, predictive of poorer outcome for this subgroup.

Insofar as identifying client access to adaptive emotion that appears to be most important to positive change for the experientially distant subgroup, this is where the CAMS may be capturing not only valuable information regarding emotion scheme typology, but also indicating that clients are engaging with deeper emotional experience. When clients are engaging with either primary maladaptive or adaptive emotion, they are processing inner experience at a deeper level than secondary emotion. This might explain why access to primary adaptive emotions was found to therapeutically beneficial for experientially distant clients.

Overall, these contradictory findings point to the complexity within the EXP scale and CAMS as they are presently conceptualized, and it is perhaps time for additional research to further deconstruct these measures and the aspects of emotional processing they truly capture.

Implications for Research and Practice

Several findings from the current study have significant implications for both clinical practice and future psychotherapy process and outcome research. First, this was an investigation that only examined clients who provided longer-term follow-up data. This paradigm was chosen in order to identify process variables that would predict long-lasting resilient changes, rather than potential temporary symptom alleviation. And as elaborated above, process variables predicting outcome differed depending on the time at which outcome was measured. Secondary emotion was predictive of poorer outcome at treatment termination, but was less important in predicting outcome 18 months following the end of therapy. In contrast, primary adaptive emotion was most important for predicting longer-term treatment outcome. Not only do the current study findings reinforce the necessity of evaluating a treatment based on whether clients are able to maintain their gains post-therapy, it cautions researchers against drawing premature conclusions regarding potential causal change mechanisms as they may change depending on when outcome is measured.

The current study also has implications for improving the match between clients and treatment. As stated, while secondary emotion was predictive of poorer outcomes, it may be that clients who were occupied with exploring unmet needs or

primary maladaptive emotion during the working phase of treatment require additional sessions in order to benefit from this treatment model. Future studies of experiential therapy might examine markers of clients who simply need additional time to benefit from this treatment model (e.g., clients who are still actively exploring the pain of primary maladaptive emotion or accessing unmet needs in the working phase of treatment), or those who are perhaps unlikely to do well in this therapy (e.g., clients who are still mainly engaging with secondary emotion during the working phase of treatment). These investigations will be able to contribute to answering the question of 'what [therapy] works for whom?' (Norcross & Wampold, 2011) by examining with even greater specificity which process indicators predict which clients will benefit from a particular treatment. For those clients who are still unable to engage in deep exploration of inner experiences in therapy by mid-treatment despite therapist intervention (either by focusing on more superficial conversation topics or by exploring mainly the secondary emotions of global distress and/or rejecting anger), initiating a discussion with him or her regarding the treatment process and the importance of deeper emotional exploration may be warranted.

This study has also illustrated that not only are both the EXP Scale and the CAMS useful research measures to evaluate client process, they also have significant clinical potential. Clinicians can employ both the EXP Scale and the CAMS to orient themselves in session, by using both scales' process and content markers to identify either (or both) the client's depth of experiencing and currently expressed emotion state. This can assist clinicians with making decisions as to what the next

appropriate step might be, whether it is encouraging deeper emotional exploration or progression to an alternate emotion state. For example, if a client is expressing that he is feeling overwhelmed and hopeless, this likely indicates that he is experiencing global distress. This enables the therapist to know that the client needs to be assisted in moving from his current highly aroused and undifferentiated emotion state to one that is more regulated and has greater personal meaning. This could entail helping the client to get in touch with the core pain underlying his overwhelming feelings (primary maladaptive emotion). Both the EXP Scale and the CAMS can be used as 'road maps' in session to move towards more helpful client process.

Finally, the finding that primary adaptive emotion during the working phase of treatment is predictive of outcome 18 months after the end of therapy is highly provocative. This indicates that how well clients are doing approximately two years later can be predicted by the presence of assertive anger, hurt/grief, self-compassion, and acceptance and agency in mid-treatment. Thus, the importance of clients accessing and exploring primary adaptive emotion cannot be overstated, and encouraging these client experiences in treatment is paramount. Further research needs to examine how clients can engage in these emotion types more readily, and investigate how therapists might facilitate and deepen this process.

Limitations and Future Directions

One of the limitations of the current study was the smaller sample size of the experientially engaged subgroup ($n = 13$). This likely reduced the power of regression analyses to detect significant relationships between certain predictors

and outcome. However, despite the small sample size, the effect sizes for the relationships between modal and peak experiencing and outcome ranged from .41 to .67, indicating medium to large effects. This signifies the importance of this predictor to outcome for this subgroup. Future research should attempt to include larger samples of experientially engaged clients in order to increase confidence in the validity of current findings. With a larger sample of experientially engaged clients, one could also explore whether age is truly related to the tendency to be more in touch with inner emotional experience. Although age was not significantly related to either the EXP or to any CAMS variables, clients in the experientially engaged subgroup were found to be significantly younger than those in the experientially distant subgroup. Future research with a larger sample could tease apart whether there is any relation between age and the tendency to be more distant or engaged with inner experience.

Second, although there were no significant differences between depressive subgroups and type of therapy received (CCT versus EFT), there are some discrepancies between the two therapies with respect to therapist process directiveness. While CCT therapists follow emerging client experience, EFT therapists are trained to be alert for, and respond to, in-session process markers that signify a client's particular emotional processing difficulties. EFT therapists may work to actively facilitate client experience of specific emotion states that are considered to have transformative power. In particular, EFT theory emphasizes the importance of assertive anger and adaptive grief experiences in the resolution of depression. Post-hoc analyses revealed that there were, in fact, significant

differences between clients who received CCT or EFT in this study on the proportion of particular CAMS emotion schemes expressed in the working phase of therapy. Specifically, clients who received CCT evidenced higher proportions of global distress, and lower proportions of hurt/grief and assertive anger compared to clients who received EFT (all $ps < .05$). This provides indirect evidence indicating that therapist interventions can indeed influence client experience of these processes. Further research should explore how therapists in either treatment might enhance helpful client process. Examination of differences in the trajectory of change between CCT and EFT may also allow an examination of the rate at which such changes occur depending on the therapy.

This leads to the third limitation of the current study. As this study was an exploration of client change processes, therapist contributions to beneficial treatment process and outcome were not explicitly examined. How the therapist may have facilitated clients to engage in primary adaptive emotion, or to move away from unhelpful secondary emotion, is unknown. Do therapists explicitly initiate interventions directing client attention to adaptive processes that clients subsequently follow? Or do therapist instructions follow and support a naturally occurring client change process? While not examined in the current study, previous research has investigated therapist interventions that promote good session and therapy outcomes. Adams (1999, 2010) has found that deeper therapist experiencing precedes and predicts deeper client experiencing. Singh (2012) has also found that therapist interventions that focus on unmet client needs are associated with higher client expression of primary adaptive emotion, and precede

significant gains in the therapy process. These studies highlight the importance of studies looking at therapist process, and also provide some insight into some unexpected findings concerning unmet needs in the current investigation.

In EFT theory, awareness and expression of unmet client needs is considered to be a pivotal step in the change process, in which clients recognize that some essential need to be loved, validated, or protected was unfulfilled. Becoming aware of unmet needs is proposed to lead to: 1) the experience of primary adaptive emotions (anger and entitlement for not having had the needs met, or grief and sadness that that such needs were not met earlier), and 2) productive action in the present in order to pursue currently unfulfilled needs. Thus, one would expect that access to needs would predict client improvement in experiential treatment for depression. However, the experience of unmet needs in the current study was not associated with better or poorer outcome. As discussed above in relation to primary maladaptive emotion, accessing needs is likely a necessary but insufficient step towards change – what is essential may be whether needs are actively owned by the client and subsequently followed by client experiences of primary adaptive anger, sadness, or self-compassion (Pascual-Leone & Greenberg, 2007). Future research might examine the impact of therapist interventions on emerging client process, and explore whether therapist focus on unmet needs is followed by client expressions of primary adaptive emotion.

Fourth, the event selection method that was used to examine emotional processing may have possibly affected the study results. Both the EXP and CAMS were rated during emotion episodes rather than sampling entire therapy sessions or

selecting random segments for coding. This sampling method was theoretically driven, as it has been previously demonstrated that depth of experiencing during emotion episodes is a robust predictor of treatment outcome for depression (Pos et al., 2009). However, because the EXP was rated during single emotion episodes, clients were already describing a situation in which they had experienced some kind of emotional response. This effectively limits the range of potential experiencing scores from 1-7 to 2-6, as Level 7 ratings are more likely to emerge from several sequential emotion episodes rather than a single episode, and Level 1 represents client narratives that focus on external events and that exclude any reference to personal significance. Future research might consider examining depth of experience and use the CAMS in other theoretically relevant segments of therapy, such as during narratives addressing core depressive themes.

Fifth, this study used access to primary adaptive emotion as a process proxy for emotion schematic change. Due to the theoretical necessity in EFT of accessing primary adaptive emotion in order to transform depressogenic emotion schemes, it was assumed that when clients engage with primary adaptive emotions that this would be a valid indicator of important underlying change as having occurred. However, in order to establish that emotion schematic change has truly occurred in treatment, it is necessary to demonstrate that clients move in or across sessions from secondary or primary maladaptive emotions before accessing primary adaptive emotions. In this study, change in proportion of primary or secondary emotions were not measured across time (Choi et al., 2015), and as such the study did not truly measure change in emotion schemes across therapy. Thus, it is

possible that accessing primary adaptive emotions represents processes other than emotion schematic change. It may also represent increases in client depth of experiencing. Future research should examine whether experiential therapy does contain evidence of sequential patterns in client process evidencing movement from secondary or maladaptive emotion schemes to primary adaptive emotion schemes, and perhaps compare whether such patterns or simple access to primary adaptive emotions is a better predictor of outcome.

Finally, future research might also examine whether sequential patterns exist in the interaction between client and therapist. Previous research studying self-critical depression used THEME analysis (Magnusson, 1993, 2000) to discover differences in emotion sequence patterns between outcome groups (Choi et al., 2015). THEME is a statistical software package that allows for the detection of complex temporal patterns that might otherwise be obscured by behavioural 'noise'. Choi and colleagues found that outcome groups were differentiated by their patterns of emotional processing. Clients in the good outcome group were distinguished by more sequences of maladaptive emotion, unmet needs, or secondary emotion that were then followed by primary adaptive emotion. Clients in the poor outcome group were found to oscillate back and forth between secondary emotion and primary maladaptive emotion. Using THEME to examine temporal patterns in emotional processing would also be able to examine the assertion that change in experiential therapy does not occur in a linear fashion, but in a 'two steps forward, one step back' process (Pascual-Leone, 2009). Pascual Leone found evidence that this sawtooth pattern predicted good session process, but whether

this pattern is also ultimately characteristic of good overall treatment outcomes remains to be examined. Use of THEME analyses could potentially provide convergent evidence for this contention.

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Table 1

Comparing experientially distant and experientially engaged client subgroups on mean proportions of individual CAMS categories during the working phase of therapy

| | Experientially Distant | Experientially Engaged | Significance of difference |
|--------------------------------------|-------------------------------|-------------------------------|-----------------------------------|
| CAMS Uncodable | 0.26 (0.15) | 0.17 (0.12) | <i>ns</i> |
| CAMS Global Distress | 0.13 (0.11) | 0.15 (0.11) | <i>ns</i> |
| CAMS Rejecting Anger | 0.12 (0.11) | 0.08 (0.10) | <i>ns</i> |
| CAMS Fear/Shame | 0.24 (0.20) | 0.27 (0.23) | <i>ns</i> |
| CAMS Negative Self-Evaluation | 0.03 (0.04) | 0.03 (0.05) | <i>ns</i> |
| CAMS Need | 0.11 (0.09) | 0.12 (0.11) | <i>ns</i> |
| CAMS Relief | 0.10 (0.10) | 0.09 (0.09) | <i>ns</i> |
| CAMS Hurt/Grief | 0.04 (0.06) | 0.11 (0.14) | <i>ns</i> |
| CAMS Assertive Anger | 0.05 (0.07) | 0.05 (0.06) | <i>ns</i> |
| CAMS Self-Soothing | 0.02 (0.03) | 0.02 (0.03) | <i>ns</i> |
| CAMS Acceptance and Agency | 0.01 (0.04) | 0.02 (0.03) | <i>ns</i> |

Note. Experientially distant subgroup ($n = 42$); experientially engaged subgroup ($n = 13$). Mean proportions and standard deviations are presented. *ns* = not significant.

Table 2

Comparing experientially distant and experientially engaged client subgroups on mean proportions of CAMS-derived emotion scheme types during the working phase of therapy

| | Experientially Distant | Experientially Engaged | Significance of difference |
|------------------|-------------------------------|-------------------------------|-----------------------------------|
| CAMS SEC | 0.25 (0.17) | 0.23 (0.13) | <i>ns</i> |
| CAMS PME | 0.26 (0.21) | 0.30 (0.24) | <i>ns</i> |
| CAMS Need | 0.11 (0.09) | 0.12 (0.11) | <i>ns</i> |
| CAMS PAE | 0.22 (0.16) | 0.28 (0.22) | <i>ns</i> |

Note. Experientially distant subgroup ($n = 42$); experientially engaged subgroup ($n = 13$). Mean proportions and standard deviations are presented. CAMS SEC = secondary emotion (Global Distress, Rejecting Anger); CAMS PME = primary maladaptive emotion (Fear/Shame, Negative Self-Evaluation); CAMS Need = needs; CAMS PAE = primary adaptive emotion (Relief, Hurt/Grief, Assertive Anger, Self-Soothing, Acceptance and Agency). *ns* = not significant.

Table 3

Pearson correlation matrix relating experiencing, CAMS emotion scheme categories, and depression at termination and 18-month follow-up for the entire sample

| Variables | 2. | 3. | 4. | 5. | 6. | 7. | 8. |
|-------------------------------------|-------|--------|------|-------|-------|--------|--------|
| 1. Modal EXP | .89** | -.45** | .25 | .22 | .44** | -.40** | -.31* |
| 2. Peak EXP | 1 | -.39** | .16 | .31* | .43** | -.39** | -.27* |
| 3. CAMS SEC | | 1 | -.26 | -.29* | -.35* | .53** | .39** |
| 4. CAMS PME | | | 1 | .22 | -.29* | -.15 | -.04 |
| 5. CAMS Need | | | | 1 | .12 | -.10 | -.22 |
| 6. CAMS PAE | | | | | 1 | -.23 | -.46** |
| 7. BDI – Termination Residual Gains | | | | | | 1 | .54** |
| 8. BDI – 18m Residual Gains | | | | | | | 1 |

Note. $N = 54$. * $p < .05$. ** $p < .01$. EXP = Experiencing in the working phase of therapy. CAMS SEC = mean proportion of secondary emotion in the working phase of therapy; CAMS PME = mean proportion of primary maladaptive emotion in the working phase of therapy; CAMS Need = mean proportion of needs in the working phase of therapy; CAMS PAE = mean proportion of primary adaptive emotion in the working phase of therapy. BDI = Beck Depression Inventory.

Table 4

Pearson correlation matrix relating experiencing, CAMS emotion scheme categories, and depression at termination and 18-month follow-up for the experientially distant subgroup

| Variables | 2. | 3. | 4. | 5. | 6. | 7. | 8. |
|-------------------------------------|-------|--------|------|------|-------|--------|--------|
| 1. Modal EXP | .86** | -.51** | .22 | .16 | .52** | -.38* | -.24 |
| 2. Peak EXP | 1 | -.42** | .10 | .31* | .46** | -.34* | -.17 |
| 3. CAMS SEC | | 1 | -.31 | -.30 | -.39* | .59** | .44** |
| 4. CAMS PME | | | 1 | .34 | -.19 | -.06 | -.06 |
| 5. CAMS Need | | | | 1 | .06 | -.10 | -.17 |
| 6. CAMS PAE | | | | | 1 | -.41** | -.48** |
| 7. BDI – Termination Residual Gains | | | | | | 1 | .60** |
| 8. BDI – 18m Residual Gains | | | | | | | 1 |

Note. $N = 42$. * $p < .05$. ** $p < .01$. EXP = Experiencing in the working phase of therapy. CAMS SEC = mean proportion of secondary emotion in the working phase of therapy; CAMS PME = mean proportion of primary maladaptive emotion in the working phase of therapy; CAMS Need = mean proportion of needs in the working phase of therapy; CAMS PAE = mean proportion of primary adaptive emotion in the working phase of therapy. BDI = Beck Depression Inventory.

Table 5

Pearson correlation matrix relating experiencing, CAMS emotion scheme categories, and depression at termination and 18-month follow-up for the experientially engaged subgroup

| Variables | 2. | 3. | 4. | 5. | 6. | 7. | 8. |
|--|-------|------|------|------|-------|-------|-------|
| 1. Modal EXP | .95** | -.22 | .32 | .35 | .20 | -.58* | -.54 |
| 2. Peak EXP | 1 | -.33 | .26 | .32 | .31 | -.66* | -.58* |
| 3. CAMS SEC | | 1 | -.02 | -.22 | -.26 | .21 | .08 |
| 4. CAMS PME | | | 1 | -.05 | -.61* | -.37 | .06 |
| 5. CAMS Need | | | | 1 | .18 | -.08 | -.38 |
| 6. CAMS PAE | | | | | 1 | .26 | -.42 |
| 7. BDI – Termination Residual Gains | | | | | | 1 | .26 |
| 8. BDI – 18m Residual Gains | | | | | | | 1 |

Note. $N = 13$. * $p < .05$. ** $p < .01$. EXP = Experiencing in the working phase of therapy. CAMS SEC = mean proportion of secondary emotion in the working phase of therapy; CAMS PME = mean proportion of primary maladaptive emotion in the working phase of therapy; CAMS Need = mean proportion of needs in the working phase of therapy; CAMS PAE = mean proportion of primary adaptive emotion in the working phase of therapy. BDI = Beck Depression Inventory.

Table 6

Hierarchical regression predicting Termination Outcome for Entire Sample

| Variables | Total R ² | ΔR ² | F change | df | β |
|-----------|----------------------|-----------------|----------|-------|--------|
| Step 1 | .16** | .16** | 9.99** | 1, 52 | |
| Modal EXP | | | | | -.40** |
| Step 2 | .33* | .16* | 2.92* | 4, 48 | |
| Modal EXP | | | | | -.23 |
| CAMS SEC | | | | | .45** |
| CAMS PME | | | | | .01 |
| CAMS Need | | | | | .06 |
| CAMS PAE | | | | | -.00 |

Note. $N = 54$, * $p < .05$, ** $p < .01$. EXP = Experiencing in the working phase of therapy. CAMS SEC = mean proportion of secondary emotion in the working phase of therapy; CAMS PME = mean proportion of primary maladaptive emotion in the working phase of therapy; CAMS Need = mean proportion of needs in the working phase of therapy; CAMS PAE = mean proportion of primary adaptive emotion in the working phase of therapy.

Table 7

Hierarchical regression predicting Termination Outcome for Entire Sample

| Variables | Total R ² | ΔR^2 | F change | df | β |
|-----------|----------------------|--------------|----------|-------|---------|
| Step 1 | .16** | .16** | 9.99** | 1, 52 | |
| Modal EXP | | | | | -.40** |
| Step 2 | .32** | .16** | 12.00** | 2, 51 | |
| Modal EXP | | | | | -.22 |
| CAMS SEC | | | | | .44** |

Note. $N = 54$, * $p < .05$, ** $p < .01$. EXP = Experiencing in the working phase of therapy. CAMS SEC = mean proportion of secondary emotion in the working phase of therapy.

Table 8

Hierarchical regression predicting Termination Outcome for Entire Sample

| Variables | Total R ² | ΔR ² | F change | df | β |
|---------------|----------------------|-----------------|-----------------|-------|-------|
| Step 1 | .11 <i>ns</i> | .11 <i>ns</i> | 2.06 <i>ns</i> | 3, 50 | |
| CAMS PME | | | | | -.23 |
| CAMS Need | | | | | -.02 |
| CAMS PAE | | | | | -.33* |
| Step 2 | .29** | .18** | 12.51 <i>ns</i> | 4, 49 | |
| CAMS PME | | | | | -.06 |
| CAMS Need | | | | | .06 |
| CAMS PAE | | | | | -.11 |
| CAMS SEC | | | | | .49** |

Note. $N = 54$, * $p < .05$, ** $p < .01$, *ns* = not significant. EXP = Experiencing in the working phase of therapy. CAMS SEC = mean proportion of secondary emotion in the working phase of therapy; CAMS PME = mean proportion of primary maladaptive emotion in the working phase of therapy; CAMS Need = mean proportion of needs in the working phase of therapy; CAMS PAE = mean proportion of primary adaptive emotion in the working phase of therapy.

Table 9

Hierarchical regression predicting Termination Outcome for Entire Sample

| Variables | Total R ² | ΔR^2 | F change | df | β |
|----------------------|----------------------|---------------|----------------|-------|---------|
| Step 1 | .09 <i>ns</i> | .09 <i>ns</i> | 2.53 <i>ns</i> | 2, 51 | |
| CAMS Hurt/Grief | | | | | -.01 |
| CAMS Assertive Anger | | | | | -.31* |
| Step 2 | .37** | .28** | 10.69** | 2, 49 | |
| CAMS Hurt/Grief | | | | | .08 |
| CAMS Assertive Anger | | | | | -.31* |
| CAMS Global Distress | | | | | .37** |
| CAMS Rejecting Anger | | | | | .38** |

Note. $N = 54$, * $p < .05$, ** $p < .01$, *ns* = not significant.

Table 10

Hierarchical regression predicting Termination Outcome for the Experientially Distant Subgroup

| Variables | Total R ² | ΔR ² | F change | df | β |
|-----------|----------------------|-----------------|----------|-------|-------|
| Step 1 | .14* | .14* | 6.51* | 1, 39 | |
| Modal EXP | | | | | -.38* |
| Step 2 | .40* | .26* | 3.71* | 4, 35 | |
| Modal EXP | | | | | -.05 |
| CAMS SEC | | | | | .51** |
| CAMS PME | | | | | .03 |
| CAMS Need | | | | | .04 |
| CAMS PAE | | | | | -.20 |

Note. $N = 41$, * $p < .05$, ** $p < .01$. EXP = Experiencing in the working phase of therapy. CAMS SEC = mean proportion of secondary emotion in the working phase of therapy; CAMS PME = mean proportion of primary maladaptive emotion in the working phase of therapy; CAMS Need = mean proportion of needs in the working phase of therapy; CAMS PAE = mean proportion of primary adaptive emotion in the working phase of therapy.

Table 11

Hierarchical regression predicting Termination Outcome for the Experientially Distant Subgroup

| Variables | Total R ² | ΔR ² | F change | df | β |
|-----------|----------------------|-----------------|----------------|-------|-------|
| Step 1 | .14* | .14* | 6.51* | 1, 39 | |
| Modal EXP | | | | | -.38* |
| Step 2 | .22* | .08 <i>ns</i> | 1.26 <i>ns</i> | 4, 36 | |
| Modal EXP | | | | | -.19 |
| CAMS PME | | | | | -.10 |
| CAMS Need | | | | | -.03 |
| CAMS PAE | | | | | -.35 |
| Step 3 | .40** | .15** | 10.10** | 5, 35 | |
| Modal EXP | | | | | -.05 |
| CAMS PME | | | | | .03 |
| CAMS Need | | | | | .04 |
| CAMS PAE | | | | | -.20 |
| CAMS SEC | | | | | .51** |

Note. $N = 41$, * $p < .05$, ** $p < .01$, *ns* = not significant. EXP = Experiencing in the working phase of therapy; CAMS SEC = mean proportion of secondary emotion in the working phase of therapy; CAMS PME = mean proportion of primary maladaptive emotion in the working phase of therapy; CAMS Need = mean proportion of needs in the working phase of therapy; CAMS PAE = mean proportion of primary adaptive emotion in the working phase of therapy.

Table 12

Hierarchical regression predicting Termination Outcome for the Experientially Distant Subgroup

| Variables | Total R ² | ΔR ² | F change | df | β |
|-----------|----------------------|-----------------|----------|-------|--------|
| Step 1 | .20* | .20* | 3.08* | 3, 37 | |
| CAMS PME | | | | | -.16 |
| CAMS Need | | | | | -.03 |
| CAMS PAE | | | | | -.45** |
| Step 2 | .40** | .20** | 11.74** | 4, 36 | |
| CAMS PME | | | | | .02 |
| CAMS Need | | | | | .05 |
| CAMS PAE | | | | | -.23 |
| CAMS SEC | | | | | .53** |

Note. $N = 41$, * $p < .05$, ** $p < .01$. CAMS SEC = mean proportion of secondary emotion in the working phase of therapy; CAMS PME = mean proportion of primary maladaptive emotion in the working phase of therapy; CAMS Need = mean proportion of needs in the working phase of therapy; CAMS PAE = mean proportion of primary adaptive emotion in the working phase of therapy.

Table 13

Hierarchical regression predicting Termination Outcome for the Experientially Distant Subgroup

| Variables | Total R ² | ΔR ² | F change | df | β |
|----------------------|----------------------|-----------------|----------|-------|-------|
| Step 1 | .15* | .15* | 3.47* | 2, 38 | |
| CAMS Hurt/Grief | | | | | -.13 |
| CAMS Assertive Anger | | | | | -.32 |
| Step 2 | .50** | .35** | 12.20** | 4, 36 | |
| CAMS Hurt/Grief | | | | | .05 |
| CAMS Assertive Anger | | | | | -.39* |
| CAMS Global Distress | | | | | .44** |
| CAMS Rejecting Anger | | | | | .37** |

Note. N = 41, *p <.05, **p < .01.

Table 14

Hierarchical regression predicting Termination Outcome for the Experientially Engaged Subgroup

| Variables | Total R ² | ΔR ² | F change | df | β |
|-----------|----------------------|-----------------|----------|-------|-------|
| Step 1 | .34* | .34* | 5.65* | 1, 11 | |
| Modal EXP | | | | | -.58* |
| Step 2 | .56 ns | .22 ns | .86 ns | 4, 7 | |
| Modal EXP | | | | | -.79* |
| CAMS SEC | | | | | .23 |
| CAMS PME | | | | | .27 |
| CAMS Need | | | | | .15 |
| CAMS PAE | | | | | .61 |

Note. $N = 13$, * $p < .05$, ** $p < .01$, *ns* = not significant. EXP = Experiencing in the working phase of therapy. CAMS SEC = mean proportion of secondary emotion in the working phase of therapy; CAMS PME = mean proportion of primary maladaptive emotion in the working phase of therapy; CAMS Need = mean proportion of needs in the working phase of therapy; CAMS PAE = mean proportion of primary adaptive emotion in the working phase of therapy.

Table 15

Hierarchical regression predicting Termination Outcome for the Experientially Engaged Subgroup

| Variables | Total R ² | ΔR ² | F change | df | β |
|-----------|----------------------|-----------------|----------|-------|---------|
| Step 1 | .43** | .43** | 8.33** | 1, 11 | |
| Peak EXP | | | | | -.66* |
| Step 2 | .75* | .32 ns | 2.30 ns | 4, 7 | |
| Peak EXP | | | | | -1.03** |
| CAMS SEC | | | | | .13 |
| CAMS PME | | | | | .42 |
| CAMS Need | | | | | .15 |
| CAMS PAE | | | | | .84* |

Note. $N = 13$, * $p < .05$, ** $p < .01$, *ns* = not significant. EXP = Experiencing in the working phase of therapy. CAMS SEC = mean proportion of secondary emotion in the working phase of therapy; CAMS PME = mean proportion of primary maladaptive emotion in the working phase of therapy; CAMS Need = mean proportion of needs in the working phase of therapy; CAMS PAE = mean proportion of primary adaptive emotion in the working phase of therapy.

Table 16

Hierarchical regression predicting 18-month Follow-Up for the Entire Sample

| Variables | Total R ² | ΔR^2 | F change | df | β |
|-----------|----------------------|--------------|----------|-------|---------|
| Step 1 | .10* | .10* | 5.47* | 1, 52 | |
| Modal EXP | | | | | -.31* |
| Step 2 | .29* | .19* | 3.28* | 5, 48 | |
| Modal EXP | | | | | -.00 |
| CAMS SEC | | | | | .20 |
| CAMS PME | | | | | -.09 |
| CAMS Need | | | | | -.09 |
| CAMS PAE | | | | | -.41* |

Note. $N = 54$, * $p < .05$. EXP = Experiencing in the working phase of therapy. CAMS SEC = mean proportion of secondary emotion in the working phase of therapy; CAMS PME = mean proportion of primary maladaptive emotion in the working phase of therapy; CAMS Need = mean proportion of needs in the working phase of therapy; CAMS PAE = mean proportion of primary adaptive emotion in the working phase of therapy.

Table 17

Hierarchical regression predicting 18-month Follow-Up for the Entire Sample

| Variables | Total R ² | ΔR ² | F change | df | β |
|-----------|----------------------|-----------------|----------|-------|--------|
| Step 1 | .17* | .17* | 3.45* | 3, 50 | |
| CAMS PME | | | | | .09 |
| CAMS Need | | | | | -.13 |
| CAMS SEC | | | | | .38** |
| Step 2 | .29** | .12** | 8.10** | 4, 49 | |
| CAMS PME | | | | | -.09 |
| CAMS Need | | | | | -.09 |
| CAMS SEC | | | | | .20 |
| CAMS PAE | | | | | -.41** |

Note. $N = 54$, * $p < .05$, ** $p < .01$. CAMS SEC = mean proportion of secondary emotion in the working phase of therapy; CAMS PME = mean proportion of primary maladaptive emotion in the working phase of therapy; CAMS Need = mean proportion of needs in the working phase of therapy; CAMS PAE = mean proportion of primary adaptive emotion in the working phase of therapy.

Table 18

Hierarchical regression predicting 18-month Follow-Up for the Entire Sample

| Variables | Total R ² | ΔR^2 | F change | df | β |
|----------------------|----------------------|--------------|----------|-------|---------|
| Step 1 | .28** | .28* | 4.83* | 4, 49 | |
| CAMS Global Distress | | | | | .25* |
| CAMS Rejecting Anger | | | | | .24 |
| CAMS Hurt/Grief | | | | | -.15 |
| CAMS Assertive Anger | | | | | -.29* |

Note. $N = 41$, * $p < .05$, ** $p < .01$.

Table 19

Hierarchical regression predicting 18-month Follow-Up for the Experientially Distant Subgroup

| Variables | Total R ² | ΔR ² | F change | df | β |
|-----------|----------------------|-----------------|----------------|-------|---------------|
| Step 1 | .06 <i>ns</i> | .06 <i>ns</i> | 2.35 <i>ns</i> | 1, 39 | |
| Modal EXP | | | | | -.24 |
| Step 2 | .33* | .25* | 3.60* | 5, 35 | |
| Modal EXP | | | | | .17 |
| CAMS SEC | | | | | .33 <i>tr</i> |
| CAMS PME | | | | | -.06 |
| CAMS Need | | | | | -.04 |
| CAMS PAE | | | | | -.45* |

Note. $N = 41$, * $p < .05$, $tr = p < .10$, $ns =$ not significant. EXP = Experiencing in the working phase of therapy. CAMS SEC = mean proportion of secondary emotion in the working phase of therapy; CAMS PME = mean proportion of primary maladaptive emotion in the working phase of therapy; CAMS Need = mean proportion of needs in the working phase of therapy; CAMS PAE = mean proportion of primary adaptive emotion in the working phase of therapy.

Table 20

Hierarchical regression predicting 18-month Follow-Up for the Experientially Distant Subgroup

| Variables | Total R ² | ΔR ² | F change | df | β |
|----------------------|----------------------|-----------------|----------|-------|----------------|
| Step 1 | .20* | .20* | 4.69** | 2, 38 | |
| CAMS Global Distress | | | | | .28 <i>tr</i> |
| CAMS Rejecting Anger | | | | | .31* |
| Step 2 | .35* | .15* | 4.32* | 4, 36 | |
| CAMS Global Distress | | | | | .18 |
| CAMS Rejecting Anger | | | | | .34* |
| CAMS Hurt/Grief | | | | | -.17 |
| CAMS Assertive Anger | | | | | -.30 <i>tr</i> |

Note. $N = 41$, * $p < .05$, ** $p < .01$, $tr = p < .10$. EXP = Experiencing in the working phase of therapy. CAMS SEC = mean proportion of secondary emotion in the working phase of therapy; CAMS PME = mean proportion of primary maladaptive emotion in the working phase of therapy; CAMS Need = mean proportion of needs in the working phase of therapy; CAMS PAE = mean proportion of primary adaptive emotion in the working phase of therapy.

Table 21

Hierarchical regression predicting 18-month Follow-Up for the Experientially Engaged Subgroup

| Variables | Total R ² | ΔR ² | F change | df | β |
|-----------|----------------------|-----------------|----------------|-------|----------------|
| Step 1 | .29 <i>tr</i> | .29 <i>tr</i> | 4.52 <i>tr</i> | 1, 11 | |
| Modal EXP | | | | | -.54 <i>tr</i> |
| Step 2 | .45 <i>ns</i> | .16 <i>ns</i> | .49 <i>ns</i> | 5, 7 | |
| Modal EXP | | | | | -.40 |
| CAMS SEC | | | | | -.16 |
| CAMS PME | | | | | -.06 |
| CAMS Need | | | | | -.21 |
| CAMS PAE | | | | | -.39 |

Note. $N = 13$, *tr* = $p < .10$, *ns* = not significant. EXP = Experiencing in the working phase of therapy. CAMS SEC = mean proportion of secondary emotion in the working phase of therapy; CAMS PME = mean proportion of primary maladaptive emotion in the working phase of therapy; CAMS Need = mean proportion of needs in the working phase of therapy; CAMS PAE = mean proportion of primary adaptive emotion in the working phase of therapy.

Table 22

Hierarchical regression predicting 18-month Follow-Up for the Experientially Engaged Subgroup

| Variables | Total R ² | ΔR ² | F change | df | β |
|-----------|----------------------|-----------------|---------------|-------|-------|
| Step 1 | .34* | .34* | 5.56* | 1, 11 | |
| Peak EXP | | | | | -.58* |
| Step 2 | .47 <i>ns</i> | .13 <i>ns</i> | .45 <i>ns</i> | 4, 7 | |
| Peak EXP | | | | | -.48 |
| CAMS SEC | | | | | -.20 |
| CAMS PME | | | | | -.02 |
| CAMS Need | | | | | -.22 |
| CAMS PAE | | | | | -.31 |

Note. $N = 13$, * $p < .05$, *ns* = not significant. EXP = Experiencing in the working phase of therapy. CAMS SEC = mean proportion of secondary emotion in the working phase of therapy; CAMS PME = mean proportion of primary maladaptive emotion in the working phase of therapy; CAMS Need = mean proportion of needs in the working phase of therapy; CAMS PAE = mean proportion of primary adaptive emotion in the working phase of therapy.

Table 23

Hierarchical regression predicting 18-month Follow-Up for the Experientially Engaged Subgroup

| Variables | Total R ² | ΔR^2 | F change | df | β |
|------------------|----------------------|--------------|----------|-------|---------|
| Step 1 | .40* | .40* | 7.23* | 1, 11 | |
| Peak EXP Level 6 | | | | | -.63* |

Note: $N = 13$, * $p < .05$. EXP = Experiencing in the working phase of therapy.

Appendix A

The Experiencing Scale

Klein, M. H., Mathieu, P., Gendlin, E., & Kiesler, D. J. (1986). The experiencing scales: A research and training manual (Vol. 1). Madison, University of Wisconsin Extension Bureau of Audio visual instruction, 1969 (copyrighted 1970).

1. **Objective and intellectual**, giving no evidence of the personal significance of events they describe.
2. **Personal but detached**; no explicit reference to feelings, reactions, or internal states.
3. **Reactions** to external events begin to appear.
4. **Marked shift inward** with a focus on exploration of feelings and internal experiences. At Level 4 clients are in direct contact with their fluid experience and speak 'from' it as opposed to 'about' it.
5. **Questions about experience** and the self are raised and explored from an internal perspective.
6. **Newly realized feelings** and experiences are integrated and explored to produce personally meaningful constructions and resolve issues.
7. Shifts and new understandings in one particular area of experience are **broadened to a wider range** of experiences giving clarity and meaning.

The following are the criteria used by raters to establish Levels of Experiencing:

1. Stage One.

The chief characteristic of this stage is that the content or manner of expression is impersonal. In some cases the content is intrinsically impersonal, being a very abstract, general superficial or journalistic account of events or ideas with no personal referent established. In other cases, despite the personal nature of the content, the speaker's involvement is impersonal, so that he/she reveals nothing important about himself and his/her comments could as well be about a stranger or an object.

a. *The content is not about the speaker.* The speaker tells a story, describes other people or event in which he is not involved, or presents a generalized or detached account of ideas. Nothing makes the content personal.

b. *The content is such that the speaker is identified with it in some way but the*

association is not made clear. The speaker refers in passing to him/herself but his/her references do not establish hi/her involvement. First person pronouns only define the speaker as object, spectator, or incidental participant. Attention is focused exclusively on external events. For example, "As I was walking down the street I saw this happen..."; "He stepped on my toe." The speaker does not supply his attitudes, feelings or reactions. He/she treats himself/herself as an object or instrument or in so remote a way that the story could be about someone else. His/her manner of expression is remote, matter of fact, or offhand as in superficial social chit-chat, or has a mechanical or rehearsed quality.

c. The content is a terse, unexplained refusal to participate in an interaction, or an avoidance or minimizing of an interaction. Minimal responses without spontaneous comments are at stage one.

2. Stage Two.

The association between the speaker and the content is explicit. Either the speaker is the central character in the narrative or his/her interest in clear. The speaker's involvement, however, does not go beyond the specific situation or content. All comments, associations, reactions, and remarks serve to get the story or idea across but do not refer to or define the speaker's feelings.

a. *The content is a narrative of events in which the speaker is personally involved.* His/her remarks establish the importance of the content but make no reference to the quality of this involvement. Remarks and associations refer to the external facets of the narrative, other people, the events, objects, the speakers actions; they do not give his/her inner reactions or perspective. If the narrative includes the speaker's thoughts, opinions, wishes, or attitudes, these only describe him intellectually or superficially. Some speakers refer to ideas and thoughts as if they were feelings; e.g., "I feel that I am a good farmer"; "I feel that people should be more considerate." If terms like "I think" or "I wish" could be substituted for "I feel" without changing the meaning, the remark is at stage two.

b. *The events narrated are impersonal but the speaker explicitly establishes that the content is important to him/her.* For example, he/she expresses interest in or evaluates an event, but does not show the quality or amount of his interest or concern.

c. *The content is a self-description that is superficial, abstract, generalized, or intellectualized.* No reference is made to the speaker's feelings or internal perspective. The segment presents the ideas, attitudes, opinions or moral judgments, wishes, preferences, aspirations, or capacities that describe the speaker form and external or peripheral perspective. One sees him from the outside.

- d. *The content reveals the speaker's feelings and reactions implicitly but not explicitly.* If the speaker is emotionally aroused, it is evident from his/her manner, not from his/her words. If the content is the sort that ordinarily would be personally significant, the speaker does not say so. If the speaker sometimes mentions his/her feelings, he/she treats them abstractly, impersonally, as objects, or attributes them to others. Third person pronouns, especially 'one feels' indicate impersonalization.
- e. *The content is an account of a dream, fantasy, hallucination, or free association.* These should be treated as narratives of external events. They are at stage two if the speaker's remarks associate him/her with the account but do not give his feeling reactions to it.

3. Stage Three.

The content is a narrative or description of the speaker in external or behavioral terms with added comments on his/her feelings or private experiences. These remarks are limited to the events or situation described, giving the narrative a personal touch without describing the speaker more generally. Self-descriptions restricted to a specific situation or role, are also stage three.

a. *The content is a narrative of events or description of an aspect of the speaker's environment (past, present, or future) with parenthetical personal remarks that give one of the following:*

1) The speaker's feelings at the time of the event or in retrospect about it. For example, "He didn't call me back and I was angry" or "He didn't call me back; thinking about it now makes me angry."

2) The personal significance or implication of the situation by relating it to the speaker's private experience. For example, "It reminded me of being scolded as a child"; "It was one of those queer moods that comes on me when I get tired. "

3) The speaker's state of awareness at the time of the event. Such remarks include details of motives, consciousness, private perceptions, or assumptions which are limited to the event. For example, : "I knew at the time that I was reacting too strongly"; " I was aware of wanting to defend myself "; " I did it even though I sensed how foolish it was." Accounts of dreams, hallucinations, fantasies, and free associations should be treated as narratives; they are at stage three if feelings are mentioned.

b. *The content is a self-description of circumscribed aspects of the speaker's life style or role or of his feelings and reaction presented only in behavioral terms.* The speaker might, for example, describe how he functions as a parent or in his job, or tell what he does when he gets angry. Personal remarks enrich the description of the situation or reaction to it, but are limited to the immediate context.

c. *In response to a direct question, the speaker tells what his feelings are or were.* The interviewer's words are not needed to identify the feeling.

4. Stage Four.

The content is clear presentation of the speaker's feelings, giving his/her personal internal perspective or feeling about him/herself. Feelings or the experience of events, rather than the events themselves, are the subject of the discourse. By attending to and presenting this experiencing, the speaker communicates what it is like to be him/her. These interior views are presented, listed, or described, but are not interrelated or used as the basis for systematic self-examination or formulation.

a. *The initial content is a specific situation that is widened and deepened by the speaker's self references to show what he/she is like more generally or more personally.* The speaker must describe feelings in great detail, refer to feelings as they occur in a range of situations, provide personal reactions to specific feelings, or relate reactions to his own self-image. The feelings can be immediate responses or remembered responses to past situations. Self-descriptive comments must deal with internal or personal aspects of the speaker, not with moral evaluations or external or behavioral characteristics.

b. *The content is a story told completely from the personal point of view.* The details of feelings, reactions, and assumptions are integral to the narrative, so that what emerges is a detailed picture of the speaker's personal experience of the events.

c. *The content is a self-characterization in which the speaker tells about his personal perspective.* In talking about him/herself he/she makes explicit his/her feelings, personality, assumptions, motives, goals, and private perceptions. By revealing these internal parts of him/herself, the speaker gives a detailed picture of one or more of his/her states of being. The material presented is not analyzed or interrelated. He use of abstract terms or jargon to describe elements of personality must be expanded with some internal detail to warrant a rating of four. For example, the statement "my ego was shattered" would need elaboration, such as "I felt if I was nothing, that no one would ever notice me".

5. Stage Five

The content is a purposeful exploration of the speaker's feelings and experiencing. There are **two necessary components**. First the **speaker must pose or define a problem or proposition about him/herself explicitly in terms of feelings**. The problem or proposition may involve the origin, sequence, or implications of feelings or relate feelings to other private

processes. **Second he/she must explore or work with the problem in a personal way.** The exploration or elaboration must be clearly related to the initial proposition and must contain inner references so that it functions to expand the speaker's awareness of his experiencing. Both components, the problem and the elaboration, must be present. The proposition or problem must be given clearly or strongly and should include references to feelings or to the personal experience of the issue. If the internal basis of the problem is weak, as in references to undesired behaviors or styles, propositions about the external precipitants of the behavior or feelings, or presentation of temporal sequence of feelings, then the exploration or elaboration must have extensive inward references. It must be clear that the speaker is focusing on his inner experience rather than simply justifying his/her behavior.

The problem or hypothesis about the self must be oriented to feelings, private reactions, or assumptions basic to the self-image. It can be presented in different ways:

1) A feeling, reaction or inner process, and in some cases behavior pattern, can be defined as problematic in itself or as seeming to conflict with other feelings or aspects of the self; for example, "My anger is the problem" or "Why am I so angry?"

2) The speaker may wonder whether or to what extent he has a specific feeling: not "What do I feel?" which would be a three or four, but "Do I really feel angry?" or "How angry am I, really?"

3) The problem or proposition can be defined in terms of the personal implication, relationships, and inner ramifications of a feeling, including its origins or causes, its place in a temporal sequence of feelings and inner events, its mode of expression, or its personal and private implications. For example: "Do I get angry when I feel inadequate?" or "My getting angry means I've lost control of myself" or "I get angry just the way my mother used to".

4) Feelings, reaction and internal processes may be compared. *All the problems or propositions about the self must be explored or elaborated with inner referents.* Examples or illustrations may show how the speaker experiences the problem or proposition in different settings or at different times; if so, the pertinence of the illustration to the problem must be explicit. The problem or proposition may be related to other internal processes or reactions. Alternatively, through hypothesis, speculation, or analogy the speaker clarifies the nature or private implication of the central problem, its causes, or ramifications.

At Stage 5 the speaker is exploring or testing a hypothesis about his/her experiencing. While he/she must define the subject of this process clearly with inner references, his manner may be conditional, tentative, hesitant, or searching.

6. Stage Six.

The content is a synthesis of readily accessible, newly recognized, or more fully realized feelings and experiences to produce personally-meaningful structures or resolve issues. The speaker's immediate feelings are integral to his/her conclusions about his/her inner workings. He/she communicates a new or enriches self-experiencing and the experiential impact of the changes in his attitudes or feelings about him/herself. The subject matter concerns the speaker's present and emergent experience. His/her manner may reflect changes or insights at the moment of their occurrence. These are verbally elaborated in detail. Apart from the specific content, the speaker conveys a sense of active, immediate involvement in an experientially anchored issue with evidence of its resolution or acceptance.

a. *The feelings involved must be vividly, fully, or concretely presented.* Past feelings or past changes in feelings are vividly presented or relived as part of the speaker's current experience.

b. *The structuring process relates these immediately felt events to other aspects of the speaker's private perspective.* This, a feeling might be related to the speaker's self-image, his/her private perceptions, motives, assumptions, to another feeling, or to more external facets of the speaker's life, such as his/her behavior. In each case the nature of the relationship must be defined so that the details of how the speaker works inside and the precise, internal impact of the changes is revealed. It is not merely the existence of a relationship, nor a sequential listing of feelings and inner experiences, but the nature and quality of the association that is made clear.

c. *The synthetic, structuring process leads to a new personally meaningful inner experience or resolves an issue.* As a result of working with his/her feelings and other aspects of his/her private perspective, and exploring their relationship to each other, the speaker has new inner experiences. These may be new feelings or changed feelings, as when the speaker says, "now I am beginning to see that my feeling of guilt is caused by my ideas about work, and it makes me feel much less worried about that sense of guilt. What a relief! " Alternatively and issue may be resolved:" You know I've always kept my anger bottled up because I've been afraid of losing control of myself. Now I realize it wouldn't be so bad if I did; maybe I'd yell or throw something, that's all." IF the speaker starts with a concrete external problem, the related feelings must be presented as part of his present experience and the emergent formulation must change his perception of the problem in some way. For example, "I never asked a girl out because I'm so short. I'm still kind of afraid a girl might call me a shrimp or something, but I'm willing to take that risk now. I guess because I realize that even if she did, it wouldn't break me up. I wouldn't like her very much, but I'd feel better about myself for having at least tried." Some elements in the emergent structure may be external, behavioural, or

intellectual as in a decision to act in a different way. Still, they must be clearly grounded to immediate feelings. It is never sufficient only to state that a resolution has taken place; the experiences underlying the restructuring process must be revealed or relived to satisfy the criteria for stage 6.

7. Stage Seven

The content reveals the speaker's expanding awareness of his immediately present feelings and internal processes. He demonstrates clearly that he can move from one inner reference to another, altering and modifying his conception of himself, his feelings, his private reactions to his thoughts or actions in terms of their immediately felt nuances as they occur in the present experiential moment, so that each new level of self-awareness functions as a springboard for further exploration.

Formulations about the self at stage seven meet the requirements for stage six with the additional stipulation that they be applied to an expanding range of inner events or give rise to new insights. The development may follow one of several different patterns.

1) The speaker may start with an internally anchored problem, explore it, and reach an internally anchored conclusion that he/she then applies to a number of other problems.

2) He/She may arrive at several related solutions to a single problem and reintegrate them. Any self-analysis is followed by a more comprehensive or extensive synthesis.

3) The speaker may use several different formulations about him/herself, each of which meets the requirements for stage six, and integrate, relate, or reduce them through a more basic or general formulation.

4) He/she may start with one conclusion of the type reached in stage six and apply it to a range of situations, each with inner referents explicit, to show how the general principle applies to a wide area of his/her experience.

Experiencing at stage seven is expansive and unfolding. The speaker readily uses a fresh way of knowing himself to expand his experiencing further. Manner at this stage is often euphoric, buoyant, or confident; the speaker conveys a sense of things falling quickly and meaningfully into place.

Appendix B

Selecting an Appropriate Measure of Outcome

Several possible measures of outcome were considered that could capture client change for this study. These included: simple difference scores between depression at pre-treatment and outcome at termination or follow-up; clinically significant or meaningful change scores; and residual gain scores.

The use of difference scores has been widely applied but carries numerous methodological concerns (Cronbach & Furby, 1970). These include low reliability, increases in both Type I and II errors (Edwards, 2001), and vulnerability in being influenced by regression towards the mean (Markus, 1980).

The value of considering clinically significant change in addition to statistical change in evaluating treatment effectiveness has been recognized (Eisen, Ranganathan, Seal & Spiro, 2007). One widely used method of measuring clinically significant change is Jacobson & Truax's (1991) approach, which involves the calculation of a 'reliable change index' (RCI) as the first step in a two-step process of measurement. The RCI takes into account the instrument's measurement error. If the client's RCI exceeds 1.96, then the client's change is determined to have been statistically reliable. The client's score is then evaluated against a second criterion – whether their post-treatment score falls within the range of a normative population. For the treatment of depression, this might entail post-treatment scores that fall below a cutoff score of '10' on the Beck Depression Inventory, signifying minimal depression symptoms. Clients are then classified into *unchanged*, *improved*, and *recovered* groups depending on whether they meet neither, one, or both criteria.

Although the use of clinically significant change scores has many merits, some drawbacks to its use also include being influenced by regression towards the mean (Evans, Margison, & Barkham, 1998), as well as the potential necessity of clients having to make, perhaps unrealistically, large improvements in order to move from the dysfunctional to normal population. This may obscure otherwise meaningful improvements made by clients. A related problem is that clinically significant change scores also result in clients being classified into categorical outcome groups, which may reduce the variability of the original measurement instrument (Aiken & West, 1991; Widiger, 1992).

Finally, residual gain scores have been commonly used to evaluate outcome in psychotherapy research. Its advantages include controlling for: initial differences between individuals, regression towards the mean, and measurement error inherent in the use of repeated measures on the same instrument (Hofmann, Moscovitch, Kim, & Taylor, 2004; Mintz, Luborsky, & Christoph, 1979). Additionally, given that we are using psychotherapy process measures that are ordinal in scale, having a continuous outcome variable also allows for greater variability to be captured.

In order to determine which measure of outcome would best suit the purposes of our study, the EXP and CAMS measures were correlated with each measure of outcome (simple difference scores at termination and follow-up, clinically significant change scores at termination, and residual gain scores at termination and follow-up) for the entire sample. While at termination all measures of outcome correlated weakly to moderately with each other (r s ranging from .02 to

.65), they did so strongly at 18-month follow-up outcome (r s ranging from .76 to .90). In addition, process measures were more strongly related to residual gain scores at both outcome timepoints (r s ranging from .09 to .55 as compared to ranging from .01 to .45 for the other two measures of outcome). Since long-term outcome was a primary interest in this study, residual gain scores at termination and long-term follow-up were used as our measure of outcome.