RELATING A MODEL OF RESOLUTION OF ARRESTED ANGER TO OUTCOME IN EMOTION-FOCUSED THERAPY OF DEPRESSION

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Abstract

The present study explored essential client performances hypothesized to be involved in resolution of arrested anger for 32 clients engaged in EFT for depression, based on a previously proposed Model of Resolution of Arrested Anger in Depression (Tarba, 2007). Five components or predictors were investigated: (a) marker of arrested anger, (b) the expression of assertive anger, (c) empathic and insightful understanding of the other/self-critic, (d) expression of primary adaptive sadness, and (e) letting go/forgiving the other/self-critic. The Marker of Arrested Anger Rating Scale (MAARS) and The Resolution of Arrested Anger Components Scale (RAACS), two 5-point scales developed at the beginning of this study, were used to rate the presence and degree of manifestation of the hypothesized components. The average of "peak" ratings was used. Final outcome was assessed using change scores on three self-report measures: Beck Depression Inventory (BDI-II, depressive symptomatology), Global Severity Index (GSI, global symptomatology), and the Inventory of Interpersonal Problems (IIP, interpersonal difficulties). This study hypothesized a positive correlation between the peak intensity of markers of arrested anger and outcome measures at pre-treatment. As well, the components of resolution were expected to predict outcome at post-treatment, and anger expression was hypothesized to be an independent unique predictor, over and above the other components. Pearson's product-moment correlations indicated a strong positive correlation ($r = .78$, $p<.001$) between the peak intensity of a marker of arrested anger and BDI-II pre-treatment scores, but not between the marker and other outcome measures (i.e., GSI and IIP). Regressions analyses showed that taken together, the components of resolution significantly predicted changes in BDI-II scores (64% of the overall variance explained), but not in GSI and IIP. Assertive anger expression is a

unique independent predictor of BDI-II and GSI change scores (43% and 35% variance explained), but not of IIP change scores. Letting go/forgiving was another independent predictor of BDI-II change scores (22% variance explained). No other components of resolution independently predicted outcome. The role of adaptively expressing and processing primary feelings of anger in the resolution of arrested anger in depression is once again confirmed by this study. The results were discussed in light of existing research in depression and emotional processing in EFT, as well as implications for practice.

This dissertation is dedicated to the late Catalin Konst (born Petrescu),
my cousin and kindred spirit

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You should be angry. You must not be bitter. Bitterness is like cancer. It eats upon the host. It doesn't do anything to the object of its displeasure.
So use that anger.
You write it. You paint it. You dance it. You march it. You vote it. You do everything about it.
You talk it. Never stop talking it.

Maya Angelou

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Introduction

The fact that accessing and expressing emotions play a decisive role in psychotherapy is no longer a mystery. However, researchers and clinicians alike wonder how these emotions unfold during therapy in a way that eventually leads to resolution and change. As noted by Greenberg and Malcolm (2002), studying the process of change allows us to specify the therapeutic tasks and client processes that account for at least part of the outcome, and to better distinguish those from other factors that may influence change (e.g., therapeutic alliance, personality traits, contextual factors, etc.). Furthermore, it is believed that understanding complex emotional and cognitive processes will help therapists facilitate the process of change (Safran & Greenberg, 1991). As such, the current study will further investigate a previously formulated theoretical model of resolution (Tarba, 2007) of arrested anger in depression in EFT. Specifically, we are interested to know whether certain in-session client performances, including the expression of assertive anger, are indeed predictive of better therapeutic outcome in depressed clients who have difficulty expressing anger early in therapy.

Anger is indisputably a powerful emotion that has received much attention in the psychological literature (Fava, Anderson, & Rosenbaum, 1990; Brody, Haaga, Kirk, & Solomon, 1999; Gilbert & Gilbert, 2003; Greenberg & Paivio, 1997; Greenberg & Watson, 2006). Moreover, researchers linked anger inhibition, submissive behavior, and poor assertiveness (especially emotional distress at expressing assertive behaviors) with depression (Akhavan, 2001; Harmon-Jones, Abramson, Sigelman, Bohlig, Hogan, & Harmon-Jones, 2002). Although it has been generally viewed as a destructive emotion that affects the individual at both intra- and interpersonal level, Paivio (1999) and Greenberg and

Paivio (1997) emphasize the importance of working with anger for its information and adaptive value. Influenced by emotion theorists, these researchers believe that anger, like any other emotion, serves an adaptive value by providing important information and action tendency to the organism and, thus, should be given a voice instead of being controlled and managed. In view of this, the current study focuses on whether certain therapeutic tasks and client performances (called components of resolution), including the expression of anger as well as other emotions, predict a positive outcome in the psychotherapy of depression for clients with arrested anger problems.

For researchers concerned with how emotional process contributes to positive changes in therapy, understanding anger expression has received some attention (Darlup, Beutler, & Greenberg, 1988). In a study concerned with the role of anger expression in psychotherapy for depression (Mohr, Shoham-Salomon & Bleutler, 1991) it has been shown that anger expression is associated positively with conflict resolution and negatively with experiences of hurt. Results, however, did not explain how anger expression unfolds during therapy to undo depression, nor did it specify what the essential components of resolution are in this process.

Studies in Emotion-Focused Therapy (EFT), a therapeutic modality that has been proven to be effective in treating depression (Greenberg & Watson, 1998), contributed significantly to understanding how the expression of anger in the context of psychotherapy may facilitate resolution. The central tenet of EFT is that enabling clients to internally attend to emotional experiences in order ultimately to access their adaptive and growth-enhancing function is curative (Greenberg, Rice, & Elliott, 1993). According to this view, the aim in EFT is to activate a network of emotion schemes in order to access adaptive information to

restructure maladaptive emotional schemes.

In a recent study, the intensive analysis of the client's performances in EFT led to the development of a theoretical model of resolution of arrested anger for depressed individuals, where suppressed or hopeless anger, or difficulty in being assertive, were considered to be at the core of depression (Tarba, 2007). This model identifies a pathway from an initial state of arrested anger to the final marker of empowerment/self-affirmation associated with the resolution of arrested anger in EFT. Six essential components (i.e., therapeutic tasks) were shown to be present in the resolution process: 1) expressing anger and standing-up for self; 2) expressing a heart-felt-need; 3) showing understanding or considering alternative ways of seeing reality (self, other or situation); 4) expressing sadness and grieving for unmet needs and lost relationships; 5) letting go of the need to be met by or forgiving a significant other or an internal critic; and 6) the self being validated by imagined other/ self-critic.

The purpose of the present study is to partially validate the previously proposed theoretical model of arrested anger resolution for these clients. Specifically, this study will investigate whether the expression of assertive anger, empathic and insightful understanding of the other/self-critic, and sadness, together with letting go and/or forgiving a significant other or self-critic for past/present violations, wrongdoing or abandonment can predict a good outcome in the EFT of depression. Also, we want to determine whether the expression of primary adaptive (assertive) anger is a better predictor of outcome than any other components of resolution for depressed clients.

While there is an impressive body of research targeting anger expression and depression (Fava et al., 1990; Snell, Gum, Shuck, & Mosley, 1995; Brody et al., 1999; Gilbert & Gilbert, 2003; Gilbert, 2006; Greenberg & Malcolm, 2002; Pos, Greenberg,

Goldman, & Korman, 2003), few studies focus on unpacking the essential client performances involved in the resolution of arrested anger for depressed individuals. Therefore, the main rationale for this study is to add to the psychotherapy body of knowledge by answering the questions: *1) 'do certain client performances predict outcome in the EFT of depression* for clients with arrested anger problems?*';* and *2) 'is any one of these components (i.e., the expression of primary assertive anger, empathic and insightful understanding of the other/self-critic, and primary sadness, together with letting go and/or forgiving a significant other or self-critic) a better predictor than any other for the resolution of arrested anger in depression?'* This research is important because it will help to better understand the process of change in depression, and hence it will advance psychotherapeutic practice and create new ground for further scientific research.

Literature Review

Current Emotion Theory

In order to better understand anger in the context of therapy, it is necessary to first explain the phenomenology of emotions, in general. Recent bio-evolutionary research suggests that there are a number of innate primary emotions consisting of joy, anger, sadness, fear, surprise and disgust (Ekman, 1984; Izard, 1993; 1977). Also, modern theorists perceive human emotion as arising from people's immediate perceptions of their current, imagined or recalled circumstances (Scherer, 2000). Emotions are viewed as relatively brief episodes of coordinated changes in the body that take place as a reaction to external or internal events of major significance to the organism. According to Izard's (1993) discrete theory, each primary emotion has a characteristic display and consists of three components: physiological arousal, motor expression or behavior, and some sort of subjective feeling. For example, in the case

of anger, the physiological response may consist of an increased heart rate, feeling hot (because of the sugar release in the bloodstream), and muscle tenseness (Izard, 1993). The behavioral component includes a specific facial expression (a frown, red face, etc.), changes in voice and tone (louder voice, even yelling), and other body movements (clenching of fists, throwing, etc.). The subjective feeling of anger refers to the person's internal experience in relation to a unique frame of reference, and may include a sense of irritation, feeling violated, mistreated, wronged, etc.

Emotions are fundamentally adaptive resources, a guiding tool that informs people of the significance of the events for their well-being; together with motivation, emotions prepare the organism for rapid appropriate action (Frijda, 1986). From this perspective, emotions are seen as involving two components that are fundamental to adaptation: appraisals and action tendencies. *Appraisals* refer to the organism's evaluation of its circumstances in terms of goals, needs and concerns (Frijda, 1986; Oatley & Jenkins, 1992), and are experienced as direct, immediate and intuitive. However, appraisals alone would not be sufficient for adaptation. In order to survive, *action tendencies* are the motivational forces that organize the individual for adaptive actions (Frijda, 1986), either by establishing, strengthening or altering the relationship with the environment.

Frijda (1986) and Lazarus (1993) have also pinpointed the role of motivation and cognition in the production and expression of emotions. Emotions are seen as connected with motivation in that they represent responses to events that are considered important for the individual in terms of their needs, goals, concerns and ideals (Frijda, 1986). For instance, the appraisal of being rejected by another person would not necessarily lead to an emotional reaction in the absence of a motivation for approval. Furthermore, cognition is considered to

be related to the appraisal component of an emotion, providing the automatic evaluation of a situation in terms of what is good or bad for the self (Frijda, 1986).

Emotion-focused theorists view emotion as foundational to the construction of a sense of self and a key determinant of self-organization (Greenberg & Watson, 2006). In addition, they argue that emotions serve an adaptive goal by providing information for self and others, and thus facilitating communication in a way that promotes survival (Safran & Greenberg, 1991). Moreover, emotions represent our primary signaling system that communicate intentions and regulate the interactions of self and others (Sroufe, 1996), giving life much of its meaning. Conversely, the experience of depression is viewed as resulting from difficulties in regulating emotions (Greenberg, & Watson, 2006).

In working with emotions in depression, emotion-focused theorists distinguished between primary versus secondary, and adaptive versus maladaptive emotions. Primary emotions are the “most fundamental, direct, initial, rapid reactions to a situation” of a depressed person (Greenberg & Watson, 2006, pp. 68). Being immediately angry at a violation or sad for abandonment are examples of primary emotions. Secondary (reactive) emotions are responses that appear as a result of other primary, internal, emotional and cognitive processes and are secondary in time or sequence to these processes. An example of a secondary emotion would be feeling sad (secondary emotion) at being violated (where the primary emotion is anger). Another crucial distinction is between primary emotions that are adaptive and provide useful information, and primary maladaptive emotions that are no longer adequate to the situation, and thus need to be accessed and transformed during the therapeutic process (Greenberg, 2002; Greenberg & Paivio, 1997; Greenberg & Safran, 1987).

Current theories of emotion have thus provided different explanations of emotion that integrate affect, appraisal, action tendencies or motivations, and cognitions. Underscoring the fundamental connection between narrative context, event and motivation, Frijda (1986) defined emotions as the felt action tendencies resulting from the appraisal of a situation/event in relation to a concern. In connection with cognitions and highly depending on motivations, emotions act as a source of information and action for the individual's well-being. Furthermore, emotions are relational in nature and act as a communicative source with one's self and environment. In view of their biologically adaptive function, experiential therapies see emotions and their expression as central to understanding dysfunction and to the process of change. The next section will provide an in-depth exploration of the emotion of anger as seen by EFT theorists.

The Emotion of Anger in Emotion-Focused Theory

Anger, a powerful emotion with profound impact on self and others, is seen by experiential theorists as stemming from a biological tendency to defend oneself when attacked or protect oneself from intrusion or to help overcome obstacles (Greenberg & Paivio, 1997, Greenberg 2002). It can be a reaction to perceived wrongdoing, violations or abandonment, and it can manifest in a variety of forms, from regenerative to destructive.

Generally speaking, anger problems have been classified as either over controlled or under-regulated (Paivio, 1999; Greenberg & Paivio, 1997). Because of its relationship with aggression and violence, under-regulated anger secured its generally unfavourable reputation as a "bad" emotion. Unsurprisingly, it had received the most attention and had led to the development of different methods of control and stress management in the mainstream psychology. Experiential theorists, however, noted that too often people are confronted with

the problem of anger over-control, or an inability to express anger in a healthy manner. It is believed that blocking anger may be related to cultural injunctions against its expression (Greenberg & Paivio, 1997; Paivio, 1999). EFT theorists have emphasized the importance of identifying and working with both unhealthy over-control of anger, as well as with under-regulated anger (i.e., rage) that is secondary to hurt and shame. In accordance with the purpose of this study, the following discussions will focus almost exclusively on the issue of anger over-control.

Greenberg and Paivio (1997) described different types of anger and their specific difficulties to serve as a guiding tool for therapeutic intervention. The first type of anger is *primary anger*, “an immediate and direct response to perceived environmental threat” (Paivio & Carriere, 2007) that is not reducible to cognitive or affective components, but is rather an integrated affective cognitive response. This can be further differentiated into primary adaptive anger, if the emotion is geared to protect the individual from an immediate danger, or is situationally appropriate, and primary maladaptive anger, when it no longer serves an adaptive function in relation to the present situation. For example, anger at being verbally abused is a primary adaptive emotion, whereas anger at being approached for intimacy by a partner when one was the victim of child abuse is a primary maladaptive one. Another category is *secondary anger* (reactive or defensive anger), which can be described as a reaction to another, more primary emotion (Greenberg & Paivio, 1997; Paivio, 1999). For instance, in the case of a person expressing anger at someone to cover more intense and intolerable feelings of sadness at loss, anger is a secondary emotion (in this case, sadness is the primary emotion). The last type of anger is called instrumental anger because of its instrumental value in achieving a goal, where anger is used to manipulate others for

secondary or personal gains. An example would be a teenager pretending to be angry to obtain more money from his parents.

In order to address difficulties in expressing anger, the EFT therapist focuses on accessing over controlled adaptive anger for its attending information. The appropriate expression of this type of anger is associated with self-empowerment, assertive expressions of need, healthy separation from the offender and clear delineation of boundaries (Greenberg, Rice & Elliott, 1993). Furthermore, expressing primary anger facilitates access to an underlying meaning system, which in turn will open the road for more in-depth exploration of unmet needs or for accessing other important emotions.

Understanding Depression and Anger in EFT Terms

The present study has to be considered in the context of research on the treatment of depression in EFT. Therefore, it is necessary to explain the conceptualization of depression in emotion-focused terms, on one hand, and to illuminate the relationship between suppressing anger and depression, on the other. The following section will provide a summary description of the emotion-focused theory of depression and an overview of current understandings of anger suppression versus expression in the context of depression.

Emotion-focused theory of depression. According to DSM V (APA, 2013), a major depressive episode is diagnosed if at least five of the following nine symptoms are met for a period of at least two weeks: depressed mood for most of the day, nearly every day; markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day; significant weight change when not dieting (i.e., loss or gain); disturbed sleep (insomnia or hypersomnia); psychomotor agitation or retardation; feelings of worthlessness or excessive or inappropriate guilt; trouble concentrating or indecisiveness;

and recurrent thoughts of death, suicidal ideation or a suicide attempt. Either depressed mood or loss of interest and pleasure has to be present for the diagnosis to be made. Clinical depression thus involves an accentuation in duration and intensity of everyday experiences, such as feelings of sadness, hopelessness, discouragement, lack of energy, interest or joy.

Interpersonal theorists see depression as being generated by role disruptions or interpersonal isolation (St. Clair, 2004), while cognitive theorists (Beck, 1972; 1973) believe that a negative triad (negative thoughts about the self, others and the world) is the key determinant of depression. In contrast, emotion-focused theory holds that depression is a result of activation of core depressogenic schemes or self-organizations (Greenberg & van Balen, 1998). Emotion-focused theorists describe two types of depression: dependence-type and self-critical depression (Greenberg, & Paivio, 1997). The *dependence-type depression* is characterized by an organization of the self as weak and insecure around attachment due to past experiences of loss or abandonment. Past experiences of invalidation and lack of affection that failed to develop a competent sense of self for a person will make that person vulnerable to what is called *self-critical depression*, formed around a bad sense of self (Blatt & Maroudas, 1992). In reality, both forms of depression are anger related and highly intertwined. According to Greenberg and Watson (1998), at the core of some forms of depression lie feelings of incompetence, inadequacy, worthlessness or badness that lead to an inferior sense of self while others involve a feeling of insecurity stemming from the experience of loss and or the fear of being alone, uncared for, abandoned or rejected. Present circumstances may activate negative emotion schemes and a self-organization that is either weak or bad, accompanied by feelings of powerlessness/ hopelessness. Research has shown that clients who are depressed experience heightened anger that is blocked or inhibited

(Akhavan, 2001; Harmon-Jones et al., 2002). In line with this, emotion-focused theorists explain the mechanism of certain forms of depression as starting with the suppression of primary adaptive reactions of anger at being violated or hurt, at suffering abandonment/ losses or being humiliated, which leads to the over control of experiencing or expressing angry feelings. This, in turn, results in interpersonal problems related to lack of assertion and boundary violation or to interpersonal problems of resignation and despair, which are most often, but not exclusively seen in the self-critical depression. By continuously suppressing their anger, individuals become alienated from their own needs and wants, and end up feeling hopeless, helpless, sad, resentful, and alienated. These feelings are common presenting complaints of clients who seek therapy for depression, and they represent, in fact, secondary feelings. The suppressed adaptive anger is the primary feeling that needs to be accessed and acknowledged in therapy.

Arrested anger and depression in EFT. Anger, a particularly troubling emotion for depressed clients, is an innate response to frustration and violation that is neither good nor bad in itself (Greenberg & Watson, 2006). Anger has an informative and adaptive value when it tells people about their need for protection from harm and pushes them to action. It can also be destructive, when it is acted-out in aggression and violence or, on the contrary, when it is suppressed. Although irritability and anger can be symptoms of some depressions, some depressions have at their core primary feelings of anger that are not adaptively expressed (Rubin, 1969). This present study focuses on over-controlled anger in relation to depression. Over-controlled anger is also called here suppressed, inhibited, unexpressed, blocked or arrested anger. However, it is important to note that some forms of depression may not have at their core feelings of anger.

The relationship between anger suppression and depression has been intensely studied. Researchers have shown that depressed clients experience strong feelings of anger (Fava et al., 1990; Brody et al., 1999). When anger becomes blocked, inhibited, and arrested, it increases stress and contributes to depression (Gilbert & Gilbert, 2003; Gilbert, 2006). Moreover, researchers linked anger inhibition, submissive behavior, and poor assertiveness (especially emotional distress at expressing assertive behaviors) with depression (Akhavan, 2001, Harmon-Jones et al., 2002). Compared with never depressed people, formerly depressed clients admit to more anger suppression and more fear of expressing their anger; they are also more likely to exhibit attitudes such as dependence, pleasing, goodness, low self-esteem related to silencing the self (Brody et al., 1999).

Jack (1991) introduced a theory of depression called "silencing the self", after she noticed that depressed women actively silenced themselves with an internal voice in order to cultivate and maintain intimate relationships. Many women who are depressed feel that they have to censor their own feelings, to devalue their experience, to repress anger, to be silent and present an agreeable self to others in order to maintain close relationships (Jack, 1991; Brody et al., 1999).

According to Snell et al. (1995), the process of experiencing and expressing anger can be classified into three main categories: anger-in, anger-out, and anger-control. Anger-in refers to some people's tendency to suppress angry feelings and thoughts, whereas anger-out refers to those who externalize their anger and react to provocations with aggressive behaviors. Lastly, anger-control refers to people who can monitor their experiencing of anger and, depending on the situation, can either express or prevent its expression. Bridewell & Chang (1997) studied these types of anger in relation to depression, and found that the

tendency to internalize anger was the most reliable predictor of depressive symptoms, followed by lack of anger control and then by the tendency to externalize anger. They concluded that it could be valuable for therapists to examine and possibly modify the tendency of clients to internalize their anger.

Gilbert & Gilbert (2003) coined the term “arrested anger” and defined it as aroused anger that is chronically not expressed or is blocked. They also made some interesting observations on the relationship between arrested anger and unmet needs. They noticed that during the situations when anger becomes aroused, a person faces a physiological choice of fight or flight, a response that is usually automatic and under the regulation of amygdala. In the case of an automatic reaction of “fight”, the person expresses their anger towards the target that has aroused it, and hence the need involved in the aroused anger is met, allowing the person to move on with his/her life. Conversely, in the case of arrested anger, when individuals are forced to repeatedly inhibit their “fight” reactions, they end up putting off their needs and feeling powerless, which in turn can lead to depression.

Emotion-focused theorists had also shown that when the sequence of arousal and expression of an emotion is not completed, the need is not satisfied and the person is left with so called “unfinished business” (Greenberg et al., 1993). As a result the individual feels hopeless and helpless most of the time, may become depressed and may react with anger which is destructive and inadequate to the situation or time. These unresolved feelings may be geared towards a significant other (called “the wrongdoer” or “the offender”), or towards a perceived bad self, which in turn is constituted by an internalized representation of a harsh, hypercritical other. Blatt and Homann (1992) believe that the internalized self-critical attitude specific to some forms of depression (i.e., “introjective depression”, characterized by feelings

of inferiority, guilt and worthlessness), is a result of excessive parental control, criticism and disapproval at the more advanced developmental stage of separation-individuation. Clients included in this study experienced depression as a result of other's real or perceived injuries to the self, and they worked with their emotions by addressing the injurer directly (in the form of the other), indirectly (in the form of self-critic) or both.

Greenberg and Watson (2006) further argue that unexpressed anger towards others (the "offender") or self lead to symptomatic powerlessness, hopelessness and helplessness. These are secondary, non-resilient responses to violation and hurt involving further closing down or giving up. Over controlling, suppressing or interrupting anger in situations that are perceived as threats prevents the individual from taking an assertive stance, which exacerbates a feeling of weakness and disempowerment. This, in turn, further arouses anger and resentment, as illustrated by the "bottle-up – blow-up syndrome" (Greenberg & Paivio, 1997). Feelings of hopelessness, helplessness, sadness, resignation, alienation, and a global sense of disempowerment are often complaints that the depressed client bring in when they first seek therapy. It is hence important for therapists to help clients uncover what lies behind these secondary reactions and express primary, more adaptive feelings. The following section will explore the general principles of EFT intervention while working with depression, in general, and with anger, in particular.

Working with Depression and Anger in Emotion-Focused Therapy

The Emotion-Focused approach was influenced by both client-centered therapy (Rogers, 1959) and gestalt therapy (Perls, Hefferline, & Goodman, 1951). Emotion-focused therapy, a relationally and interpersonally based therapy (Greenberg, Rice, & Elliott, 1993), has empathy at the core of the therapeutic work. In addition, there is a strong task component

in which the therapist is leading the "process", not the client, in order to clarify and make sense of emotionally focused dilemmas.

In line with client-centered therapy tradition, EFT holds that the therapist's role is to provide an environment conducive of change (Greenberg, Watson, & Goldman, 1998) through congruence (genuineness), empathy, and unconditional positive regard (prizing) for the client. A comfortable, non-judgmental atmosphere that provides support and communicates understanding allows clients to feel validated as unique individuals with idiosyncratic experiences. This facilitates an increased trust in the therapist, and the client feels increasingly empowered to explore and express emotions and needs. The client's difficulties slowly begin to come into focus, as do their needs leading to a reorganization of their goals (Greenberg et al, 1998).This helps the client process their emotions and access their needs; sometimes, the self-rejecting, contemptuous view of the self felt when one is depressed may be changed with a more accepting and trusting attitude for self, others and the world.

Once the therapeutic alliance is built and the foundation for therapeutic work is laid, understanding the depressogenic process and developing a focus is the next step in working with depression in EFT (Watson & Greenberg, 1996). This means that the therapist follows the client's speech content for the most emotionally relevant experience, and guides the process in a co-constructive process. The early goal of therapy is to help the client take ownership of their role in creating the depressogenic cycle, which in turn will allow them to feel empowered and become confident in their role as agents of change.

In order to develop a focus for the client's particular difficulty, the therapist engages in "process diagnosis" approach (Greenberg et al., 1993). This involves moment-by-moment

observations and evaluations of the client's processing style (called client micromarkers), such as in the case of addressing a complaint through the use of blame or instrumental anger. Based on these moment-by-moment formulations of client experiencing, the therapist could then choose to focus on a specific processing task (e.g., attending, experiential search, active expression or interpersonal contact), with the goal of promoting contact to emotional experience (Greenberg et al., 1993).

Another role of the micro-process analysis and diagnosis is to identify and differentiate client's emotional experiences. For example, is the client's immediate anger a primary or a secondary emotion? Is it an adaptive or a maladaptive experience? Is the client's verbal content matching the non-verbal behavior (i.e., is it congruent)? What is the client level of emotional regulation (e.g., overcontrolled or underregulated)? In answering these questions, the therapist gains a better understanding of the client's processing style, as well as distinguishes the types of emotional responses and schemes that stay at the core of depression. According to Greenberg and Watson (2006), the client co-activates different emotion schemes that, taken together, produce a unified sense of self in relation to the world. In depression, the self is organized experientially as unloved and worthless, and helpless and incompetent, depending on which emotion schematic memory is activated (e.g., memories of loss, humiliation, failure, etc.). Client's current losses or failures evoke previous emotional schemes, and leaves the depressive self without resilience and powerless.

In addition to assessing client's moment-by-moment experiences, process diagnosis also involves evaluating more complex affective problems presented by the client. Greenberg and Watson (2006) identified two major classes of markers for specific tasks, which may involve interpersonal issues or self-self relations. Interpersonal markers are statements that

indicate the presence of persistent unresolved needs and feelings toward a significant other (called “the other”) and are often related to themes of loss, neglect, or abuse in the form of *unfinished business.* The tasks used to successfully resolve these problem states are empty-chair work and empathic exploration. The self-markers indicate how clients treat themselves and process emotion, which typically involves either neglecting themselves and their experience, or being controlling and punitive of themselves.

Neglectful self-statements indicate that clients cannot identify what they are feeling, have difficulties focusing on their feelings, assuming an external stance, or dismissing/ downplaying the importance of their experience. The therapeutic task here is to help clients become aware of their feelings by using focusing and empathic exploration.

Controlling and punitive self-statements are specific for *conflict splits*, and indicate excessive self-criticalness, placing excessive demands on themselves to fulfill obligations, or invalidating/ interrupting their emotional experience such as anger. Conflict splits, including self-evaluative and self-interruptive splits, operate as a window into the depressogenic process, and reflect part of an individual's self who is harshly critical. The self-evaluative split is characterized by criticism and feelings of being torn, whereas the self-interruptive split is one where a part of the self interrupts and prevents the expression and symbolization of emotional experience. In this study, we call “the self” that part that is weaker and needs to be voiced, whereas the critical or persecutory part is called “the other”, since it reflects an introjected image of a significant other in relation to the client. Conflict splits are most representative of a self-critical depression (Greenberg, Elliott, & Foerster, 1990; Greenberg et al., 1998). With self-critical statements, the primary task is to help clients confront the self-persecutory part of the self and become aware of their negative statements by using two-chair

work. However, although one type of affective problem may be predominant for a depressed individual, other affective problems may emerge throughout the course of therapy.

As client markers of a specific difficulty emerge, the therapist takes a more active, task-oriented approach to treatment by directing client's process. Specific tasks are suggested, based on both tacit and explicit therapeutic knowledge of how to proceed. Therapeutic models of addressing different therapeutic tasks had been extensively discussed by Greenberg et al. (1993), and may include emotion-focused interventions such as systematic evocative unfolding, focusing, the empty chair, two-chair dialogue and, empathic attunement (see Greenberg et al., 1993 for an in depth explanation). With the direction of the therapist, the client engages in different therapeutic tasks in an attempt to make sense and integrate the features of the event causing difficulty for the client as the experiencer. The therapeutic process involves a co-constructed dialectic, in which the client is the expert on the content to be discussed, whereas the therapist is a process-expert, choosing interventions that feel most appropriate.

In the case of EFT for depression, where suppressed or hopeless anger is involved (i.e., over controlled, maladaptive primary anger), the goal is not only to access the core, more adaptive and primary emotions (e.g., anger, sadness and pain, etc.), but also to enable the person to process these feelings more fully. EFT of depression assumes that maladaptive primary shame and fear are at the core of depression and focuses on accessing primary adaptive anger. It is believed that appropriate expression of this type of anger encourages behaviors such as self-empowerment, assertive expression of need(s), interpersonal separation and boundary definition (Paivio, 1999; Paivio & Greenberg, 1995; Greenberg, 1993). Helping the client access the primary anger that is out of awareness and re-own it to

transform the maladaptive emotion will also allow access to the underlying network of meaning, which will consequently lead to the exploration of other underlying emotions and a fuller expression of feelings. Greenberg and Paivio (1997) have identified five different affective tasks involved in the expression of anger: 1. overcoming rational over control and unassertiveness; 2. resolving lingering resentment and bad feelings; 3. resolving anger due to betrayal and abandonment; 4. expressing anger at trauma and abuse, and 5. focusing on core feelings of anger.

In working with over controlled primary anger, Greenberg and Paivio (1997) propose that the first stage is to identify markers of anger avoidance, such as intellectualizing, numbing, minimizing or rationally controlling one's anger, feelings of helplessness and depression instead of expressing anger, and lingering feelings of resentment. Greenberg and Paivio (1997) believe that many people avoid their anger by focusing externally on events or people, in the form of chronic blame (which signals an underlying resentment) or complaint (a fusion of sadness, hurt and anger). These emotions need to be further differentiated before they can be explored and expressed.

Furthermore, the ultimate goal in working with maladaptive primary emotions such as suppressed or hopeless anger is to access the whole dysfunctional emotion scheme that stays at its core. A sense of self that is worthless (bad-me) or insecure (weak-me), which is often learned in the early development (Greenberg et al., 1993), may lead to difficulties in allowing and adaptively expressing anger, which in turn result in feelings of powerlessness, defeat and depression. In order to change, the client needs to reach to the core sense of self, while simultaneously accessing alternate emotions, in addition to the therapist offering a corrective interpersonal experience (Paivio, 1999; Greenberg & Paivio, 1997).

In addition to over controlled anger, clients may express further along the line secondary feelings of anger, which may take the form of hostile self-criticism, often generating feelings of shame, guilt and depression. Anger directed at self or feelings of self-contempt are characteristic of this type of anger; it is usually re-enacted in two-chair dialogue for conflict splits as self-denigrating thoughts for perceived transgressions, shortcomings, unacceptable behavior or emotional experience. The goal here is to “unpack” the cognitive-affective sequences and access the primary emotion (e.g., primary adaptive anger, sadness, etc.) that leads to secondary anger.

Last, but not least, clients may need to work with instrumental anger, which is a learned response used to regulate others’ behavior for secondary gains. Greenberg and Paivio (1997) emphasize that the therapist should not try to arouse or experientially explore this type of anger, but rather confront the client or provide interpretive conjectures. The underlying goal in working with instrumental anger is to help clients understand their own needs and motivations, and help them use alternative ways of achieving their goals.

The Contribution of Narrative Expression to the Process of Change

Many studies exploring the clients’ narrative expression have proved that the narrative meaning-making contributes significantly to the process of change (Angus, 2012: Angus & Bouffard, 2002; Angus & Greenberg, 2011; Angus, Levitt & Hardtke, 1999; Bruner, 2002; Dimaggio & Semerari, 2001; Gonçalves, Machado, Korman & Angus, 2002; White, 2001). Michael White and David Epston (1990), the pioneers of narrative theory, proposed that human beings build their own reality and knowledge of the world through personal stories (or narratives) they create to describe their lives. In discussing the role of "I" in a person's narrative, Richert (1999) and other authors in the narrative tradition (Bruner,

1986; Guidano, 1995; Harre & Gillett, 1994) notice that the "I" represents the "author" or "narrator" within the story, and has the privileged position of overview relative to the "me" who is embroiled in specific action sequences.

In narrative theory the root of dysfunction is understood in terms of a "disempowering narrative" (White, 1993), defined as a story in which the protagonist is severely constrained, and in which certain possibilities are not even open to her/his consideration. The therapeutic work involves at least generating, if not even accepting that personal story (White, 1993). As Bruner (2002) noted, narrative is the name for a special repertoire of instructions and norms of what is to be done and not to be done in life and how individual experience may be integrated into a generalized and culturally established canon. In clients' detailed repertoire, we as therapists notice that in his/her interactions with others, a certain story or theme had become underlined, emphasized, noticed, imposed, told and re-told more than others. If the story that is told most often by significant others in somebody's life happens to be problem saturated (i.e., the story is full of problems), it will have a considerable impact on defining somebody's identity.

As a result, the therapeutic goal consists exactly in changing or deconstructing the negative narrative that had developed in relation to others. When they narrate experiences in therapy, clients try to come to terms with a radically challenged sense of self. Nooney (2004) sees identity as being constantly formed and re-formed through experiences with others, and through their understandings of what is expected of them by the dominant culture in which they live.

Meaning making and emotions are understood to be complex and intertwined processes that both play a crucial role in an individual's change (Angus & Greenberg, 2011;

Greenberg & Angus, 2004). Emotions happen to an individual that is the central character in a narrative and as such, narrative provides the context for understanding clients' experienced emotions and represents the basis on which emotion-focused work unfolds in the process of change. A series of ongoing process-outcome research studies conducted by Levitt and Angus (2000) looked at the interrelationship between story-telling and emotion processes in client-centered and experiential psychotherapy. Results from the intensive analyses of a number of single cases suggest that clients' disclosures of emotionally-charged personal narratives are foundational to the process of change in therapy (Angus & McLeod, 2004).

Emotion and narrative processes contributes to the construction of new personal meanings or to the reconstruction of self-identity by articulating individual stories that are initially scattered, as well as by constructing an overall life story that looks and feels whole and intelligible. In the dialectical constructivist model, at the basis of somebody's sense of self is the organization of internal experience into a coherent narrative (Whelton & Greenberg, 2001). Greenberg and Angus (2004) view the self as a "multi-process, multi-levelled organization emerging from the interaction between ongoing, moment-by-moment experience and higher-level reflexive processes which attempt to interpret, order and explain elementary experiential processes". In line with this, emotions represent a major source for self-expressing and self-experiencing; hence, articulating, organizing and ordering emotions into a coherent narrative are major goals essential to change. Individuals thus constantly create the self they are about to become by synthesising biologically-based information and culturally-acquired learning (Greenberg & Angus, 2004). In depression, clients generally enter therapy with narratives related to failure, loss or humiliation (Greenberg & Watson, 2007). The role of anger expression is to help people change narratives of disempowerment

to more empowered selves.

The Process of Change in Therapy: Relating Process to Outcome

Even when a treatment has been demonstrated to be effective in helping the depressed client, the question related to what are the processes of change remains a crucial one (Greenberg & Foerster, 1996; Greenberg & Newman, 1996). The focus of the outcome studies is on the relationship between successful client performances and long-term outcome, along with the links between therapeutic methods and the client performances and ultimately outcome (Greenberg & Newman, 1996). In understanding these relationships, there is the promise of improved prediction and control, and improved explanation of therapeutic change.

First, a general overview of factors that are considered to influence change in therapy is provided. Next, details about the results obtained in the experiential approach through the employment of process research methods are given. As such, results of different studies that had been targeting the emotional processes shown to help clients move from depression to resolution are presented. Finally, a closer look at how anger expression unfolds during therapy to lead to the resolution of depression is provided.

In the recent years, psychotherapy researchers were preoccupied with the issue of how change occurs in therapy and identified a series of factors that are common across different treatment modalities, such as the therapeutic alliance, the therapist's personality, and client's adherence to treatment (Wampold, 2001). However, one of the most longstanding and controversial debates concerned the issue of therapeutic value of catharsis or emotional arousal in therapy. For example, a study of depression related client's expression of affect and the therapist stance with outcome in cognitive-behavioral and

interpersonal therapy (Coombs, Coleman, & Jones, 2002). Results showed that “collaborative emotional exploration” was related to positive outcome in both treatments. Even though client’s expression of affect did not differ significantly in the two treatment modalities, those clients who scored high on painful affect (characterized as high affect that is difficult to regulate) had poorer outcomes in these brief treatments, raising the concern that evoking experience of painful affect in therapy may not be helpful. Similarly, Nolen-Hoeksema and her colleagues (Nolen-Hoeksema, Morrow, & Fredrickson, 1992) argue that focusing on symptoms, causes and consequences of clients’ depression can exacerbate and prolong a person’s depressed mood. Furthermore, they advocate distracting clients from their negative affects and striving for an “unemotional” problem solving approach to treatment.

In contrast, Pennebaker and his colleagues (Pennebaker & Susman, 1988; Pennebaker, Colder, & Sharp, 1990) have found that people who engage in deeper emotional processing (such as writing about traumatic or depressive events) show substantial improvement in well-being. Moreover, in a study that looked at emotional processing of depressive events, Hunt (1998) found that although greater short-term attention to negative feelings induced short-term emotional pain, those who tolerated this pain felt better in the long run than those who engaged in problem solving and avoided processing their feelings after the depressive event. Similarly, Jones and Pulos (1993) found that the evoking affect and bringing disturbing feelings into awareness were positively correlated with outcome in both dynamic and cognitive-behavioral therapies. Other studies have also shown that in-session emotional arousal is one of the strongest predictors of outcome (Beutler, Clarkin, & Bongar, 2000; Iwakabe, Rogan, & Stalikas, 2000), especially when high arousal is paired with good therapeutic alliance (Iwakabe et al., 2000).

Similarly, experiential therapies such as EFT emphasize that emotions should not be controlled, nor should they exclusively dictate our actions and decisions. Greenberg (1996) suggests rather that emotions should be one piece of a larger picture, "an integration of will, intellect, desire, and emotions into a holistic response of the self" (p. 322). Greenberg (1996) believes that simple catharsis of any feeling is not always useful and can be mistakenly viewed as the way emotion is typically handled in emotion-focused therapy. Solely accessing and promoting arousal of bad feelings such as hopelessness or other maladaptive secondary emotions such as rage masking primary sadness, only serves the purpose of highlighting the maladaptive internal process. In Greenberg's view, the transforming nature of allowing and accepting emotion occurs when new meaning emerges from the emotional process.

In line with Greenberg's view, other authors have shown that emotional expression is therapeutic only for certain people under specified circumstantial conditions (Pierce, Nichols, & DuBrin, 1983). Littrell (1998) showed that even though the experience of strong emotions is necessary for change, the mere expression of emotions in a cathartic way as an end in and of itself is not sufficient for change. Instead, the author argues that the ultimate goal of evoking and experiencing in psychotherapy should involve the restructuration of emotional experiences in order to promote new emotional responses and personal meanings.

Other studies also support the idea that in order to promote change, in-therapy emotion needs to be simultaneously aroused, reflected on and symbolized in order to facilitate the process of making meaning about the self-experience (Greenberg & Pascual-Leone, 1997; Pennebaker, 1997; Warwar & Greenberg, 2000; Whelton & Greenberg, 2000).

In line with this, Pennebaker (1997) emphasizes that the key to integrating one's traumatic experience into a coherent whole is to express and process both narrative information (i.e., details about the nature of the trauma event) and emotional information (i.e., betrayal, hurt, anger, etc.) simultaneously. The combination of both narrative and emotional expression and processing changes the way trauma is symbolized, moving the individual from a chaotic and disorganized representation to one that is clearly understood and organized as a coherent story (Pennebaker, 1997).

Similarly, Warwar (2004) found the combination of high levels of arousal with high reflection on emotional processing which are characteristic for high levels of experiencing to be a good predictor of outcome in the therapy of depression. Missirilian et al. (2005) showed that mid-therapy emotional arousal predicted self-esteem scores at post-treatment, whereas mid- and late treatment perceptual processing predicted lower interpersonal difficulties. Moreover, mid-therapy emotional arousal in conjunction with perceptual processing predicted reductions in depressive and global symptoms better than either of these variables alone. Goldman, Greenberg, Pos (2005) provided further evidence that depth of emotional experiencing predicted reduction in symptoms and an increase in self-esteem, in experiential therapy treatments for depression.

Finally, Boritz, Angus, Monette and Hollis-Walker (2008) showed the relation between autobiographical memory specificity and expressed emotional arousal to be significantly associated with outcome, in that higher proportions of specific autobiographical memory (ABM) were significantly related to higher levels of expressed emotional arousal across all stages of therapy for recovered clients. In contrast, among unchanged clients, higher proportions of specific ABMs were associated with lower levels of expressed

emotional arousal, although this relation was only at a trend level. These research findings suggested that within experiential treatments for depression only the integration of the degree of narrative specificity and the evocation of expressed emotional arousal, rather than these processes taken separately, had implications for therapeutic recovery.

Other studies identified both working alliance and the depth of emotional processing as essential to client change in experiential therapy (Greenberg & Watson, 2006; Pos et al., 2003; Pos, Greenberg, & Elliott, 2008). Moreover, in a study measuring emotional processing and the alliance across three phases of therapy (beginning, working and termination), working phase emotional processing was found to directly and best predict reductions in depressive and general symptoms, and gains in self-esteem (Pascual-Leone, 2005). Also, the author showed that the alliance significantly contributed to emotional processing and indirectly contributed to outcome within the working and termination phases of therapy. Thus, in the context of a good therapeutic relationship, making sense of one's aroused emotional state seems most effective in facilitating therapeutic change.

Recently, Greenberg, Auszra and Herrman (2007) found that the productivity of processing aroused emotions, rather than arousal alone, distinguished good from poor outcomes. Productive and non-productive client emotional expressions were distinguished using the Client Emotional Productivity Scale, built on three central dimensions: emotional activation, emotion type and manner of processing. An emotional expression is considered productive if clients experience a primary emotion in such a way that they can extract useful information inherent to an adaptive emotion, and can change a maladaptive emotion with a more adaptive emotional experience.

Besides studies documenting the importance of working alliance, and emotional arousal, experiencing and productivity in therapy, EFT researchers have also investigated other emotional processes that are related to positive outcome. In trying to understand the process of change in therapy, they questioned what emotions need to be targeted and about what issue; how are these emotions expressed, by whom, to whom, when and under what conditions. For example, intensive analyses of the client's change process in the empty-chair dialogue led to the development of a model of resolution of unfinished business in EFT (Greenberg, 1991; Greenberg & Foerster, 1996). The researchers have hypothesized that four performance components – intense expression of feeling, expression of need, shift in representation of other, and self-validation or understanding of the other discriminate between resolution and nonresolution performances. Indeed, resolved empty-chair dialogues were found to result in greater assertion of needs and a new view of the other. In addition, in another UFB study relating process to outcome in EFT, clients who expressed previously unmet interpersonal needs to the significant other, and manifested a shift in their view of the other, had significantly better treatment outcomes (Greenberg & Malcolm, 2002).

However, other studies have shown that the assertion of needs is a better predictor of outcome than a new view of the other in productive therapy sessions (McMain, Goldman, & Greenberg, 1996), which may be due to the fact that in the case of abuse, for example, resolution can occur without changing the view of the other. Moreover, McMain (1995) related changes in self-other schemas to psychotherapy outcome in the treatment of unfinished business, and found that the change in the representation of the other is not a significant predictor of treatment outcome. Only change in the representation of the self as indicated by increased self-autonomy, self-affiliation, and positive responses to the other

predict successful outcome at post-therapy and four-month follow-up. These studies, in combination, provide substantial evidence that degree of client engagement in expression of emotions and unmet needs during Empty Chair Work predicts successful resolution of unfinished business with significant others.

Further efforts in elaborating models of resolution were made for two-chair dialogue for conflict splits, where the focus was on understanding self-critical processes in depression. In 1983, Greenberg (1983) proposed a three-stage model of successful two-chair work, consisting of Opposition (conflict), Merging (softening and mutual understanding), and Integration (negotiation of mutually satisfying compromises). Moderate support was found for the model (Mackay, 1996), and as a result, adding a Pre-opposition stage (for people who experienced a substantial interruption of contact) was also suggested. McKee (1995) found significantly more instances of focused (inwardly exploring) and emotional (distorted by overflow of emotion) vocal qualities in clients engaged in two-chair dialogue than clients engaged in empathic exploration. Further research supports the importance of softening of the critic in the resolution of two-chair dialogues. Sicoli and Halberg (1998) showed that in sessions in which the critic softened there was a significantly greater expression of "wants and needs" that is associated with resolution. Similarly, Whelton and Greenberg (2001) found that high contempt and low resilience in response to the critic related to depression proneness. In her extensive process study on conflict splits, Stinckens (2001) found that in working with the two-chair technique, process-experiential/EFT therapists frequently addressed client self-criticism by integrating parts of self, and did so more frequently than other experiential therapists. She also found that PE/EFT therapists avoided distancing the

critic. Successful attempts to integrate opposing parts of the self and to avoid distancing the critic were in turn related to positive outcome.

Anger expression in empowering and building hope in depression: research. Proponents of cognitive-behavioral therapy (CBT) consider emotional displays that are too intense are unhealthy and disruptive (Consedine, Magai, & Bonnano, 2002), and that during therapeutic work, clients should be encouraged to inhibit negative and undesirable emotions such as anger and sadness (Buschman, 2002; Bonnano & Kaltman, 1999; Friedman & Booth-Kewley, 1987, Kenedy-Moore & Watson, 1999, Mayne, 1999). Some CBT practitioners believe that clients need to learn anger control and inhibition during therapeutic sessions, or avoid unpleasant feelings. Contrary to these opinions, different studies have demonstrated that anger is a positive emotion when it serves its primary biological-adaptive function (Sicoli, 2005; Harmon-Jones, Lueck, Fearn, & Harmon-Jones, 2006; Rubin, 1969).

Different studies have found supportive evidence for the importance of expressing anger in the therapeutic environment, while specific conditions under which the expression of anger had to take place had been clarified. Van Velsor and Cox (2001) showed that, in the case of survivors of sexual abuse, anger expression is a mean of developing self-efficacy, healing memories, and correctly attributing blame. Moreover, Brody and his colleagues (Brody, Haaga, Kirk, & Solomon, 1999) suggests that the treatment of depression can benefit from the constructive expression of anger, when the therapists encourages and guides clients to calmly discuss a problem with the target of their anger (Brody et al., 1999). Also, Greenberg and Watson (2006) suggest that depressed clients in therapy need to work through their secondary feelings to access the core emotions, including anger, associated with distress.

Sicoli (2005) investigated the resolution of hopelessness in depression. She proposed and validated a model of the resolution of depressive hopelessness by using a comparative group design, and found out that resolvers were more likely to display the processing tasks of expressing negative cognitions and self-agency, allow overall emotion, acknowledge and allow anger, express wants and needs and attain a resilient stance. In addition, clients who resolved their hopelessness were more likely than unresolved clients to report lower post-session ratings of hopelessness, to feel more satisfied about the session, to feel they experienced more change as a result of the session, to achieve higher therapist degree of resolution ratings and to report significantly greater improvements in their depression post-therapy.

Mohr, Shoham-Salomon, Engle, and Beutler (1991) measured the expression of anger in experiential therapy for depression and found that high level of expressed anger were associated with successful conflict resolution. Eight students were selected for this study, each having at least two sessions (one with and the other without a successful resolution). The results demonstrated that expressed anger was more intense in sessions subsequently rated as successful in resolving conflict compared to unsuccessful ones.

The importance of anger expression and the process of change in resolving anger events were also studied in psychodynamic interpersonal therapy (Mackay, Barkham, Stiles and Goldfried, 2002). In using the technique of staying with the feeling, Mackay et al. (2002) showed that clients who successfully stayed with the feeling of anger reached a higher level of emotional arousal, which was in turn related to a decrease in clients' psychopathological symptomatology and interpersonal dysfunction (Missirlian, Toukmanian, Warwar, & Greenberg, 2005). In addition, depression decreased over the course of therapy, and positive

results were maintained at follow-up. The results support that the expression of primary anger is a factor of change in the resolution of depression.

The expression of anger in therapy was related to positive outcomes, in some cases showing a decrease in depressive symptoms, and it was hence favored by theorists as a way toward resolution (Fava et al., 1990; Brody et al., 1999; Akhavan, 2001; Harmon-Jones et al., 2002; Gilbert & Gilbert, 2003; Gilbert, 2006; Gianvito, 2002; Paivio, 1999). However, as noticed by Olatunji, Lohr and Bushman (2007), simply arousing and discharging anger during therapy is not always the best option and in some conditions it might become counter-productive due to an increase in aggressiveness. In a series of counseling analogue studies on catharsis and anger, Bohart (1980) showed that neither clients who showed high levels of in-session arousal and discharge of anger, nor those engaged in an intellectual and rational analysis of their anger reduced or resolved anger; moreover, aroused but unprocessed anger lead to increased aggressiveness. On the contrary, what helped to resolve anger was anger arousal and expression in conjunction with the cognitive exploration of its meaning during empty-chair dialogue. As a result of this study, Bohart (1980) advanced a cognitive theory of catharsis, in which he proposed that the combination of anger expression and cognitive processing may help resolving anger by means of either improving the clients' ability to cope with the provoking situation or changing their perception of self. These studies support the idea that to promote therapeutic change, arousing, expressing and transforming anger is equally important for change to take place.

The Present Study

Relating process to outcome for resolution of arrested anger in depression. In spite of some efforts to elucidate the conditions in which anger expression is related to

positive outcome, these studies failed to provide a clear understanding of how anger unfolds during therapy to facilitate resolution of arrested anger for depressed clients. Gianvito (2002), Tregoubov (2006) and Tarba (2007) engaged in an intensive analysis/exploration of the process of resolution of arrested anger in depression using the Task Analytic method (TA); an in-depth presentation of their findings is further provided.

In a pilot study, Gianvito (2002) employed TA to analyze and describe the anger resolution process of four female clients in process-experiential therapy, using Greenberg's (1998) rational model of anger resolution. One anger event that occurred during empty-chair dialogue was analyzed for one session for each client, and different components of the resolution process were delineated. As such, Gianvito found that clients who resolved arrested anger tended to express assertive anger, needs, hurt and sadness, grief and empowerment more frequently than non-resolvers. Also, the experiencing levels were higher for more resolved compared to less resolved events, with the components of assertive anger and empowerment having the highest experiencing ratings.

Tregoubov (2006) studied the process of resolution of arrested anger in depression in one good and one poor case and proposed a preliminary rational-empirical model of depression. He proposed different client components of competence, such as directing anger at an appropriate target, expressing needs, separating self from a significant other, and expressing sadness during therapy sessions. He also found that when anger that was suppressed by the client is aroused again during therapy, it allows for a gradual emotional processing that leads to changing bitterness and resentment with empowerment, which appears to help with the resolution of depression.

The EFT model of resolution of arrested anger in depression. In 2007, Tarba furthered the results of these studies and proposed a new and improved EFT Model of Resolution of Arrested Anger for depressed clients (see Figure 1). The proposed model represents the basis for the current investigation, which intends to further provide empirical evidence for some of the previous findings. In this section, a detailed presentation of the theoretical model that acts as ground for the present research is provided.

The model of resolution of arrested anger was the result of an intensive analysis of five therapy cases (three resolved and two unresolved) and explained how anger unfolds in the process of overcoming depression in cases where arrested anger was initially present.

Six essential components or client performances that took place between the initial marker of arrested anger and the final marker of empowerment/self-affirmation were found to be essential in the resolution of arrested anger in depression: 1) expressing anger and standing-up for self; 2) expressing a heartfelt need; 3) considering alternative way of seeing reality (self, other or situation); 4) expressing sadness and grieving; 5) showing empathic understanding for a significant other or an internal critic; 6) and the self being validated by imagined other or self-critic. Additional non-essential steps in the model included: 1) expressing undifferentiated/ fused anger and sadness with complaint and hopelessness; 2) addressing self-interruptive processes (fear, beliefs and shutting down); 3) acknowledging avoidance of people or confrontations; 4) imagining and processing the criticism and invalidation from imagined other or self-critic; 5) and expressing non-hostile requests and encouragements as the imagined other or self-critic.

In the theoretical model, the identified components carry the label ‘step’, which describes a component of competency or a certain stage of resolution. Numbers in ascending

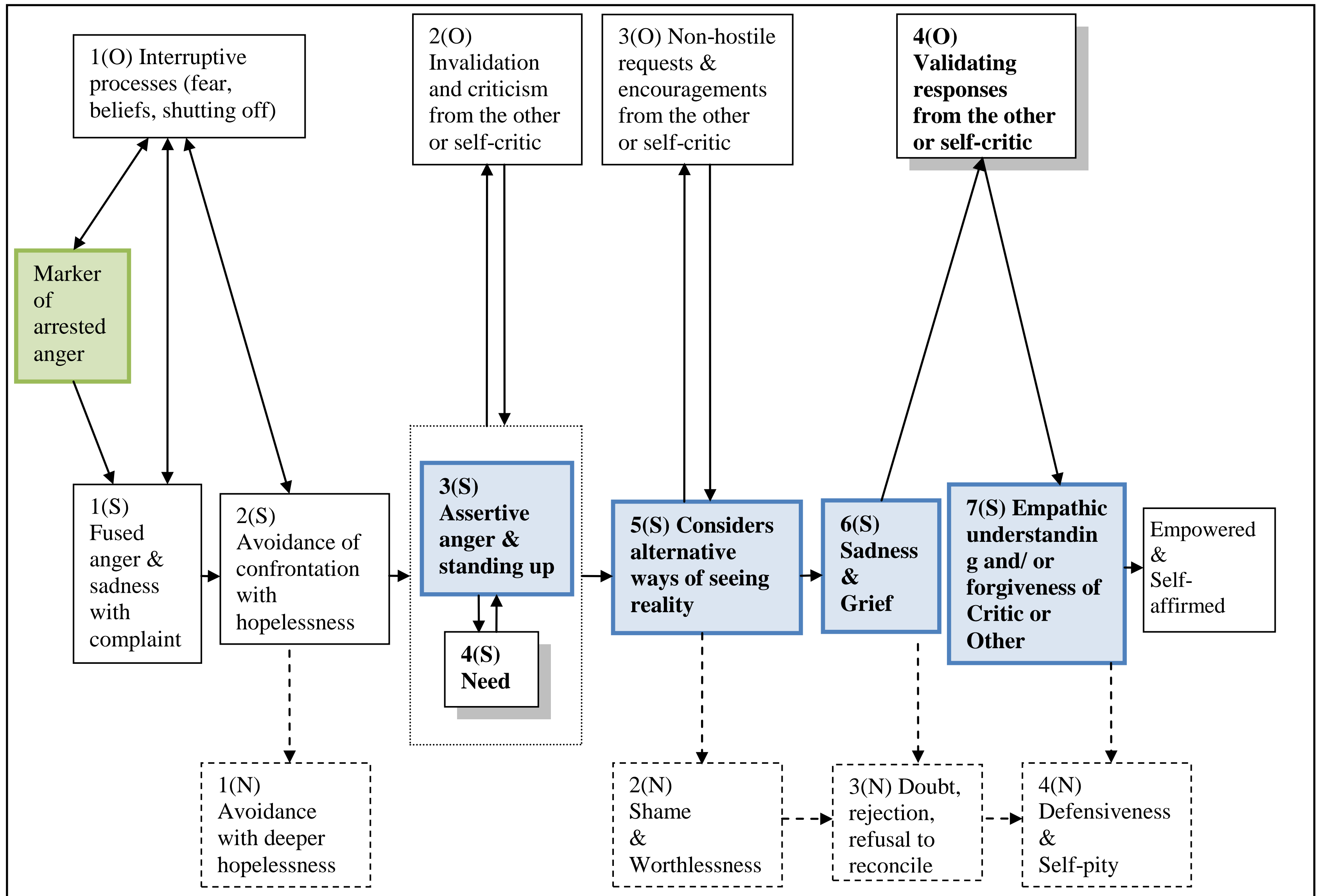

*Figure 1***.** The EFT Rational-Empirical Model of the Resolution of Arrested Anger in Depression (according to Tarba, 2007).

order, meant to describe the succession of components as they appear in the process of resolution, follows any step. The components' labels also include letters: S (to signal components in which the self engages), O (to signal interruptive processes, the other or self-critic), or N (to signal components most characteristic for clients that do not resolve arrested anger).

Similar to Gianvito and Tregoubov's findings, this model shows that adaptively expressing anger during therapy counteracts feelings of hopelessness and leads to acceptance and forgiveness, which in turn appears helpful in undoing depression. Moreover, in the model proposed by Tarba (2007) blaming anger was differentiated from assertive anger and was seen as a rather initial, however primitive stage of resolution. Also, clients resolving arrested anger tended to use a rather blaming-*approach* style, while non-resolution clients used blaming-*distancing* anger, remaining "stuck in anger" and unable to move toward a more assertive, boundary-setting stance.

Another interesting distinction arose in that, while Tregoubov found that only clients who resolve are able to acknowledge and label their anger, Tarba (2007) showed that both resolution and non-resolution clients did so. The difference between resolution and non-resolution clients in her study was that resolvers were able to understand their anger as a protection against hurt and criticism, and conceive of an alternative reality related to self, other or situation, thus creating a new meaning for their depression. For the resolution clients, the emergence of a more differentiated narrative seemed to be at basis of transforming anger into acceptance. Both studies also found that accessing primary feelings of sadness is an essential step to positive change in depression. Clients who resolve arrested anger seem more able to access, allow and process (i.e., grieve) their feelings of sadness,

betrayal and hurt, while non-resolution clients prevent themselves from experiencing the depth and intensity of pain and disappointment, thus remaining stuck in the vicious cycle of emotional numbness–blame–alienation.

The previous foundational study was discovery-oriented and focused on formulating a theoretical model of resolution of arrested anger in depression, having no specific hypotheses. The present research uses Tarba's theoretical EFT Model of Resolution of Arrested Anger in Depression (2007), and is intended to empirically validate the components that were found to be essential to resolving arrested anger, namely the markers of arrested anger, the expression of assertive anger, empathic and insightful understanding of the other/self-critic, expression of primary adaptive sadness, and letting go/forgiving the other/self-critic.

The components of resolution. The original theoretical model of resolution of arrested anger makes reference to various essential and non-essential components of resolution. However, only markers of arrested anger, together with four essential components of resolution, were selected to be included in the present research and are shortly described here. For a more detailed presentation of the specific criteria used to define the marker of arrested anger and the resolution components, see Appendices A and B.

Marker of arrested anger. Generally, the client presents in a way that indicates anger is present at some level, but it is either suppressed, or it seems defeated and hopeless when acknowledged. There are content indications of anger related to past/present violations, wrongdoing, or abandonment from the other (i.e., the offender). The marker of arrested anger has the following defining features:

a) Verbally, client's speech includes statements of suppressed or collapsed anger;

the statements may take the form of covert or dismissed expressions of suppressed anger (e.g. blame, resentment, or incongruent affect and behavior), or they may refer to anger explicitly, but in a hopeless, helpless, powerless, or defeated manner. The client may use passive or negative verbs (e.g., “I can‘t”), stereotype expressions (e.g., “what‘s the point?”, “you know?”), passive voice and third person in a generic way (e.g., “the entire situation was created by my father“ or “he did all of these things and on top of it, imposed rules on us”).

b) Behaviourally, the client exhibits nonverbal behaviour that reflects a combination of both anger and hopelessness that may include some of the following: muscular tension, slight frowning, petrified expression of face, clench of the jaw, lowered head, eyes to floor, slumped or defeated body posture, fading voice, pauses, long silences, sighs, tears, shrugs, laughter (incongruent with speech content).

c) The state of arrested anger is experienced by the client in a rather external and intellectual manner. Similarly, clients may present their narrative in an intentionally detached manner.

Expression of assertive anger (primary adaptive anger). The client makes a clear statement of anger at the other (the offender) for past/present violations, wrongdoing, or abandonment. Sometimes anger is expressed at self-critic in chairs, who usually represents the internalized voice of a significant other. The primary emotion of anger is clearly differentiated and vividly expressed. The client feels entitled to have his voice heard and to speak up for own needs and rights, and fights back. Assertive anger differs from blaming anger, which is a less adaptive, secondary emotion expressed as holding the other accountable without a real affirmation of the self.

The following features characterize this component:

a) Verbally, client's statements reflect a clear expression of anger at the other (the offender) or self-critic for past/present violations, wrongdoing, or abandonment. Assertive statements consist of an adaptive, vivid expression of anger in the form of standing up or speaking up for oneself, setting limits and affirming the self in what seems to be a fight for one's own right to be. An expression of needs, direct or implied, may also take place. Client uses the first person ("I") to express assertive anger, in contrast with using the second person ("you") when conveying blaming anger.

b) Behaviorally, the client exhibits a strong, undefeated, elevated physical state and a sense of anger, rebellion, sticking out, firmness, and endurance. This may include one or more of the following: raised, strong voice; frowning; bright, glorious expression of the face; raised head and shoulders; erect body posture or slight leaning towards the other; clenching of the fist or pointing finger.

c) Clients exhibit high levels of emotional arousal and experiencing.

d) Assertive anger is expressed in a productive manner (i.e., anger is primary adaptive, experienced in the moment and in a fully aware manner without becoming overwhelming; it is freely expressed rather than blocked and it is related to a therapeutically relevant theme.

Expression of empathic and insightful understanding toward the other or self-critic. After expressing anger, clients exhibit a state of calmness and reflection that allows them to consider alternative ways of seeing the reality of the other, the self-critic or a situation. In the process of resolution, this takes the form of an insightful understanding of the whole picture, where formerly scattered pieces of a puzzle start to relate to each other and fall into place.

However, the insightful nature of this component refers to a deep realization that is not entirely intellectual, but, more importantly, emotional. Clients become able to relate to the other, self or a situation in an empathic way that is less judgmental and more compassionate. In other words, understanding is insightful because it takes place at a deeply intuitive level as a result of emotional search and reflection. It is empathic because it promotes compassion, which in turn lays the foundation for letting go or even forgiveness.

There are three ways in which this empathic and insightful understanding is gained:

1) by understanding the other's point of view – the client starts to see the other's perspective, attenuating circumstances or intentions in a more positive light;

2) by agreeing with the other or self-critic's comments about clients' mistakes, which may be seen as taking responsibility for his/her own contribution to the events – the client may understand the mistreatment in terms of its relational context and admit to his or her own negative contribution to the relationship dynamic, by acknowledging a problematic way of relating interpersonally that made the mistreatment from the significant other possible;

3) by acknowledging hurting significant others in turn or in certain situations, as well as expressing feelings of guilt for his/her own contribution.

The following feature characterizes this component:

a) Verbally, client makes statements that reflect a clear expression of empathic understanding, which can take the form of: 1. an understanding the other's point of view, 2. agreeing with the self-critic in regards to own "weaknesses", or 3. owning personal guilt for contribution to hurting significant others in turn or in certain situations.

b) Behaviorally, the client exhibits nonverbal behavior that reflects a reflective, mostly relaxed state, shown by eyes looking away as in searching or pondering; finger stroking on chin, hand to the cheek or holding head; head tilted with eyes looking up; few gestures or use of hands; slow and clear speech, deep voice, moderate to low tone; calmness; body slightly leaning away or towards the other/the therapist.

c) Client exhibits high levels of experiencing, but low emotional arousal.

Expression of sadness (primary adaptive). The client makes a clear statement of sadness related to violations of identity (criticism-related feelings: being dismissed, disrespected, invalidated, humiliated) or attachment violations (abandonment-related feelings: being left alone, neglected, discounted or rejected). Sadness is experienced, symbolized and expressed separately, in an adaptive way, and is accompanied by a sense of resilience and hope.

The following features characterize this component:

a) Verbally, client's statements that reflect a clear expression of sadness, pain or hurt at the other or self-critic for criticism or abandonment. Clients with unresolved feelings of abandonment may also express grief in statements reflecting a sense of sorrow or regret for what was missed.

b) Behaviorally, the client looks depressed and downcast. Client's behavior may include: downsized or sunk body posture, lowered head and shoulders, downcast facial expression; intense crying and sobbing; low, weak voice; lowered, internal and focused voice.

c) Client exhibits high levels of emotional arousal and experiencing.

d) The expression of sadness and pain is productive (i.e., sadness is primary

adaptive, experienced in the moment and in a fully aware manner and it does not become overwhelming; it is also freely expressed rather than blocked and related to a therapeutically relevant theme).

Letting go of unrealistic expectations and/or forgiving (self or other). The client makes a clear statement of letting go or express forgiveness and love at the other or self-critic for past/present violations, wrongdoing or abandonment. In the case of letting go, the client discloses and elaborates upon the meaning of the past in a non-defensive manner, starting to let go of hurt or unrealistic expectations (e.g., that the offender will become non-critical, will take responsibility, verbally ask for forgiveness, etc.) and accepting the present as it is. For the cases where unfinished business was involved, forgiveness also takes place.

The following features characterize this component:

a) Verbally, client's statements must reflect a clear expression of letting go of past and unrealistic expectations, or forgiveness at the other/ self-critic for violations, wrongdoing or abandonment.

b) Behaviourally, the client exhibits nonverbal behavior that reflects a sense of relief, calmness and serenity. This may include one or more of the following: eyes making direct contact with the other/self-critic or the therapist, softened facial expression, upright head, relaxed body posture, hand palms turned up, clear speech, deep voice, moderate to low tone. When expressing forgiveness, clients will show signs of high emotional arousal (e.g., intense gaze, tears, reaching out or touching the imagined other).

c) Client exhibits high levels of experiencing and moderate to high emotional arousal. Letting go or forgiving is currently experienced in an elaborated form that is

expressed in an internally felt manner. The level of emotional arousal is moderate when letting go, whereas when expressing forgiveness is high.

Rationale and goals of the present study. Despite the fact that some studies have tried to measure the role of anger expression in depression (Akhavan, 2001; Harmon-Jones et al., 2002; Gilbert & Gilbert, 2003; Gilbert, 2006), previous researchers have failed to explain and/or validate the steps involved in the processes of change in depression. Previous models of anger expression have been based on one or a combination of the following approaches: 1. Descriptions based on clinical experience; 2. Phenomenological studies using self-reports; and 3. Theoretical models. As such, these models do not necessarily reflect what actually goes on in therapy, but rather what researchers hypothesized and what clinicians perceive and interpret. Some previous studies had investigated the process of resolution of arrested anger through intensive task analysis and built theoretical models of resolution as a result, but no hypotheses were put forth and tested. The present research was intended as a continuation of the previous studies and aimed at testing various hypotheses on a separate, larger sample. In short, it was aimed at validating some of the essential components hypothesized to be involved in the resolution of arrested anger for depressed clients.

The present study focused on three main lines of empirical inquiry. Of these three lines of empirical inquiry, the first proposed hypothesis examined the relationship between the peak intensity of a marker of arrested anger at the beginning of therapy and three pre-treatment scores. Pearson’s Product Moment Correlation was employed to test this hypothesis. The average of "peak" ratings (i.e., the highest ratings made by two independent raters using a 5-point scale) for each of the four components were correlated with pre-

treatment scores as measured by the Beck Depression Inventory (BDI-II), the Global Severity Scale (GSI) and the Inventory of Interpersonal Problems (IIP).

The second line of inquiry involved three sub-hypotheses and assessed how four components selected from the discovery-oriented study (Tarba, 2007) predicted the clients change scores on the BDI-II, GSI and IIP at post-treatment. This was accomplished through a series of Simultaneous Linear Regression Analyses. Each set of analyses was aimed at assessing how the four components or predicting variables (expression of assertive anger, empathic and insightful understanding of other/self-critic, sadness and letting go/ forgiving) representing the core processes of resolution of arrested anger predicted outcome (BDI-II, GSI and IIP scores at post-treatment). The average of "peak" ratings (i.e., the highest ratings made by two independent raters using a 5-point scale) for each of the four components were used as predictor variables. The change scores for the three outcome measures (i.e., BDI, GSI and IIP) were used as the dependent variables. A change score is defined as the difference between the value of a variable measured at one point in time (i.e., post-treatment BDI, GSI and IIP scores) from the value of the variable for the same unit at a previous point in time (pre-treatment BDI, GSI and IIP scores). The choice of using change scores in the analysis of the models in favor of other methods is further addressed and argued in the section entitled Measuring pre-post changes using change scores (p.59).

A third line of inquiry aimed at exploring the unique contribution of assertive anger expression to the resolution of arrested anger, as well as the individual contribution of each other component to resolution (i.e., understanding, sadness and letting go/forgiving). This was also accomplished through a series of Simultaneous Regression Analyses where the independent variable was the average of “peak” ratings for the components of resolution and

the dependent variables were change scores for various outcome measures (BDI-II, GSI and IIP).

Three main hypotheses were tested:

1. The peak intensity of a marker of arrested anger at the beginning of therapy is expected to have a significant positive relationship with various measures of depression, pathology and relational difficulties at the pre-treatment stage. In other words, it is expected that the more a person presents in a state of arrested anger at the beginning of therapy (i.e., either by suppressing the anger or experiencing hopeless anger), the more likely he/she is to experience depression, high symptoms of general psychopathology, as well as interpersonal difficulties.

2. Various components of resolution of arrested anger (i.e., expression of assertive anger, empathic and insightful understanding of the other/self-critic, sadness, and letting go or forgiving the other/self-critic) will significantly predict change on the three outcome measures, as it follows:

> 2.a. Taken together, assertive anger, understanding, sadness and letting go/forgiving will significantly predict decreased level of depression at post-treatment;
>
> 2.b. Taken together, assertive anger, understanding, sadness and letting go/forgiving will significantly predict lower overall psychological symptoms at post-treatment;
>
> 2.c. Taken together, assertive anger, understanding, sadness and letting go/forgiving will predict significant reduction in interpersonal difficulties.

3. For depressed clients with underlying suppressed or hopeless anger difficulties, the expression of assertive anger during therapy will uniquely predict change on the three outcome measures above and beyond all the other components. It follows that:

   3.a. The adaptive expression of assertive anger is expected to explain a significantly higher variance in the depression change scores as compared to other three components of resolution (understanding, sadness and letting go/forgiving).

   3.b. The adaptive expression of assertive anger is expected to explain a significantly higher variance in the global symptomatology change scores in comparison to other three components of resolution (understanding, sadness and letting go/forgiving).

   3.c. The adaptive expression of assertive anger is expected to significantly explain more variance in the interpersonal difficulties when compared to other three components of resolution (understanding, sadness and letting go/forgiving).

Method

Participants

Sample. The sample of this study consisted of 32 clients who came from several larger subject pools originally recruited for three clinical trials completed at the York University Psychotherapy Research Clinic between 1991 and 2002, namely the Unfinished Business, York I and York II studies. The cases were selected based on the presence of at least three markers of arrested anger during the first three sessions (see Case Selection and Case Rating for more details) that were agreed upon and rated by two independent coders. Of the 32 selected cases, seven cases (21.9%) were originally part of the Unfinished Business

Study (Paivio & Greenberg, 1995), 12 cases (37.5%) were selected from the York I Depression Study funded by the National Institute of Mental Health (Greenberg & Watson, 1998) and 13 cases (40.6%) were selected from the York II Depression Study funded by Social Sciences and Humanities Research Committee (Goldman, Greenberg, & Angus, in press). Given the amount of time and effort involved in reviewing most or all therapy sessions available for each subject, selecting relevant therapeutic segments and rating them, the number of clients included in this sample were considered to be a reasonable if not good representation for the purpose of this study.

Participants recruitment. Clients in the original projects from which the current research sample was drawn had been recruited and clinically screened through similar procedures. In the recruitment stage, the research programs advertised the availability of brief psychotherapy treatments for either depression (for two of the clinical trials) or long-standing interpersonal grievance (for the other trial). Advertisements were distributed throughout York University campus and surrounding community, as well as through local media sources (i.e., newspaper and radio) and various mental health organizations (i.e., York University Counselling Center, local hospitals in Toronto). A feature article describing the research program appeared in a major newspaper. The advertisements were calling for participants between ages 18 to 65, who were not involved in pharmacotherapy or psychotherapy treatments at that time. Moreover, depending on the study, the advertisement invited participants who either had symptoms of depression that had lasted more than two weeks or had unresolved “emotional injuries” or “unfinished business” with a significant other that have persisted for two or more years.

Participants screening. Self-referred participants were initially screened over the phone through brief structured interviews that aimed at assessing presenting symptoms of depression or specific longstanding interpersonal difficulties. All screening interviews (by phone or face-to-face) were conducted by advanced graduate students in clinical psychology. Individuals meeting the initial telephone criteria were then invited to participate in one or two face-to-face diagnostic and research interviews. The Structured Clinical Interview for the DSM-III-R (SCID) (Spitzer, Williams, Gibbon, & First, 1989) was used as the basis of clients' admission to the treatment programs.

All three of the clinical trials from which the sample was drawn were brief psychotherapy treatments (ranging from 12 to 20 sessions). Given the limited time and targeted nature of the research projects, certain inclusion and exclusion criteria were used. Participants not meeting inclusion and exclusion criteria were referred to suitable services or agencies in the community.

For York I and II projects, the target group consisted of individuals who were experiencing symptoms of depression and signed an informed consent form for participating in Emotion-Focused Therapy psychotherapy. Inclusion criteria for acceptance into York I and II treatment programs were:

a) Meeting criteria for a Major Depressive Disorder according to DSM-III-R criteria.

b) A BDI score no less than 16 (BDI; Beck, Ward, Mendelson, Mock & Erbaugh, 1961).

c) Client agreement for therapy sessions to be audio and videotaped and agreement to complete research measures.

d) A Global Assessment Score greater than 50 greater on the Structured Clinical

Interview for the DSM-III-R (SCID; Spitzer, Williams, Gibbon & First, 1989).

For the Unfinished Business Study (UFB), the target group consisted of individuals with long-standing interpersonal grievance(s).

Exclusion criteria used for all these research programs were:

a) Severe psychological disturbance that required long-term therapy including a diagnosis of various Axis II disorders (i.e., borderline or schizoid personality disorder) or another Axis I disorder (i.e., schizophrenia) with the exception of an anxiety disorder diagnosis.

b) Any psychosis.

c) Any neurological impairments or severe intellectual deficits.

d) Any significant medical problems.

e) Receiving psychotherapy from another source at the time of the interview.

f) Use of psychotropic medication for depression or diagnosis of an addiction disorder.

g) High risk for suicide at the time of the interview.

Participants selected for the studies were given a full explanation of the brief psychotherapy program and what it entailed. They were informed about the limited nature and type of treatment (i.e., 16-20 sessions of Process experiential/ Emotion-Focused Therapy at no cost in exchange for their participation), as well as their right to withdraw at any point in time. Clients agreed to complete various pre-therapy, post-session and outcome questionnaires and be audio and videotaped at each therapy session. In addition, clients were asked to fill out various 6, 12 and 18-month follow-up measures. All clients gave informed consent permitting the collected research data to be utilized in future psychotherapy research.

Consent for the current study was secured as part of the larger York I and II projects, and York Emotional Injury Study.

Sample demographics. The research sample of 32 clients included 23 females and nine males with ages between 22 and 63 (M = 37, SD = 10.4). Of these, 16 were between the ages of 20 and 35, 11 between the ages of 36 and 50, and five were between the ages of 51 and 64. Seven clients were single, 20 were married or common-law, and five were separated or divorced. The education level of the selected sample included 12 who had completed high school, 12 who had completed some college or university, and 8 with some post-graduate or professional school educations.

Information about socio-economic status was not uniformly collected across the three clinical trials and could not be obtained at a later date. Moreover, there was no formal collection of information on ethnicity in the original studies. Based on clients' appearance and own accounts about their culture during the psychotherapy sessions, they seemed to have come from diverse cultural backgrounds: approximately 65% Canadians, 12% Jewish, 10% Latino, 6% Italian, 4% Eastern European, and 3% Asian.

Therapists

Therapists utilized in the original studies (York I, York II and UFB) received the same training, consisting of at least one year of supervised training in process-experiential/ Emotion-Focused Therapy and an additional 48 hours of training over the course of 24 weeks. Training was based on the manualized treatment protocol for process-experiential treatment (Greenberg, Rice & Elliott, 1993). Training for the clinical trials involved didactic instruction, viewing videotaped sessions of therapy, live demonstration, and in-vivo practice of the treatment with fellow trainees. Therapists were screened for adherence to the treatment

protocol. All therapists had a minimum of three years of clinical experience and non-registered therapists were monitored and supervised weekly by a registered psychologist. Adherence to treatment protocol was ensured through weekly video-supervision of therapy sessions by a registered psychologist.

Measures

Process measures. Three process measures were developed and used for the present study: The Marker of Arrested Anger Checklist (MAAC), the Marker of Arrested Anger Rating Scale (MAARS), and the Resolution of Arrested Anger Components Scale (RAACS).

The Marker of Arrested Anger Checklist (MAAC). Supported by theory and research, this checklist contains descriptive criteria for what constitutes a marker of arrested anger and was used by the principal investigator in the identifying and selecting clients with arrested anger to be included in the present study. The criteria outlined in this checklist are: 1) Presence of at least one client statement of suppressed or hopeless (collapsed) anger. 2) Presence of a non-verbal behaviour reflecting a combination of both anger and hopelessness. 3) The state of arrested anger is experienced in the present as a rather external, intellectual or intentionally detached presentation of a personal narrative. This measure is presented in Appendix A.

The Marker of Arrested Anger Rating Scale (MAARS). This scale measures the degree to which a marker of arrested anger is present or absent for a specific client during a therapeutic event. The MAARS is a five-point Likert-type scale with ratings that range from 0 (“arrested anger definitely absent”) to 4 (“arrested anger definitely present”). The scale contains a detailed description of the main features of a marker of arrested anger, as well as specific criteria associated with various levels of presence (i.e., intensity) for the marker of

arrested anger. Reliability for this measure is reported as part of the results. This measure is presented in Appendix B.

Resolution of Arrested Anger Components Scale (RAACS). This is an ordinal scale that assesses the process components experienced by clients when resolving arrested anger in relation to a person or an anger-laden event in their past. Previous findings (Tarba, 2007) showed that resolving arrested anger in depression is a process that involves clients achieving various processing tasks. The RAACS contains four main processing tasks, components or performances, as follows: 1) the expression of assertive anger (primary adaptive), 2) the expression of insightful and empathic understanding of the other; 3) the expression of sadness (primary adaptive); and 4) letting go of unrealistic expectations and/or forgiving. Each of the individual components of the scale has a unique rating scale. For each task of the RAACS (e.g., expression of anger, sadness, etc.), there are five different levels described that range quantitatively from “0” to “4” and qualitatively from absence of expression to maladaptive/unproductive expression to adaptive and productive expression; hence, higher ratings connote a greater level of task completion and each subsequent level represents a step closer toward resolution of that particular task. Thus, a rating of 3 for the "expression of assertive anger" task is considered a higher level of task resolution than a rating of 0, 1, or 2. The goal for the rater is to judge whether a component is indeed present or not, and to what degree. However, the criteria used for rating each level of different client performances are based on an in-depth qualitative description that moves beyond a numeric value. This measure is presented in Appendix C. Reliability measures for RAACS are also reported as part of the results.

Outcome measures. The following outcome measures were used at pre- and post-treatment to assess clients' levels of depression, global symptomatology and interpersonal difficulties.

Beck Depression Inventory (BDI-II; Beck, 1972; Beck et al., 1961). The BDI-II, long form, is a 21-item self-report inventory with the purpose of assessing the severity of depression and has been found to have good internal consistency with ranges from .73 to .92 (Beck, Steer, & Garbin, 1988). Clients scoring below 10 are considered to be in the normal range of depressive symptomatology and those scoring above 16 are considered depressed (Beck, Steer, & Garbin, 1988). The BDI-II (long form) was administered at the assessment stage, pre-therapy, mid-therapy, post-therapy and at post-treatment follow-up.

Symptom Checklist-90-Revised *(*SCL-90-R; Derogatis, 1983). The Symptoms Checklist-90-Revised is a self-report tool used to provide a measure of the severity and distress experienced in relation to various clinical symptoms. This 90-item scale consists of nine symptom subscales including somatization, obsessive-compulsive behaviour, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideations, and psychoticism. This measure also provides a Global Severity Index (GSI) which considers the number of symptoms endorsed in conjunction with the degree of distress to provide an overall distress score (Derogatis, Rickels, & Roch, 1976). The nine subscales of the SCL-90-R have been found to show convergent validity with the related subscales on the MMPI (Derogatis et al., 1976), have good internal consistency and test-retest reliability with a range from .77 to .90 and from .80 to .90, respectively (Derogatis, 1983).

Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988). The IIP is a self-report measure developed to identify interpersonal

difficulties and the intensity of distress experienced by individuals in response to them. The IIP consists of 126 items, which are divided into two groups: 48 items are organized into "things I do too much" and 78 items are reflective of "things I find hard to do". The items converge around six dimensions of problematic interpersonal behaviours (problems with assertiveness, intimacy, sociability or submissiveness, overly responsible for others, and overly controlling). Individuals rate each item on a five-point Likert scale ranging from 0 (not at all) to four (extremely), reflecting the extent to which the particular situation causes them distress. Internal consistency has been reported to range from .89 to .94 and test-retest reliability with a range from .82 to .94 (Horowitz et al., 1988). The IIP was administered before, at midpoint and following the completion of therapy and at follow-up post-treatment.

Procedure

Developing process measures. In order to address the research questions, the first stage of this study involved developing the three process measures previously mentioned. At this stage, the principal investigator in conjunction with her supervisor developed one measure assessing the presence of a marker of arrested anger (i.e., Marker of Arrested Anger Checklist), and two measures aimed at rating the markers of arrested anger (i.e., Marker of Arrested Anger Rating Scale), as well as the different components of resolution (i.e., Resolution of Arrested Anger Components Scale). The development of the three process measures was grounded on theory and informed by intensive moment-by-moment observations made during the previous discovery-oriented study (Tarba, 2007). Moreover, the EFT Model of Resolution of Arrested Anger in Depression (see Figure 1) proposed in the previous Task Analysis was foundational to developing the measures, which were intended to represent a continuation and refinement of previous findings. These instruments measured

the independent or predictor variable for each line of inquiry. Reliability for the measures is reported as part of the results.

Raters training. Two advanced doctoral students with both clinical experience and knowledge of EFT were trained for at least 35 hours in using The Marker of Arrested Anger Rating Scale (MAARS) and the Resolution of Arrested Anger Components Scale (RAACS). Raters were initially given additional EFT readings and information pertaining to the understanding of the specific concepts involved in this study. Real client examples (other than those used for the study) reflective of the marker and components of resolution, as well as various levels of presence, were then provided in the form of transcripts or videotaped segments to help them understand and consolidate their knowledge of the process components experienced by clients, as well as the differences between various rating levels. In the final stage of training, the principal investigator and the raters practiced rating together another set of therapeutic segments to ensure adherence to the rating protocol and a satisfactory high level of agreement before engaging in the actual rating.

Selection of cases for the study. Thirty-nine clients were initially preselected by the principal investigator based on recommendations made by therapists, researchers and clinicians who were previously involved in the original research programs (i.e., York I, York II and UFB Studies). They reflected on cases and suggested clients who appeared to have had manifestations of arrested anger or general difficulties with expressing anger in the beginning of therapy. Other sources for data mining were the samples used by other psychotherapy process researchers at York University who were working on the aforementioned studies. Finally, random sampling of cases from the archival data was used when other sources were exhausted.

The present study is based on 32 cases where at least three markers of arrested anger were found by the principal investigator to be present during the first three sessions of therapy for each case. The Marker of Arrested Anger Checklist was used to ensure the segments selected had met the criteria for the presence of a marker of arrested anger. Based on this, the principal investigator watched the first three sessions for the preselected cases and found that seven out of 39 cases did not present sufficient evidence for a marker of arrested anger and hence did not meet the inclusion criteria for the study. Also, all the cases included in the present study were controlled for the quality of the therapeutic alliance and had similar scores on WAI (Working alliance Inventory, Horvath & Greenberg, 1989).

Selection of therapeutic segments/excerpts. After selecting the cases based on the presence of three markers of arrested anger, the principal investigator reviewed 590 therapy sessions in search for therapeutic segments relevant for each component of resolution. The segments could be selected at any point in therapy, based on their actual occurrence and relevance to the theoretical model of resolution of arrested anger. While for one specific case (i.e., case number 517) all components of resolution were identified by session 8, for the majority of cases the investigator had to review the entire therapy course to be able to identify therapeutic segments for each components of resolution. A therapeutic segment is an excerpt of a therapeutic event that reflects a specific therapeutic task (for example, expression of sadness). The excerpts selected for this study had to have two main characteristics: 1) during their course, the client sustained experiencing an emotion (for example, anger, sadness, forgiveness, etc.) for at least two to three minutes; and 2) based on a clinical judgment made by the principal investigator and informed by the process measures, it was considered to be the best expression of a specific emotion and a fair representation of

client's general in-session processing style.

Informed by the process measures and her own clinical judgement, the principal investigator reviewed each client's therapy session until three segments pertinent to each essential component of resolution (i.e., expression of assertive anger, understanding, sadness and letting go/forgiving) was found for each client. This led to a selection of 480 therapeutic excerpts that were available for rating. The rationale behind selecting three segments for the marker and each component of resolution was to ensure that there is enough evidence for a specific client that they did not present a higher level of expression of a certain component later in therapy, thus defending against a researcher bias. The principal investigator reviewed each and every client session, in their chronological order, until she was able to pick the best or most representative examples for that client's performances, regardless of their occurrence in time, while continuing to observe their occurrence in the next sessions.

Therapeutic segment rating. At this stage of the study, the two independent raters, blind to outcome, who were previously trained in using the process measures, were invited to make judgements on the peak intensity of a marker of arrested anger and four components of resolution of arrested anger for the 32 cases. Videotapes, audiotapes and/or transcripts of each segment were used for rating. Videotaped segments were used for rating in the majority of cases, as they provide the greatest benefit to viewing and rating the nonverbal aspects of the client's presentation. For example, it is impossible to "see" slouching in a chair on an audiotape (that is, unless it has been previously noted on the transcript). However, as videotaped recordings were unavailable in some instances, five audiotaped segments accompanied by transcripts were instead presented for rating; the use of transcripts was intended to ensure the best input possible for the rater.

Clients' performances were rated one at a time, in their actual order of occurrence. Prior to initiating the actual rating for a certain client, a short description of the case was offered to facilitate rating in the context of each case's idiosyncratic narrative. Raters were then shown a small therapy excerpt which that was cued slightly earlier than the marker of arrested anger. This allowed the rater to gauge a baseline level of emotional experiencing and processing style for each client. Only after rating for presence of the marker of arrested anger, were raters asked to independently make their judgments on the process components using the MAARS and RAACS.

For each marker of arrested anger and each process component, a minimum of one and maximum of three segments were rated for presence and completion level using the process scales. According to the procedure, whenever a component segment for a specific client was rated as "2" or less (i.e., moderately present to completely absent), another two segments were presented to the raters to ensure that the specific client did not accomplish a higher level of expression later in therapy. In the same vein, whenever a component was rated as "4" or "5" (i.e., ratings corresponding to a good and very good presence, respectively), no other excerpts were presented to raters. A level of "4" or "5" is consistent with the concept of a one-time change event, which is considered a necessary, but sufficient condition for change to take place. This means that in some instances the raters had to be presented with and rated only one excerpt, whereas in other instances they were presented and rated as many as three excerpts. Hence, of the 480 excerpts selected for rating, the first rater was presented and actually coded only 302 segments, while the second rater rated only 309 segments. Table 1 shows the total number of sessions reviewed by the principal investigator, excerpts selected for rating, segments actually rated and number of data entries.

Table 1. *Number of sessions and therapeutic excerpts included in the study.*

Case selection and rating	Principal investigator	Rater 1	Rater 2
Sessions reviewed by principal investigator	~ 590	-	-
Therapy excerpts selected for rating	480	-	-
Therapy excerpts actually rated	-	302	309
Total data input ratings	-	160	160

Finally, consistent with the idea of one-time change event, 160 data entries with the highest rating values (i.e., "peak" ratings) were input on behalf of each rater (a total of 320 data points for both raters). For example, in watching excerpts showing the expression of assertive anger for client 010, Rater 1 coded the first excerpt as 2. According to the procedure, the rater was shown two more excerpts to make sure that this particular client did not reach a higher level of expression later in therapy. The next two excerpts were rated as 3 and 3, respectively. Of these three ratings of assertive anger expression for this particular client (i.e., client 010), the highest value (i.e., the value of 3) was input and considered for the final data analysis for rater 1.

Measuring pre-post changes using change scores. In the current study, change scores for the three outcome measures (i.e., BDI, GSI and IIP) were used as the dependent variables and regressed onto the components of resolution. A change score represents the difference between the value of a variable measured at one point in time (i.e., post-treatment BDI, GSI and IIP scores) from the value of the variable for the same unit at a previous point

in time (pre-treatment BDI, GSI and IIP scores). In the past, the use of raw score differences, also called difference, change or gain scores, in the analysis of pretest-posttest designs has been a subject of heated debate, with some authors rejecting and criticizing the reliability of this method (DuBois, 1957; Cronbach & Furby, 1970; Burr & Nesselroade, 1990). The same authors also argued that the ANOVA of residuals or the use of pretest scores as covariates in the analysis of posttest scores (ANCOVA) are more appropriate analytical strategies for measuring change in various types of designs, because their presumed advantage of controlling for similarities at baseline and increased power.

However, more recently, various authors (Allison, 1990; Dalecki & Willits, 1991; Thomas & Zumbo, 2012) have argued that regression analyses using change scores as the dependent variable are the more appropriate method of analysis of change in specific circumstances and may even present advantages over residual change scores. The choice between an analysis of gain scores and an analysis where pretest scores are controlled for (e.g., ANCOVA or ANOVA of residuals) depends on a number of factors.

First, according to Fitzmaurice, Laird, and Ware (2004), the choice between these methods depends on the research question. As such, these authors argue that the use of standardized residuals or ANCOVA is recommended when the following question needs to be answered: given that participants in different groups start with similar scores, how do they differ at posttest? The same authors believe that change scores, rather than looking at differences between groups, are a better method of finding how an entire group, on average, differs in gains at two points in time? Fitzmaurice and colleagues (2004) argue that this latter question is most often the question investigators intend to ask, which also coincides with the purpose of the present study (i.e., understanding how the entire sample, rather than individual

clients compared to each other or a controlled group, changed as a result of the EFT treatment). Cohen, Cohen, Aiken, and West (2003) further argue that even though change scores can overcorrect the posttest by the pretest, the interpretation of what is best to use "depends on our theoretical model of change, and that difference scores may be exactly what we need to match our model" (p. 571, footnote). Currently, it is believed that change scores provide unbiased results in a much wider array of research designs and recommend their use as preferable to ANCOVA or standardized residuals, especially for comparisons of groups within same conditions (Collins & Horn, 1991; Cribbie & Jamieson, 2000). Moreover, various authors (Feng, Diehr, Peterson, & McLerran, 2001; Oakes & Feldman, 2001) agree that analysts should use ANCOVA cautiously, usually only for randomized control trials and only for tests of main effects.

Second, past arguments against the use of raw change scores referred to the tendency of scores to regress toward the mean over time (Cronbach & Furby, 1970). However, Rogosa (1988) argues that this phenomenon only occurs in very specific situations that depend on the measurement time (e.g., comparing weight gains in boys and girls at specific developmental stages). Moreover, Rogosa (1988) further argues that when the variance of a measure changes over time (i.e., increases or decreases in the presence of a newly introduced independent variable), “regression toward the mean does not hold” (Rogosa, p. 187). Moreover, it is believed that using a residual-change approach or an ANCOVA in addressing this rather rare phenomenon does not necessarily solve the potential problems associated with it (Rogosa, 1988; Allison, 1990). Maris (1998) further notices that regression toward the mean does not imply that the change score estimator is biased, just as much as the absence of regression toward the mean does not imply lack of bias of the change scores.

Third, another common criticism of gain scores is their presumed unreliability of measurement (Gupta, Srivastava, & Sharma, 1988; Linn & Slinde, 1977; Lord, 1956). Contrary to this view, in more recent years, the analysis of change scores is seen by an increasing number of authors (Zimmerman & Williams, 1982; Rogosa & Willett, 1983; Fitzmaurice, 2001) as able to provide both a reliable and unbiased estimate of true change. Rogosa (1988) argues that if all individuals change at nearly the same rate over a given time, then change scores show that you cannot detect individual differences that do not exist. He concludes that "the difference score is an unbiased estimate of true change" (Rogosa, 1988, p. 180).

Fourth, while the change scores analysis was associated with low statistical power, using residual gain scores or controlling for pretest scores was considered by Burr & Nesselroade (1990) to be a superior method dealing with lack of power, especially in the case of randomized control trials (Fitzmaurice et al., 2004). However, Oakes & Feldman (2001) note that this view is wrongfully based on the untenable assumption that pretests are measured without error, and further argue that when measurement error is assumed, change scores models are equally or even more powerful than standardized residual models. In addition, when small sample sizes are involved, change scores offer greater power because it estimates one fewer parameter than an ANCOVA (Maxwell & Delaney, 1990; Oakes & Feldman, 2001).

Last, but not least, the use of change scores offers the advantage of better interpretability in comparison to standardized residuals or ANCOVA, which represent statistical transformations lacking direct informative value. Allison (1990) considers that an ANOVA of residuals, one of the alternative methods to change scores, estimates a difference

in residualized scores that no longer have a sensible scale or unit, whereas gain scores have the advantage of indicating precisely how scores changed from pretest to posttest. In other words, change scores indicate whether a group stayed constant, improved, deteriorated, and by precisely how much. In the case of a therapeutic intervention, for example, a mean difference of 20 points in BDI-II as shown by change scores is immediately meaningful to clinicians and easily interpretable.

Summary of data sets and analyses. This research makes use of a very rich data set consisting of a large number of EFT client sessions that occur in 32 cases in order to test three general hypotheses, each containing a subset of hypotheses. Table 2 provides an overview of hypotheses, methods of rating the marker of arrested anger and components of resolution, and analysis used to test each general hypothesis in the current study. This overview of methods will be referred to as needed throughout the presentation of hypotheses testing results in the following sections.

Table 2. *Overview of methods of rating and statistical analysis used.*

Hypothesis	Method of rating	Statistical Analysis
H.1. Marker of Arrested Anger at pre-treatment H.1.a. The peak intensity of a Marker of Arrested Anger in the initial sessions is positively correlated with BDI-II scores at pre-treatment H.1.b. The peak intensity of a Marker of Arrested Anger in the initial sessions is positively correlated with GSI scores at pre-treatment H.1.c. The peak intensity of a Marker of Arrested Anger in the initial sessions is positively correlated with IIP scores at pre-treatment	*The Marker of Arrested Anger Rating Scale (MAARS)*	Pearson's Product Moment Correlations
H.2. Predictors of therapeutic outcome H.2.a. Taken together, assertive anger, understanding, sadness and letting go/forgiving predict lower post-treatment depression level; H.2.b. Taken together, assertive anger, understanding, sadness and letting go/forgiving predict lower overall psychological symptoms at post-treatment; H.2.c. Taken together, assertive anger, understanding, sadness and letting go/forgiving predict reduction in interpersonal difficulties	*Resolution of Arrested Anger Components Scale (RAACS)*	Simultaneous multiple linear regression(s) predicting: H.2.a. BDI-II change scores H.2.b. GSI change scores H.2.c. IIP change scores
H.3. Assertive anger as unique predictor of therapeutic outcome H.3.a. The adaptive expression of assertive anger predicts a drop in depression levels over and above the other predictors. H.3.b. The adaptive expression of assertive anger predicts a drop in overall symptomatology levels over and above the other predictors. H.3.c. The adaptive expression of assertive anger predicts reduced interpersonal difficulties over and above the other predictors.	*Resolution of Arrested Anger Components Scale (RAACS)*	Semi-partial correlations for predictors of: H.2.a. BDI change scores H.2.b. GSI change scores H.2.c. IIP change scores

Results

The final stage of this study consisted of calculation of inter-rater reliability and validity for the two scales, as well as the empirical testing of the proposed hypotheses. Cohen's Kappa statistics were used to calculate the inter-rater reliability coefficients. Various correlation procedures (t-tests for repeated measures, Pearson's product-moment correlation, etc.) were used for testing the overall efficacy of the EFT treatment, the significance of the relation between predictors and outcome, as well as between the peak intensity of a marker of arrested anger and depression scores at pre-treatment stage (i.e., the first hypothesis). In order to test the second main hypothesis relating client performances (i.e., expression of primary assertive anger, sadness, empathic and insightful understanding, and forgiveness/letting go) to outcome (i.e., reduction in depression, general symptomatology and interpersonal difficulties), a series of simultaneous regression analyses were performed. Change scores, the difference between post-treatment and pre-treatment BDI-II, GSI and IIP scores, were used in conducting the regression analyses, based on recent literature supporting the use of change scores that was previously discussed in this paper (i.e., Measuring pre-post changes using change scores, p. 59). Semipartial correlations were calculated to address the third hypothesis about the unique predictive quality of assertive anger expression and the other individual components of resolution. All statistical analyses were conducted using the software program SPSS version 22.0 and a minimum significance level of .05 was used throughout.

Inter-rater reliability

The extent of agreement between the two raters was assessed using Cohen's Kappa statistics. In terms of the peak intensity of a marker of arrested anger evaluated using The *Marker of Arrested Anger Rating Scale (MAARS)*, the agreement between the two judges was

k = .95. The kappa coefficient for the ratings of various components of resolution using the developed measure *Resolution of Arrested Anger Components Scale (RAACS)* were as follows: a. for the expression of assertive anger, inter-rater reliability was k = .91; b. for empathic and insightful understanding of the other, inter-rater reliability was k = .87; c. for expression of primary adaptive sadness, k = .91, and d. for letting go or forgiving the other, the inter-rater reliability was k = .91. All reliability coefficients were significant. Given these results, one can conclude the data produced using the MAARS and RAACS as process measures was precise and consistent.

Preliminary analyses

Treatment outcome. To assess the overall effect of the EFT treatment, three repeated measures t-tests were used to test whether the degree of change in scores was significant from pre- to post-treatment. For each measure, the means, standard deviations, significance of mean differences and effect sizes are reported in Table 3. Of note, the

Table 3. *Results for the three outcome measures at Pre- and Post-Treatment (N=32).*

Measure	Pre		Post		Change Scores		df	Paired sample t-test	Effect size
	Mean	SD	Mean	SD	Mean	SD			
BDI-II	26.31	7.11	7.72	7.45	-18.59	10.50	31	10.02**	.87
GSI	1.51	.48	.62	.43	-.89	.71	31	7.08**	.78
IIP	1.56	.41	1.06	.53	-.50	.59	31	4.75**	.65

**p < .001
Note. BDI-II = Beck Depression Inventory. GSI = Global Severity Index. IIP = Inventory of Interpersonal Problems. SD = standard deviation.

direction of change is the same for these three measures. At the end of therapy, clients reported significantly lower levels of depression (BDI; t (31) = 10.02, p <.001), global symptomatology (GSI; t (31) =7.08, p <.001) and interpersonal problems (IIP; t (31) = 4.75, p <.001) than at the beginning of treatment. The results indicate a large effect size of EFT treatment on BDI-scores (Cohen's *d* = .87) and a moderate to large effect sizes on GSI (Cohen's *d* = .78) and IIP scores (Cohen's *d* = .65).

Correlations among different components of resolution. The relationships between all components of resolution (i.e., assertive anger, understanding, sadness and letting go/forgiving) were examined by means of a series of Pearson r correlations, which are presented in Table 4. As expected, all process variables involving the expression of assertive

Table 4: *Pearson R correlations between ratings of various components of resolution (N=32).*

Components of resolution	Assertive Anger	Understanding	Sadness	Let go/ Forgive
Assertive Anger	1.00			
Understanding	.67**	1.00		
Sadness	.65**	.60**	1.00	
Let go/ Forgive	.60**	.73**	.76**	1.00
Mean	2.81	3.92	3.66	3.50
(SD)	(1.18)	(1.28)	(1.08)	(1.26)

** p < .001

anger, understanding, sadness, and letting go/forgiving are positively and significantly correlated with each other (p<.001). The highest correlations were found between clients' ability to let go/forgive during therapy and the adaptive expression of sadness (*r* =.76, p<.001), as well as understanding (*r* =.73, p<.001). Similarly, the expression of assertive anger was found to be highly correlated with the empathic and insightful understanding of the other/self-critic (*r* =.67, p<.001), as well as with the expression of adaptive sadness (*r* =.65, p<.001) and with letting go (*r* =.60, p<.001). These findings are in line with the hypothesized view proposed by Tarba in 2007 that these components are interconnected with each other and that the expression of one component acts as a facilitative mechanism for the expression of another.

Correlations between process variables (predictors) and outcome. Pearson product-moment correlations (r) were computed for the relation between various components of resolution and outcome change scores. As shown in table 5, there were several notable relations between process variables and different outcome measures. Specifically, clients' BDI-II change scores were negatively correlated with all the components of resolution, indicating a decrease in depression at post-treatment for clients whose expression of anger, understanding, sadness and letting go/forgiving during the course of therapy was higher. The strongest relationship was between BDI-II change scores and the expression of assertive anger (*r*=.77, p<.001). This is consistent with the idea that assertive anger expression is a major component of change in EFT for depression. Similarly, BDI-II change scores were negatively correlated with letting go/forgiving (*r*=.67, p<.001), the expression of empathic and insightful understanding towards the other/ self-critic (*r*=.65, p<.001) and the adaptive expression of sadness (*r*=.54, p<.001).

Table 5. *Pearson R Correlations between the components of resolution and outcome measures (N=32).*

Components of resolution	Outcome		
	BDI-II change	GSI change	IIP change
Assertive Anger	– .77**	– .43*	– .23
Understanding	– .65**	– .33	– .23
Sadness	– .54**	– .14	.10
Let go/Forgiving	– .67**	– .18	– .01
Mean	– 18.60	– .89	– .50
(SD)	(10.50)	(.71)	(.59)

* p < .01, ** p < .001

In addition, GSI change scores were found to be negatively correlated with the expression of assertive anger ($r = -.43$, $p<.01$), showing that the more clients express assertive anger during therapy, the less they endorse general symptomatology at post-treatment. However, no other components of resolution (i.e., the expression of understanding, sadness and letting go/forgiving) were significantly correlated with a change in GSI scores.

Finally, none of the relationships between IIP change scores and process variables (i.e., assertive anger, understanding, sadness and letting go/forgiving) were significant.

Test of Hypotheses

Statistical results addressing the research hypotheses are presented and discussed in this section. To test the first hypothesis, Pearson's zero-order correlations were used to determine whether there was a positive correlation between the peak intensity of a marker of

arrested anger and various outcome measures at the beginning of therapy. For the second and third hypotheses (i.e., H.2. and H.3.), a series of simultaneous regression models were estimated to predict BDI-II, GSI and IIP scores from various components of resolution.

Findings for the marker of arrested anger at pre-treatment hypothesis (H.1.). In order to test the first hypothesis, Pearson's zero-order correlations were used. Table 6 shows the correlations between various outcome scores at pre-treatment, as well as between

Table 6. *Correlation table for the relationship between the marker of arrested anger and various outcome measures.*

Variable	Zero-Order *r*			
	Marker of arrested anger	BDI-II scores (pre-treatment)	GSI scores (pre-treatment)	IIP scores (pre-treatment)
BDI-II scores (pre-treatment)	.78** (p=.000)			
GSI scores (pre-treatment)	.20 (p=.28)	.34 (p=.06)		
IIP scores (pre-treatment)	.31 (p=.08)	.21 (p=.25)	.36* (p=.04)	
Mean	4.05	26.31	1.51	1.56
SD	(.79)	(7.11)	(.48)	(.41)

** p < .001, * p < .05

outcome and the peak intensity of a marker of arrested anger.

There was a positive correlation between GSI and IIP scores ($r = .36$, $p < .05$) at the pre-treatment stage, indicating that clients who endorsed more general symptomatology also reported higher levels of interpersonal difficulties. No significant relationships were found between BDI and GSI pre-treatment scores, on one hand, nor between BDI and IIP scores, on the other.

As expected, a strong positive correlation ($r = .78$, $p < .001$) between peak intensity of a marker of arrested anger (as measured by MAARS) and BDI-II pre-treatment scores was found, thus partially confirming the first hypothesis of the study. This indicates that the more clients present within a state of arrested anger (i.e., either suppressed or hopeless anger), the more likely they are to rate themselves high on BDI-II at the beginning of therapy. A 95% confidence interval estimate is (.59, .88), suggesting that the population correlation is a value between .59 (moderate effect) to .88 (strong effect). The peak intensity of a marker of arrested anger was not significantly associated with GSI and IIP scores at pre-treatment.

Findings for resolution of arrested anger hypotheses (H.2.). In the second hypothesis, various components of resolution (as measured by RAACS) were hypothesized to significantly predict outcome change scores. The components of resolution (predictors) include clients' expression of assertive anger, empathic and insightful understanding of the other/self-critic, adaptive sadness and letting go/forgiving. The outcome (criterion variables) included BDI-II, GSI and IIP change scores, which are measures of level of depression, global clinical symptomatology and interpersonal difficulties, respectively.

A series of simultaneous regression models were estimated to test the second and third hypotheses. The data was also screened for violations of assumptions. Scatterplots of the residuals were examined to confirm that the assumptions of normality, homoscedasticity

and linearity were met, with no evidence found that these assumptions were violated. Correlations among predictor and criterion variables were also examined and did not demonstrate multicollinearity, given that the tolerance values were within normal limits.

H.2.a. Predicting clients' level of depression. The results of the simultaneous regression analysis predicting BDI-II change scores from various components of resolution as measured by RAACS are presented in table 7.

Table 7. *Simultaneous Multiple Linear Regression predicting BDI-II change scores on the presence of various components of resolution,*

Predictor	BDI-II change scores				
	B (SE)	sr^2	*t*	Sig.(p)	95% CI
Assertive Anger	– 5. 66 (1.43)	– .43	– 3.95	.001**	– 8.6 - (–2.72)
Understanding	– .50 (1.43)	–.04	– .35	.73	– 3.44 – 2.43
Sadness	2.17 (1.73)	.14	1.25	.22	– 1.39 – 5.73
Letting go/ Forgiving	– 3.36 (1.60)	– .22	– 2.09	.05*	– 6.65 – (– .07)

* p < .05, ** p < .001

The results of the simultaneous regression analysis indicate that the overall model was significant. The adjusted $R^2 = .64$ for this regression model is significant, $F(4, 27) = 14.64$, $p < .001$. That is, clients who express more assertive anger, understanding, sadness, and letting go/forgiving are significantly more likely to improve, showing a significant decrease

of their depression level (as shown by BDI-II change scores). Thus, 64% of the overall variance of the BDI-II change scores in the sample is accounted for by the expression of various components of resolution. Thus, support was found for hypothesis H.2.a.

In terms of the predictive value of each component taken separately, it was found that the expression of assertive anger is significantly related to BDI-II change scores, over and above all other variables, unstandardized B = – 5. 66, t (27) = – 3.95, p=.001. This indicates that controlling for understanding, sadness and letting go/forgiving, a one point increase in the rating of assertive anger is associated with a decrease of 5.66 in BDI-II scores. In other words, clients who express more assertive anger during therapy tend to experience greater changes in their BDI-II scores translated in lower depression levels at the end of therapy. A 95% confidence interval for this effect is (– 8.6, – 2.72).

Similarly, controlling for assertive anger, understanding and sadness, letting go/forgiving uniquely predicted greater changes in depression as shown by BDI-II change scores, unstandardized B = – 3.36, t(27) = – 2.09, p=.05. Hence, clients' higher expression of letting go or forgiving can significantly predict lower post-treatment depression levels. A 95% confidence interval for this effect is (– 6.65, – .07).

The understanding effect was not significant, p= .73, nor was the sadness effect, p= .22. Therefore, while controlling for the other components, the expression of understanding or sadness does not significantly predict changes in BDI-II depression scores.

In short, assertive anger and letting go/forgiving independently predicted change on the BDI-II scores. Moreover, all the components of resolution, taken together, incrementally contributed to a significant change in BDI-II scores at post-treatment.

H.2.b. Predicting global symptomatology. The results of simultaneous regression analysis predicting GSI change scores from various components of resolution as measured by

RAACS are presented in table 8.

Table 8. *Simultaneous Multiple Linear Regression predicting Global Severity Index (GSI) change scores on the presence of various components of resolution.*

Predictor	GSI change scores				
	B (SE)	*sr*²	*t*	Sig. (p)	95% CI
Assertive Anger	–. 32 (.15)	– .35	– 2.10	.05*	– .63 - (–.01)
Understanding	– .10 (.15)	– .11	– .67	.51	– .41 – .21
Sadness	– .18 (.18)	.17	.99	.33	– .20 – .56
Letting go/ Forgiving	.03 (.17)	.03	.20	.85	– .31 – .38

* p < .01

The results of the second regression analysis indicate that there was not a significant overall effect of the set of predictors (i.e., components of resolution) on GSI scores. The adjusted R^2= .13 for the model predicting GSI change scores on the components of resolution was not significant, F (4, 27) = 2.14, *p*=.10. Therefore, assertive anger, understanding, sadness and letting go/forgiving were not significantly related to GSI change scores, failing to support the H.2.b hypothesis.

However, results also revealed assertive anger to be an independent, significant predictor of GSI change scores, unstandardized B = –.31, t (27) = – 2.10, p=.05. Controlling for understanding, sadness and letting go/forgiving, a one point increase in the rating of

assertive anger was associated with a .38 decrease of GSI scores. Clients' expression of assertive anger during therapy predicted GSI change scores, such that they endorsed less global symptomatology at post-treatment. A 95% confidence interval for this effect is (–.63, –.01).

H.2.c. Predicting interpersonal difficulties. The results of simultaneous regression analysis predicting IIP scores from various components of resolution as measured by RAACS are presented in table 9.

Table 9. *Simultaneous Multiple Linear Regression predicting Inventory of Interpersonal Problems change scores on the presence of various components of resolution.*

Predictor	IIP change scores				
	B (SE)	*sr²*	*t*	Sig. (p)	95% CI
Assertive Anger	–. 18 (.13)	– .25	– 1.43	.16	– .45 - .08
Understanding	– .15 (.13)	– .21	– 1.20	.24	– .42 – .11
Sadness	.25 (.16)	.28	1.61	.12	– .07 –.57
Letting go/ Forgiving	.05 (.14)	.06	.35	.73	– .25 – .35

* p < .01

The set of predictors (i.e., components of resolution) failed to significantly predict IIP change scores. The adjusted R^2= .09 for the model predicting IIP change scores on the

components of resolution was not significant, F (4, 27) = 1.72, p=.18. Hence, no support was found for hypothesis H.2.c.

Findings for assertive anger as unique predictor hypotheses (H.3.). To describe the unique contribution of various components of resolution, in particular assertive anger, to the resolution of arrested anger, the relationship between a specific component of resolution and outcome (i.e., BDI, GSI and IIP scores) was estimated while simultaneously controlling for all the other predictors in the model. A series of squared semipartial correlations (i.e., sr^2) were calculated for all the predictors and are shown in Tables 7, 8 and 9.

Unlike the “unstandardized regression coefficients”, which indicate the “raw” contribution of each predictor without taking into account the fact that different predictors have different scales of measurement, the squared semi-partial correlation is considered to be a superior method of measuring the strength of a predictor due to its more conservative, yet complex nature (Cohen, Cohen, West, & Aiken, 2013). The semi-partial correlation for a given predictor represents the proportion of variability in the outcome that is uniquely explained by the predictor after removing the proportion of variability explained by the other predictors, as well as the *shared* proportion of variability explained by the predictors (i.e., variability explained by the combined effect or correlation between predictors). In other words, semi-partial correlation for a predictor gives the amount that R-square would decrease if the predictor was removed from the model. Currently, the report of semi-partial correlations has become standard practice when addressing the strength of prediction of certain variables.

In predicting BDI-II change scores in the current study, results indicate that clients’ expression of assertive anger is the strongest unique predictor of BDI-II change scores, with approximately 43% of the variability in BDI-II change scores being uniquely explained by it.

Moreover, the expression of letting go or forgiving self or the other explains approximately 22% of the variance in BDI-II change scores, making this the second most important predictor of BDI-II post-treatment scores. The expression of understanding and sadness were not found to be unique independent predictors of BDI-II change scores. Therefore, as expected, hypothesis H.3.a was supported by findings.

The expression of assertive anger was also found to be a significant unique predictor, explaining approximately 35% of the variance in GSI change scores. None of the other components of resolution (i.e., understanding, sadness and letting go/forgiving), taken separately, were found to be significant predictors of GSI change scores. As hypothesized (H.3.b), the expression of assertive anger was found to be a unique significant predictor of GSI change scores.

In predicting IIP change scores, none of the components of resolution (i.e., assertive anger, understanding, sadness and letting go/forgiving) were found to significantly explain any of its variance. In particular, anger expression did not uniquely and significantly contribute to explaining the variance in IIP change scores, thus failing to support hypothesis H.3.c.

Summary of results

A complete task analysis consists of two distinct phases: a discovery phase, in which a model of resolution or completion of therapeutic tasks is constructed, and a verification phase, in which measures for rating the degree of task completion is built and the model is tested in various ways and related to successful therapeutic outcomes. The current study has empirically tested three distinct hypotheses, each including three sub-hypotheses, about the model of emotional processing that was produced in the preceding, discovery-oriented study (see Tarba, 2007). Strong evidence in support of the previously proposed EFT model of

Table 10. Summary of results for all hypotheses and sub-hypotheses.

Hypothesis	p-value	Support sub-hypothesis
H.1. Positive correlation between the Marker of Arrested Anger at pre-treatment and:		
H.1.a. BDI-II scores at pre-treatment	p< .001	Yes
H.1.b. GSI scores at pre-treatment	p< .28	No
H.1.c. IIP scores at pre-treatment	p< .08	No
H.2. Taken together, assertive anger, understanding, sadness and letting go/forgiving predict:	p< .001	Yes
H.2.a. lower post-treatment depression level (BDI-II change scores);	p< .10	No
H.2.b. lower overall psychological symptoms at post-treatment (GSI change scores);		
H.2.c. reduction in interpersonal difficulties (IIP change scores)	p< .09	No
H.3. Assertive anger is a unique independent predictor of:		
H.3.a. depression levels	p< .001	Yes
H.3.b. overall symptomatology	p< .05	Yes
H.3.c. interpersonal difficulties.	p< .16	No

resolution of arrested anger in depression was found as a result of the present study (see Table 10). Each hypothesized finding provides verification of a different aspect of the model in that different components of resolution were related to therapeutic outcome (as measured by BDI-II, GSI and IIP scales).

Moreover, another important finding was that the two measures developed (i.e., Marker of Arrested Anger Scale, MAARS, and Resolution of Arrested Anger Components Scale, RAACS, to evaluate clients' in-session performances) has been proven to have a high degree of inter-rater reliability. These two measures open the door to further understanding of how clients' performances are linked with the resolution of arrested anger in depression.

Discussion

The main purpose of this study was exploring the essential client performances believed to be involved in the resolution of arrested anger in depression. In order to validate these essential components, this study tested five components derived from the EFT Model of Resolution of Arrested Anger in Depression (Tarba, 2007) that was built as a result of a discovery-oriented task analysis of five individuals who underwent Emotion-focused therapy. The five components under investigation were: markers of arrested anger, followed by the expression of assertive anger, empathic and insightful understanding of the other/self-critic, adaptive sadness, and letting go/forgiving the other/self-critic. Ratings of these components were made by two independent, blind-to-outcome raters, who judged their presence and degree of manifestation by using two 5-point scales developed in the beginning of this study: The Marker of Arrested Anger Rating Scale (MAARS) and The Resolution of Arrested Anger Components Scale (RAACS). As a result, approximately 305 ratings selected from 32 therapy cases were made by each coder. To test various hypotheses, the average of "peak" ratings for each component were used and related to three outcome measures. The first outcome measure was the level of depressive symptomatology as measured by the Beck Depression Inventory (BDI-II). Two additional measures included the Global Severity Index (GSI, as part of the SCL-R-90) to measure global symptomatology, and the Inventory of Interpersonal Problems (IIP) to measure interpersonal difficulties. Pearson's product-moment correlations were used to investigate the correlation between the peak intensity of a marker of arrested anger and outcome measures at pre-treatment. Furthermore, using a series of simultaneous regression analyses, this study investigated whether the essential components of resolution of arrested anger, taken together, predicted changes in depression levels, global symptomatology and interpersonal difficulties at post-treatment. Lastly, due to

computational and explanatory superiority in comparison with other methods, semipartial correlations were used to confirm whether clients' expression of assertive anger was indeed a unique independent predictor of change. In the next section, the findings from each hypotheses and sub-hypotheses will be discussed in turn.

Marker(s) of Arrested Anger at Pre-treatment

The peak intensity of a Marker of Arrested Anger in the initial sessions was expected to be positively correlated with BDI-II, GSI and IIP scores at pre-treatment (hypothesis H.1). This hypothesis was partially supported. The results indicated a strong positive correlation ($r = .78$, $p<.001$) between the peak intensity of a marker of arrested anger and BDI-II pre-treatment scores, but not between the marker and other outcome measures (i.e., GSI and IIP at pre-treatment). This suggests that whereas there is a significant association between clients' difficulties with anger expression (i.e., suppressed or hopeless anger) at the beginning of therapy and depressive symptoms, the same is not true for the relation between arrested anger and clients' general symptomatology, as well as the difficulties they might experience at an interpersonal level. This may be due to the fact that the GSI lists a variety of symptoms that are not necessarily anger related, such as somatisation, obsessive-compulsive, anxiety, phobic anxiety, paranoid ideation and psychoticism. In other words, a high score on GSI may include, but not be limited to, clients' anger-related difficulties. In the same vein, not all the interpersonal difficulties measured with the IIP scale are directly related to anger, such as those reflecting coldness, social inhibition, or intrusiveness. On the other hand, the IIP also includes subscales that measure a person's tendency to be domineering/controlling, vindictive/self-centered, non-assertive, overly accommodating and self-sacrificing – traits that could be more readily associated with anger. However, instead of assessing situational anger that is felt in reaction to an event or a person, these subscales are

rather a reflection of trait-anger or personal proneness towards an angry stance, which could help explain why the peak intensity of markers of arrested anger was not found to correlate significantly with these measures. More on the issue of IIP subscales and their informative value is discussed in the Limitations of the study section. Another aspect that could explain why the peak intensity of markers of arrested anger was not correlated significantly with IIP scores is that in some instances, such as when a member of the interpersonal dyad cannot tolerate the expression of anger, arrested or suppressed anger might help maintain those relationships and act as an immediate protective mechanism against attachment ruptures or relationship dissolution.

Predicting Changes in Depression, Global Symptomatology and Interpersonal Difficulties

As stated in the second hypothesis (H.2.), various process measures were expected to significantly predict improvement in outcome (i.e., BDI-II, GSI and IIP scores). The predictors or process variables included the expression of assertive anger, empathic and insightful understanding of the other/self-critic, adaptive sadness and letting go/forgiving the other/self-critic. This hypothesis was also partially supported. Taken together, these components were indeed found to significantly predict changes in BDI-II scores. Approximately 64% of the overall variance of the BDI-II change scores was accounted for by the proposed components of resolution, indicating the significant value of expressing these emotions or performing these steps for decreases in level of depression at post-treatment. However, the overall set of predictors (components) failed to significantly predict changes in GSI and IIP at post-treatment.

Assertive anger as a unique predictor of change

The third hypothesis (H.3.) looked at the strength of prediction of each component of resolution with special attention on the expression of anger, stating that assertive anger expression is a unique independent predictor of depressive symptoms, general symptomatology and interpersonal difficulties at post-treatment, over and above the other predictors. This hypothesis was also partially confirmed. When considered separately, there seem to be important distinctions between the predictive values of each component of resolution on therapeutic outcome. As expected, assertive anger expression was found to be a unique independent predictor of BDI-II and GSI change scores, accounting for 43% and 35%, respectively, of the variance in BDI-II scores. This underscores the importance of clients' working through their anger difficulties during therapy in order to reduce depressive and more global symptomatology. Moreover, letting go/forgiving was found to be another significant independent predictor of BDI-II scores, accounting for 22% of the variance in BDI-II scores. However, support was not found for the unique independent contribution of assertive anger expression to explaining IIP scores at post-treatment.

Theoretical and Clinical Implications

Markers of arrested anger as cues for therapeutic work. A marker of arrested anger, best described as clients' observable state of suppressed or hopeless/collapsed anger when speaking about past violations, wrongdoing or abandonment from a significant other, includes a series of features: verbal (resentful utterances, direct or covert statements of blame, silences, sighs, etc.), behavioral (tension, petrified face, clenched jaws, slumped body posture, etc.) and experiential (detached, external, intellectual). Client's speech contains statements where: 1. anger is not acknowledged verbally (suppressed), but hinted at covertly (e.g., complaint, blame, resentment) or plainly dismissed (blocked, interrupted, constricted,

avoided, etc.), and 2. anger is mentioned in a defeated or hopeless voice (talking about rather than from anger, with accompanying hopeless and fearful expression).

For example, in the third session, this client (case number 312) is talking about her parents' failure to acknowledge and accept her in spite of their differences, showing a mixture of feelings related to anger (e.g., complaint, suppressed anger, helplessness, etc.) and renunciation to expressing her needs.

> T: it's almost like I need you to acknowledge that even though I'm not like you I'm still okay, I'm not what you expect or -
> C: - yeah like just – I, I don't know, I want that recognition like I have really, they really never gave me any recognition like for anything [complaint], like I just never could do anything right [blocked, inhibited anger] like no, it got to a point it was like okay um - this is just, this is just it, like just do, I figured just do your own thing [secondary, reactive anger] and, but yet it's so hard (collapsing anger) like to, to keep on doing that while, not being able to come to terms with them, and just like the whole thing like, that I closed myself off to this so much like I [withdrawal, avoidance], I don't want to fight like this ongoing battle of back and forth and back and forth [suppressing anger] like you should [acknowledging need to express anger], but no, every time like I have the nerve like to come forward with something and say okay this is you know, this is what I do, well I know it didn't fit into their, what they thought was best for me or their expectations [helpless].

The findings of this present study are consistent with theoretical views and scientific evidence that are both old and new. Initially, Freud (1917) pioneered the idea that anger turned inward may be at the core of depression. More recently, the relationship between anger suppression and depression has received increasing empirical support (Fava, Anderson, & Rosenbaum, 1990; Brody, Haaga, Kirk, & Solomon, 1999). In a study by Bridewell and Chang (1997), where 215 undergraduate student participants from a Midwestern university completed self-report measures of depression, anxiety, and anger expression (i.e., anger in, anger out and anger-control), the tendency to internalize anger was also shown to be the most reliable predictor of depressive symptoms, accounting for 46% of outcome variance. Moreover, blocked, inhibited or arrested anger has previously been shown to be associated

with increased levels of stress and depression (Gilbert & Gilbert, 2003; Gilbert, 2006). Some clients from the present study spoke about using an imagined self-critic or internalized voice to actively silence themselves during a two-chair dialogue by censoring their feelings, devaluing their experience, repressing or "silencing" their anger, and presenting an agreeable self to others in order to cultivate and maintain close relationships. This observation is consistent with the notion of "conflict splits" or problems that arise when one part of the self attacks or inhibits the expression of another fundamentally adaptive part of the self (Elliott et al., 2004). Greenberg and colleagues (Greenberg et al., 1993) have continuously developed and refined the two-chair dialogue technique to address the conflict splits, which represent the expression of internalized standards that are set up in early formative years by significant attachment figures and that gradually become part of individual identity.

However, this study adds to the understanding of how clients' anger difficulties may connect to feelings of depression, as the marker of arrested anger was defined in this study not only as suppressing the unwanted feeling, but also failing to express it adaptively (i.e., collapsing into hopelessness whenever attempts to it were made). During therapy, approximately 14 clients in this study linked their inability to sustain an angry stance with a more basic fear of losing control over their anger or not knowing how to express it safely, which was connected with an underlying fear of losing a significant other or being rejected. Consistent with these observations, the hopeless or collapsed anger seems to be indicative of a different "anger pathology", i.e., being unable to express anger in a healthy manner. In light of some empirical data, various possible explanations for this inability may include individual neuro-affective differences (e.g., asymmetric cortical responses to anger-evoking events, as proposed by Harmon-Jones et al., 2002), familial factors such as deficient parental modelling or lack of exposure to safe, adaptive or productive expressions of anger (Buck,

1993; Krause, Mendelson & Lynch, 2003), personality factors (Akhavan, 2001), and life experiences (bullying, trauma, political oppression, etc.). In addition, as observed by Greenberg and Paivio (1997) and Paivio (1999), difficulties with expressing anger may also be due to cultural injunctions against its expression.

The components of resolution as predictors of change in depression. One of the most important findings of this study was the predictive power that the four components of resolution, taken together, have on the therapeutic outcome (depression levels as measured by BDI-II). Specifically, the entire set of various components of resolution (i.e., assertive anger expression, understanding of the other/self-critic, primary adaptive sadness and letting go/forgiving, taken together), was shown to explain an overall 64% variance in BDI-II change scores. Of all the components of resolution, assertive anger expression and letting go/forgiveness were found to be the strongest independent predictors of change in depression levels, explaining 43% and 22%, respectively, of the variance in change scores. However, the overall model including all the components of resolution predicted greater changes in outcome variance than anger expression and letting go alone. Except for the assertive anger expression, which was found to explain 35% of variance in GSI change scores, no other component of resolution was shown to significantly predict changes in global symptomatology and interpersonal difficulties. This section will discuss in detail the findings and theoretical implications applicable for each component of resolution.

The adaptive function of anger. The expression of primary adaptive anger (assertive anger) was found to be the most important unique predictor of decreased depression (as measured by BDI-II) and global symptomatology (as measured by GSI) at post-treatment. Assertive anger expression explained 43% and 35%, respectively, in the variance of BDI-II and GSI change scores. As predicted, clients' expression of assertive anger (primary

adaptive) included in this study was associated with vivid in-chair statements and behaviors and acted as a corrective experience for mistreatment, wrongdoing, abandonment, violation, etc., sometimes leading to a sense of having one's needs met as a result of it. This finding is consistent with other emotion-focused research studies that connected anger expression with positive outcome in EFT for depressed individuals (Pos et al., 2003) or for "unfinished business" cases (Greenberg & Malcolm, 2002). These studies showed the importance of bringing the disavowed anger into awareness and integrating it with action and life experiences. The results of this study are consistent with the previously developed theoretical model of resolution of arrested anger in depression (Tarba, 2007), showing that accessing, exploring and modifying arrested anger and its meanings seems to be indeed the primary component in the resolution process.

Based on the descriptive features of what constitutes an assertive anger expression segment (i.e., productive and adaptive expression), observations from the tapes showed that the true therapeutic value of expressing anger was achieved when clients used its informational and self-regulatory rather than cathartic function (i.e., empowering versus venting anger). In spite of high emotional arousal and experiencing, it was the clients' ability to adaptively express anger in a manner that remained well-contained and thus productive that was important.

Below is a short example of a full expression of assertive anger (client 418, session 6), in which the client engages in a very dynamic and vivid two-chair dialogue with her father, holding him accountable for lack of appreciation and love, while also taking an assertive stance in relation to her unmet needs. Notice how she spontaneously engages into expressing her feelings of anger and needs without much prompting from the therapist.

T: right.

> C: I'm angry at you and I needed- I needed the love and you weren't there to give me any love [expression of anger and needs]. you were busy working all the time and I can understand that, but we're all busy working and you know, we become adults and we have family and you know, people when they have children are supposed to give their children love and you- I feel you didn't- you didn't give us any love [holding father accountable]. your idea of love was putting food on the table and clothes on our back- that was your idea of- of love. It had nothing to do with ah hugs and kisses and verbal acknowledgement [unmet needs], it had to- you felt you were showing that you loved us, that you were doing your job as a provider, that's what you felt. and you thought that was enough and it actually wasn't enough, not for me, not for my sisters! [assertive anger]
> T: right yeah. How do you feel? Tell him!
> C: oh, I'm angry! very angry! [acknowledges and allows anger expression] you know?
> T: because I needed
> C: I needed- I needed to to, be hugged once in a while as a child you know? Or told that I was okay, you know? I think that's normal. [assertive need]

Similarly, a review of the empirical literature done by Olatunji et al. (2007) shows that simply "venting" or letting anger out is no longer supported for its alleged beneficial effects. Rather than simply venting, resolution clients elaborated and explored the meaning and role of anger in their lives, thus facilitating insight into the protective role of their anger against the harm, criticism or wrongdoing of significant others.

"Stuck in anger", some clients engaged in other unproductive expressions of anger, such as blame, rage or verbal destructiveness. These clients often had difficulties with expressing other emotions, too, and they did not show improvement on any of the outcome measures at the end of therapy. As shown by Greenberg and Watson (2006), "therapy involves arriving at core adaptive emotions and using them to help transform core maladaptive emotions". Blame, while possibly an intermediary stage between arrested and assertive anger, still is an unproductive form of anger that prevents individuals from resolving arrested anger. When clients in this study were unable to take ownership of their own feelings of anger, they seem to continue being externally focused on the "what" and the "why" rather than on the "how", which in turn prevented the transformation of blame into

assertiveness.

For example, this client (517, session 4), is talking to her mother about her absence. Feelings of resentment, as well as blame (i.e., “you” language) are present. She states:

> "... just feeling very - well my mother was never there – you were never there for me, and it was your choice. Why didn’t you try more? Why did you have to live like you were the only one with feelings in the world? I resent you, I really do, and there is nothing to change that!"

Sometimes extreme statements of hate, wish for revenge, annihilation and destruction of the other (the wrongdoer) or self were made. In talking “about” rather than “from” their anger, these clients expressed interpersonal desolation, despair and a sense of being hollow, emptied of life, estranged from their own experience, detached from the other, and sometimes distant from the entire world. Consider this excerpt (client 303, session 7), where the client expresses rejecting anger at her mother in a manner that sounds definitive and irrevocable. Of note, this client’s level of emotional arousal was high, and the emotional expression was unproductive.

> “ I am so mad at her! No, I HATE her! I do not want to see her, not now, not ever! She thinks she can just show up one day and I’ll give up everything for her?! No, I don’t even want to talk to her, don’t ask me to tell her how I feel. What if she’s unhappy? She deserves it, and I am not willing to make her feel better. She’s not allowed to speak to me, and I will not speak to her. There’s nothing there for us, there never will. Even if I’m unhappy, this will never change!”.

According to Paivio and Pascual-Leone (2010), these types of client responses may be indicative of other underlying difficulties requiring longer term treatment, such as dysregulated affect, history of trauma and abuse, enduring personality traits, chronicity (i.e., longstanding unexpressed anger and hostility).

The unique contribution of clients’ ability to allow, symbolize, and express their “bottled-up” anger during therapy was shown by this research. The vibrant, authentic and enlivened anger expression that is attachment-based and motivated by affiliative needs seems

to act as an adaptive mechanism of change that leads to decreased symptomatology (depressive or otherwise) and an overall improvement of clients' psychological state. In short, as expected, this study confirms some EFT assumptions related to the importance of healthy anger expression and the criteria for primary adaptive anger (Paivio & Carriere, 2007). EFT theorists consider anger as a basic affect and a healthy resource that provides energy and a sense of empowerment, prepares individuals to protect themselves from threat or harm, and correct perceived wrongdoing (Greenberg & Paivio, 1997). In addition, this study also showed that the productive anger expression is different from simple venting and involves making sense of emotions by understanding the full context of a situation and the significance of an interpersonal dynamic, as well as by taking in the reality of the other (the wrongdoer) in the safety of the therapeutic environment is an important step in the resolution of depression. This aspect will be discussed in the next section.

Empathic and insightful understanding of the other or self-critic. In conjunction with other components of resolution, the empathic and insightful understanding of the other/self-critic, which represents a dialectal synthesis of emotion and reason, contributed to the prediction of BDI-II change scores. This component represents the stage where clients reach a calm and reflective stance that allows them to consider alternative ways of seeing the reality of the other, the self or a particular interpersonal/relational context, such as uncontrollable external circumstances, misunderstandings or inefficient communication patterns. As previously noted by Greenberg and Watson (2006), the arrival at this stage is seen as a primary objective in EFT for depression, as it represents the stage of "integration of head and heart". After the primary goal of working on their unresolved feelings of anger was reached by bringing their anger into light, allowing, symbolizing and expressing it in an adaptive manner, some clients naturally moved into a stage of reflective examination and

meaning making. The empathic and insightful understanding was reached by changing the representation of experience through various paths, such as by reflecting on the experience of the other, on their inner experience, and/or on the relational context in which the violation took place.

For some clients, being able to shift into the other's position (both mentally or physically, during chairwork), enact and eventually take the other's world in, as if they were the other, facilitated a process of change in the mental representation of the other and a new understanding of their perspective, attenuating circumstances and intentions. The ability to shift positions requires a flexibility similar to that involved in the developmental process of separation-individuation (Mahler, Pine, & Bergman, 1973), where the child first understands that the object and the self are two different beings and then gains a new sense of self as both autonomous but also still relationally connected to the other, what Margaret Mahler called "the psychological birth of the self". Similar to this process, clients in this study who were able to shift positions and express an understanding of the other in chairs showed an increased awareness of their own boundaries in relation to the other, which in turn led to an increased sense of agency and self-determination, as well as a new acceptance of the reality and the recognition that the other is a human and has limitations.

In the following example (client 024, session 14), the client speaks to her mother, whom she holds accountable for allowing her husband (client's father) to abuse her. Here, the client shows not only a clear understanding of mother's struggle, but also expresses empathy and concern for her. Feelings of anger and hurt are also expressed, but the client is able to move past them and show empathic understanding to her mother in spite of them.

> C: Mom, I'm so disappointed with you for allowing all this shit to happen [mixed sadness and anger]. You continue to allow it to affect your life and mine [concern].
> T: yeah, tell her how much it hurts you to see her like that

C: it hurts me, it does. It hurts me most to see you suffering [sadness]. Even as a child, I started to notice how sad and hurt you were [empathy], and I did not know what to do [helplessness]. You were struggling to make dad stop, you tried being calm and understanding [acknowledgement], and then you asked him to stop drinking or else …, yet he never changed and you were still hurting [empathic understanding]. I remember the tears [empathy], and I remember how it made me feel.
T: I felt…
C: I felt hopeless, and I still feel like that today (...)! Your weakness makes me feel like shit (sighs, pauses) [hopeless, then angry]… You tried your best, and I understand that it takes time to be able to leave a bastard like him… you had no support, nobody to turn to, not even a place where you could go to if you decided to leave him [acknowledges mother's conflict].
T: so what do you say, I understand you?
C: How can I be upset with her? Seriously, if I was her, I'd probably had done the same thing! It's not like she was really weak and acted defeated, but she had no other choice, she had us to take care of… and she was so alone [understanding context and limitations]. But today you have me, remember? [softens towards mother, offers consolation].

Other clients reached the understanding stage by reflecting on their own inner experience and creating meaning out of it. They seemed able to take a step back from the immediate experience and think in retrospect about their feelings, the needs, expectations, and goals. In stepping back and reflecting, clients started to also notice patterns of responding or personal styles of behavior that influenced the specific relational dynamics, and often acknowledged in a non-defensive way and took responsibility of their own contribution to a problematic situation that made them depressed. In the end, clients were thus able to assume different vantages on the meaning of their depression in their lives and eventually generated new solutions to the old problems.

In this example (client 318, session 8), engaged in a two-chair dialogue with her mother, the client takes responsibility for her own contribution to current difficulties and agrees with her mother that she should stand up for people that are important to her.

C: - (sniff) (p:00:00:09) I feel better - ah (p:00:00:12) I guess I'm repeating, ah (p:00:00:10) what my parents did - um, doing the best um - with the knowledge that was available to them at that time [acknowledges own limitations]
T: mm-hm

C: - and I was doing the same thing - - um - - it's true I shouldn't ah - - - for the people who mean a lot to me - I should sort of ah stand up more for them - and don't let things - um - sort of - slide and think they'll get better on their own - because they don't [acknowledges necessity to change behavior]
T: so you kind of agree with her
C: yeah
T: she's right, eh? can you say that to her, 'I- I agree'
C: I agree with you that you're right, I shouldn't let things slide and should stand up [agrees with mother]
T: okay, is there anything
C: for the things that are important to me, and for the people that are important to me (sniffs)

These paths that led to reaching the empathic and insightful understanding of the other/self-critic resemble the essential components of clients' reflective self-examination in therapy proposed by Watson and Rennie (1994), namely inquiry, examination and evaluation. As noted by these authors, clients need to first inquire into their inner and outer experience, examine and explain their behaviors and feelings as they represent them, and evaluate the symbolic representations of their experience for goodness of fit and strategic implications.

There were, however, clients who were unable to successfully reach this reflective and understanding stance towards the other or self. Contemplate the following example where the client (client 426, session 6) talks about her husband and his affair:

"I'm trying to understand what happened for you [struggles to understand]. You told me you felt alone at that time, and that nothing felt right for you: job, kids, me… You had your own reasons, I guess [unconvinced]. And yet, I cannot accept it, you should have come to me [blame, expectations], but no, you went to her [bitter]… you should have chosen to be a respectful husband and a loving father [violated expectations], but no, instead you chose the easy way out [harsh judgment] (…) I don't know, it all seems unbelievable to me [refuses to understand]."

At the opposite end of understanding, some clients expressed rejection, disgust or harsh judgement of the other, while others were unable to imaginary enter the other's world or refused altogether to imagine the other in chairs. Other difficulties observed at this stage

involved: expressing a wish to cut emotional connection with the other, refusing to consider a reconciliation, denying the other's reality or right to be, distancing from the other, expressing disappointment, skepticism, or making judgmental, intolerant remarks, and in one case even denying the existence of God or of any sources of justice. Difficulties in engaging in reflection and reaching an understanding are assumed to be related to attachment difficulties in the individual's developmental history, severe violations of trust, trauma, or more stable personality traits (Greenberg and Watson, 2011). These scenarios suggest the need to focus on clients' relational history, in order to facilitate building more coherent narratives, reach a healthy differentiation from the other, learn better emotional regulation skills and develop better internal models. This can be accomplished during longer term therapy or through other therapeutic approaches (e.g., relational, psychodynamic, etc.), where clients are given ample opportunity to address issues of trust, build stronger attachments with their therapists over time and eventually change their maladaptive patterns of relating to others.

In line with other researchers' view on the importance of narrative reorganization in the therapy of depressed individuals (Angus, Goldman & Mergenthaler, 2008), this study showed that taking a step back to reflect on experience was an important step in clients' resolution. The primary effect of clients reaching the stage of understanding was that clients reorganized their thoughts and feelings towards the self, other and the past violation in a more coherent personal story with a clear beginning, middle and end. Research has shown the health benefits that storytelling and re-writing personal narratives has on people's lives (Pennebaker, 2000). This, in turn, facilitated the development of a new narrative where the self was seen as empowered, worthwhile and agentic, both in relation to past difficulties as well as for future endeavours. As noted by Angus and Greenberg (2011), narratives provide a structure for the events in people's lives as they mentally represent and coordinate the

temporal sequence of actions, people, and events, thus giving them perspective and meaning for their experiences.

Differentiating and processing primary sadness. Even though not an independent or unique predictor in itself, clients' expression of primary adaptive sadness contributed to explaining overall changes in BDI-II scores in connection with other components. In the present study, primary adaptive sadness was experienced, symbolized and expressed separately from anger and was usually accompanied by expression of needs and a sense of resilience and hope. This is consistent with foundational EFT assumptions that positive change in depression is brought not by mere expression of assertive anger, but also by accessing and processing primary sadness at invalidation and/or loss (Greenberg & Paivio, 1997). As expected, two major themes were noticed, including themes of violations of self-identity or attachment (abandonment from the other). Clients voiced their disappointment, regret, current loss or grief over past interpersonal hurts, which is consistent with the categories of sadness that were noticed by Greenberg and Watson (2011, p.62).

Consistent with findings from other empirical research, the expression of primary adaptive sadness is one of the important therapeutic ingredients that contribute to the resolution of arrested anger in depression. In line with this, some studies have demonstrated the association between the use of emotional acceptance and greater recovery from negative emotions in anxiety and mood disorder patients (Campbell-Sills, Barlow, Brown, & Hofmann, 2006). Moreover, Liverant (2008) studied the effects of the experimental manipulation of emotional acceptance and suppression on the experience of sadness over time. Results demonstrated that emotional suppression led to reductions in sadness in the short-term; however, despite increased sadness during a mood inducing episode, acceptance was associated with a steeper decline in sadness during the recovery period. In line with this,

the present study suggests that the expression of primary adaptive sadness may be an effective emotion regulation strategy that prevents affective flattening and facilitates the natural experience of sadness, grief and eventually resolution in depressed clients.

For example, a client engaged in a two-chair dialogue with her sister (client 103, session 10) expresses sadness and grief over their lost relationship and good times spent together. The experiencing level is high, as well as the level of emotional productivity.

> T: I want you to try to speak to her from the hurt. Tell her.
> C: Well, you've really hurt me. You've been so – [expresses sadness and hurt]
> T: Tell her "I"
> C: I feel really hurt by the things you've said. I feel really hurt by your disapproval. By you think you're better than me. I feel really hurt by the things you've said about me to other people. I feel really hurt because for years while I was going around telling people how close we were, you were going around telling people what an asshole I was. [expresses hurt]
> T: (…). Let's stay with it rather than all these words [re-focusing].
> C: Okay [becomes internally focused]... I'm sad about it because there was a time you know that we were very close and we did everything together and – [sadness]
> T: Tell her what you miss.
> C: I miss our friendship. I miss the things we used to do together [grief] (…)
> T: Tell her again, "I miss what I had with you."
> C: Yeah, I miss what I had with you and I realize that, you know, things change as time goes on but I never thought they would change like this [grief for lost relationship]. I never thought that we would become to the point where we didn't like each other [cries] (p: 00.00.25) [sadness with grief].

On the contrary, some clients in this study suppressed the expression of sadness or expressed it in a way that was unproductive. For example, while prompted by their therapists to attend to their sadness and experientially engage in it, some clients collapsed into hopelessness and helplessness, while others looked disconnected from their experience (e.g., sad with no tears, detached, alienated, lonely, desperate).

Here is an example of maladaptive and debilitating sadness (client 420, session 7), where the level of arousal and experiencing is extremely low, and the expression of sadness at his ex-wife's affair is clearly unproductive.

> T: speak from that pain…
> C: It seems like the world came to a stop and now I cannot move towards others [isolation, desertion], I'm stuck in this place of nowhere [powerless], and it hurts like hell [detached]. Nothing will ever change for me [hopeless]... I guess I deserve to feel like that, it's my burden to carry [guilt]. I feel that there won't be anybody out there to hear me, to save me [isolation, helplessness].

While this could be related with difficulties with affect regulation, in some cases clients expressed a fear of remaining "stuck in sadness" and actively suppressed its manifestation. The paradoxical increases in negative emotions in response to emotional suppression have already been demonstrated by previous studies (Gross & Levenson, 1997; Levitt et al., 2004). Others demonstrated that fear of sad mood was a significant moderator for the relationship between sadness intensity and the effectiveness of suppressing sadness (Liverant, 2008). More specifically, while suppression seemed an effective strategy of reducing negative emotional experience when the fear of depressed mood was lower, it failed to produce decreases in sadness when the fear of depressed mood was moderate or high. In line with this, observation of clients' performances in this study indicate that it is mainly when clients overcame their fear of sadness expression and tolerated high levels of emotional arousal, while also regulating its expression that they started to show improvement.

Letting go/forgiving. Together with assertive anger expression, letting go of an unrealistic expectation and/or forgiving (self or other) was found to be an independent unique predictor of outcome, accounting for 22% of the variance in BDI-II change scores. As expected, clients' ability to let go of hurt, unmet needs or unrealistic expectations (related to the other's feelings or actions), as well as expressing forgiveness and love at the other or self-critic for past/present violations, wrongdoing or abandonment (for unfinished business cases) towards the end of therapy was proved to be the second most significant component of resolution after assertive anger expression.

Consistent with previous emotion-focused research studies showing the importance of letting go and forgiving in resolving depression (Greenberg, Warwar and Malcolm, 2008; Malcolm and Greenberg, 2000), the current study suggests that letting go may act as a mechanism of undoing depression. It is quite possible that this happens when clients become able to change anger with letting go by refocusing attention from maladaptive and unrealistic expectations related to self alone to interpersonal transactions that involve holding the other accountable, but also understanding, reconciling and integrating newer representations of the other and reality. This view is similar to that of Pyszczynski and Greenberg (1992), who in their analysis of depressogenic process proposed that the roots of depression can be found in people's inability to sever investment to rigid and narrow goals that are perceived as reflective of one's self-worth and that are no longer feasible. Also, emotion-focused theorists suggest that full resolution occurs "when clients reach a sense that they are worthwhile and able to let go of previously unfinished bad feelings" (Elliott et al., 2004, p.263). Consistent with this, clients in this study who were able to express adaptive feelings of anger and sadness experienced a new sense of self that seemed empowered and more resilient. This, in turn, was followed by a natural renunciation to the hurtful past and a disengagement from unrealistic expectations regarding the future. Resolution clients seemed more able to undergo this dialectical process of disengaging from hurt and anger at attachment or identity violations while at the same time re-establishing the emotional connection with the wrongdoer, sometimes by making heart-felt statements of forgiveness and love that were responded in such by the other/self-critic.

Consider this excerpt (client 414, session 14), where an empty chair dialogue between the client and her inner critic takes place. In the critic position, the client initially expresses regret over inability to do better under past circumstances, then the self in the other chair

moves towards a more compassionate, encouraging and accepting stance. Forgiveness is not only spontaneously expressed at self-critic, but it is also accompanied by a direct expression of self-acceptance and love.

> T: mm-hm, so you- you did the best you could - can you say that to her?
> C: I did the best that I could at that time and - under the circumstances [defends herself] and um - - (sniff) - and that's all I did - could have done - was the best - (sniff)
> T: - anything else you want to tell her? -
> C: (sniff) – I'm really sorry I let you down
> T: - okay - come back here - - - okay - she says she did the best she could – she's sorry
> C: (p:00:00:20) (sigh) (sniff) (sigh) I guess you can't ask for anymore then when somebody's thinking they are giving their best
> T: mm-hm - - so what do you want to say to her?
> C: - - - (sigh) - maybe you're being too hard on yourself [empathy]
> T: mm-hm
> C: - um - - and you should allow yourself to be human - and can make mistakes at times [softening, acknowledges vulnerability] - and to be able to ah - to forgive yourself – I forgive you! You have to forgive yourself and accept that you did your best. I don't hold a grudge against you, no! You know I don't. I love you, and I want you to be happy, because if you're happy, I'm happy, and that's all that matters now [forgiveness with acceptance].

In this study, forgiveness was another facet in the resolution process that was related to decreased depression. The protective function of forgiveness against depression has already been shown by empirical studies (Toussaint, Williams, Musick, & Everson-Rose, 2008). In addition, there is little doubt that a relationship between anger and forgiveness exists and they are both facilitators of change in depressed individuals, but no consensus exists about the direction of this influence. Many theorists believe that forgiveness is or should be used as a remedy to alleviate anger (Brandsma, 1982; Dobbins, 1999; Enright, 2001; Enright & Fitzgibbons, 2000. However, findings of the present study suggest that clients are able to forgive and let go when their anger and hurt were sufficiently expressed and processed; in turn, forgiveness and letting go facilitated softening and an experientially felt renunciation at anger. This study suggests that resolution of arrested anger seems to take

place by moving from anger expression to forgiveness to letting go of anger, in a circular process. In line with this, it is quite possible that clients who were able to express assertive anger found it easier to express forgiveness and eventually let go of it.

Fitzgibbons (1986) described forgiveness as “the surrender of one’s desire for revenge” (p. 629) and contended that anger is not fully resolved until a conscious decision is made to let go of the desire for revenge or to forgive. Clients in this study did not merely make “conscious decisions” to let go and forgive, but rather arrived at this stage of felt-experience though intensive emotional work and processing of primary underlying emotions of anger and hurt at violations, which were shown to be necessary steps in the resolution of their depression. As previously posited by emotion-focused theorists (Malcolm and Greenberg, 2000), the present study suggests that helping clients to first allow and express anger at violation and hurt before letting go and forgiving is of utmost importance for the resolution of arrested anger in depression. This is also supported by some authors who believe that attempting to reduce anger too early by means of “conscious” efforts to forgiveness might not be beneficial for clients who were victims of serious mistreatment and abuse (Davenport, 1991; Merwin and Smith-Kurtz, 1988). Pargament and Rye (1998) juxtaposed anger with forgiveness as a means of coping with betrayal and victimization and concluded that anger is an important coping mechanism and a source of power that counteracts feelings of paralysis and loss of control that accompanying mistreatment.

Consider the following example of a two-chair dialogue (client 501, session 9) where the client struggles to forgive her over-controlling grandmother (her most important attachment figure in childhood), who continues to make unreasonable requests and impact her current life in a negative way:

C: you did that to protect me, and I could forgive that. Because I can understand that I

was weak and you wanted me to get up and going
T: so, what are you saying, that you understand why she's so hard on you?
C: yes
T: can you tell her that?
C: (sighs) I mean, I understand that you want the best for me, and you're pushing me for better, but I feel that in doing that you've suffocated me, and I cannot accept that! I can't get past it. I know what you're trying to do, and I don't trust that you're honest. I have a feeling that one day you will suffocate me again if I let you get away with it. So I won't!
T: I cannot accept it. Say it again!
C: I can't! I want to do the right thing, but I simply can't let go of what you did, because I know that I shouldn't trust you again.

Not giving up the anger too early to make room for forgiveness quite probably acts as a mechanism of preventing a sliding back into old precarious patterns of trust and vulnerability that could be deleterious for clients. In conclusion, while some may argue that letting go of anger and forgiving is preferable and even possible, the findings of this study support the contrary idea that forgiving without an in-depth processing of anger remains a rather superficial and maladaptive act that can be damaging to the person's overall well-being.

Predicting global symptomatology and interpersonal difficulties. In spite of the significant findings established in the present study, empirical evidence was not found for hypotheses addressing the relationship between the peak intensity of markers of arrested anger at pre-treatment, on one hand, and global symptomatology and interpersonal difficulties, on the other. This study also failed to demonstrate that various components of resolution were related to changes in global symptomatology and interpersonal difficulties. Specifically, out of all the components of resolution, only assertive anger expression was found to be a significant unique predictor of depressive symptoms (43% variance explained) and global symptomatology (35% variance explained), but not of interpersonal problems. The expression of understanding of the other/self-critic, adaptive sadness and letting

go/forgiving were not found to relate to changes in global symptomatology and interpersonal problems. These results are consistent with those of Goldman (1997) and Pos (1999). Various possible explanations for these failed hypotheses are presented here.

First, the insignificant associations between the markers of arrested anger at pre-treatment and GSI and IIP scores already suggest the improbability of significant changes at a later stage (i.e., completion of therapy), regardless of clients undergoing certain steps (i.e., components of resolution). Indeed, the findings show that clients' resolution performances were not significantly related to GSI and IIP scores.

Second, the fact that neither the markers, nor the components of resolution, were significantly related to changes in global symptomatology may not be surprising, since the outcome measure used (GSI) screens for a variety of symptoms including somatisation, obsessive-compulsive, interpersonal sensitivity, anxiety, phobia, paranoid ideation, psychoticism, etc.. These may have a more complex underlying substrate, including but not limited to difficulties of anger expression. The same may be the case when it comes to the insignificant association found between both markers and components of resolution with changes in interpersonal difficulties.

Third, observations on clients' individual performances during their treatment course indicate that approximately seven clients, especially coming from the UFB sample, had particular difficulties with emotional regulation, showing either an over-constricted expression or an overflow of emotions that was difficult to control, which matches previous observations about overcontrolled or underregulated affect (Paivio, 1999; Greenberg & Paivio, 1997). These difficulties seemed to have been associated with previously unaddressed developmental or attachment difficulties, repeated violations or a history of pervasive trauma. In spite of therapists' efforts in this study to address such problems, these

aspects of individual clients' characteristics might suggest the need for more intensive, longer-term therapeutic work that involves learning better emotional regulation skills and developing better internal object representations/models.

Although most clients reported feeling better on indices measuring depression, the limited duration and scope of the treatment provided may not have been enough for clients to experience changes in their global symptomatology and interpersonal concerns. External factors, such as a particular context (e.g., unemployment, financial difficulties, etc.), social (e.g., lack of stable support network, hostility at workplace, etc.) or environmental factors, that were not central to the presenting problem, may also carry a weight in influencing global symptomatology and modulating interpersonal difficulties.

Therapeutic implications. The findings of the present study have not only important theoretical, but also significant clinical implications. Generally speaking, this study guides therapists working with depressed individuals when arrested anger resides at its core in two ways: 1. by specifying what client performances are most likely to lead to resolution (i.e., the "what" of successful resolution), and 2. by clarifying "when" pursuing certain therapeutic tasks is best employed.

To begin with, identifying markers of arrested anger during therapeutic work may be one of the most important steps leading to the successful resolution of depression for two reasons. First, the identification of a marker of arrested anger at the beginning of therapy may lead to uncovering what stays behind feelings of hopelessness, helplessness, sadness, resignation, alienation, or a more global sense of disempowerment, all secondary reactions and help facilitate the expression of more primary adaptive feelings. In other words, it promotes more focused, goal-oriented therapeutic work that aims at bringing primary adaptive anger or other underlying emotions into the open and processing them. The

identification of markers of arrested anger may therefore act as cues for different EFT interventions, such as the use of two-chair dialogue or empty chair work. In the case of two-chair dialogue, therapists are encouraged to focus on self-evaluative or self-interruptive splits that prevent clients from accessing, differentiating, symbolizing, freely expressing and ultimately transforming their primary feelings of anger to achieve self-acceptance and an integration of the two conflicting parts of the self. In the case of empty chair work, therapists should orient their efforts to address unfinished emotional business and lingering feelings of anger and hurt at significant other's violations in order to facilitate letting go of resentments and unmet needs, self-affirmation and self-assertion. Second, recognizing a marker of arrested anger and later attempting to express it could facilitate clients' deconstruction of their fears related to anger expression, while providing a teaching window about the adaptive function of anger and the safer, as well as healthier ways of expressing it. Third, consistent with the idea that arrested anger prevents the expression of needs and the request for such needs to be met proposed by Gilbert and Gilbert (2003), clients could undergo a therapeutic transformation in the way they voice their needs and wants, especially at an interpersonal level. Last, but not least, in line with research showing that formerly depressed people endorse more fear of expressing their anger compared with those who were never depressed and are also more likely to embrace self-defeating attitudes that lead to experiencing depression again (Brody et al., 1999), the identification of markers of arrested anger in the early stages of therapy and addressing it accordingly could prevent future relapse into depression for some clients.

Similarly, accessing, allowing and expressing certain emotions (primary adaptive anger and sadness) and helping clients to reach certain steps (empathic and insightful understanding of the other/self-critic and letting go/ forgiving) were shown to be important

therapeutic interventions. However, in line with Greenberg's suggestions (2002), this study shows that therapists engaging and facilitating different therapeutic tasks should always consider three basic process diagnostic issues to best guide their interventions: (1) whether to access an avoided emotion – for example, a therapist might wonder "Is it important for this client to access and process his avoided hopelessness or is it a useful protective mechanism?", "will accessing hopelessness most likely uncover primary feelings of anger that are momentarily buried", (2) whether to further differentiate an emotion – for example, "this client is expressing anger, but what kind?" and "what would be the ideal/most productive form of expression?", and (3) whether to change it or stay with it – for example, "is it more important to preserve the state of primary anger in this client or help her move on and change anger with forgiveness?".

In addition, the success of clients' performances (components of resolution) also depends on the following:

1. Helping clients differentiate emotions and process them separately, while at the same time being able to regulate their in-session emotional experience;

2. Distinguishing between productive versus unproductive emotions and understand transitory states between full productive expression and its opposite (e.g., blame at mid-way between rejecting, destructive anger and assertive primary anger, or intellectual understanding versus understanding that is both empathic and insightful at the same time);

3. Encouraging clients to take ownership and responsibility for their own emotions and search for a meaning that is relevant both at the intrapsychic, as well as at the relational level; and

4. Continuing to maintain a relational stance in addressing clients' issues, with the understanding that emotions have informational and activation value only in relational

context.

Based on broader EFT principles and guidelines about when it is best to access various emotions and how to address some of clients' blockages in emotional expression, the developments of this study provide clear sets of criteria of what constitutes an important stage in the resolution of arrested anger in depression.

Limitations of the Study and Suggestions for Future Research

Case selection and sample size. The intensive nature of analysis specific to psychotherapy process research presents certain challenges to the researcher. One of these challenges is related to the reduced number of cases that can be selected for analysis and empirical study. In addition, the present study was based on archival data produced as a result of other initial larger projects involving depressed individuals within a specific therapeutic frame (i.e., EFT). The process of identification of appropriate cases to be included in the study was based solely on the peak intensity of markers of arrested anger and did not take into account other potential etiological factors of depression, such as genetic predisposition, neurobiological substrate or other environmental factors (e.g., history of mental illness in the family, poverty, physical or sexual abuse, significant loss at an early age, etc). Identifying and selecting therapeutic segments relevant to different components of resolution, as well as the rating process proved to be arduous and time-consuming tasks. As such, the 32 cases selected for analysis and empirical validation of the model of resolution of arrested anger in depression is a limited number and represents one of the limitations of the current study. It is a fact well-known that the power of statistical tests is compromised in research involving small sample sizes, as they are more susceptible to the influence of outliers and may experience large within group variability affecting the results. Given the small sample size, as well as the specificity of case selection criteria (i.e., presence of

markers of arrested anger) and of therapeutic EFT interventions, the findings of the present study cannot be generalized to a larger population or to other therapeutic interventions. Future research examining the relation between various components of resolution and outcome measures with a larger sample size and within other therapeutic frames would minimize the above effects.

Process and outcome measures. Due to the archival nature of this study, the outcome measures used in this study were confined to those previously administered in the original larger studies. Thus, the present study used only self-reported outcome measures of depression, global symptomatology and interpersonal difficulties. Using other measures such as STAXI (State Trait Anger Expression Inventory), a psychological test which measures the intensity of anger in an individual and the disposition to experience angry feelings, and Rosenberg Self-Esteem Scale could have potentially added to the understanding of how various client performances relate to outcome (resolution of arrested anger in depression). Moreover, only total scores on measures of global symptomatology and interpersonal difficulties were available, thus limiting the possibility of conducting a more in-depth analysis of the relationship between the essential components of resolution and various subscales of symptomatology (e.g., obsessiveness, psychoticism, anxiety, etc.) and/or anger as an individual trait (personality tendencies towards control, vindictiveness, nonassertiveness and over-accommodation). From a scientific perspective, relating the essential components of resolution (i.e., anger expression, understanding, sadness and letting go/forgiving) to various GSI and IIP subscales in addition to total scale scores would have been ideal. However, due to limited availability of data, such investigation was not possible. In the future, relating the components of resolution to each subscale of the GSI and IIP could provide a better understanding of how various symptoms, individual differences and

personality traits or tendencies (e.g., proneness to anger) may influence the outcome.

Moreover, the process measures developed for this study are based on judgments made solely by external observers, which fails to consider clients' own accounts of what and how much they experienced certain emotions at certain points in therapy. A study by Warwar, Greenberg and Perepeluk (2003) found that there was a discrepancy between client reports of in-session experienced emotions and the emotions that were actually expressed. In the future, a combination of ratings done by both external raters and clients themselves would be a more useful methodological application that could lead to a better picture of clients' emotional processes and performances. Based on grounded theory analysis (Rennie, 2006), including clients' own accounts or ratings as a basis of validation and confirmation of external observer measures would help with noting potential discrepancies between external and subjective ratings, as well as with obtaining a more complex set of data and reaching more comprehensive conclusions. The use of Interpersonal Process Recall interviews (Rennie, 1992) that involves tracking clients' accounts of their experience in the session, as well as adding measures of clients' subjective ratings for their emotions and levels of experience, might be a solution to this problem in the future.

Other suggestions for future research. In addition to these, future research can focus on studying the mediation analysis for the relationship between different components of resolution, especially anger expression, understanding and letting go/forgiving, with the possibility that understanding the other/self-critic may act as a mediator between the other two components. Similarly, pilot qualitative and quantitative studies involving longer-term therapies, where issues such as clients' affect regulation, attachment styles and trauma related difficulties are included and specifically addressed in therapy, can lead to a much richer understanding of how various components of resolution relate to therapeutic outcome.

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Appendix A

Marker of Arrested Anger Checklist

Generally, the client presents in a way that indicates anger is present at some level, but it is either suppressed, or it seems defeated and hopeless when acknowledged. There are content indications of anger related to past/present violations, wrongdoing, or abandonment from the other (i.e., the offender).

Criterion 1: Statements of Suppressed or Collapsed Anger

Client's speech contains at least one of the following two types of statements:

a. statements where anger is not acknowledged verbally, but hinted at; there is an indication of suppressed anger that is either covert (e.g. blame, resentment) or dismissed (incongruent affect and behavior);

One or more statements must reflect a clear sense that anger is present, but not acknowledged or allowed, which may include the following:

- Covert references to anger: complaint, blame, bitterness, cutting or sarcastic remarks, irony, dark humor
- Explicit dismissal of anger: blocked, interrupted, or constricted references to violation, wrongdoing or abandonment from the other; fear of confrontation, avoidance or fear of getting angry; denying or minimizing own emotional reactions in relation to the other's behavior

b. statements where anger is mentioned in a defeated or hopeless voice. The individual talks about anger, but its expression is restricted, blocked or hopeless out of fear or from lacking a true sense of entitlement.

One or more statements must reflect feelings of defeat and/or hopelessness in relation

to a violation, wrongdoing or abandonment from the other. They may include the following:

- Hopelessness in relation to the other or an unfinished business, resignation, silences, a sense of futility, defeat, feeling that one cannot win, giving up or submitting without a fight, refusing to feel (angry), lacking a true sense of entitlement; denying own right to feel angry; denying usefulness of anger; minimizing own anger, or the importance of expressing anger in general; feeling meek, beaten, inadequate or unentitled ("I'm not sure I have a right”).

Note: Verbally, the client may use passive or negative verbs (e.g., “I can‘t”), stereotype expressions (e.g., “what‘s the point?”, “you know?”), passive voice and third person in a generic way (e.g., “the entire situation was created by my father“ or “he did all of these things and on top of it, imposed rules on us”).

Criterion 2: Non-Verbal Cues

The client exhibits nonverbal behaviour that reflects a combination of both anger and hopelessness that may include some of the following:

- muscular tension
- slight frowning
- petrified expression of face
- clench of the jaw
- lowered head, eyes to floor
- slumped or defeated body posture
- fading voice
- pauses
- long silences

- sighs
- tears
- shrugs
- laughter (incongruent with speech content)

Criterion 3: Current Experiencing

The state of arrested anger is experienced in the present as a rather external, intellectual or intentionally detached presentation of a personal narrative (consistent with level 2 on the Experiencing Scale).

Appendix B

Marker of Arrested Anger Rating Scale (MAARS)

0. **Arrested Anger Definitely Absent:** None of the criteria for arrested anger met. The client neither experiences nor articulates a sense of supressed and/or hopeless anger.
1. **Arrested Anger Moderately Absent**: Only one of the criteria for arrested anger met. Clients may mention anger briefly without elaboration or, clients may talk about past episodes in their history without a clear sense of what particular feelings are aroused. For example, client may talk about or experience mixed feelings of sadness, shame and anger, without a clear differentiation of anger.
2. **Arrested Anger Somewhat Present**: Two of the criteria for arrested anger are not fully met or are met weakly. The client's statements may hint at feelings of arrested anger. However, bodily cues do not support the impression of a defeated/hopeless self. In addition, the level of experiencing is either too low or too high.
3. **Arrested Anger Moderately Present**: One of the criteria for arrested anger is not fully met. The client may make one or more clear references to anger followed by attempt to supress it or hopelessness; a non-verbal sense of defeat may also be present. However, the experiencing level may be either too low or too high, presenting as both impersonal and overly general, or, on the contrary, moving from arrested anger into the stage of anger expression.
4. **Arrested Anger Definitely Present:** All three criteria are met fully. The client's statements reflect a consistent experience of arrested anger (e.g., supressed or hopeless anger). The client expresses a non-verbal stance that is defeated in nature, and the angry state is not fully experienced in the present, but rather "spoken of" intellectually.

Note: In case a video segment is unavailable, Criterion 2 regarding non-verbal behaviour cannot be evaluated. In this circumstance, if the other two criteria are met clearly, rate the session as definitely present. If you feel that arrested anger was not "definitely present", please outline which criteria were not met and explain your rating.

CLIENT NUMBER & SESSION:________________

RATING GIVEN: _________________

COMMENTS:

Appendix C

Resolution of Arrested Anger Components Scale (RAACS)

Introduction to the Resolution of Arrested Anger Components Scale

It is common for clients struggling with depression and anger related themes to also experience periods of hopelessness and despair within a therapeutic setting. Therefore, knowing the process that depressed clients move through as they attempt to resolve their arrested anger is important in facilitating the client's journey through this debilitating state. As such, the Resolution of Arrested Anger Components Scale is a psychotherapy process measure that serves the purpose of offering a method of assessing the process components depressed clients experience when resolving arrested anger in relation to a person or an anger-laden event in their past, and to what level of completion clients experience each component. It is assumed that resolving arrested anger is a process that involves clients achieving various processing tasks. The process is believed to be cyclical in nature rather than a linear progression through tasks. Thus, clients will often graduate from experiencing one processing task but may revisit that same task at a later point in the session. Clients will experience the repeated processing task either at the same level of completion or at a different level of completion.

Using the Task Analytic method, Tarba (2007) proposed a theoretical model for the resolution of arrested anger in depressed clients, where different components of resolution were highlighted. The present study retained only those process components that were considered decisive in resolving arrested anger. The process of resolution of arrested anger in depression is not a linear one, it is rather cyclical and progressive (i.e., the client may return to previous steps at any point). The cyclical nature of the process propels the clients toward

resolution, as with each re-entry into a specific level of the model new information is revealed or is processed in a slightly new way that allows for new meanings and experiences to take place. The successful resolution cases tend to progress further and further along the model as the sessions move on, while the non-successful ones tend to remain stuck in the same "vicious cycle" for a long time, which reinforces feelings of powerlessness, doubt, rejection of the other, and defensiveness. When a client becomes entrenched in a particular step or level, the meaning of depression and its underlying feeling of anger cannot be fully processed and resolution is unlikely. An important note is that this dynamic process is not imposed on the client, but rather facilitated and supported by the therapist.

The segment of measure is an excerpt of a therapeutic event that reflects a specific therapeutic task (for example, expression of sadness). The most relevant segments were selected from the entire therapy process, in their actual order of occurrence. After the initial marker of arrested anger was identified, all therapy sessions following it were reviewed, and segments were extracted based on their actual occurrence and relevance to the theoretical model of resolution of arrested anger. Depending on each client's processing pace and style, different components of resolution became apparent sooner or later in the process. As such, for some of the clients, all therapy sessions up to the last one were reviewed, while for others this was not necessary.

Also, whenever a component segment is rated as "0" (i.e., completely absent), another two or three segments are presented to the raters to ensure that the specific client did not accomplish a higher level of expression later in the therapy.

The purpose in assessing such a large segment is to determine whether certain process tasks are predictive of a good therapeutic outcome for depression. The scale is

measuring the degree of intensity of different processing components, by identifying their defining features and differentiating in a subtle way between a present or absent component. The raters are judging which of the processing components outlined in the Resolution of Arrested Anger Components Scale each client has achieved in examining the entire therapy process.

It is recommended that raters will make their final judgements based on some knowledge of each clients' presenting concerns and style of processing. For this, they will be exposed to segments of therapy that took place before any of the components, which usually take place in the first or second session. This will facilitate the rating process and help the rater understand the overall flavour of the processing style and content. As well, it will provide the rater with a baseline processing style for each client in order to help assess changes in the level of experiencing from beginning to the end of the therapy.

The initial theoretical model of resolution of arrested anger outlined seven processing components (Tarba, 2007, p.43) that are each considered necessary but not sufficient in themselves for the resolution of arrested anger to occur. Of those, only four components considered essential to the resolution process were included in the present rating scale, although some additional idiosyncratic features may be found in certain client performances.

The first component is the "expression of assertive anger." In this step, clients move from unproductive expressions of anger or undifferentiated feelings of anger and hurt to a primary emotion of anger, usually linked to the idiosyncratic impact of the significant other's mistreatment. The primary emotion of anger is clearly differentiated and vividly expressed (for example, the client speaks directly to the other or the self-critic), while needs and wants become evident. Clients come to feel more certain and accepting of their anger, which leads

to the beginning of the development of an empowered self that contributes to undoing depression.

Component two is labelled "Expression of empathic and insightful understanding toward the other or self-critic". Here, clients progress from anger and need expression into a state of calmness and reflection, which allows them to evaluate reality from a different perspective and in a new way. This component represents a shift in the clients' narrative, which facilitates meaning making and the progression towards resolution of arrested anger. In addition, in taking responsibility for their own flaws or for a past event, clients reinforce their sense of agency and control.

Component three is entitled "Expression of primary adaptive sadness". Here, clients experience the depth of primary sadness at missing having needs met and in some cases, of consequent grief at the loss of what was missed. Sadness is experienced, symbolized and expressed separately, in an adaptive way. The pain for invalidation or lack of love is present, and some clients may also grieve lost relationships, time and possibilities.

The final component in the resolution of arrested anger is "Letting go of an unrealistic expectation or Forgiving (self or other)". After accessing core feelings of pain and/or grief, the client discloses and elaborates upon the meaning of the past in a non-defensive manner, starting to accept the present as it is. Compassion and empathic understanding of the other may take place in the form of forgiveness.

General Guidelines for Using the RAACS

Although attempts have been made to simplify the rating procedure, the Resolution of Arrested Anger Components Scale has proven to be a complex measure requiring specialized training to use. The ordinal rating levels describing each component tend to

eliminate the need for raters to make a dichotomous choice as to whether the client has fully completed each processing task or not. Instead, the descriptive and inclusive nature of the rating levels allow for increased ease in coding varying client performances and "grey areas". Thus, the RAACS recognizes the complexity and range of client performances in completing each processing task. The ratings made are related to different therapy outcome measures to see whether certain components predict the successful resolution of arrested anger. The raters will be blind to the therapeutic outcome (i.e., clients' results on different measures of depression).

Prior to initiating the rating process, a few suggestions will be offered to facilitate the ease of rating. Raters will have undergone specific training in using the RAACS involving the viewing of actual therapy sessions to consolidate one's understanding of the process components experienced by clients, as well as the differences between various rating levels. Once the training is complete, reliability will be calculated to ensure the ratings are consistent with another rater. Transcript and videotapes (or audiotapes) of each segment will be provided. It is recommended that videotapes be utilized whenever possible as they provide the greatest benefit to viewing and rating the nonverbal aspects of the client's presentation. For example, it is difficult to "see" slouching in a chair on an audiotape (that is, unless it has been previously noted on the transcript). The transcript is especially needed when video or audio segments are poorly recorded, to ensure the best input possible for the rater. Once the "rating materials" are in order, it is prudent for the rater to review the segment in question in its entirety.

Before starting the actual rating for a certain client, judges are shown a small therapy excerpt which is cued slightly earlier than the marker of arrested anger for several reasons.

Firstly, this allows the rater to gage a baseline level of emotional experiencing and processing style for each client. Secondly, the purpose of viewing a segment prior to the marker of arrested anger functions to explore whether any of the process components precede the marker in any capacity. Only after rating the marker of arrested anger, raters will start making their judgments on the process components using RAACS. Given our assumption that clients do not access, express or process their emotions in any particular order, the rater should not be alarmed or confused if the process components unfold in a different sequence. For example, a client may be more comfortable with and explore feelings of sadness before engaging into expressing anger. Hence, ratings of each client's emotional components will be made in their actual order of occurrence.

Rating Process Using the RAACS

For each process component outlined in the RAACS, there will be at least one segment to be rated for the presence and completion level. A judgment will need to be made by the rater as to the presence or absence of each process component in addition to rating the quality of completion of that component. In cases where a component is rated as "2" or less, another two or three segments will be shown to ensure that the client did not achieve a higher level of expression later in therapy.

For the purpose of rating, view each process component (i.e., assertive anger, considering alternative ways of seeing reality, primary adaptive sadness and letting go of unrealistic expectations or forgiveness) as separate and mutually exclusive tasks. The purpose of rating using the RAACS is to determine which task components were completed by the client and identify the quality of the processing. Raters may notice that clients fully engage in some processing tasks but not others.

Each of the individual components of the scale has a unique rating scale; that is, each rating scale was developed to represent the individuality inherent in each task component. Each of these rating scales is considered an ordinal scale in that higher ratings connote a greater level of task completion. Thus, a rating of 3 for the "expression of assertive anger" task would be considered a higher level of task resolution than a rating of 0, 1, or 2. The goal for the rater is to judge whether a component is indeed present or not, and to what degree.

The Resolution of Arrested Anger Components Scale

Expression of assertive anger (primary adaptive). The first component in the resolution of arrested anger components scale represents the expression of assertive anger. The client makes a clear statement of anger at the other (the offender) for past/present violations, wrongdoing, or abandonment. Sometimes anger is expressed at self-critic in chairs, who usually represents the internalized voice of a significant other. The client moves from complaint with hopelessness and undifferentiated feelings of anger and hurt to a primary emotion of anger, usually linked to the idiosyncratic impact of the significant other's mistreatment. The primary emotion of anger is clearly differentiated and vividly expressed. The client feels entitled to have his voice heard and to speak up for his own needs and rights, and fights back. Coupled with this are hope and confidence in the self to cope with the situation. The client expresses this adaptive angry state both in the speech form and content, and nonverbal behaviour.

Instead of trying to suppress their anger or taking a defeated, hopeless stance, clients move to speaking directly to the other or self-critic about a situation in the past, criticism or abandonment from an empowered position. Assertive anger differs from blaming anger, which is a less adaptive, secondary emotion expressed as holding the other accountable

without a real affirmation of the self. Blaming anger is a necessary and facilitating step in moving from arrested anger to assertive anger, and it usually takes place before the client is able to fully access and express primary, more adaptive feelings of anger. As a result, blaming anger will be marked in this scale as a mid-way to full expression of assertive anger.

The following features characterize this component:

1. *Verbal component:* At least two statements must reflect a clear expression of anger at the other (the offender) or self-critic for past/present violations, wrongdoing, or abandonment. Assertive statements consist of an adaptive, vivid expression of anger in the form of standing up or speaking up for oneself, setting limits, affirming oneself, that generally look like a fight for one's own right to be. An expression of needs, direct or implied, may also take place. Statements reflecting a stronger sense of self may also be present in expressions of hope about some aspects of the future, increased confidence, self-affirmation, and self-esteem. The clients take an empowered stance and feel victorious, unbeaten, justified in their anger, and dignified. Speech content is contextualized and specific instead of generic. Verbally, the anger is labeled and usually addressed directly to the other. Client uses the first person ("I") to express assertive anger, or second person ("you") when conveying blaming anger

2. *Nonverbal component*: The client exhibits nonverbal behavior that reflects a strong, undefeated, elevated physical state and a sense of anger, rebellion, sticking out, firmness, and endurance. This may include one or more of the following: raised, strong voice; frowning; bright, glorious expression of the face; raised head and shoulders; erect body posture or slight leaning towards the other; clenching of the fist or pointing finger.

3. *High levels of emotional arousal and experiencing*. There must also be evidence that

the state of assertive anger is currently experienced in an elaborated form that is expressed in an internally felt manner (consistent with level 3 or 4 on the Experiencing Scale).

4. *Productive*: Expressed anger is considered productive if at least 4 of the following criteria are met: 1) anger is primary adaptive, 2) anger is experienced in the moment, 3) anger is experienced in a fully aware manner, such that anger is fully owned (i.e., the clients see themselves as agents rather than victim of their anger) and does not become overwhelming; 4) anger is freely expressed rather than blocked, and 5) anger is related to a therapeutically relevant theme.

Each segment will be assigned one of five ratings (from 0 to 4) in reference to the expression of assertive anger. Provided below are descriptions of each rating level and representative examples where appropriate. Choose the rating that best describes the identified segment.

Rating of 0*:* The client does not reflect any aspects of primary adaptive anger state. Anger is rather felt and expressed in a destructive, revengeful, and/or unforgiving form. It feels like hate that cannot be undone and stays in the way of forgiveness. It also seems definitive, unchangeable, like a rigidness and/or unwillingness to forgive. In this case, the secondary maladaptive anger serves like a protective blanket against regaining emotional connection with the other or against forgiving. The level of experiencing is either too low or too high, and the expression is clearly unproductive.

Contemplate the following example where a client is speaking to her mother in chairs, who gave her away for adoption as a baby and attempted to reconnect with the client twenty years later:

> “ I am so mad at her! No, I HATE her! I do not want to see her, not now, not ever! She thinks she can just show up one day and I’ll give up everything for her?! No, I

> don't even want to talk to her, don't ask me to tell her how I feel. What if she's unhappy? She deserves it, and I am not willing to make her feel better. She's not allowed to speak to me, and I will not speak to her. There's nothing there for us, there never will".

In this example, it is clear that the client acknowledges and experiences high level of anger. However, her feelings seem out of control and oriented more toward revenge and destruction rather than resolution. Notice how she does not address the mother and refuses to even consider speaking to her.

Rating of 1: Anger is expressed in a maladaptive and non-productive manner. Even though acknowledged and named, its expression is either underregulated or overregulated. Contrary to a rating of "1", anger here does not have that quality of complete, definitive and insoluble rejection or refusal to speak to the other. When anger is underregulated, the person seems overwhelmed by it. The client is unable to develop and maintain a working distance from it, and is losing contact with self or the therapist. On the contrary, when anger is overregulated, the client looks distant, cold, intellectual and unaffected by his/her anger. There is a strong disconnect between the verbal content and the level of experiencing. The intensity of anger is either too low or too high, and the client is not sufficiently able to extract its informational value. Finally, the client does not seem to own his/her anger and make good use of its action tendency.

Consider the following several examples:

Example A: "I feel so angry that I can swipe you away. You deserve a good punch, and if you keep pushing me, maybe I'll come home one day and beat you to death!"

In this response, the person is clearly expressing anger, but the anger is too intense and overwhelming, is underregulated and lacks the necessary level of control that could make it effective or productive.

Example B: "I was angry, yeah, but you know what?! It doesn't affect me anymore, I'm a busy person, you know? I have so many other things to do instead of just thinking why I'm angry or wasting so much time over it."

In the above response, although the client speaks about anger, he seems disconnected from his feelings, as if he tries to diminish or to rationalize the need to control his anger. The level of experiencing seems too low, and anger here is unproductive.

Rating of 2: Anger is present and expressed in a blaming voice. This is the rating applicable to the "you"-anger. Able to express it quite vividly, clients in this state are yet incapable to move forward and change blaming, resentful anger with a more assertive, self-affirming anger. The client, unable to move from "you" to "I" language, may seem "stuck in blame." There are two types of blaming anger that can be identified: blaming-approach anger ("I needed you and you weren't there for me", "Why didn't you try more?") and blaming-distancing anger ("It's only your fault and I don't want to see you", "You make me sick, leave me alone"). The blaming-approach anger promotes contact and has at its core an implicit need for understanding, support or love. Blaming-distancing anger has the quality of cutting off or pushing away. Both types of anger are important since they constitute the beginning of a real, adaptive expression of anger. However, they do not have the same quality and productiveness as a full expression of primary adaptive (assertive) anger.

Example A: The client is talking to her mother about her absence. She states, "... just feeling very - well my mother was never there – you were never there for me, and it was your choice. Why didn't you try more? Why did you have to live like you were the only one with feelings in the world? I resent you, I really do!" Here, the client is feeling resentful at her mother, but she expresses it in a blaming voice using the "you" language. However, there is a

sense that the client is attempting to make contact rather than reject her mother.

Example B: In this example, the client is blaming her father for lack of support and love.

> T: tell him what he did to you
> C: you destroyed- I feel he- you destroyed my life - like, you know, not, not completely, my mother was / (laughs)- but you know you did nothing to nurture me and and ah help me in life, you did nothing at all, you've fed me and you've clothed me- to a certain point, you know, and always heard about it you know and ah (blaming-rejecting anger, generic)
> T: tell him what it was like to be called a devil and go to church every Sunday (therapist evokes specificity)
> C: it was horrible, you know, you made me feel ah..that I was always bad and that I guess when I was a child not now but when I was a child somehow, I was going to die and I was going to go to hell because I was a bad, you know a bad person. (…)

Note how the client is expressing her anger in a strong voice, however, her anger is directed at her father in a rather blaming fashion. The client clearly experiences anger but the process is not fully elaborated upon, as she remains stuck in blame, while placing herself in the position of a victim.

Rating of 3: The client's statements reflect a consistent experience of anger at the other or self-critic for past/present violations, wrongdoing or abandonment. The primary emotion of anger is clearly present, however, one of the defining characteristics of assertive anger is not fully met. The client's statements may be overly general or abstract, or he/she may display a physical state that is not fully consistent with the expressed anger. Other possibilities would be that the client's experiential level is lower than expected, or that the experience of anger is not fully owned (i.e., there is still a sense that the client sees him/herself as victim rather than an agent in full control of their anger). Also, segments when the client seems to be stumbling for a short moment while expressing anger (by self-interrupting, diverting or blocking), could be marked as "4."

In the following example, the client expresses anger at her father for not wanting and

mistreating her as a child.

T: (laughs) right. what happens in the face of that? stay with him.
C: oh, I get very angry (assertive anger).
T: un-hum
C: oh I do and I just tell him I now, more so I don't see him as much but there was a time when
T: tell him
C: I think you're a terrible father and you're an asshole (blaming-distancing anger)- that's what I would say to him (assertive). my sisters would be like (gasp, laugh) (interrupting)
T: you sound very angry.
C: oh very angry (assertive anger). yeah, there's no need for it. (blocking)
T: un-hum. what do you feel now? try to imagine him here. let's try to see I mean
C: I'd like- well I feel I've always questioned why, why him and mom ever had children. (diverting) I always wondered that cause you could tell by the way they were toward- really I get- didn't want children. they didn't want girls, I know my dad didn't want girls and he got four of them so maybe that was God's way of punishing him (laughs) but you know (owned anger)
T: tell him
C: yeah, I don't know why he- you had children because you know they were so-he was so- you're so into yourself. And I deserved much better! (assertive anger)

The primary emotion of anger is clearly expressed, and the content and dynamic of client's statements lead us to believe that there is also a high experiential level of anger. However, you can note the instances when she is stopping herself from expressing, but she regains focus immediately after therapist's interventions.

Rating of 4: The client makes a clear statement of anger at the other (the offender) or self-critic for past/present violations, wrongdoing, or abandonment. The primary emotion of anger is clearly differentiated and vividly expressed, and meets all the defining characteristics of this component (assertive statements, nonverbal behavior, high experiential level, and productivity). The client stands up, refuses to continue to accept the situation as it is, and seems no longer afraid to speak up, establish boundaries, or express feelings, thoughts and desires freely. A strong sense of having been wronged is recognizable in the voice. The client begins to feel that he or she is entitled to have needs met, to be loved and respected,

mainly to better treatment from the other.

Below is an example of a full expression of assertive anger. The client engages in a very dynamic and vivid two-chair dialogue with her father.

> T: right.
> C: I'm angry at you and I needed- I needed the love and you weren't there to give me any love. you were busy working all the time and I can understand that, but we're all busy working and you know, we become adults and we have family and you know, people when they have children are supposed to give their children love and you- I feel you didn't- you didn't give us any love (assertive anger and needs). your idea of love was putting food on the table and clothes on our back- that was your idea of- of love. It had nothing to do with ah hugs and kisses and verbal acknowledgement, it had to- you felt you were showing that you loved us, that you were doing your job as a provider, that's what you felt. and you thought that was enough and it actually wasn't enough, not for me, not for my sisters! (assertive anger)
> T: right yeah. How do you feel? Tell him!
> C: oh, I'm angry! very angry! you know?
> T: because I needed
> C: I needed- I needed to to, be hugged once in a while as a child you know? Or told that I was okay, you know? I think that's normal. (need)

Here the client moves back and forth between blaming and assertive anger, and finally gives voice to her unmet needs. Notice how she spontaneously engages into expressing her feelings of anger and needs without much prompting from the therapist.

Expression of empathic and insightful understanding toward the other or self-critic. The second component in the resolution of arrested anger components scale represents the expression of an empathic, insightful understanding of the other, self-critic or a situation. The expression of assertive anger and needs usually promotes a state of calmness and reflection in the clients, which allows them to consider alternative ways of seeing the reality of the other, the self-critic or a situation. This resembles the stage of de-escalation in interpersonal conflict, where fight-and-flight reactions are overcome and peace starts to set in.

In the process of resolution, empathic understanding facilitates the re-construction of

clients' personal narrative in their continuous search for meaning. It takes the form of an insightful understanding of the whole picture, where formerly scattered pieces of a puzzle start to relate to each other and fall into place. However, the insightful nature of this component refers to a deep realization that is not entirely intellectual, but, more importantly, emotional. Clients become able to relate to the other, self or a situation in an empathic way that is less judgmental and more compassionate. In other words, understanding is insightful because it takes place at a deeply intuitive level as a result of emotional search and reflection. It is empathic because it promotes compassion, which in turn lays the foundation for forgiveness.

Understanding is a complex process that requires a great deal of time and effort, and involves a long term schematic re-organization that enables clients to see the other, self or situation in a more complex and multi-faceted way (e.g., as being different, having attenuating circumstances, or being both good and bad at the same time). Segments shown to exemplify this component usually contain the final stage of this process, where clients present and analyze their understanding.

There are three ways in which this empathic and insightful understanding is gained:

- by understanding the other's point of view - the client starts to see the other's perspective (e.g., father‘s principles of living life are different, but they are still valid), attenuating circumstances (e.g., it was difficult to raise a child in those times, parents lacked financial security, etc.) or intentions (e.g., self-critic wants to protect from hurt, to stimulate ambition in order to favour success) in a positive manner, while acknowledging that truth is not solely restricted to "personal truth"; clients understand and accept the other and their differences, or sees how the other has a right to his/her own feelings. Clients may also start to

see the whole picture - they acknowledge that other uncontrollable factors may have contributed to the wrongdoing or hurt, and integrates the other's worldview/feelings into their own.

- by agreeing with the other/self-critic's comments about clients' "weaknesses" (defensiveness, avoidant style, passivity) or confrontations to take immediate action (e.g., fighting procrastination or withdrawal, dealing with people when upset, etc.). The client may understand the mistreatment in terms of its relational context and admit to his or her own negative contribution to the relationship dynamic, by acknowledging a deficient way of interacting with others that led to mistreatment from the significant other (e.g., not expressing feelings or needs directly or in a timely manner, avoiding confrontations, shutting up themselves, bottling up feelings, or not taking appropriate, immediate action). In other words, clients become aware that in spite of the fact the significant other contributed to the hurt (for which he/she is responsible), yet there was something about clients' own way of relating that allowed it to happen;
- by acknowledging feelings of guilt for his/her own contribution to hurting significant others in turn or in certain situations.

Thus, through this process, the client understands the other's perspective, while taking responsibility for his/her own flaws. As a result, a softening in expression takes place and clients may become able to empathize with the offender's feelings. The narrative changes, allowing for both subjective realities to come into the bigger picture and make sense of it from a different, more encompassing position. It contributes essentially to meaning making, or making sense of one's personal history and narrative.

The level of emotional arousal in this component is low, but the experiencing level in

the moment is heightened and the voice is internally focused. Instead of a hopeless, whining voice, there is a sense of calmness and rational acceptance present, as if the situation is not only understood, but also emotionally contained. Often, this component is followed by client's acknowledgement and expression of vulnerability, admitting to sometimes feeling weak, needing help or guarding oneself when in danger of being hurt.

The following feature characterizes this component:

1. *Verbal component:* At least two statements must reflect a clear expression of empathic understanding that can take the form of: 1. an understanding of the other's point of view, 2. agreeing with self critic on one's own "weaknesses", or 3. owning personal guilt for one's own contribution to hurting significant others in turn or in certain situations. A sense of assuming responsibility is also present. Speech content may be generic or specific (with references to particular instances in the other's world, for example). Verbally, understanding is labeled as such; client may either address the other or the therapist.

2. *Nonverbal component*: The client exhibits nonverbal behavior that reflects a reflective, mostly relaxed state. This may include one or more of the following: eyes looking away as in searching or pondering, then returning to making eye contact; finger stroking on chin, hand to the cheek or holding head; head tilted with eyes looking up; little gestures of hands; slow and clear speech, deep voice, moderate to low tone; calmness; body slightly leaning away or towards the other/the therapist. Eyes look away and return to engage contact only when answering.

3. *High levels of experiencing, low emotional arousal.* There must also be evidence that the state of empathic understanding is currently experienced in an elaborated form that is expressed in an internally felt manner (consistent with level 3 or 4 on the Experiencing

Scale). However, the level of emotional arousal is low, and the client speaks in an internal, focused voice.

Each segment will be assigned one of five ratings in reference to the expression of empathic and insightful understanding. Provided below are descriptions of each rating level and representative examples where appropriate. Choose the rating that best describes the identified segment.

Rating of 0: The client rejects other, self-critic or situation and refuses to understand. One or more of the following may qualify as a rejection of the other or self-critic: keeping the other at bay, cutting off the connections or any emotional strings with the other, refusing to consider a reconciliation, denying the other's or self-critic's reality or right to be, separating, distancing from the other's reality. This may take place in the form of refusing to see the other or self-critic in chair, or refusing any chairwork altogether. Refusing to understand the other, self-critic or situation may take the form of one of the following: refusing to consider the other's reality, point of view or differences, denying other reality or possibilities, or refusing to accept or trust the other's explanations. Client sees differences as definitive, inacceptable and/or irreconcilable.

Consider the following example where a client is prompted by the therapist to start chairwork with a neglecting mother:

> C: she always complained that she was tired and that my father never took any of the burdens away from her (acknowledging circumstances), so… that was that
> T: what do you mean?
> C: She worked two jobs at that time, and when she came home, she was already dead, I mean, she was unable to even change her clothes. We were part of the burden (bitterness).
> T: Can you tell her about that?
> C: (0:01:24) no. I can't! (rejection) I can't stand to think how she'd whine about her special circumstances, and how miserable her life was, and this and that… (refusal to understand)

T: tell her about …
C: no! I'm not even sure I want to (rejection)! What am I supposed to say to her, that I feel for her? (refuses to understand) No, I simply can't talk to her. (rejection)

The client presents some facts about her mother's life that may have contributed to the neglect. However, the client not only refuses to talk to her mother about how she felt, but also ridicules her "special circumstances."

Rating of 1: Clients are struggling to understand, without much success. They may seem torn and hesitant about considering or accepting other possibilities. Another possibility is that clients may express some superficial, rational understanding, but easily become judgmental, critical and condemning of the other or self-critic ("you should have"), imposing their own views, values and beliefs onto the other's reality.

Contemplate the following example where the client talks about her husband and his affair:

"I'm trying to understand what happened for you (struggles to understand). You told me you felt alone at that time, and that nothing felt right for you: job, kids, me… You had your own reasons, I guess (acknowledges husband's unhappiness). And yet, I cannot accept it, you should have come to me, but no, you went to her (bitter)… you should have chosen to be a respectful husband and a loving father, but no, instead you chose the easy way out (judgmental) (…) I don't know, it all seems unbelievable to me (doubting husband's reality)."

In this example, the client's struggle to make sense and understand what happened to her husband that made him drift away is clearly failing as she speaks. A sense of hopelessness is also present.

Rating of 2: The client reaches some level of rational understanding, which however lacks the quality of an empathic and compassionate acceptance of the other or self-critic. The level of experiencing is low for empathy or emotional connection with the other or self-critic. In contrast with the emotional "understanding of" the other or self-critic, this appears like a cognitive "understanding that" something has happened to contribute to the offense.

Here is an example of a client who speaks to his ex-wife, who mistreated him and took all his assets when she left.

> C: I mean, I know you had some problems in your previous marriage, you were abused and left to live without a penny. (turns to therapist) You know, her former husband was a jerk, he treated her really badly (acknowledges wife's difficulties).
> T: you seem to understand …
> C: yes, sure. it's understandable! (impersonal) it was hard for her to trust me. I mean, she had all the reasons in the world to be careful around men (rational understanding) (0:01:20) Anyway… (changing subjects)

The client understands his wife's lack of trust and mistreatment as related to the way she was treated in her previous marriage. However, there is no real emotional connection with his wife while talking (he turns to the therapist and starts explaining). His discourse seems rehearsed and rational, but lacks warmth.

Rating of 3: The client reaches some understanding of the other, self or a situation at both rational and empathic levels. However, empathy is not fully experienced in the moment or in a fully elaborated form (i.e., there are still elements of externality in the discourse). Or statements of understanding are followed by short intermissions of anger, displease or blame.

In the following example, the client speaks to her mother, whom she holds accountable for allowing her husband (client's father) to abuse her.

> C: Mom, I'm so disappointed with you for allowing all this shit to happen (mixed sadness and anger). I'm even more upset to know that you continue to allow it to affect your life and mine (anger).
> T: yeah, tell her how much it hurts you to see her like that

> C: it hurts me, it does. It hurts me most to see you suffering (sadness). Even as a child, I started to notice how sad and hurt you were (empathy), and I did not know what to do (helplessness). You were struggling to make dad stop, you tried being calm and understanding, and then you asked him to stop drinking or else …, yet he never changed and you were still hurting (empathic understanding). I remember the tears (empathy), and I remember how it made me feel.
> T: I felt…
> C: I felt hopeless, and I still feel like that today, and even though I understand what's going on with you, I still feel angry at you! Your weakness makes me feel like shit (sighs, pauses) (hopelessness followed by anger)… You tried your best, and I understand that it takes time to be able to leave a bastard like him… you had no support, nobody to turn to, not even a place where you could go to if you decided to leave him.
> T: so what do you say, I understand you?
> C: How can I be upset with her? Seriously, if I was her, I'd probably had done the same thing! It's not like she was really weak and acted defeated, but she had no other choice, she had us to take care of… and she was so alone. But today you have me, remember?

Here, the client shows not only a clear understanding of mother's struggle, but also expresses empathy and concern for her. However, a sense of unsettledness is also present in the form of anger and hurt. Client's discourse still lacks the sense of detached and serene understanding.

Rating of 4: The client comes to a full empathic understanding the other's point of view, agrees with self-critic on one's own "weaknesses", or owns personal guilt for his/her own deeds. This may mean that the client accepts the other and their differences, and/or sees how the other has a right to his/her own feelings. Also, the client may start seeing the violation or hurt as part of a bigger picture, by acknowledging that other uncontrollable factors may have contributed to the wrongdoing or hurt, and by integrating the other's worldview/feelings with his/her own. As a result, a softening in expression takes place and clients may become able to empathize with the offender's feelings. The narrative changes, allowing for both subjective realities to come into the bigger picture. The client makes sense of reality from a different, more encompassing position, which feels like an emotional and

empathic “understanding of” the other or self-critic.

Here the client talks to her mother and agrees that she should stand up for people that are important to her, while assuming responsibility for past maladaptive behaviour.

> C: - (sniff) (p:00:00:09) I feel better - ah (p:00:00:12) I guess I'm repeating, ah (p:00:00:10) what my parents did (understands own behavior) - um, doing the best um - with the knowledge that was available to them at that time
> T: mm-hm
> C: - and I was doing the same thing - - um - - it's true I shouldn't ah - - - for the people who mean a lot to me - I should sort of ah stand up more for them - and don't let things - um - sort of - slide and think they'll get better on their own - because they don't (acknowledges necessity to change behavior)
> T: so you kind of agree with her
> C: yeah
> T: she's right, eh? can you say that to her, 'I- I agree'
> C: I agree with you that you're right, I shouldn't let things slide and should stand up (agrees with mother)
> T: okay, is there anything
> C: for the things that are important to me, and for the people that are important to me (sniffs)

Expression of sadness (primary adaptive). The third component in the resolution of arrested anger components scale represents the expression of primary adaptive sadness. The client makes a clear statement of sadness related to violations of identity (criticism-related feelings: being dismissed, disrespected, invalidated, humiliated) or attachment violations (abandonment-related feelings: being left alone, neglected, discounted or rejected). Clients freely express the depth of primary sadness at missing having needs met and in some cases, of consequent grief at the loss of what was missed. Sadness is experienced, symbolized and expressed separately, in an adaptive way. A sense of resilience and hope about some aspects of the future is also present, even though it may or may not be directly expressed, but rather implied. Clients express this adaptive sad state both in the speech form/content, and nonverbal behaviour.

The following features characterize this component:

- *Verbal component:* At least two statements must reflect a clear expression of sadness, pain or hurt at the other or self-critic for criticism or abandonment. Feelings of primary adaptive sadness are clearly differentiated and vividly expressed. Clients with unresolved feelings of abandonment may also express grief in statements reflecting a sense of sorrow or regret. The client feels comfortable and freely expresses sadness or grieves in the presence of the therapist. Verbally, sadness is labeled as “hurt”, “pain” or a synonym. Grief is expressed as sorrow and regret for a loss (“I am sorry that/for …”) and is usually addressed directly to the other. Client either uses the first person, singular (“I”) to express sadness, or first person, plural (“we”) when grieving.
- *Nonverbal component*: The client exhibits nonverbal behavior that reflects a depressed, downcast look. This may include one or more of the following: downsized or sunk body posture, lowered head and shoulders, downcast facial expression; intense crying and sobbing; low, weak voice; lowered, internal and focused voice.
- *High levels of emotional arousal and experiencing*. The level of emotional arousal when expressing sadness is high. There must also be evidence that the state of sadness is currently experienced in an elaborated form that is expressed in an internally felt manner (consistent with level 3 or 4 on the Experiencing Scale).
- *Productive*: The expression of sadness must qualify as productive. Sadness is considered productive if at least 4 of the following criteria are met: 1) sadness is primary adaptive, 2) sadness is experienced in the moment, 3) sadness is experienced in a fully aware manner, which involves that sadness is fully owned (i.e., the clients see themselves as agents rather than victim of their anger) and does not become overwhelming; 4) sadness is freely

expressed rather than blocked, and 5) sadness is related to a therapeutically relevant theme.

Each segment will be assigned one of five ratings in reference to the expression of sadness. Provided below are descriptions of each rating level and representative examples where appropriate. Choose the rating that best describes the identified segment.

Rating of 0: The client does not reflect any aspects of primary adaptive sadness state. It has the quality of destructive, hopeless, inconsolable pain. Sadness is expressed in either self-destructive or rejecting forms, such as dejection, isolation, alienation, or disgusted rejection of the other or self-critic. Clients seem emotionally disconnected from their feelings, presenting as down with no tears or few tears, detached, alienated, lonely, isolated. The level of arousal and experiencing is either too high or too low, and the expression is clearly unproductive.

Here’s an example of maladaptive and debilitating sadness:

> T: speak from that pain…
> C: It seems like the world came to a stop and now I cannot move towards others (isolation, desertion), I’m stuck in this place of nowhere (powerless), and it hurts like hell (detached). Nothing will ever change for me (hopeless)... I guess I deserve to feel like that, it’s my burden to carry (guilt). I feel that there won’t be anybody out there to hear me, to save me (isolation, helplessness).

Rating of 1: Sadness is expressed in a maladaptive and non-productive manner. Even though acknowledged and named, its expression is either underregulated or overregulated. Contrary to a rating of “0”, sadness here does not have that quality of self-destruction or definitive rejection of the other or self-critic, but retains its hopelessness. When sadness is underregulated, the person seems overwhelmed by it, becoming unable to develop and maintain a working distance from it, and losing contact with self or the therapist. On the contrary, when sadness is overregulated, the client looks distant, cold, intellectual and unaffected by his/her feelings of sadness and hurt. There is a strong disconnect between the

verbal content and the level of experiencing, and the client is not able to extract its informational value. Finally, the client does not seem to own his/her feelings of hurt, pain or grief and make good use of their action tendency.

Consider the following example:

C: (sobbing) it’s so hurting me, I want to get rid of this pain, I can’t stand it anymore! (overwhelming pain) You’re still hurting me every time I see you (sobs). (00:00:57) even when I don’t see you, it’s hurting me to know that you are there laughing at me (pain and shame). You used to love me, now I’m a clown for you, and it feels like whatever I do, you’re only becoming more distant (helpless).

In this response, the person is expressing maladaptive pain that is too intense and overwhelming, lacking the necessary level of control that could make it effective or productive.

Rating of 2: This rating is applicable when clients express sadness, but in a manner that renders its expression unproductive. Clients seem “stuck in secondary sadness,” meaning that while they may be able to attain a certain level of emotional arousal and experiencing when expressing pain and hurt at violations or abandonment, they are yet incapable to move forward and change it with primary adaptive sadness. In other words, clients may get in touch with their feelings of hurt and pain, but cannot move past them, by making sense of what happened or re-constructing their narrative.

In the following example, the client is engaged in empty chairwork with her sister, who criticizes her for lack of accomplishments.

C: she always says that I’m not trying hard enough…
T: and what happens when you hear that?
C: I feel sad. I feel that she’s actually saying that I’m incapable.
T: and what I need from you is…

> C: I don’t even know what I need. I feel sad, but I cannot make sense of it. It’s just a small thing, and I don’t seem capable of moving past it.

Here the client acknowledges her feelings of sadness, but seems unable to deepen and make sense of it. Also, she is unable to access the need associated with the sadness, and seems stuck in an feeling empty of meaning.

Rating of 3: The client's statements reflect a consistent experience of sadness for criticism or abandonment. The primary emotion of sadness is clearly present; however, one of the defining characteristics of expression of primary sadness is not fully met. The client’s statements may be overly general or abstract, or he/she may display a physical state that is not fully congruent with the expressed pain or hurt. Other possibilities would be that the client’s experiential level is lower than expected, or that the experience of sadness is not fully owned (i.e., there is still a sense that the client sees him/herself as victim rather than an agent in full control of their sadness). Also, segments when the client seems to be stumbling for a short moment while expressing sadness (by self-interrupting, diverting or blocking), could be marked as “4.”

In the following example, the client expresses sadness that her father rejected and mistreated her as a child.

> T: (laughs) right. what happens in the face of that? stay with him.
> C: um, I don’t know, my stomach hurts, and there’s a pain here (points to the chest). I get that every time he speaks to me, because I remember how it used to be… the beating and all, and it makes me terribly sad (cries). He would beat me for nothing, really, and even today he continues to be an asshole, he treats me so badly.
> T: can you tell him that?
> C: yeah, I guess… dad, all you did made me sad, and even today, you still have the power over me, you can make me feel like shit in a second.

The client acknowledges sadness and stays with it, trying to make sense of what happens when she has to see her father. However, there is a sense that the client positions

herself as a powerless victim in relation to her father.

Rating of 4: Clients freely express their feelings of sadness and pain for invalidation or lack of love, and sometimes they may also grieve lost relationships, time and possibilities. The primary emotion of sadness is clearly differentiated and vividly expressed, and meets all the defining characteristics of this component (congruent verbal and nonverbal expression of pain or hurt, high experiential and arousal level, and productivity).

Below is an example of a full expression of sadness. The client talks to her sister in chairs and expresses hurt for her disapproval and invalidation; later on she grieves the lost relationship.

C: Yeah. It's like she's pushing me away. It's like she's pushing me away. You know, and I guess I became very hurt by it because we used to be… I become very hurt by it.
T: Now, I want you to go to the hurt place. Let's talk about it.
C: Yeah.
T: See if you can go inside.
C: Oh, I'm still hurt by it. I think about it all the time. I probably think about her everyday (acknowledges sadness).
T: Oh, really?
C: Yeah, oh yeah, because it bothers me.
T: So where do you feel the hurt?
C: In my – I guess it's sort of like you know, you get that tightness in your throat?
T: Yes, yes. So, do you feel it now?
C: Yeah, yeah, yeah (acknowledges high level of experiencing).
T: I want you to try to speak to her from the hurt. Tell her.
C: Well, you've really hurt me. You've been so – (expresses sadness and hurt)
T: Tell her "I"
C: I feel really hurt by the things you've said. I feel really hurt by your disapproval. By you think you're better than me. I feel really hurt the things you've said about me to other people. I feel really hurt because for years while I was going around telling people how close we were, you were going around telling people what an asshole I was. (hurt)
T: (…). Let's stay with it rather than all these words (re-focusing).
C: Okay. I'm sad about it because there was a time you know that we were very close and we did everything together and – (sadness)
T: Tell her what you miss.
C: I miss our friendship. I miss the things we used to do together (grief).
T: I want you to see her.

> C: I miss, you know, I guess – it's hard. I miss it but I don't. I miss what it was I think, I miss what it was and I realize that people go on with their lives and they – but, you know –
> T: Tell her again, "I miss what I had with you."
> C: Yeah, I miss what I had with you and I realize that, you know, things change as time goes on but I never thought they would change like this (grief for lost relationship). I never thought that we would become to the point where we didn't like each other (sadness).

Here the client clearly shows a deep level of sadness and hurt at her sister, and easily re-gains focus at therapist's suggestions. She follows the expression of sadness with grief for the lost relationship and good times spent together.

Letting go of unrealistic expectations or forgiving (self or other). The fourth component in the resolution of arrested anger components scale represents either letting go of the past and unrealistic expectations, or forgiving the other/self-critic. The client makes a clear statement of letting go or expresses forgiveness and love at the other or self-critic for past/present violations, wrongdoing or abandonment. In the case of letting go, the client discloses and elaborates upon the meaning of the past in a non-defensive manner, starting to let go of hurt or unrealistic expectations (e.g., that mother will become non-critical and accepting), and accepting the present as it is. A deeper level of emotional understanding of the other/ self-critic takes place, which is not intellectual or rational, but entirely compassionate and empathetic. A sense of relief and calmness, together with a healthy, adaptive detachment from the offender or critic is also present.

For the cases where unfinished business was involved, forgiveness also takes place. Forgiveness is a complex inter- and intra-personal process that takes place once the client expresses having experienced a shift in his/her stance or feelings towards the wrongdoer. As a result, anger toward the other/self-critic is changed with acceptance and understanding. A sense of resilience and hope about some aspects of the future may also be present. Clients

express this state of letting go or forgiving both in language form/content, and nonverbal behaviour.

The following features characterize this component:

1. *Verbal component:* At least two statements must reflect a clear expression of letting go of past and unrealistic expectations, or forgiveness at the other/self-critic for violations, wrongdoing or abandonment. When letting go, clients verbally express a sense of acceptance, compassion and hope. Clients with unresolved feelings of abandonment may also express forgiveness. Verbally, letting go is labeled as "accepting", "being over (something)" or "not expecting (something from someone)". Forgiveness is labeled as such ("I forgive you for/that …") and is usually addressed directly to the other.

2. *Nonverbal component*: The client exhibits nonverbal behavior that reflects a sense of relief, calmness and serenity. This may include one or more of the following: eyes making direct contact with the other/self-critic or therapist, softened expression on face; upright head, relaxed body posture, hand palms turned up; clear speech, deep voice, moderate to low tone. When expressing forgiveness, clients will show signs of high emotional arousal (e.g., intense gaze, tears, reaching or touching to the other).

3. *High levels of experiencing, moderate to high emotional arousal.* There must also be evidence that the state of letting go or forgiving is currently experienced in an elaborated form that is expressed in an internally felt manner (consistent with level 4 or more on the Experiencing Scale). The level of emotional arousal is moderate when letting go, whereas when expressing forgiveness is high. The client speaks in an internal, focused voice.

Each segment will be assigned one of five ratings in reference to the expression of letting go or forgiving. Provided below are descriptions of each rating level and

representative examples where appropriate. Choose the rating that best describes the identified segment.

Rating of 0: The client is either unable to let go of past/an unrealistic expectation, or he/she clearly expresses rejection and refuses to forgive the other/self-critic. The client may speak about fear of letting go, of trying something new or getting past a relationship with the other. The client may also express guilt around letting go, or not feeling strong enough to let go of the past, face the future, and renounce to "hope in vain" for something unattainable. In the case of unfinished business, the client rejects other/self-critic and refuses to forgive. This may take place in the form of refusing to see the other or self critic in chair, rejecting the other's attempt to reconcile, or simply stating "I don't forgive you!" Client's statements seem definitive, unforgiving, uncompassionate, or even hateful; they may extend beyond the wrongdoer, and may take the form of statements of hate or lack of trust in others.

Consider the following examples:

Example A: "I don't even know what to do, I feel like I'm torn. I realize that I may never get what I need from him, but yet, I cannot give it up. I just can't!"

Example B: "I cannot forgive her for what she did to me. I will never forget, and least I'll forgive. I will not let her have that satisfaction!"

Rating of 1: Clients are struggling to let go or forgive, without much success. They may seem torn and hesitant about letting go, accepting or forgiving. Clients in this state seem to cling onto the past with desperation, struggling to accept or forgive, but lacking hope or trust. Another possibility is that clients may shortly express some forgiveness, but easily become rejecting and unforgiving of the other or self-critic.

Here's an example of a client who struggles to let go without much success:

> C: I want to resolve this, that's why I'm here today! I really do! And yet there's something in me that screams for her appreciation and love. I know she's unable to be the way I need her, she simply can't be like that, kind and understanding (sighs). I don't know, I just can't stop from wishing, and the more I wish, the more I get hurt.

Rating of 2: The client makes some statement of letting go or forgiving, but seems unconvinced or retains some doubt about the other/self-critic. The levels of experiencing and emotional arousal are both low. In contrast with the full expression of letting go or forgiving, this appears like a cold, dispassionate, and intellectual acceptance of the other or self-critic.

Consider the following example, where the client talks to her harsh self-critic in chairs:

> C: you did that to protect me, and I could forgive that. Because I can understand that I was weak and you wanted me to get up and going
> T: so, what are you saying, that you understand why she's so hard on you?
> C: yes
> T: can you tell her that?
> C: (sighs) I mean, I understand that you want the best for me, and you're pushing me for better, but I feel that in doing that you've suffocated me, and I cannot accept that! I can't get past it. I know what you're trying to do, and I don't trust that you're honest. I have a feeling that one day you will suffocate me again if I let you get away with it. So I won't!
> T: I cannot accept it. Say it again!
> C: I can't! I want to do the right thing, but I simply can't let go of what you did, because I know that I shouldn't trust you again.

Rating of 3: The client reaches the level of letting go or forgiving the other or self-critic. However, one of the criteria for letting go or forgiving is not fully met. For example, clients may verbally express a sense of acceptance, compassion and hope, but display a stiff posture and a dull face expression; or they may follow these statements with short intermissions of anger, displease or blame. Another possibility is that compassion and forgiveness are not fully experienced in the moment or in a fully elaborated form (i.e., there are still elements of externality in the discourse).

Rating of 4: The client is fully able to let go of the past or unrealistic expectations, or expresses forgiveness. One of the following scenarios may qualify for a rating of 4: 1. Clients accept what happened or let go of unrealistic hopes, 2. clients directly express forgiveness and/or love towards the offender/ self-critic; 3. while impersonating the self-critic, a deep, vivid expression of love or regret toward the injured or silenced self is present; 4. self-critic softens in chairs, makes reconciliations, accepts; critic may also let go of the toughness, making room for the weaker, less expressed side of the self. Scenarios 3 and 4 are considered variations of letting go of past or unrealistic expectation, or forgiving a part of the self that was critical and self-destructive. For each of these scenarios, all the defining characteristics of this component must be met (congruent verbal and nonverbal expression of letting go and/or forgiving, high experiential level and moderate to high arousal level).

In this segment, an empty chair dialogue between the client and her inner critic takes place. The client starts by defending the rightfulness of her past actions and the critic (herself) responds with empathic understanding.

T: - - - okay, come over here (C. sniffs) - - what- what do you want to say to that?
C: (sigh) (p:00:00:07) I tried
T: mm-hm
C: um - I thought at the time that was the best thing
T: mm-hm
C: - - - - but I guess it wasn't - it wasn't good enough, but at the time I thought that was the best
T: tell her what it was like for you
C: (p:00:00:06) it hurt a lot and I wanted to protect them, and I thought at the time that if I interfered more, or said more, (sniff) it would make him even angrier and make things- the situation worse
T: mm - so you thought
C: so I
T: you'd make things worse - if you interfered -
C: mm-hm
T: so you
C: so I backed off - and - ah - hoping he'd cool off - and ah - calm down - - and sometimes that worked and sometimes it didn't

T: mm-hm, so you- you did the best you could - can you say that to her?
C: I did the best that I could at that time and - under the circumstances (defends herself) and um - - (sniff) - and that's all I did - could have done - was the best - (sniff)
T: - anything else you want to tell her? -
C: (sniff) – I'm really sorry I let you down
T: - okay - come back here - - - okay - she says she did the best she could – she's sorry
C: (p:00:00:20) (sigh) (sniff) (sigh) I guess you can't ask for anymore then when somebody's thinking they are giving their best
T: mm-hm - - so what do you want to say to her?
C: - - - (sigh) - maybe you're being too hard on yourself (empathy)
T: mm-hm
C: - um - - and you should allow yourself to be human - and can make mistakes at times - and to be able to ah - to forgive yourself – I forgive you! You have to forgive yourself and accept that you did your best. I don't hold a grudge against you, no! You know I don't. I love you, and I want you to be happy, because if you're happy, I'm happy, and that's all that matters now.