

# PROTECTION FROM DANGEROUS EMOTIONS: INTERRUPTION OF EMOTIONAL EXPERIENCE IN PSYCHOTHERAPY

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A dissertation submitted to the Faculty of Graduate Studies in partial fulfillment of the  
requirement for the degree of

Doctor of Philosophy

Graduate Programme in Psychology  
York University  
North York, Ontario

April 2018

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## Abstract

**Objective:** To identify the central elements in depressed clients process of self-interruption of emotion (SIE) in an experiential therapy session. **Research Design:** A two-study, multi-method research design was used to examine both the overt performance and subjective experience of SIE. **Methods:** The first study involved a task analysis (Greenberg, 2007) of the performance of SIE by 10 clients in an experiential therapy session. A marker of SIE was defined. Parameters were defined that demarcate an SIE event in a therapy session where a client interrupted their experience of emotion. Fourteen SIE events were subjected to a task analysis. From this analysis, a performance model of client SIE was conceptualized. The second study involved a quasi grounded theory analysis (Glaser & Strauss, 1967) of Interpersonal Process Recall interviews with depressed therapy clients, about the in-session experience of emotion during a period where self-interruption occurred. Thirteen participants' IPR accounts, obtained while they watched a videotaped segment of a therapy session containing a marker of self-interruption of emotion, were subjected to a grounded analysis. A hierarchical categorical model of the subjective experience of SIE was conceptualized, that was crowned by a core category 'Protection from Dangerous Emotions.' **Results:** Models of performance and subjective experience of SIE were conceptualized, compared, and integrated. A final integrative process model of SIE was proposed. In this model, it was explained that SIE occurred when the client's experience of an emotionally vulnerable sense of self precipitated protective secondary reactive emotions and/or behaviours of emotional control and avoidance. The client's

experience of vulnerability in the self-interruptive process included one or more of five features: 1. Awareness of the visceral experience of emotion, 2. An internal sense of emotional conflict, 3. Hazy emotional experience, 4. A weakened sense of self, 5. An urge or action of expression of emotion. Two patterns of self-interruption of emotion were identified. In the first dominant pattern, clients moved through four distinct phases that culminated in limited awareness of emotional experience. The second, minor pattern was similar with the exception that the process of interruption did not include awareness of reactive secondary emotion. **Conclusions:** The process of self-interruption of emotion can be identified by specific markers as it occurs in a therapy session. Key tasks for therapists when working with clients who interrupt emotion in session are facilitating the regulation of the client's experience of emotional vulnerability and reactive secondary emotions, such as fear, shame, anger, guilt and/or sadness. The relational context within which SIE occurs in therapy requires further exploration to identify aspects of therapist performance and subjective experience that contribute to the client's process of interruption of emotion. Further study of SIE in clients with diverse problems, across a variety of therapy modalities is required. In addition, study of the resolution of self-interruption of emotion in therapy is needed.

## **Dedication**

To my husband Jim, for his patience and understanding when I was immersed in writing. Your expertise and support at stressful points along the way made the completion of this dissertation possible.

To my daughter Hannah, who has lived with the intrusion of the dissertation for many years. My hope is that I have set an example for you to never give up on your dreams.

To my parents John and Dorothy Weston, who waited patiently for me to finish.

## Acknowledgments

I would like to thank the therapy clients who participated in the York I and York II studies, for without them my dissertation research would not have been possible. I was particularly touched by the clients who shared with me, a stranger, their private experiences of emotional vulnerability.

I owe more than I can express to my supervisor Professor Leslie Greenberg who supported me unconditionally over the many years it took to complete this dissertation. I am grateful for his infectious enthusiasm about my dissertation topic, and the opportunity to learn from someone who is a rare combination of a gifted clinician and a clinical researcher. I greatly appreciate his generosity in taking the time to teach me about his method of task analysis and supporting me in using it in a novel way in my research.

I would also like to thank my committee members for their unwavering support. I am very grateful to Professor Lynne Angus for her encouragement over the years that helped to maintain my motivation. Her thoughtful comments and questions challenged me to think more deeply about aspects of my research in ways that resulted in a stronger dissertation. I am also indebted to Professor Karen Fergus for her enthusiastic support, helpful suggestions that resulted in improvements to the dissertation, and belief in the value of this work.

I am especially grateful to my friend Lily who generously offered support and encouragement in many forms that sustained me during trying times. I would also like to express my gratitude to Sandra Jackson for her words of encouragement, dissertation

weekends at the Jackson cottage, and making private office space available when I was in the thick of data analysis and writing. I also want to thank Rebecca Pedersen for being there in the early stages of my research and for invaluable feedback in the final stages of completing the dissertation process. A special thanks to Diane Lawless for her encouragement and shared understanding of the dissertation process when it also involves working and raising a family.

Finally, I want to express my deepest appreciation to Jim and Hannah for their love, support, and belief in me during this long journey that we took together.

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## CHAPTER ONE

### Introduction

Various theories of psychotherapy propose that the inhibition or “interruption” of emotional experience and expression is a central phenomenon underlying psychopathology and therefore is a focus of change in therapy (Borkovec, Alcaine, & Behar, 2004; Fosha, 2000; Greenberg & Safran, 1987; Greenberg, Rice, & Elliott, 1993; Hayes, 1987, 2004; Linehan, 1993; McCullough, 1997; Stolorow & Atwood, 1992). Support for this thesis is found in numerous empirical studies across a wide range of psychotherapies showing that therapy clients with a variety of psychological problems have better outcomes when they are able to fully experience or process emotional experience. In this chapter, theories and empirical studies relevant to the role of interruption of emotional experience in psychopathology and psychotherapy will be reviewed and summarized. Then, the rationale for the present study of self-interruption of emotion will be explained, and an over view of the research design will be provided.

### Literature Review

#### Theoretical perspectives on inhibited emotion

**The psychodynamic view.** Freud’s concept of affect and its role in psychopathology underwent a number of revisions as he refined his views on the nature and function of neurosis. Freud viewed both affect and emotion as impulses or “processes of discharge, the final manifestations of which are perceived as feelings” (Freud, 1915/1986, p.153). In a footnote in his paper on the unconscious, affect is described as motor discharge, both secretory and vasomotor in nature that is experienced in the body

and does not have an external referent. While emotions are also experienced internally as a process of discharge, Freud argued that they may be differentiated from affects in that they have an external referent, e.g., love and/or hate toward another.

In his early writings with Breuer (1961) on hysteria, Freud argued that hysterical symptoms were the products of the repressed memory of an affectively toned psychic trauma. According to Freud's hydraulic model, in the normal process of resolving psychic trauma the "energetic reaction" to the event that evokes an affect is allowed full expression in actions, words, or in its "mildest form" tears. Freud referred to this healing process as "catharsis." In the hysterical neurosis, however, Freud argued that the "energetic reactions" are suppressed and the memory of the trauma retains its associated affect. Freud and Breuer proposed that the remedy for hysteria was the "abreaction" of the repressed event under hypnosis. In the hypnotic state, the suppressed "energetic reactions" are disinhibited and expressed. Freud stressed the importance of the arousal and expression of affect in this process.

For we found, to our great surprise at first, that each individual hysterical symptom immediately and permanently disappeared when we had succeeded in bringing clearly to light the memory of the event by which it was provoked and in arousing its accompanying affect, and when the patient had described that event in the greatest possible detail and had put that affect into words. Recollection without affect almost invariably produced no results (1961, p.6).

Freud later abandoned the repressed memory model. He went on to develop a conflict model in keeping with his view of the important role played by instinctual drives, such as sex and aggression, in psychopathology.

In the conflict model, Freud argued that individuals seek to avoid feelings of “unpleasure,” that arise when pleasurable drive based fantasies or representations are met by internal resistance. According to Freud, when the balance between pleasure and unpleasure tips in favour of the latter, the process of repression is triggered and the fantasies are kept out of consciousness.

To fully understand the process of repression, it is necessary to understand Freud’s concept of instinctual representation. According to Freud (1915/1986), instinctual representation involves both an idea or set of ideas and a “quota of affect,” which is the transformed psychic energy of the drive-based impulse. He argues that during repression the two elements are separated and undergo different processes. Furthermore, he argues that both ideas and affects may be said to be unconscious as a result of repression. However, the term “unconscious” holds a different meaning for ideas as compared to affects.

Freud (1915/1986) proposes that in the case of ideas, repression involves the suppression of existing mental structures at the unconscious level. In contrast, Freud viewed affect as the discharge of psychic energy. He further argued that affect exists as a potential that develops as the discharge is allowed to proceed without interference. The process of repression results in unconscious affect in the sense that “it is a potential beginning which is prevented from developing” (Freud, S., 1915/1986, p.153). Freud

viewed the repression of affect as a central process in psychopathology, which is evident in his statement that the “true aim of repression” is “to suppress the development of affect” and “its work is not complete if this aim is not achieved” (1915/1986, p. 152). However, he did not go on to develop a comprehensive theory of affect (Stein, 1991).

Initially, Freud also argued that the repression of instinctual impulses resulted in the transformation and discharge of the initial drive based affect as anxiety. In other words, repression triggered anxiety. He later changed this view as he further elaborated on the central role of anxiety in neurosis (Freud, 1926/1957).

He now argued that anxiety was a “signal” raised by the ego after its evaluation of an internal or external danger associated with the drive-impulses of the id (1926/1957). This “signal anxiety” then triggered the repression of the feared material. In proposing this perceptually rooted form of anxiety, affects could now be viewed as either drive-linked potentials or drive-independent structures “linked to subjective experience, fantasy, and object-relations” (Stein, 1991, p.33). As Stein has noted (1991), Freud’s inquiry into the subjective experience of feelings of anxiety and affect in general did not extend past his description of “unpleasure,” due to his investment in the drive/energy based model.

The particular danger that gives rise to anxiety varies according to Freud’s developmental stages (1926/1957; 1949). He argues that at birth and in infancy, the danger is biologically grounded helplessness following separation from mother and the non-gratification of need. During the period of dependency in early childhood, the feared danger is the loss of the mother. In the phallic phase, the child fears loss through castration (in males) or

the loss of love (in females). During the latency phase the child fears anger, loss of love, and punishment by the super-ego. Finally, the adult fears death.

Freud also described a second, more primitive type of anxiety that arises automatically in situations similar to the birth experience, which he saw as the “prototypical” state of danger. According to Freud (1926/1957; 1949), the baby experiences anxiety at birth following separation from its mother and the satisfaction of "instinctual need" that only she can provide. Freud argued that the non-gratification of need is experienced by the new born baby, and later in early infancy, as a feeling of psychological helplessness, rooted in biological helplessness. This primitive anxiety will be automatically triggered whenever a trauma similar to the birth experience threatens to occur. Freud (1926/1957, 1949) referred to this type of neurosis as “psychoneurosis,” and viewed it as untreatable by analysis.

Common to both primitive and signal anxiety is the experience of “the felt loss of the object” (Freud 1949, p.106). According to Freud, the anxiety is a reaction to the felt loss, and its function is the avoidance of the experience of “unpleasurable tension.” More specifically, the threat of danger re-evokes an early trauma (“primitive anxiety,” e.g., loss-unmet instinctual need-helplessness) or is signalled by anxiety (“signal anxiety”). The instinctual impulse or impulse based fantasy (ideas and affects) is then repressed at the level of the unconscious. Finally, the anxiety is bound by the neurotic symptom, e.g., hand washing of the obsessive neurotic.

In summary, while Freud acknowledged the central role of repressed affect in psychopathology, he neither developed a comprehensive theory of affect nor did he elaborate

on the subjective experience of repressed affect (Stein, 1991). His main interest lay in developing a drive-based meta-theory of psychopathology.

In contrast to the traditional Freudian view that psychopathology is rooted in the repression of instinctual impulses or drives, subsequent psychodynamic conceptualizations of psychopathology recognize the central role of unconscious affect. The inter-subjective view of Stolorow and Atwood will be summarized below.

**Inter-subjective theory.** Atwood and Stolorow (1984; Stolorow & Atwood, 1992) have re-conceptualized the traditional psychodynamic unconscious within an inter-subjective framework. In their view affects, not drives, play a central role in the development and experience of psychopathology.

Three forms of “experience near” unconscious mental processes are proposed: the pre-reflective unconscious, the dynamic unconscious, and the unvalidated unconscious. According to Atwood and Stolorow (1984), the pre-reflective unconscious refers to the structure of a person’s subjective world that is shaped by organizing principles operating outside conscious awareness. These organizing principles solidify in accordance with the particular quality of the interplay between the child and caregiver’s subjective worlds. An example of an organizing principle is “I must be pleasing to my parents,” which has evolved from experience where the child’s failure to please led to parental disapproval and the withholding of love.

Both the dynamic unconscious and the unvalidated unconscious develop in childhood, in the context of inter-subjective affect experiencing and regulation, where caregivers are not adequately attuned to the child's "emotional states and needs" (Atwood & Stolorow, 1984).

In the case of the dynamic unconscious, Atwood and Stolorow (1984) explain that parts of the child's experience deemed threatening to the maintenance of psychological organization and connection to caregivers are repressed at a cost to psychological well-being that endures across the lifespan. The exploration of the dynamic unconscious through the analysis of resistance in the transference is a central focus, to make clear the client's fears and expectations of traumatic, inadequate responses from the analyst should they expose the "walled off" or dissociated affects.

According to Atwood and Stolorow (1984), it is also important to pay attention to the unvalidated unconscious that developed when the child did not receive affirming responses to affective expression and aspects of experience were never symbolized. Atwood and Stolorow (1984) describe how in some cases, these individuals are vulnerable to "fragmented, disorganized, or psychosomatic states. They are characterized by vaguely defined and tenuously held perceptions that are easily effected by others judgements." In addition, in keeping with the unsymbolized nature of their experience, affects are felt as "diffuse bodily states."

In summary, Atwood and Stolorow (1984) propose that the origin of psychopathology lies in the experience of repressed, unintegrated, and/or unsymbolized affect, rooted in early experience of affectively mis-attuned or neglectful caregivers. They also emphasize the importance of restricted or unavailable affect in psychopathology, and offer an interesting and differentiated understanding of unconscious affect. However, they do not describe the process whereby affects are repressed. Empirical support for their theory is limited to a few case studies.

**Integrative Theories of Psychotherapy.** A number of theories of psychotherapy have been proposed that integrate concepts from particular schools of psychotherapy and emotion theory. The first of these to appear was Greenberg, Rice, and Elliotts' (1993) Emotion Focused theory (EFT), followed later by McCulloughs' (1997) Short-term Psychodynamic theory (STPT) and Foshas' (2000) Accelerated Experiential Dynamic Psychotherapy model (AEDP). Each of these perspectives on psychopathology points to the central role of inhibited or interrupted processing of emotion, as will be described in the following sections.

***Emotion focused therapy (EFT).*** According to Greenberg and colleagues, affects and emotions play a central role in the process of survival, growth and psychological well-being (Goldman & Greenberg, 2015; Greenberg, 2010; Greenberg & Paivio, 1997; Greenberg & Pascual-Leone, 2006; Pos & Greenberg, 2007; Greenberg et al, 1993; Greenberg & Safran, 1987; Greenberg & Watson, 2006).

Greenberg and Paivio (1997) contrast the concepts of affect and emotion. They define affect as the “automatic, unconscious, autonomic, physiological, motivational and neural response to stimulation” (pg.7). Affect functions to draw our attention to that which is urgent or important in life. In contrast, emotions are defined as the “conscious products of ...unconscious affective processes” (p.7). Furthermore, emotions are “relational action tendencies” that serve to “establish, maintain, or disrupt our relationship with the environment in the form of a readiness to act” (pg.7). Action tendencies “arise as a function of automatic appraisals of the relevance of situations to our basic concerns.” In this way, emotions are sources of adaptive information about need and wants that helps orient us toward and realize

goals because they are biologically based sources of adaptive information about the personal significance of events. More specifically, processing the personal meaning of emotional experience helps orient us toward the satisfaction of needs which are essential for our well-being (Greenberg & Watson, 2006).

However, not all emotions are adaptive. Greenberg and colleagues (Goldman & Greenberg, 2015; Greenberg, 2010; Greenberg & Paivio, 1997; Greenberg & Pascual Leone, 2006; Greenberg et al, 1993; Greenberg & Safran, 1987; Greenberg & Watson, 2006) identify three classes of emotion to help distinguish adaptive from maladaptive emotion: primary, secondary, and instrumental. Primary emotions are the initial bodily experienced emotional responses to experience in the world, e.g., anger in response to a boundary violation. They may also be subdivided into primary adaptive and primary maladaptive emotional responses. For example, a primary emotional response of fear can through learning be expressed as a maladaptive emotional response of panic. Secondary emotions are the emotional reactions to the initial primary emotions, e.g., sadness in reaction to primary anger. Instrumental emotions are those used to attain a goal, e.g., use of sadness to gain support.

According to Greenberg and colleagues (Greenberg, 2010; Greenberg & Pascual Leone, 2006; Greenberg et al, 1993), psychopathology results from problems in the creation of emotional meaning that originate from schematic dysfunction. They argue that “emotion schemes” are complex internal goal directed, action oriented, embodied representations that synthesize information from multiple sources, including autobiographical memories, to give us our sense of self-in-the-world. An emotion scheme integrates cognition (appraisals, beliefs, expectations, memories), motivation (needs, concerns, intention, goals), affect (physiological

arousal, sensory/bodily feeling), and action (expressive motor responses and action tendencies) (Greenberg et al, 1993). By attending to all of these aspects of an emotion scheme, we fully apprehend the personal meaning of our emotional experience. It is from this higher order synthesis that we experience a coherent sense of self and self-identity narrative (Greenberg & Angus, 2004). According to Greenberg et al (1993; 2004; 2006), dysfunction in self-organization arises when: 1. dysfunctional emotion schemes are activated, e.g., a bad/weak self, 2. there are problems in the symbolization of emotion schemes, and 3. there is an incoherent integration of autobiographical memory and emotion.

Greenberg and colleagues (Goldman & Greenberg, 2015; Greenberg & Paivio, 1997; Greenberg et al, 1993; Greenberg & Safran, 1987; Greenberg & Watson, 2006) have identified the “self-interruption” of emotion a key form of processing difficulty that contributes to dysfunction in the ability to access, express, and make meaning of adaptive emotion and related needs.

*Self-interruption of emotion.* For some people the experience of allowing emotional experience is difficult to the point where they quell their primary emotional reactions, needs, and associated tendencies to act in an adaptive manner. This “self-interruption” or maladaptive over-regulation of emotional experience and expression then becomes an important focus in therapy (Goldman & Greenberg, 2015; Greenberg, 2010; Greenberg et al, 1993).

The concept of self-interruption has evolved from Perls earlier conception of “retroreflection” as a turning back of emotions, thoughts, and behaviours on the self (Perls, Hefferline, & Goodman, 1951). According to Perls et al (1951), retroflected emotion results

in distortion, incomplete expression, and suppression which in turn contributes to neurosis. Perls did recognize that it was adaptive to regulate emotion in certain situations, but he argued that problems arose when retroflection characterized the individual's way of processing emotion. As he put it, "neurotic abuse is when you have, once and for all, censored a part of yourself, throttled and silenced it, so that it may no longer lift its voice in your aware personality" (Perls et al, 1951, p.162).

Initially, Greenberg (1979) referred to the retroflective process as a "subject/object split" in a study of the resolution of splits in two chair therapy. Greenberg et al (1993) further developed the concept of self-interruption of emotion, to make more explicit the centrality of "interruptive activity against the self" and thereby of emotion (1993, p.217). For example, muscle control may be used as a means of over-regulating the experience of anger.

How does self-interruption lead to dysfunction? According to Greenberg et al (1993), the natural expression of emotion and associated needs are interrupted, leaving the person unable to act in an adaptive manner.

This process of interruption has roots in relational experience where attempts to express feelings and needs have been consistently met with disapproval, humiliation or abuse. The individual functions as a "divided self," with one part of the self that is engaged in activity to control the expressive action of another aspect of self. The end result is that the person develops processes of self-control to guard against vulnerability or painful experience.

Greenberg et al (1993) conceptualize the process of self-control in terms of the activation of emotion schemes which are automatically inhibited and kept out of awareness by ensuing behaviours that serve to inhibit emotional experience and expression. The end result

of this process may be either awareness of the inhibitory process itself, such as choking back tears, or its end result, such as muscular tension.

A hallmark of EFT is that therapist interventions are guided by the recognition of client markers that indicate engagement in a form of emotional processing that underpins their symptoms (Pos & Greenberg, 2007). In the case of clients who act to interrupt the flow of their emotional experience, therapists are attentive to markers of SIE, such as verbal statements indicating opposition to emotional experience, and the resolution of self-interruption of emotion is a central focus in therapy. Toward this end, the client engages in “two chair enactment” for the purpose of bringing to awareness the ways in which the interruptive aspect of self serves to suppress emotional experience. In doing so, the client gains both awareness and experience of how interruption occurs under their own power by specific means. Secondly, dialogue is fostered between the part of self that interrupts emotional experience and a respondent part that challenges it. Resolution of interruption is evident when suppressed emotional experience is experienced and expressed freely.

Greenberg and colleagues (Greenberg & Paivio, 1997; Greenberg et al, 1993; Greenberg & Watson, 2006) identify specific tasks that the client engages in while working with the therapist toward resolution of interruption: 1. the recognition of personal agency in the interruptive process, e.g., accept responsibility that it is me doing this to myself; 2. bringing to awareness the experience of the emotion to make clear its nature; 3. the symbolization of interrupted emotion in awareness so that it can be differentiated, expressed and integrated fully into the experience of self and its organization, 4; The assertive expression of needs associated with the adaptive action tendency, e.g., need to push away

abusive other. Greenberg et al argue that with awareness and synthesis of the primary concerns, feelings and needs of the self, informed choice, adaptive functioning, and a coherent sense of self are possible.

***Short-term psychodynamic theory.*** McCullough (1997) proposes a short-term anxiety-regulating model of psychotherapy that both explains psychopathology and acts as a template for therapists to follow in effecting change. The model is integrative, combining concepts from behavioural, psychodynamic, experiential and emotion theories.

McCullough et al (1997; 2003) conceptualizes the foundation of psychopathology as the inhibition of affects, or "affect phobias," especially those connected to the desire for attachment. She defines affect according to Tompkins (as cited in McCullough, 1997), who argues that it is a central motivator of human behaviour because the related strength of feeling in the body serves to animate experience. McCullough contends that "the primary pathogen is the unmet longing for human connection, that is, what is wanted and not wanted from the self and others that is too painful, shameful, or anxiety-laden to bear" (1997, p.16).

The foundation of the model is Malan's conceptual schema of "The Two Triangles" (as cited in McCullough, 1997). Malan's model represents the central principles of psychodynamic psychotherapy, that defenses and anxieties inhibit the expression of "true" feeling, where "feeling" refers to uncontrolled sexual and aggressive impulses. The three poles of the "Triangle of Conflict" represent the process of defensive functioning, where (1) drive-based impulses (2) are inhibited by defenses (3) because of associated feelings of anxiety. "The Triangle of Person" represents the client's pattern of responding to others (1) in the past, (2) in current relationships, and (3) with the therapist. These two triangles are used to

help conceptualize the particular qualities of the defensive process in the context of attachment to others. The therapist seeks to determine what feelings are being avoided, why the feelings are being avoided, and how the feelings are being avoided.

In a move away from traditional psychoanalytic thinking, McCullough has revised the drive-impulse pole of Malan's model. She has done so by incorporating ideas from Tomkins' emotion theory (as cited in McCullough, 1997).

As McCullough explains (1997), Tomkins views emotion as a general category for internal bodily experience. He argues that emotion is comprised of drives, pain, and affects. Drives are a biological transport system for moving things in and out of the body, e.g., hunger/food. He understands pain as a signal system for danger.

In contrast to traditional Freudian theory, Tomkins (as cited in McCullough, 1997) argues that affects, not drives, are the primary motivational system. According to Tompkins, affects activate behaviour, influence decisions, direct choices and impel a person to action. Moreover, adaptive affects have action tendencies that are "soothing, protective, care-soliciting and care-giving" (McCullough, 1997, p.16). Examples of affects include anger-rage, shame-humiliation, fear-terror, enjoyment-joy, and surprise-startle.

As McCullough describes (1997), affects and drives are interrelated and their associations learned. She explains that, according to Tomkins, affects amplify drives and give them positive or negative valence, which in turn informs choices. For example, the drive for attachment together with enjoyment/joy leads to eagerness to form social bonds/romantic love (positive valence). Or the drive of hunger together with shame or fear leads to disordered eating (negative valence). McCullough (1997) emphasizes that because these associations

have been learned in the context of early attachment experiences, they are malleable. In contrast, drives have not been learned and therefore are difficult to change.

According to McCullough, the goal of treatment is to regulate “the anxieties or inhibitory affects that block affective experiences needed to resolve problems in the patient’s life” (1997, p.429). McCullough et al (2003) identify five types of inhibitory affects: anxiety/panic, shame/humiliation, guilt, emotional pain/anguish, contempt/disgust that contribute to psychopathology when over or under-regulated. However, she explains that “anxiety” is used as a blanket term for any and all of these inhibitory affects in keeping with the parallel she has drawn between the classic model of phobia where fear is evoked to external cues and the concept of internal affect phobia that is the central concept in her model.

McCullough et al (1997, 2003) explain how the regulation of inhibitory affect is achieved in therapy by the restructuring of defenses and anxieties that block or inhibit the experience and expression of adaptive affects. There are three stages involved in this endeavour: 1) defense restructuring, which involves recognition of defensive patterns (cognitive insight), and relinquishing defensive patterns (cognitive insight and affect experiencing); 2) affect restructuring, involving affect experiencing to desensitize phobic avoidance, and expression and integration of positive and negative affect in relationship with an imagined significant other, and 3) self-other restructuring, which involves the alteration of self-image and other-image in light of the work done in the previous two stages. McCullough emphasizes that the therapist is very active, empathic, and supportive to help regulate the client’s experience of aversive affects, e.g., anxiety, shame, fear, pain, guilt.

To summarize, McCullough and colleagues (1997, 2003) propose that the inhibition or "phobic avoidance" of affects associated with the desire for attachment is the foundation of psychopathology. Hence, the focus of treatment is on restructuring defenses and anxieties that block the experience and expression of adaptive affects. McCullough's model is grounded in a rational understanding of psychopathology, derived from existing psychodynamic, behavioural, and emotion theories, as well as reported impressions gained from review of numerous therapy tapes as stated in the introduction to her manual on treating affect phobia (2003). However, there are no published reports of any systematic empirical study of the phenomenon of inhibition of emotion or "affect phobia" in therapy.

*Accelerated experiential dynamic psychotherapy (AEDP)*. Fosha (2000) developed the AEDP model by integrating concepts from a wide variety of theories, including: short-term dynamic psychotherapy theories of Alpert (1992; as cited in Fosha, 2000), Davanloo (1990; as cited in Fosha, 2000) and Malan (1976; as cited in Fosha, 2000); attachment theories of Ainsworth (1978; as cited in Fosha, 2000) and Bowlby (1980; as cited in Fosha, 2000); emotion theory of Tomkins (1962; 1963; as cited in Fosha, 2000), and experiential psychotherapy theory of Greenberg & Safran (EFT; 1987).

In the AEDP model, affect experience and expression in relationship are regarded as essential to healthy psychological functioning. In keeping with emotion theory, Fosha defines affect as "a wired-in adaptive, expressive, communicative aspect of human experience" (2000, p.13). According to Fosha, who uses the terms "affect" and "emotion" interchangeably, psychopathology results from problems in "the efficient processing of emotions" (p.14).

More specifically, she argues that psychopathology results from the inability to experience "core affects" and their related adaptive potentials. Core affect is defined as "all aspects of emotional life experienced directly and viscerally in the absence of defenses and anxiety" (2000, p.16). The signature of core affective experience is the involvement of the body at a visceral and motoric level. Fosha explains that,

Visceral experience is the centerpoint of the cycle of core affect, the indispensable element of the affective model of change. The capacity to experience core affect directly and deeply is what everything else depends on, and is what the strategies of intervention of AEDP aim to reliably facilitate in patients (pg.24).

There are two types of core affective experience: "core emotions," e.g., fear, joy, anger, sadness, and "core states" which are characterized by "openness, contact...experience is intense, deeply felt, unequivocal, sensation is heightened" (p.20). She describes two types of adaptive action tendencies that are activated by the expression of "core affective experience:"

1. Adaptive relational tendencies, the disposition to make contact and connect with others,
- and 2. Adaptive self-actualization tendencies that foster actualization of the self's needs

(Greenberg & Safran, 1987).

According to Fosha, difficulties in experiencing core affect are linked to the quality of early experience in the relational-affective environment. She argues that early experience in an unsupportive emotional environment robs the child, and later the adult, of the ability to regulate affective experience in an adaptive manner that promotes well-being. The child learns that emotional experience and expression leads to aversive consequences, e.g., loss of parental love, punishment. In this way, the experience of core affect becomes linked to

"aversive affects" or "red signal" affects, such as anxiety, shame, fear and aloneness. The child develops a chronic reliance on defenses that serve to keep the experience of distressing emotional experience at bay and ensure the stability of the relationship with the primary caregiver. This pattern of defensive functioning persists in adulthood and is the focus of change in the therapy relationship.

Fosha (2000) identifies a sequence of emotional experience at the centre of psychopathology as follows. The experience of core affects is followed by "secondary affective reactions" such as fear, shame, emotional pain, feeling alone or a primary depressive reaction of hopelessness, helplessness and despair that are grounded in early experience. In turn, these secondary reactions evoke "red signal affects," such as anxiety or shame, which she describes as "prototypical," or other affects such as fear of loss, helplessness, or pain. These signals of danger serve to activate the defense mechanisms that block emotional experience altogether. Defense mechanisms serve to protect a sense of self as open and exposed and include various behaviours of avoidance as well as defensive affects, such as contempt, "weepiness" or aggressive anger for example.

The central agent of change in AEDP therapy is the experience of core affect in relationship without anxiety, shame, and related defenses. Therefore, the goal of treatment is to develop the patient's "affective competence" by unblocking restricted affect, and facilitating the client's "core" affective experience in relationship with the therapist. In this way, the adaptive potential of core affective experience is available to the patient. Ultimately, the client's affective competence is demonstrated by the "capacity to feel and deal while

relating” (Fosha, 2000, pg.42), which involves fully processing the deep feelings of core affects while maintaining a sense of closeness in relationships.

How is restricted core affective experience unblocked? Fosha draws on Malan’s conceptual framework (described above- see McCullough, 1997) of “The Two Triangles” of conflict and person to help organize and track the client’s affective relational experience and to find a focus for intervention. This model represents the moment by moment process of the patient’s internal experience, across the dimensions of past and present relationships. In this way, current patterns of relating with significant others and the therapist are linked to past maladaptive patterns.

Fosha has added a third schema, the “self-other-emotion triangle,” to represent more explicitly the “relational affective context” within which emotional experience occurs (2000, p.103). This triangle represents how the experience of an emotionally significant event (triangle of conflict) “is embedded within a matrix of self-other interactions, and how representations of self-other interactions are dynamically linked” (p.103). In other words, the self-other-emotion representation encompasses both the triangle of conflict and person, and can be used as a means of identifying patterns of relationship and affect across time. Understanding of the particular pattern of relationship(s) and associated defensive and core affects sets the stage for the experiential work that needs to be done to access core affective experience.

In following the AEDP model, three strategies of intervention are employed to help patients access core affective experience within a close patient-therapist relationship: 1. Relational strategies, 2. Restructuring strategies, and 3). Experiential-Affective strategies.

*Relational strategies.* Relational interventions are designed to facilitate the development of a reciprocal affective bond that helps the patient feel safe in the relationship. Fosha stresses that the therapist's interventions go beyond validation, support and empathy to include behaviours that encourage the development of intimacy and closeness in the relationship. She proposes that the patient's experience of safety renders defenses unnecessary, thereby permitting the full experience and expression of core emotions, intimacy, and mutuality.

The disclosure of emotional experience is a two-way street involving both the client and the therapist's revelation of emotional experience. The AEDP therapist makes clear to the patient from the start that the feelings that arise between them "can and need to be discussed openly." Fosha (2000) describes therapist self-disclosure as encompassing both reflection of the patients' experience and the personal emotional reactions of the therapist as a distinct person in the relationship. In this way emotional intimacy is developed in the context of a corrective relational-affective experience.

Fosha astutely points out that the traditional psychoanalytic focus on the negative transference overlooks the fact that patients often find positive relational experiences anxiety provoking "as they are linked with the pain of frustrated past yearnings" (2000, p.220). Therefore, the AEDP therapist supports and affirms both positive and negative qualities of the patient's relational experience. Fosha argues that by processing both the positive and negative experiences together, a deeper sense of intimacy and trust is fostered.

*Restructuring strategies.* The restructuring of defenses is a central focus in AEDP, especially when the relational and experiential-affective techniques fail to melt the defenses.

Restructuring interventions are used throughout the therapeutic process, and involve a collaborative approach to the interpretation of the client's experience. The therapist presents ideas and hypotheses for the client to consider. The three triangles are used to identify "both lifelong and moment-to-moment patterns of the patient's affective and relational responses and understand their roots and function" (Fosha, 2000). As the patient's awareness of different internal states increases, the focus shifts to fostering understanding of the elements of the specific self-other-emotion triangle underlying each state. For example, awareness that the inhibition of the core affect of anger related to the dynamic of a subservient unworthy self in relation to a perceived powerful other involves the defensive exclusion of anger by the fear of being abandoned.

*Experiential-affective strategies.* The experiential-affective interventions are used in two clinical contexts: 1. As a means to bypass defences, e.g., affect is not easily accessible, and 2. When affect has already been evoked and can be deepened and worked through. Fosha draws heavily from Greenberg and colleagues (1987; 1993) and Davanloo (1990; as cited in Fosha, 2000) when describing interventions designed to facilitate the client's awareness of feeling.

Fosha has adopted Greenberg et al's (1987; 1993) focus on emotional processes, which is evident in her emphasis on the importance of moment-to-moment tracking and focusing on the client's affective experience. This attention to affective processes facilitates the client's

awareness of emotional experience and the exploration of feelings that are central to his psychopathology.

Especially important in circumventing defenses is Davanloo's (1990; as cited in Fosha, 2000) focus on how the patient's emotional experience is grounded in the body. Fosha (2000) refers to this work as "experiential biofeedback," which serves to inform the patient about the link between visceral, sensory, and motoric experience and emotional reactions. This intervention is useful when working within the frameworks of: 1. The triangle of conflict, to aid in the differentiation of defense, anxiety and affect; 2. Self-other-emotion triangle, to help the patient focus on the different physical correlates of "good" or pleasurable vs. "bad" or unpleasurable self-states; and 3) The triangle of comparisons to help the patient focus on the difference in experience of affect-facilitating vs. affect-disallowing environments (Fosha, 2000, p. 280).

In summary, Fosha (2000) argues that "core" affect experience and expression is central to healthy psychological functioning. More specifically, she argues that emotional experiences cannot be fully apprehended without understanding the relational contexts within which they occur, the associated emotions, and the specific ways in which they are handled. Fosha offers clinical vignettes and case studies to support her theoretical writings. However, systematic study of the process whereby clients block affective experience is lacking.

### **Cognitive-behavioural theory of emotional avoidance.**

*Acceptance and commitment therapy (ACT).* According to Hayes, the developer of the model, Acceptance and Commitment Therapy (ACT- "pronounced as a word") is a synthesis of "first wave" behaviour therapy and "second wave" cognitive therapy

paradigms (Hayes, 1987, 1999, 2004; Hayes, Pistorello, & Levin, 2012). He argues that while the behaviourists failed to consider cognition, cognitive psychology was limited in that it adopted a mechanistic view of mind that does not adequately represent human experience and behaviour as purposeful and oriented by personal values.

Hayes extends his critique to the current emphasis on DSM disorders and symptom reduction as this approach has not succeeded in identifying any diseases nor has it proven beneficial in terms of helping people live a meaningful life in accordance with personal values and related goals (1999, 2004, 2012).

According to Hayes and colleagues (1999, 2004, 2012), psychological health, which he defines as a process of growth involving purposeful, values-based action, is endangered by the human capacity to engage in problem solving as a means of addressing uncomfortable internal experiences. In short, attempts to control uncomfortable thoughts, feelings, and emotions by deliberate avoidance of experience are at the core of psychological problems.

ACT is grounded in the philosophical principles of functional contextualism (Hayes, 2004), a form of pragmatism, and guided by the tenets of Relational Frame Theory developed by Hayes and colleagues (Hayes, 2004; Hayes et al, 2012) from the functional contextual empirical study of language and cognition in human subjects. Each of these conceptual foundations of ACT will be described further below.

*Functional contextualism.* According to Hayes (2004), the focus of functional contextual inquiry follows from the premise that there is no objective truth or reality. Rather, the pursuit of knowledge is bound by the historical and situational context within which an event occurs. Hayes explains that the ultimate goal of functional contextualism is

“the prediction and influence of ongoing interactions between whole organisms and historically and situationally defined contexts” (2004, p.646). Thus, in seeking to understand “the nature and function of an event...the core analytic unit is the ‘ongoing act in context’ ” (p.646). Within this contextual paradigm, change is brought about by the manipulation of contextual variables, as described further in a later section.

Furthermore, according to Hayes, the truth of an outcome is assessed in light of the “pragmatic truth criterion,” which is that pre-determined goals underpinned by personal values are seen to be met and make a meaningful difference in an individual’s life. As Hayes puts it, “What is considered true is what works” (2004, p.646).

*Relational frame theory.* According to Hayes, Relational Frame Theory is a contextualist theory of cognition that is grounded in an “active behaviour analytic research programme” (Hayes, Pistorello & Levin, 2012, p.979). The main thesis of RFT is that behaviour is under the influence of verbal/cognitive relational networks and therefore it is essential to examine language and cognition to make sense of behaviour.

Hayes argues that RFT addresses the limitations of both the first wave of behavioural therapy and second wave of cognitive therapy because it offers a novel approach to language and cognition that underscores how humans “learn to relate events under arbitrary contextual control” (2004, p.648). He identifies three central properties of relational learning.

First such relations show mutual entailment or “bidirectionality.” If a person learns that A relates in a particular way to B in a context, then this must entail some kind of relation between B and A in that context. For example, if a person is taught that hot is the same as boiling, that person will derive that boiling is the same as hot. Second,

such relations show combinatorial entailment: if a person learns in a particular context that A relates in a particular way to B, and B relates in a particular way to C, then this must entail some kind of mutual relation between A and C in that context...Finally, such relations enable a transformation of stimulus functions among related stimuli (Hayes, 2004, p.648).

Relational responding that includes all three properties is called a “relational frame,” wherein “events can acquire functions through indirect, relational” (e.g., cognitive, linguistic) means. Experience that is encoded or represented in language/cognition is generalized to other contexts through relational linguistic/cognitive frames. Accordingly, Hayes argues “it is necessary to analyse cognition in order to understand human behaviour” (2004, p.649). He does not make explicit the role of emotion in human behaviour, other than to acknowledge that the avoidance of emotional experience serves to perpetuate cognitive/linguistic frames that are associated with psychological problems. This point will be discussed further below in the description of the ACT clinical model.

In ACT, unlike traditional cognitive behavioural therapy, the mechanism of change in behaviour is not through problem solving the content or frequency of thoughts, e.g., by challenging irrational beliefs. Rather, change is effected by altering the context that perpetuates thoughts or the “frame.” Hayes explains why this new focus on context is essential:

[No] learned behaviour is ever fully unlearned, once a particular relation occurs it never returns to zero strength. Even the most pathological thought will never fully be eliminated in that sense. Fortunately, the impact of thinking is argued to be

contextually controlled and not causal in a mechanical way (Hayes, Pistorello & Levin, 2012).

How change is effected in ACT by changing the context rather than verbal behaviour/thought and associated emotion and action will be described further with examples in the explanation of the ACT model below.

*ACT clinical model.* In ACT (Hayes et al, 1999, 2003, 2004), clients are encouraged to examine their current problem solving strategies of control and avoidance of experience and assess their effectiveness. Cognitive/linguistic sets or frames that define problems and solutions to negative effect are challenged through various methods, including exercises, homework and the use of metaphors that allow for a new awareness that it is impossible to control automatic thoughts and feelings.

The core construct in the ACT clinical model of psychological well-being is “psychological flexibility,” defined by six processes: Acceptance, Being Present, Values, Defusion, Noticing Self, and Committed Action. Psychopathology is defined by the inverse of these processes, as described below.

*“Experiential avoidance/Acceptance.”* Experiential avoidance refers to action in the service of getting rid of or controlling unwanted internal events, such as sensations, thoughts, emotions and memories. According to Hayes and colleagues (2004, 2006, 2012), it is the avoidance of experience, especially in the extreme, that contributes to psychological suffering. The vicious circle of avoidance of experience that is rooted in relational frames is explained in the following example.

Thoughts of a dead spouse might be cued by pictures, depressed mood, a comment in a conversation, a beautiful sunset, or any of myriad other cues. Unable to control pain by situational means, humans try to avoid the painful thoughts and feelings themselves. Unfortunately, many of these means (e.g., suppression) will ultimately themselves come to cue the avoided event because they strengthen the underlying relational frames (“don’t think of x” will serve as a contextual cue for “x” and the psychological presences of the actual event it is related to) (Hayes, 2004, p.650).

In contrast to a language based problem-solving approach, with an emphasis on changing or avoiding thoughts and controlling emotional experience, ACT promotes the acceptance of experience, including uncomfortable and painful thoughts, sensations, feelings, and emotions.

Hayes explains,

In ACT, acceptance is not merely tolerance - it is the active, non-judgemental acceptance of experience in the here and now...Acceptance means actively experiencing events, as they are and not what they say they are. This means feeling feelings as feelings, thinking thoughts as thoughts, sensing sensations as sensations, and so on, here and now (2004, p.656).

In essence, exposure is inherent in ACT. However, Hayes explains it is not for the purpose of regulation of emotion as is the case in traditional behavioural exposure therapies. Rather, “Acceptance and exposure in in ACT lead to a different kind of exposure: experiencing actively and fully in the present, moment by moment, for the proximal purpose of experiencing actively and fully in the present, moment by moment” (Hayes, 2004, p.656).

In summary, by changing the problem-solving context of control over or avoidance of thought that serves to exacerbate and perpetuate emotional suffering and distress, we slip the knot of language and create openness for growth.

*“Attentional rigidity to the past and future/Being present.”* Hayes et al (2012) argue that empirical studies have shown that rigid attention to the past and future promotes a variety of psychological problems. ACT help clients learn how to focus attention fully on the present moment through the use of mindfulness practices and exercises that facilitate the capacity for attentional control.

*“Unclear, compliant, or avoidant motives/values.”* In ACT, there is a focus on value driven action as evidence suggests that individuals are unlikely to reach goals when behavioural change is motivated by guilt or compliance (Hayes et al, 2012). ACT therapists help clients to clarify values through various exercises before moving on helping them live values in the here and now. They do so by collaboratively identifying related goals, actions that would achieve goals, and obstacles to taking action. Hayes emphasizes that this work entails accepting and embracing painful thoughts, feelings and emotions that function as barriers, e.g., changing the context or relationship to psychological events as opposed to changing them.

*“Cognitive fusion/defusion.”* The process of cognitive fusion involves the “illusion of language” where thought functions in a literal sense with negative consequences to psychological well-being. Hayes explains,

Because of derived stimulus relations and transformation of stimulus functions, thoughts often function as if they are what they say they are. The thought ‘I am bad’

can seem to mean that the person is dealing with *being* bad, not with thinking ‘I am bad’ (Hayes, 2004, pg.654).

In ACT, changing the context rather than the thought “I am bad” involves learning techniques that shift the focus from the importance of the content or frequency of the thought and its veracity to changing the strength of the “attachment” to it. For example, mindfulness practice is one of many methods of cognitive defusion employed in ACT, as it involves learning through practice how to observe thoughts as mental events as opposed to literal phenomena.

“*Conceptualized Self/Noticing Self.*” According to Hayes et al (2012), the “conceptualized self,” described as an inflexible self-narrative, leaves one vulnerable to psychopathology and therefore is a focus of change. He argues,

The conceptualized self often reduces behavioural flexibility because the attempt to be right about such descriptions can lead to rejection of contradictory content. Events that threaten the conceptualized self can evoke strong emotions and lead to heightened experiential avoidance based on the need for consistency within the narrative (Mendolia & Baker, 2008). When a person over identifies with a particular self-conceptualization, events outside the narrative can seem to invalidate life itself, as illustrated by a string of recent suicides of extremely wealthy individuals who have lost their fortunes in the international economic downturn (Hayes et al, 2012, p.984).

The focus of change in ACT is not on the content of the conceptualized self and self-narrative. Rather, ACT underscores the importance of an observing or “transcendent sense of self” as it functions as a “safe place” from which to observe changing or distressing thoughts, feelings and emotions. In other words, change occurs at the level of context by changing the

relationship to psychological events that may not cohere with individual self-narratives. Through various ACT exercises clients develop the capacity to observe the “rapidly changing content of experiences” while also noticing “the continuity of consciousness itself” and an enduring sense of “I” across events (Hayes, 2004, p.655). Engaging the client in use of the central chessboard metaphor in ACT, as a representation of the difference between an enduring sense of self and avoided experience, is an example of one such exercise (Hayes et al, 2012). Clients are encouraged to consider different aspects of experience, such as thoughts, beliefs and emotions, as conflicting chessboard pieces and observe the “battle” between the positive/good and negative/bad. In keeping with the idea of changing context or the cognitive/linguistic “frame,” the client is asked to consider thinking of themselves as the board and not the chess pieces.

*“Inaction, impulsivity, or avoidant persistence/committed action.”* The ACT therapist works to elicit explicit client commitment to actions in keeping with self-identified goals. These commitments are woven throughout traditional behavioural methods of change, such as behavioural activation, skill development, and exposure. However, the difference in ACT is that committed action takes place in a context of flexibility, openness and awareness that facilitates action rooted in personal values. Clients choose specific committed actions and self-monitor progress. When they do not meet these commitments the therapist’s attitude is one of awareness with interest and without judgement as obstacles to committed action are explored. In effect, the therapist models how one engages in change at the contextual level by approaching problems with openness, presence in the moment, and acceptance of experience.

In summary, ACT is a “third wave” behavioural therapy developed by Hayes et al (1996, 1999, 2004) to address the limitations of previous behavioural and cognitive behavioural models. ACT is a pragmatic, principled approach grounded in the philosophy of functional contextualism and the assumptions of Relational Frame Theory, as described by Hayes (1987, 1999, 2004). Unlike traditional cognitive-behavioural therapy models, the clinical model of ACT is based on the assumption that the content of human experience is not the source of psychological problems. Rather, attempts to control or avoid experience, that is bound by immutable language based relational frames, by taking a problem solving approach to the content of thoughts, feelings and emotions is the root of larger problems in living. Instead, by changing the context that gives life to problematic thoughts, beliefs and feelings through various ACT strategies, the therapist helps the client to become unbound from the linguistic/cognitive frames that are detrimental to psychological well-being. This change facilitates the client’s ability to fully experience thoughts, feelings and emotions while moving forward in keeping with personal values, which in turn allows for personal growth.

*Avoidance theory of worry and generalized anxiety disorder.* Borcovec et al (1994; 2004) emphasize the role of cognition in the inhibition of emotional processing. In the face of a perception of threat and activation of the fear system, the cognitive act of worry is understood as an ineffective behaviour that addresses the threat while also serving to avoid the distressing feelings and experiences of emotion that encompass a fear response. Because of this process of cognitive avoidance, the emotional processing of fear is inhibited.

The act of worrying is negatively reinforced as distressing fear-based thoughts and images are superseded by less disturbing verbal acts of worry, which in turn dampen bodily based aversive feelings. Positive reinforcement of flight to worrying also occurs should the feared experience or situation not occur, which in turn fosters and perpetuates the belief that worry serves a useful function. According Borkovec (1994; 2004), when this pattern of behaviour is chronic, individuals are caught in a web of generalized anxiety that interferes with the ability to accurately perceive threat, process fear and respond accordingly, not to mention that the distraction of worrying also interferes with the ability to attend to other emotional experience. In clinical diagnostic terms of the Diagnostic and Statistical Manual, 5<sup>th</sup> edition, such individuals are said to suffer from Generalized Anxiety Disorder.

In summary, the cognitive avoidance of emotional experience by worry is an ineffective solution to difficulties processing fear as the inhibition of emotional processing by worrying leaves individuals vulnerable to the ongoing distress and impairment of Generalized Anxiety Disorder.

In reviewing the various theories outlined above, it is clear that psychodynamic, inter-subjective, experiential, and cognitive schools share a common view that difficulties in the processing of emotion underlie psychopathology and must be addressed to effect change. There is also support in the empirical literature for the role of interruption/inhibition/avoidance of emotion in psychopathology. This literature will be reviewed in the following section.

## **Empirical Literature Review**

Greenberg and colleagues have conducted a number of process and outcome studies of experiential therapy for depressed clients that have shown that emotional processing in the form of experiencing, accepting, and making meaning of emotion is positively correlated with a reduction in depression scores and interpersonal problems (Elliott, Watson, Greenberg, Timulak & Friere, 2013; Goldman, R., Greenberg, L. & Angus, L., 2006; Goldman, Greenberg and Pos, 2005; Greenberg & Watson, 1998).

A series of studies, summarized below, have shown the relationship between specific aspects of emotional processing (arousal, resolution of particular emotional processing difficulties, phase of treatment) and outcome.

Therapy clients who had higher degrees of resolution of self-criticism or unfinished business with a significant other in an emotion focused therapy treatment (EFT), by virtue of the demonstrated experience and expression of adaptive emotion and related needs, maintained reductions in depression scores in an 18-month post treatment follow-up study (Greenberg & Pedersen, 2001).

The relationship between emotional arousal and therapy outcome has also been studied. Warwar (2003) reported that increases in the intensity of expressed emotional arousal over the period of early to mid-therapy combined with depth of experiencing late in therapy best predicted outcome. A recent reanalysis of Warwar's data also showed that emotional arousal indirectly contributed to good outcomes for depressed clients who participated in brief experiential psychotherapy, as it was mediated through the process of experiencing that involves allowing and making meaning of emotion (Pos, Paolone, Smith, & Warwar, 2017).

An inverse relationship between arousal and reflection was shown by Misserlian, Toukmanian, Warwar, and Greenberg (2005), who concluded that when high levels of arousal are evoked within the first half of treatment emotional experience is more amenable to cognitive processing, and especially later in treatment when reflective processing was greater. In turn, as reflective processing increased expression of emotional arousal lessened. In other words, high arousal potentiates reflective processing, which in turn mitigates arousal. Carryer & Greenberg (2010) tested whether the premise of a non-linear relationship between physiological arousal and performance (Yerkes & Dodson, 1908; as cited in Carryer & Greenberg, 2010) could be extended to the domain of psychotherapy and the construct of emotional arousal. Results showed a non-linear pattern of arousal where low and extreme expressed emotional arousal was associated with poor outcome, and an “optimal frequency” of expressed intense emotional arousal that did not exceed 25% of the therapy hour was associated with a good outcome. In a review of the literature on emotion processes in psychotherapy, Greenberg & Pascual Leone (2006) concluded that while arousal alone “is not sufficient for emotional processing...working with aroused emotion is predictive of positive outcome in therapy over and above the contributions of the therapeutic alliance.”

In a study of the significance of early and late emotional processing in depressed therapy clients who received treatment by brief experiential psychotherapy, emotional processing deepened over the course of treatment and occurrence late in therapy was the best predictor of decreases in symptoms and improvements in self-esteem (Pos, Greenberg, Goldman & Korman, 2003). A follow up study more precisely showed that emotional processing that occurred during the working phase of treatment best predicted symptom

reduction as well as increases in self-esteem, beyond the contribution of the therapy alliance (Pos, Greenberg & Warwar, 2009).

Greenberg, L., Auszra, L. & Herrmann, I (2007) compared good and poor outcome cases for depressed clients in an experiential therapy along the dimensions of both productivity and arousal of expressed emotion. They reported that when compared to poor outcome clients, those clients with good outcomes expressed more productive emotions and more productive highly aroused emotions. In a later study, Auszra, Greenberg & Hermann (2013) assessed the predictive validity of the construct of “Client Emotional Productivity” (CEP), defined as “optimal client in-session emotional processing, possessing seven features: Attending, symbolization, congruence, acceptance, regulation, agency and differentiation” (p.738). They concluded that CEP was associated with positive changes with respect to depression scores and reports of general symptoms. More specifically, they report that the working phase of CEP was a greater predictor of improvement than early phase CEP, high expressed emotional arousal in the working phase and the working alliance. They suggested that these findings support the idea that clients were better able to process “activated primary emotion in a productive manner” as per CEP.

Task analytic and qualitative studies of the resolution of emotional processing difficulties also support the premise that allowing and expressing emotional experience is central to positive outcomes for therapy clients. Conversely, the inhibition or avoidance of emotion was central to the chronic experience of hopelessness or emotional pain.

In a task analysis of the resolution of hopelessness in depressed clients treated with emotion focused therapy, Sicoli (2005) identified the essential components of this process as acknowledgement and acceptance of emotion, as well as expression of related needs and meaning (Sicoli, 2005). Furthermore, Sicoli's findings showed that "Individuals who tended to avoid experiencing and expressing emotions were less likely to experience an alleviation of their hopeless state or experience positively valenced emotions such as hope, relief or optimism" (pg.136). A qualitative study of the transformation of self through emotional pain demonstrated that in contrast to individuals who engaged in various means of "covering" painful experience, those who worked through pain by allowing "brokenness" and verbalizing associated feelings and new self-awareness experienced healing that was manifested in greater acceptance of self and others (Bolger, 1996). The capacity to reflect on emotional experience and generate new self-understanding is an essential part of constructing and transforming self-narratives, a process that has that has been linked to positive therapy outcomes (Angus & Hardtke, 2007; Greenberg & Angus, 2004).

Pennebaker and colleagues (Pennebaker, 1997; Pennebaker & Beall, 1986) have demonstrated the benefits of putting emotional experience into words that are organized into a coherent narrative and writing about its personal significance, in terms of a resultant sense of emotional well-being, and positive effects on functioning of the autonomic nervous system and immune system.

Studies by Gross and colleagues on emotional suppression show that while this style of emotion regulation reduces the expression of negative emotions such as anger or sadness, it may also result in a decrease of positive emotional experience by blunting positive emotions

(Gross & John, 2003; Gross & Levenson, 1993; Gross & Levenson, 1997). In addition to a negative effect at the individual level, a decrease in positive emotion such as love has implications for the possibility of forming healthy attachments with others. It was also found that in contrast to individuals who were able to engage in emotion regulation using cognitive reappraisal, emotion suppressors were not as likely to communicate emotions in relationships, which in turn had a negative impact on interpersonal functioning. There is also empirical support for a relationship between emotion suppression and psycho-emotional problems. Gross and John (2003) reported that emotion suppression predicted a negative relationship with well-being, as suppressors endorsed a higher number of depressive symptoms, as well as lower ratings for self-esteem, life-satisfaction, and optimism. Beblo, Fernando, Klocke, Griepentstroh, Aschenbrenner, & Driessen (2012) reported that patients diagnosed with a diagnosis of major depressive disorder had higher rates of emotion suppression as compared to a healthy control group, and suppression of emotion was associated with symptoms of depression.

A meta-analysis of 50 correlational studies showed an association between the suppression of emotion and more symptoms of psychopathology across disorders, such as depression, eating disorders, anxiety disorders, and substance-use disorders (Aldao, Nolen-Hoeksma, & Schweizer, 2010). They reported a relationship between symptoms and strategies of emotion suppression and avoidance and symptoms of psychopathology, with medium to large effect sizes.

Ioannou, & Fox (2009) studied the relationship between emotional expression and symptoms of disordered eating. They reported a negative relationship between emotional

expression and eating disorder symptoms (ED), where the inhibition of emotion, especially anger, was associated with higher levels of symptoms.

Emotion suppression as an emotion regulation strategy has also been shown to predict poor psychotherapy outcomes for cognitive behaviour therapy (CBT). In both an inpatient and outpatient sample of individuals who participated in CBT, delivered by therapists in accordance with standardized treatment manuals, emotion suppression predicted a lack of improvement at termination of treatment (Scherer, Boecker, Pawelzik, Gauggel, & Forkmann, 2017). In the inpatient sample only, emotion suppression also predicted improvement but not remission for a subset of patients.

Hayes and colleagues argue that the emotion regulation strategy of experiential avoidance is central to the development of psycho-emotional problems (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996; Hayes, Strosahl, & Wilson, 1999). They define experiential avoidance as the suppression, avoidance or control of undesirable emotions, feelings, thoughts and other private experience. While this strategy seems to work in the short term as it brings relief from distressing emotional experience, they argue that over the long term this strategy serves to initiate, exacerbate, and perpetuate psychological difficulties. Results from correlational studies have shown that individuals who score high on the Acceptance and Action Questionnaire (AAQ), a self-report measure of the construct of experiential avoidance, also scored higher on measures of psychopathology including depression, anxiety and trauma and also scored lower on quality of life (Hayes et al, 1996; 1999; 2004).

Emotional processing has also been associated with positive outcomes in the treatment of individuals suffering from severe and debilitating mental health problems. Traumatized clients who are able to allow the experience of emotional arousal without engaging in escape behaviour associated with fear avoidance have better outcomes (Foa, Rothbaum & Furr, 2003; Pavio, Hall, Holowaty, Jellis & Tran, 2001). Therapy clients diagnosed with Borderline Personality Disorder, a disorder of pervasive emotion dysregulation, have been successfully treated with Dialectical Behaviour Therapy, which involves a focus on both acceptance and problem solving, as well as skills training in mindfulness (including mindfulness of emotion), distress tolerance, and emotion regulation skills that promote emotional awareness, acceptance and regulation (Linehan, 1993; McMMain, Links, Gnam, Guimond, Cardish, Korman, & Streiner, 2009). Studies have also shown that there is a relationship between higher levels of emotional awareness and increased impulse control (Greenberg & Pascual-Leone, 2006; Lane & Schwartz, 1987). Results from a randomized control trial of McCullough's "Affect Phobia Treatment," a short-term dynamic psychotherapy that focuses on affect avoidance, showed that an increase in self-compassion over the course of therapy predicted a decrease in psychological and interpersonal difficulties in clients diagnosed with personality disorders (Schanche, Stiles, McCullough, Svartberg & Nielsen, 2011). There was an inverse relationship between inhibitory affects (anxiety, shame and guilt) and both "activating affects" (sadness, anger) and measures of self-compassion. As inhibitory affects decreased and activating affects increased, self-compassion also increased. These findings support self-compassion as an important goal of psychotherapy and indicate that increase in the experience of activating

affects and decrease in inhibitory affects seem to be worthwhile therapeutic targets when working to enhance self-compassion in patients with personality disorders.

In a study of university students (McCubbin & Sampson, 2006) responses on the 'Perception of Threat from Emotion Questionnaire,' a reliable measure of the stable beliefs that individuals hold about their emotions that was developed for use in the study, was the strongest predictor of obsessive compulsive behaviour as measured by The Padua Inventory (as cited in McCubbin & Sampson, 2006). The perception of threat from anger was the strongest predictor of obsessive-compulsive behaviours. In clinical samples, success rates for therapy clients diagnosed with obsessive-compulsive disorder have been correlated with the actuation of anxiety and blocking of its inhibition during treatment involving exposure and response prevention (Foa & Franklin, 2000; Franklin & Foa, 2011).

There is also strong empirical support across the five major models of Generalized Anxiety Disorder for the proposition that individuals suffering from this disorder engage in various means of experiential avoidance, including thoughts and emotions, which in turn impedes emotional processing (Behar, DiMarco, Hekler, Mohlman, & Staples, 2009; Borkovec, Alcaine & Behar, 2004; Borkovec, Roemer & Kinyon, 1995). The five major models of GAD, as cited in Behar et al (2009) are: the Avoidance Model of Worry (AMW; Borkovec, 1994); the Metacognitive Model (MCM; Wells, 1995); the Emotion Dysregulation Model (EDM; Mennin, Heimberg, Turk & Fresco, 2002); the Acceptance Based Model (ABM; Roemer & Orsillo, 2002); and The Intolerance of Uncertainty Model (IUM; Dugas, Letarte, Rheume, Freeston & Ladouceur, 1995).

To address the finding that poor outcomes in CBT for GAD were associated with pre-treatment interpersonal problems and emotional processing deficits, Borkovec and colleagues added treatment of these problems to the standard CBT treatment of worry in a randomized control trial (Behar et al., 2009). Participants were randomized to either the CBT+IEP condition, which involved standard CBT and interpersonal and emotional processing therapy, or the CBT+SL condition, which involved standard CBT and supportive listening. While there were no differences on the outcome measures at the end of treatment, at the 24-month follow-up the CBT + IEP condition showed a significant positive difference in measures of functioning. The outcome measures used in this study were not specified.

In a meta-analysis of studies of psychodynamic therapy, the relationship between the therapist's facilitation of the client's experience and/or expression of emotion and therapy outcome was examined (Diener, Hilsenroth, & Weinberger, 2007). The therapist's facilitation of client emotional experience was shown to be positively associated with successful treatment, as measured by changes in "depressive symptom" scores or "overall change" (no specifics about this outcome variable were given). Success rates differed by 30% when outcomes between those clients who participated in a therapy with an affective focus were compared with those where this was not the case, with a medium effect size of  $r=0.30$ ,  $p<0.01$ , leading the authors to conclude "the more therapists facilitate the affective experience/expression of patients in psychodynamic therapy, the more patients exhibit positive changes (Diener et al, 2007, p.939)."

Furthermore, a number of authors have argued that the cumulative body of research literature across the spectrum of psychotherapies, including client-centered, psychodynamic

and cognitive-behavioural, supports the hypothesis that emotional processing is a common factor that accounts for change (Coombs, M., Coleman, D., & Jones, E. 2002; Greenberg & Pascual-Leone, 2006; Whelton, 2004). In view of this conclusion, understanding the factors involved in processing difficulties such as the self-interruption of emotion is vital.

The process whereby emotional experience is unconsciously repressed (Freud, 1915/1986; Stolorow & Atwood, 1992), interrupted (Greenberg; 1993) or inhibited (McCullough, 1997; Fosha, 2000) has been described primarily from a rational, theoretical perspective, with illustrative excerpts from therapy transcripts or single case studies. There is a small empirical literature on the process of interruption of emotion in therapy clients. This literature will be reviewed below.

**Process studies of interruption of emotional experience in therapy.** In a qualitative study of transformation of self through the experience of pain, Bolger (1996) interviewed seven women in a therapy group for adult children of alcoholics, about their experience of pain at three points over a six-month period. The interviews were analyzed following the method of grounded theory as described by Rennie, Phillips & Quartaro, (1988). From these analyses, a model of transformation through pain was conceptualized.

In this model, Bolger described pain as the subjective experience of “brokenness “of the self that was defined by a sense of woundedness, disconnection, loss of self and awareness of self, that participants recalled using visceral and spatial descriptors. She conceptualized the central features of working through pain as “Allowing brokenness” of the self, and “Staying with Brokenness” and related painful emotions so that they could be processed. Allowing and staying with brokenness facilitated transformation from a “covering” of the self in the service

of avoiding pain to a newfound sense of self-understanding, as well as an increase in acceptance of self and others.

The model of working through pain includes the category “Covering,” which represents a step in the process of transformation where participants had difficulty allowing pain or “brokenness.” Covering was defined by four types of responses that included: “interrupt” feelings or the sense of “breaking apart,” “hiding” pain predominantly by avoidance or denial, “holding” onto pain, and “restoration” of a pre-existing awareness of self. The process of “interrupt” as described in this model will be described in further detail as it bears directly on the focus of the present study.

In Bolger’s model, participants’ experience of “interrupt” occurred in the context of difficulty staying with the sense of self as breaking and the experience of painful feeling, and functioned to stop the subjective experience of pain and brokenness altogether. The experience of “interrupt” was heterogeneous and included automatic onset for some, whereas others engaged in deliberate actions, such as stopping feelings by holding them in or pushing them down. Some participants allowed pain to a degree and maintained control over the amount, timing, and duration of painful feeling. For others, painful feelings were not allowed at all because to do so would violate standards or beliefs. Overall, those participants who experienced interruption of painful experience did not progress to the experience of “staying with brokenness,” which was the key factor that differentiated those participants who experienced a positive transformation of self from those who did not.

In a study of the resolution of hopelessness in depressed therapy clients engaged in process-experiential therapy, Sicoli (2005) developed a process model of the performance of

resolution using Greenberg's (1999) method of task analysis. Five central components in the process of the resolution of hopelessness were identified: the identification of "negative cognitions and self-agency in the production of hopelessness," acknowledgement of "primary adaptive emotions of sadness, pain or anger," "allowing, differentiating and accepting primary adaptive emotions of sadness, pain or anger," the identification and assertive expression of wants and needs, and the "emergence of a sustained resilient self."

Clients who did not resolve hopelessness engaged in interruption of this process in ways that did not allow for the experience of primary adaptive emotions of sadness, pain or anger, which is a central component in the model of resolution. Client's interruption of their own emotional experience was manifested in the following ways: difficulty tolerating the feeling of emotion or accepting the existence of it, responding with explicit behaviours of contempt or expressions of discomfort, changing the topic, intellectualization of experience or complaining. Sicoli concluded that whatever way the client engaged in interruption of emotion the outcome was the same, which was "to break the momentum in processing this deeply felt experiential level of experiencing and become stuck in the interrupting behaviour. This inevitably returns the client to experiencing a collapsed hopeless state" (2005, p.98).

In summary, there is a consensus across the theoretical and empirical literature that the inhibition or interruption of emotional experience plays a central role in psychological problems and disorders. In two empirical studies, self-interruption of emotion was identified as a barrier to the process of resolution of either emotional pain or hopelessness in therapy clients (Bolger, 1999; Sicoli, 2005). While some aspects of the process of self-interruption of

emotion (SIE) were touched upon in these studies, the process of SIE was not the major focus of inquiry and therefore an intensive analysis was not undertaken.

### **Rationale for the Present Study**

From the literature reviewed above, it is clear that while the interruption of emotional experience is recognized as problematic in terms of a negative impact on psychological well-being and therapy outcomes, understanding of the process whereby clients interrupt emotional experience in therapy is limited, and grounded primarily in theoretical assumptions informed by clinical impressions, case studies and illustrative examples from therapy sessions (Fosha, 2000, Greenberg et al, 1993, McCullough, 1997). To date, there are no systematic empirical studies of this process. This research study will fill this void through intensive analysis and description of the process of self- interruption of emotion (SIE) in psychotherapy.

The importance of rich description of the complex phenomenon of therapy process has been noted. Greenberg (1999) argues that research in psychotherapy would be more illuminating and clinically relevant if it were anchored in the rigorous description of processes in psychotherapy in order to explicate their unique components and patterns. Grounded in a descriptive foundation, modelling of therapy process can then provide clinically meaningful information to therapists about what to attend to in therapy, the nature of particular problematic processes, explanation of change mechanisms, and intervention strategies.

In keeping with this view, the present study provides both a phenomenologically grounded representation and a performance model of the interruptive process in therapy clients, outlining essential components, qualities, and patterns. The resultant multifaceted

understanding of the phenomenon of interruption of emotion is a step toward the development of a model of resolution and effective interventions therapists can use to help clients resolve this problem in therapy.

### **Overview of the Research Design**

A general overview of the research design will be provided here. Further detailed information is provided in the relevant method sections that are described in later chapters.

Inquiry into the process of interruption was guided by a central question: What are the defining components, qualities, and features of client self-interruption of emotion in therapy? To answer this question a two-study, multi-method research design was used. The methods of task analysis (Greenberg, 2007; Pascual-Leone, Greenberg, & Pascual-Leone, 2014) and grounded theory (Glaser & Strauss, 1967; Rennie, Phillips & Quartaro, 1988) were used to capture the overt performance of inhibitory behaviour and the subjective experience of interrupting emotional experience respectively.

Using these two methods allowed for the study of SIE from three vantage points to make explicit both the nature of its complexity as a phenomenon with overt and private features and how understanding of that complexity is framed by the researcher's subjectivity (Agnew & Pyke, 1987). The three vantage points and research questions specific to each are outlined below.

1. The researcher's a priori rational understanding of self-interruption of emotion (SIE). What are my assumptions, biases, and beliefs about interruption of emotion?

2. Observation of the client's performance of SIE in therapy. How do clients interrupt their experience of emotion in therapy? What overt behaviours do they engage in during this process?

3. Client's recall of their phenomenological experience of interrupting emotion. What is the client's subjective experience of interrupting emotion? What are the qualities of the perceptions, feelings, and sensations experienced in conscious awareness?

In the first study, the rational-empirical method of task analysis was used to make explicit the researcher's rational understanding of SIE and to provide a descriptive model of the essential steps or components involved in the client's overt or observable performance of SIE in a therapy session (Greenberg, 1986; Greenberg, 1999). In a traditional task analysis, the descriptive model would be subjected to further refinement and verification in a second phase of analysis. In the verification phase, the presence or absence of components is determined by raters who apply objective measures of components of the model to examples of the task of interest.

The verification phase of traditional task analysis was not undertaken in the present study. Rather, to further explore and understand the phenomenon of SIE in therapy, a second study was undertaken to examine the client's subjective experience of interruption of emotion.

The methods of interpersonal process recall (Elliott, 1986) and quasi-grounded theory (Glaser & Strauss, 1967; Rennie, Phillips & Quartarro, 1988) were used to study the client's phenomenological experience of SIE that is grounded in clients' accounts of subjective experience. One intention underlying the qualitative study of SIE was to begin the process of

developing a comprehensive grounded theory of the client's subjective experience of interrupting emotion in therapy, as one does not exist to date. Another intention was to consider how therapy clients' subjective experience of SIE, as represented from the grounded analysis of client accounts, compares with therapy clients' in session performance (engagement in observable behaviour) of SIE. The guiding question here was "Does the subjective experience model corroborate and/or add to understanding of SIE as represented in the performance model?" It is necessary to clarify here that this comparative analysis differs from the positivist tradition of verification, where hypotheses derived from pre-existing categories and concepts of an existing theory are tested by 'objective' measures and instruments.

Glaser and Strauss (1967) explain the balance of theory generation and verification as follows:

While verifying is the researcher's principal and vital task for existing theories, we suggest that his main goal in developing new theories is their purposeful systematic generation from the data of social research. Of course, verifying as much as possible with as accurate evidence as possible is requisite while one discovers and generates his theory- but not to the point where verification becomes so paramount as to curb generation. Thus, generation of theory through comparative analysis both subsumes and assumes verifications and accurate descriptions, but only to the extent that the latter are in the service of generation (p.28).

In the present study of SIE by depressed therapy clients, the categories in the subjective experience model and the components in the performance model were compared to

one another as a means of cross verification. Similarities and differences were noted, and a final integrative model of therapy clients' SIE was proposed. This final round of integrating information about clients' performance and subjective experience of SIE was another iteration of comparative analysis toward the development of a comprehensive theory of SIE in therapy.

## CHAPTER TWO

### **Study I: Descriptive Task Analysis of the Therapy Client's Performance of Self- Interruption of Emotion**

The goal of this study was to conceptualize a model of depressed therapy clients' performance (explicit behavior) of self-interruption of emotion in an EFT therapy session.

#### **Method**

The method of task analysis (Greenberg, 2007; Greenberg & Foerster, 1996; Pascual Leone, Greenberg, & Pascual Leone, 2014) was followed to study the client's performance of SIE in an EFT therapy session. From this analysis, a model of the client's performance of SIE was developed.

#### **Procedure.**

*Participants.* Client therapy sessions were selected for analysis from data banks of two studies involving experiential psychotherapy (EFT and CC) for depression conducted at York University: the NIMH funded Depression I study (Greenberg & Watson, 1998), and the Ontario Mental Health funded Depression II study (Goldman, Greenberg, & Angus, 2006). Both studies were undertaken at the York University Research Clinic, a research facility where faculty and graduate students in clinical psychology conduct psychotherapy process and outcome research.

Clients in both studies were solicited by advertising the treatment studies through local media (i.e., radio and newspaper) and at a variety of local mental health services (i.e., hospitals, York University Counselling Center). Individuals were sought who were

experiencing symptoms of depression and who were interested in participating in psychotherapy in the context of a research study. Potential candidates were screened through a telephone interview and those who met criteria for inclusion at this stage were invited to participate in an intake assessment. Inclusion criteria for the treatment studies were:

- a) Meets criteria for a clinical depression according to the Diagnostic and Statistical Manual-III-R (DSM-III-R).
- b) A Beck Depression Inventory score (BDI; Beck, Ward, Mendelson, Mock & Erbaugh, 1961) of at least 16.66 or above.
- c) Client consent for therapy sessions to be audiotaped and videotaped.
- d) Agreement to complete research measures.
- e) A Global Assessment of Functioning Score above 50 on the Structured Clinical Interview for the DSM-III-R (SCID; Spitzer, Williams, Gibbon & First, 1989).

Individuals were excluded from the program if there was any indication of the following:

- a) Evidence of severe psychological disturbance that required longer-term therapy, such as a diagnosis of an Axis II disorder (i.e., borderline or schizoid personality disorder) or another Axis I disorder (i.e., schizophrenia, a substance use disorder) with the exception of a diagnosis of an anxiety disorder.
- b) Any evidence of psychosis.
- c) Any evidence of neurological impairments or severe intellectual deficits.
- d) Any complex medical conditions.
- e) Currently participating in another psychotherapy treatment.
- f) Currently taking psychotropic medication for depression

g) Current assessment of a high risk of suicide.

Appropriate referrals were sought for clients who were deemed ineligible for the study.

Study participants were given 16-20 sessions of psychotherapy for treatment of depression at no cost in exchange for their participation.

Clients were randomly assigned to one of two treatment conditions: client centered therapy (CC) or emotion focused therapy (EFT; formerly known as process-experiential therapy). Each condition involved participation in one-hour weekly psychotherapy sessions at the York University Research Clinic. Clients whose sessions were selected for the task analysis were all participants in emotion focused therapy.

All clients agreed to complete various pre-therapy, post-session and outcome questionnaires. They also consented to be audio and videotaped at each therapy session. In addition, in the York II study, clients were asked to fill out six, 12 and 18-month follow-up BDI questionnaires to assess their level of depression in addition to participating in two post-therapy interviews. Participants' consent for the current study was obtained retroactively under the larger Depression I and II trials. All clients in these larger studies gave informed consent that permitted the research data to be used in future psychotherapy process studies. This included the proviso that they could be asked to participate in a taped post-session interview about their experience in the therapy session.

***Clinical transcript sample.*** Transcripts for ten clients were selected from the combined York Depression I and II samples for the task analysis, as they met the criteria for occurrence of self-interruption of emotion in a therapy session. These criteria are described in detail in a later section. Multiple therapy sessions were selected for two of the clients. For one client, two sessions were selected on the basis that the client

interrupted two different emotions. For another client, three sessions were selected for the same reason. One transcript was selected for each of the other eight clients, who interrupted a single emotion. In total, 14 SIE events from 10 clients were used for the task analysis of SIE (See Table 1). In addition, in keeping with the method of task analysis, three clients who allowed emotion in a therapy session were selected as exemplars of allowing emotion (See Table 2).

Table 1. Empirical Task Analysis Frequency Table: SIE Events

<b>Client #</b>	<b>Session #</b>	<b>Therapy Type</b>	<b>Emotion</b>	<b># of events</b>
1	1	EFT	Crying/Inchoate	1
2	4	EFT	Emotional Pain/Hurt	1
	6	EFT	Emotional Pain/Sadness	1
3	9	EFT	Inchoate	1
	18	EFT	Anger	1
	14	EFT	Fear	1
4	20	EFT	Hurt	1
5	8	EFT	Sadness	1
6	9	EFT	Anger	1
7	13	EFT	Anger	1
8	5	EFT	Sadness	1
	5	EFT	Hurt	1
9	11	EFT	Anger	1
10	11	EFT	Sadness	1
			Total	14

Table 2. Empirical Task Analysis Frequency Table: Allow emotion

<b>Client #</b>	<b>Session #</b>	<b>Therapy Type</b>	<b>Emotion</b>	<b># of events</b>
1	20	EFT	Love	1
2	12	EFT	Hurt, Sadness	1
3	11	EFT	Sadness	1
			Total	3

*Client demographics.* Of the 10 clients selected for task analysis of SIE, six were female and four were male. There were missing values for one client on age, marital status, education, pre-treatment BDI, and Global Assessment of Functioning (GAF). In addition, there was a missing value for education for one client. Ages ranged from 22 to 51 years ( $M = 39.6$ ,  $SD = 11.07$ ). Four clients were married, two were divorced, one was widowed, and three were never married. Three clients completed high school, three clients completed some post-secondary education, and three clients completed post-secondary education.

According to the GAF scale, clients were assessed as experiencing moderate symptoms of distress with respect to social, occupational or academic functioning (GAF;  $M = 64$ ,  $SD = 3.1$ ). The average pre-therapy depression score on the long form of the BDI was 25.4 ( $SD = 3.92$ ). The mean scores reported above indicate that clients were experiencing symptoms in the moderate range with respect to levels of distress and depression.

*Therapists.* In the sample of sessions from 10 therapy clients included in the task analysis, six therapists each worked with one client and two therapists each worked with two clients. Two therapists were registered clinical psychologists, one held a doctorate in clinical psychology, and all of the remaining therapists were doctoral candidates in the Clinical Psychology programme at York University. The therapist ages ranged from 28 to 55 years. The therapists' clinical experience ranged from two to 25 years.

All therapists had a minimum of one year of supervised training in emotion focused therapy. In addition, they participated in 48 hours of additional training over a period of 24 weeks. Therapists were trained following the manualized treatment protocol for emotion focused therapy (Greenberg, Rice & Elliott, 1993). Therapists' tapes were reviewed to ensure adherence to the treatment protocol (Greenberg et al, 1993). Non-registered therapists received weekly supervision by a registered psychologist.

### **The Rational-Empirical Method of Task Analysis**

Greenberg (1976; 1984; 1999, 2007) advocates a rational-empirical approach to the study of significant psychotherapy events. An "event" is defined as "the whole of the interaction between client and therapist-beginning, middle, and end-which pertains to the particular cognitive-affective problem which is of interest to the investigator" (Greenberg & Foerster, 1996).

The rational-empirical method of task analysis has typically been used in the psychotherapy literature as a method of identifying the essential components "involved in the resolution of a task or problem" (Greenberg, 1999). In this study, a novel application of

the task analytic method was undertaken as the phenomenon of interest was the problem of self-interruption of emotion itself as opposed to the resolution of this problematic process in therapy. Here, resolution refers to the process of working through the problem of interrupting emotional experience so that the client is free from behaviours that serve to block or inhibit the experience and expression of emotion in therapy. The rationale for this unique focus of the task analysis, i.e. the study of the self-interruptive process as opposed to its resolution, was the premise that a thorough understanding of a problem is an important step in the process of understanding how it might be resolved. The use of a modified task analytic method to answer the research question “What are the essential components in the process of interruption of emotion for depressed clients in an experiential therapy session?” is in keeping with Bakan’s (1967) view that research inquiry benefits from the flexible use of methods that are tailored to research questions.

Task analysis originated in industrial psychology where it was used to analyze the behavioural components required to carry out a task in the workplace (Greenberg, 1999). It has also been used to study the performance of cognitive tasks to better understand information processing (Pascual-Leone, 1976; as cited in Greenberg, 1999). As a method of analyzing processes, task analysis is well-suited to the study of psychotherapy process. Greenberg and colleagues (1976; 2007; Pascual Leone & Greenberg, 2014) have developed a method of task analysis specifically for the study of "key psychotherapeutic events" in experiential therapy, such as problematic reactions (Rice & Greenberg, 1984), conflict in couples (Greenberg and Johnson, 1988), unfinished business (Greenberg & Malcolm, 2002),

splits within intrapersonal experience (Greenberg, 1992), hopelessness (Sicoli, 2005), and global distress (Pascal-Leone & Greenberg, 2007).

Greenberg (2007) explains how the method of task analysis as an iterative process of model construction and refinement involving two phases, discovery and verification. In the discovery phase, rational and empirical analyses are used to investigate the "moment by moment performance of clients" working with a specified cognitive-affective task.

To begin the discovery phase, the researcher's rational understanding of the components of a phenomenon is made explicit in the form of a preliminary model. Then, subsequent sequences of therapist-client responses are analyzed to describe the central components or steps involved in the phenomenon under study. These empirically grounded components are then compared to the rational model, which is revised in light of this new information. In an iterative manner, additional examples of client performance are analyzed and the model further refined.

With an eye to the verification stage of the task analysis, how the steps or components might be measured is also considered. In the verification phase of the task analysis, examples of the task of interest are gathered and then rated on measures of the components outlined in the model. In this way, the model is further refined by verification of the presence or absence of the components.

The task analytic method involves different steps in the discovery phase as compared to the verification phase, as outlined by Greenberg and colleagues (1996; 2007; 2014). As the present study is limited to the discovery phase, only steps relevant to this phase of analysis will be outlined below.

There are a number of steps involved in the discovery phase of the task analysis, each with a particular type of result. Each step and related results will be described below in the following order: Describe the task (definition and identification of marker), explicate the clinician-investigator's cognitive map, specify the task environment, construct the rational model, conduct the empirical task analysis, and develop the final rational-empirical model.

**Step one: Describe the task.** Task analysis begins with a specific behavioural description of a cognitive-affective problem in therapy. In this study, the problem of interest was the self-interruption of internal experience or expression of emotion in a therapy session, defined as follows:

Self-interruption of emotion is a moment or period when a client, in a therapy oriented toward exploring emotional experience, interrupts or inhibits an emerging feeling or emotional experience.

Patterns of behaviour consistent with the occurrence of the phenomenon are analyzed. These patterns, once described and defined, serve as markers of the phenomenon. A behavioural marker of SIE was defined as described below.

***Definition of a Marker of SIE.*** A marker of the occurrence of a self-interruptive process was defined from analyses of therapy transcripts from studies of depression conducted at York University. Transcripts were selected and reviewed to identify passages where clients engaged in verbal/non-verbal behaviour that compromised the full experience or expression of emotion. Typically, three exemplars of a marker are chosen for analysis and this convention was followed by the inclusion of exemplars from three clients.

Initially, the primary researcher on the above-mentioned studies suggested a client for inclusion in the analysis as she was identified as someone who engaged in self-interruption of emotion during her treatment. All of the client's therapy transcripts were reviewed and two sessions were selected on the basis that the client engaged in the interruption of emotion, and that they interrupted a different emotion in each session. These passages were analyzed and specific behaviour(s) were identified that indicated the process of self-interruption of emotion was occurring. Next, two other clients' sessions were randomly selected for inclusion from the pool of therapy transcripts noted above. This process of random selection involved the researcher choosing a client for review of all transcribed therapy sessions and continuing this process until two more clients were identified who engaged in SIE. In total, one session was selected for one client as this was the only session where SIE occurred and three sessions were chosen for another client as SIE of three distinct emotions occurred in each of the sessions. In total, six sessions from three clients were selected for analysis of the features of a marker of SIE.

The analyses of markers of SIE were reviewed with an expert in task analysis and revised accordingly. The marker of SIE was defined as follows:

1. Presence of statements of opposition to, "fighting against," stopping the initial feeling and/or expression of emotion and/or statements indicating physiological changes that served to restrict or constrain the emotion, such as swallowing or physically containing feeling or muscular tension, as reported by the client in the transcript.

2. Paralinguistic communication i.e., sighing or silence in the context of stopping emotion, as noted in the transcript.
3. Statements indicating loss of awareness of initial experience of emotion.

For example, a marker of SIE might involve the acknowledgement of an experience of emotion quickly followed by the action of “sucking it in” or a desire not to allow the emotion. Below are examples of markers of SIE.

Marker of SIE-Sadness 019/3

C: Ooh, very sad!

T: Very! Sad, uh-huh.

C: (sigh)

T: Can you let yourself feel the sadness?

C: Silence (6 seconds)

T: Let the tears flow if you need to?

C: Silence (6 seconds). Oh a part of me is fighting it too.

Marker of SIE-Anger 019/18 UFB

T: What’s happening inside now?

C: Ooh! I’m just (sigh), I’m oh! I want to scream at him so badly.

T: What do you want to scream at him?

C: Ooh! He just, oh I can’t even express it I’m just so! Furious with him (big sigh).

T: It doesn’t sound angry.

C: I know it doesn’t sound angry. It’s (sigh)

T: (sound of a bang) How dare you!

C: It didn't even mean! anything to him. It was just sort of, you just

T: You just abandoned us. Can you tell him that?

C: Ooh! No! That's the problem. I can't tell him that. I can feel my, I am just sucking it all in.

Marker of SIE-Hurt/crying 106/4 UFB Mother

T: So what's happening for you now as you speak?

C: Um (pause). I'm feeling kind of tearful.

T: Can you stay with that, see what words come? Tearful? Sad?

C: I don't want to feel tearful.

In addition to defining a marker of SIE, which indicates the occurrence of interruption, parameters were defined for the identification of the beginning and end of an SIE event in a therapy transcript.

**Demarcation of SIE events.** Transcripts containing a marker of SIE, as defined above, were selected from a pool of experiential therapy session transcripts from the York 1 (Greenberg & Watson, 1998) and York 11 (Goldman, Greenberg, & Angus, 2006) depression studies conducted at York University. Then, the transcripts were reviewed and the criteria for the demarcation of an SIE event in a therapy transcript were delineated as follows:

1. The event must contain a marker of SIE, as defined above.

2. The event includes the context that the self-interruption is situated in, e.g., sequences of client-therapist interactions, occurring in an experiential therapy oriented toward the experience and expression of emotion, preceding and following the marker.

3. Consideration of the context within which the marker is embedded will inform the decision about where the SIE event begins. Talk turns that are about the emotion that occurred prior to the marker are included. In addition, talk turns that provided information about the referents for the emotion are included, e.g., the significant other the client felt anger toward, the meaning of anger.

4. Talk turns involved in the unfolding of the process of SIE are included, i.e. following the marker the client and therapist continue to focus on expression of the client's internal experience of inhibition of emotion.

5. The decision where to end the SIE event is informed by a change in topic (e.g., client is no longer dealing with SIE) or the client's interruption of a different emotion (this would be considered a separate SIE event) or there is a shift in process to the allowing of emotion.

6. An SIE event may contain multiple interruptions of the same emotion.

7. Tangential material that appears within the event may be excluded.

All SIE events were delineated following these criteria, beginning around the marker and stopping at the end of the SIE event.

**Step 2: Explicate the clinician-investigator's cognitive map.** In this step, the subjectivity of the researcher is made explicit by a discussion of biases and assumption about the phenomenon under study prior to constructing a rational or empirical model. My biases and assumptions about self-interruption of emotion have been informed by

years of study as an undergraduate psychology student and a graduate student in clinical psychology. I have taken courses in theories of psychotherapy, including client centered and emotion focused therapies. I have also participated in psychotherapy training as a client centered and emotion focused therapist, both in graduate level clinical courses and as a research therapist in the York II depression study at York University.

In summary, my views on self-interruption of emotion have been informed by my reading of EFT theory (as described above in the literature review) and related coursework as a graduate student, as well as clinical experience as an EFT therapist. My explicit statements of my assumptions about SIE at the outset of the study are as follows:

1. Emotions are a source of meaning and organizing action or motivation.
2. Emotions provide information that is essential to the well-being of the individual.

Therefore, the acknowledgement and allowing of emotion and the effective expression of related needs is inherently adaptive.

3. There are two general classes of emotion. One class is primary emotion, which refers to the first emotional response to a situation. Primary emotions can be adaptive and offer useful information that organizes action toward the attainment of a need or goal. Alternatively, primary emotions can be maladaptive when they take the form of longstanding, fixed feelings that do not provide the impetus to act in a manner that moves a person toward desired goals or outcomes. The person's subjective experience is one of feeling "stuck." The other class is secondary emotion, which refers to emotion that can interfere with an initial adaptive primary

- or core emotion and hence obscure the adaptive process of allowing emotion, meaning making and adaptive action.
4. The interruption of emotion in therapy is a maladaptive process as it leaves the individual cut off from information that is essential to a sense of well-being predicated on: allowing the physiological arousal and subjective experience of an emotion, knowledge of the significance or meaning of an emotion and the nature of related needs and goals, and motivation to move or act in a direction or manner that is consistent with the expression and fulfilment of those needs.
  5. Therapy clients may engage in a variety of behaviours that serve to interrupt or stop the experience or expression of emotion.

**Step 3: Specify the task environment.** At this stage, the environment in which the process under study occurs is identified. In this study, SIE events were limited to sessions of experiential therapy where the therapists were adherent to the protocol for emotion focused therapy (EFT). For further details of the EFT protocol, the reader is referred to “Facilitating Emotional Change” (Greenberg, Rice & Elliott, 1993).

This step also involves the consideration of whether the phenomenon of interest does in fact occur during a therapy session. Both the writer and an expert judge examined sessions where clients referred to an experience of stopping themselves from allowing the experience and/or expression of emotion. From this review it was concluded that the process of SIE does occur in a therapy session.

**Step 4: Construct the rational model.** In this step, the researcher engages in a rational analysis of the phenomenon of interest for the purpose of constructing a

theoretical model. In the present study, the investigator asked the question “How do therapy clients interrupt or stop themselves from allowing awareness or experience of emotion?” A speculative model was conceptualized to answer this question, drawing on a rational understanding largely influenced by the reading of psychotherapy theory, clinical experience and discussion with peers and a clinical supervisor.

To clarify the investigator’s understanding of SIE based on theoretical writings, rational models of the process of SIE were conceptualized from the writings of Freud, McCullough, Fosha, Stolorow, and Greenberg as discussed in the literature review. These models also served as additional explicit statements of the writer’s understanding and assumptions about the phenomenon of interruption of emotion.

The first rational model (Figure 1) is a synthesis of Freud, McCullough and Fosha’s conceptualization of the process whereby drives/impulses/core affects are repressed. The model represents the central psychodynamic process of the activation of a drive/impulse or affect, a response of anxiety or another affect, followed by the activation of a defense that serves to hold the threatening drive/impulse or affect at bay.



The second rational model is a representation of Atwood and Stolorow's conceptualization of unconscious affect in its three forms (Figure 2), including the repression of symbolized affect by "walling off" or dissociation or as unsymbolized experience. This model makes explicit the writer's assumption that affect/emotion can exist as a conscious or unconscious phenomenon.

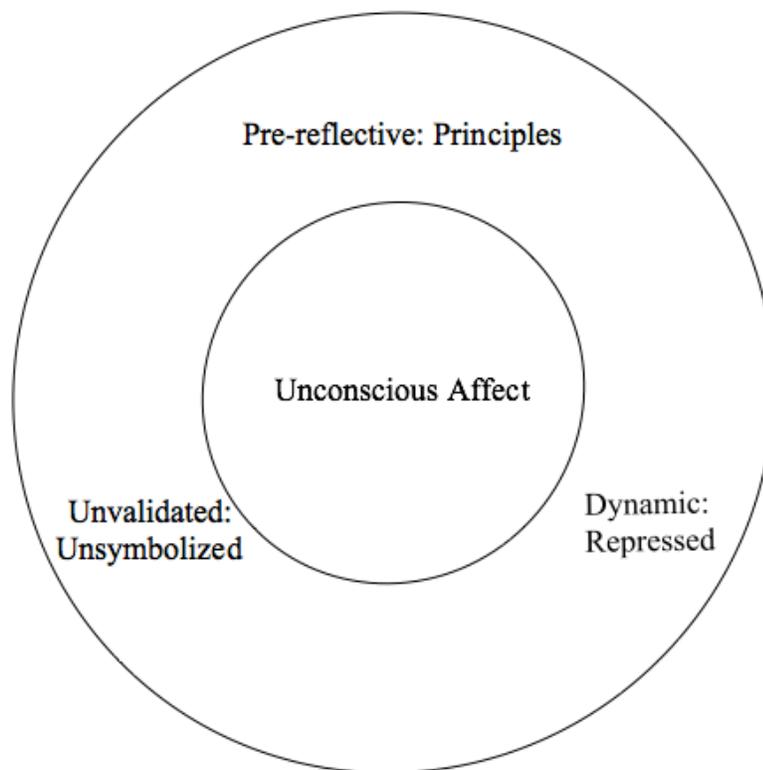


Figure 2. A model of unconscious affect adapted from Atwood & Stolorow, (1984;1992)

The third rational model represents the process of Self-Interruption of Emotion as conceptualized by Greenberg et al (Figure 3). In this process model, emotion schemes (as defined in the summary of EFT above) are activated and then countered by the activation of inhibitory behaviour (s), followed by the symbolization in awareness of the process of inhibition and the end result of this process.

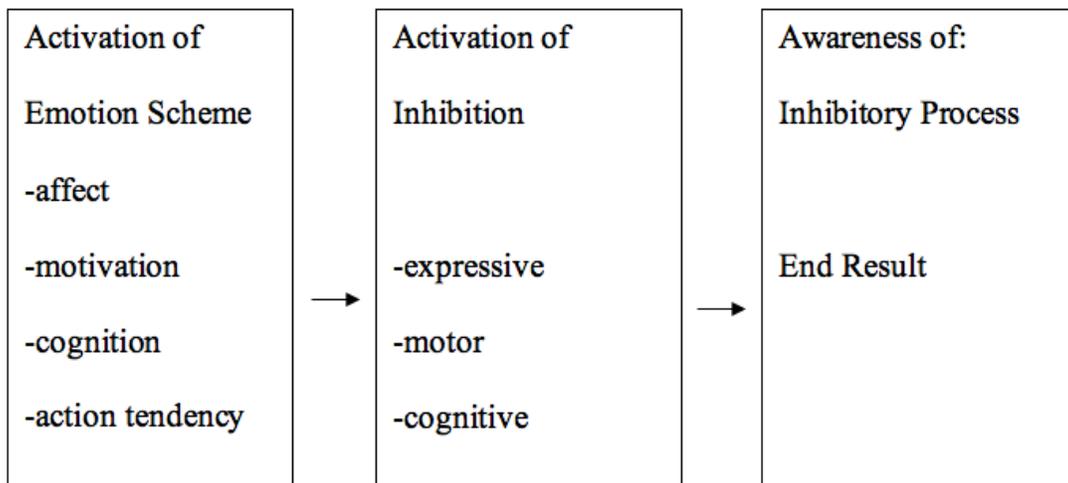


Figure 3. Rational model of self-interruption of emotion.

(Adapted from Greenberg, Rice, & Elliot, 1993).

**Preliminary rational model.** Incorporating ideas from the models shown above, a preliminary rational model of interruption of emotion was conceptualized to represent the investigator's rational understanding of the phenomenon of self-interruption of emotion (Figure 4). The components of this model are described below.

1. Unsymbolized affect: The first component is defined in keeping with the idea that unsymbolized affects are felt as "diffuse bodily states" (Stolorow and Atwood, 1992). A

distinction is made here between affect and emotion, where the former is understood as an un-differentiated, un-symbolized feeling in the body, as compared to a bodily felt sense that has been differentiated and symbolized in conscious awareness as a specific emotion. In effect, affect and emotion are located along a continuum of emotional awareness. At this step, the client may hold a vague awareness of undifferentiated bodily sensations or be aware of a general sense of physiological arousal. There is an absence of the identification of a specific emotion and related needs, meaning or urges to act in a manner consistent with the emotion.

2. Awareness of experience of emotion and expressive urges: At this stage, the client is consciously aware of an internal experience and names or identifies it as a specific emotion (“I feel/am sad”). The client describes the experience of emotion in terms of physiological changes, specific cognitions and/or action urges. Awareness of the significance or meaning of the emotion may also be described (sadness related to the loss of love and nurturance, hurt about the perceived attack by another). The motivation or urge to express an emotion may also be in awareness, such as an urge to sob, lash out in anger toward another or express feelings of an emotion. The motivation to express may involve awareness of a need related to the awareness of a specific emotion (anger and a related unmet need for a significant other to acknowledge unfair treatment, fear and a need to flee, hurt and a need for comfort).

3. Express Inhibition of emotion: On the heels of awareness of emotion and urges to express, the client acts to inhibit emotion by physiological and/or cognitive means. They may describe how emotion is inhibited by behaviour such as tensing muscles or swallowing.

Prohibitions may be expressed against allowing emotion in the form of inhibitory cognitions or beliefs, such as “It is weak to show emotion.” They may express the desire not to allow the expression of emotion (“I don’t want to feel tearful”). The clients may also express inhibitory or secondary/ “red signal” emotions, such as fear, shame or guilt about the initial awareness and/or expression of emotion that serve to interrupt it.

4. Awareness of inhibitory process and end result: At this stage, the client describes awareness of how emotion has been inhibited and the end result of this action. Clients may describe awareness of how muscular tension, beliefs or another emotion has left them feeling emotionally constricted, drained or shut down.

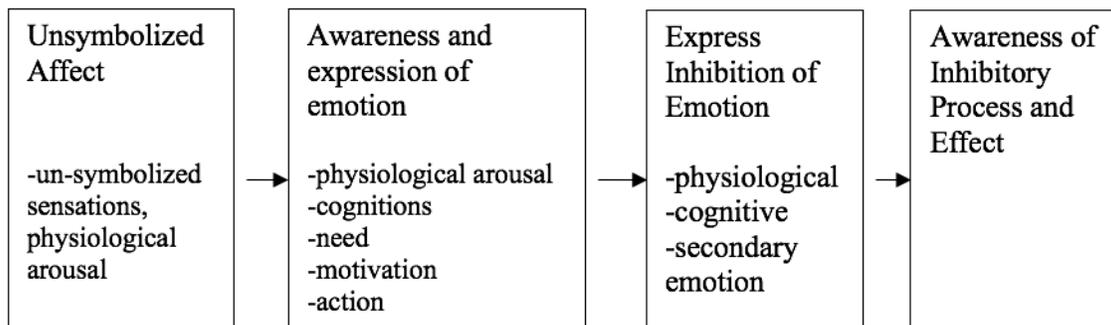


Figure 4. Rational model of interruption of emotion.

**Step 5: Conduct the empirical task analysis.** The next step in the task analysis is to construct an empirical model based on a task analysis of observations of actual client performance. In this way, the central components of the performance of SIE are identified. At the same time, the investigator starts to think about how these components could be measured with an eye toward the verification phase. As this study of SIE was

purely a descriptive task analysis, the latter step was not included in the analysis and remains for consideration in a future study involving the verification of the final rational-empirical model.

Following convention (Greenberg, 2007), the empirical analysis involved the sequential analysis of exemplars of the performance of interruption. In addition, these performances were compared with examples where clients allowed emotion in a therapy session, to discriminate between components essential to the performance of interruption of emotion as compared to that of allowing emotion. The investigator sought to answer the questions “How is the process of interrupting emotion different from that of allowing emotion? What are the core components that differentiate the two processes?”

**The empirical analysis.** SIE events were chosen that exemplified or were clear cases where the client stopped or interrupted emotion in keeping with the strategy of “pure gold sampling” (Greenberg, 2007). Typically, the analysis begins with the analysis of three exemplars of the phenomenon of interest. In this study, three clear examples of interruption were chosen for three different clients. However, for two clients, more than one example was analyzed. The rationale here was that the additional examples were for different emotions and the commonality of interruption across emotions was also of interest to the writer. Session numbers ranged from 1-18. The SIE events involved the emotional experience of anger, sadness, hurt, fear or inchoate feeling.

To begin, one client was identified to the writer by the principal investigator as having clearly engaged in SIE over the course of her therapy. The writer examined all transcribed sessions for this client and identified two that contained markers of SIE for

two different painful emotions of hurt and sadness. SIE events were demarcated in the transcripts according to the criteria outlined in a previous section.

The SIE events were analyzed systematically with a line by line analysis to identify and describe components of the process of SIE. For each event, components were recorded on a piece of paper in the form of a process diagram.

The process of analysis at this stage is similar to other qualitative methods (Glaser & Strauss, 1967; Strauss & Corbin, 1990; Giorgi & Giorgi, 2003) where the analyst moves from summaries of language used by the research participant to more abstract, “higher order” categories. At the first level of analysis, the elements in the process of SIE were described in language that was close to that of the client. As the analysis progressed, central components were described using more abstract, conceptual language that captures an experience or behaviour. For example, the statement by the client *“I don’t want to try to say the words. To admit them somehow”* was first summarized as “Does not want to say/admit words” and later included under the more abstract categorization “Opposition to verbal expression.”

The process diagrams from the first client were compared and components common across the two SIE events were identified and cast in a preliminary empirical model.

For reliability, the writer reviewed the results of the analyses of the initial two SIE events with an expert in the task analysis of psychotherapy events (Dr. L. Greenberg). Discrepancies in the conceptualization of components were addressed and consensus was reached as to the central components in the process of SIE.

The investigator then selected and reviewed additional therapy transcripts from the completed York I (Greenberg & Watson, 1998) and York II (Goldman, Greenberg, & Angus, 2006) depression studies. The first two client's transcripts that contained a marker of SIE were chosen for inclusion in the task analysis. For one client, three session transcripts each contained a marker of SIE for three different emotions of anger, fear, and inchoate emotion. For the second client, one transcript contained a marker of SIE for crying/inchoate feeling. These four SIE events were demarcated in the transcripts according to the criteria outlined above. Empirical models were drawn for each client outlining the central components of the process of SIE. These models were reviewed with the expert in the task analysis of psychotherapy events (LG) and revisions were made in accordance with feedback.

Descriptive information about the session number, type of emotion and number of SIE events for each participant is shown in Table 3 below.

Table 3. Empirical Task Analysis Frequency Table: SIE Events for three initial clients

Client #	Session #	Therapy Type	Emotion	# of events
1	1	EFT	Crying/Inchoate	1
2	4	EFT	Emotional Pain/Hurt	1
	6	EFT	Emotional Pain/Sadness	1
3	9	EFT	Inchoate	1
	18	EFT	Anger	1
	14	EFT	Fear	1
			Total	6

Following the analyses of each of the three client's performances as described above, a preliminary empirical model was drawn to represent the common aspects of the process of interruption. A similar process of task analysis was conducted for the performance of allowing emotion. Three examples of allowing in-session emotion from three different clients were analysed and the central elements in the process of allowing emotion were conceptualized and drawn in an empirical model. Information about the session number and the type of emotion for each example of allowing is shown in Table 4 below.

Table 4. Empirical Task Analysis Frequency Table: Allow emotion.

<b>Client #</b>	<b>Session #</b>	<b>Therapy Type</b>	<b>Emotion</b>	<b># of events</b>
1	20	EFT	Love	1
2	12	EFT	Hurt, Sadness	1
3	11	EFT	Sadness	1
			Total	3

By comparing the models of interruption and allowing of emotion, components that differentiate them and that are essential to SIE were identified. The preliminary empirical model of SIE, and the contrasting empirical model of allowing emotion, are shown in Figure 5 below. The components across the top of the diagram represent the process of allowing emotion. The components along the bottom represent the process of SIE at this stage in the task analysis.

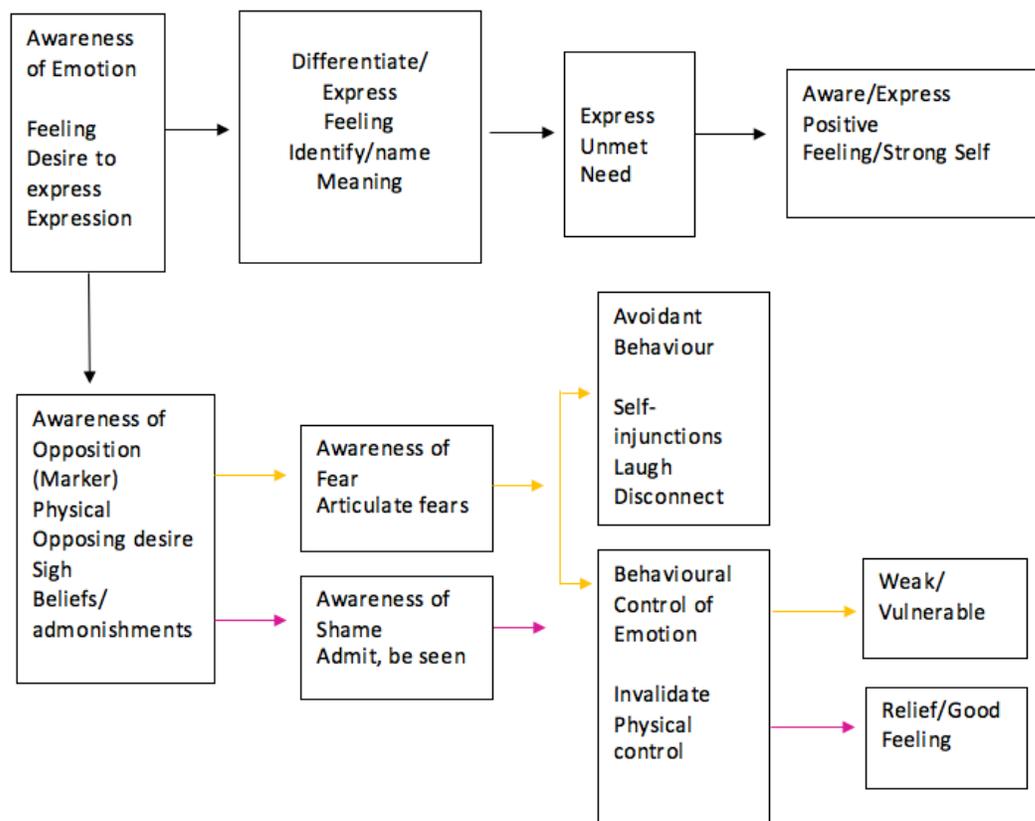


Figure 5. Preliminary Empirical Model

**Step 6: Develop the rational-empirical model.** The rational and preliminary empirical models of interruption were compared and revisions to the rational model were made accordingly. A summary of the revisions to the rational model at this stage follows. The resultant preliminary rational empirical model is illustrated in Figure 6 below.

In the rational model, the components ‘Unsymbolized affect’ and ‘Awareness and expression of emotion’ were drawn sequentially. While these components were validated in the empirical analysis in that the process for all clients involved one or the other, the sequential pattern was not validated. Also, both components were not represented across the process of interruption for all clients. In light of this new information, these two components were subsumed under the component ‘Awareness/expression of emotional experience’ This component is conceptualized as a continuum of experience, with unsymbolized affect unfolding as a process of differentiation/symbolization of emotional experience in awareness that culminates in verbal or non-verbal (crying) expression. Clients may describe experience anywhere along this continuum for the component to be judged as present. The example below is an illustration of one client’s progression from unsymbolized affect/feeling to the differentiation and expression of emotional experience.

In her first therapy session, the client began the session by telling the therapist about what brought her to therapy. She explained that she had been suffering from depression and a skin problem that she was told was related to stress. As she acknowledged a need to “deal with what’s really bothering me” she began to cry. She further explained that she cries often and that she feels like she has “no control” over it. As illustrated in the passage below, she worked with her therapist to differentiate un-symbolized feeling.

C: Part of me wants to sort of let it all out (pause), but I don't know what it is that I'm supposed to let out (crying).

T: Mm-hm. So there's a lot in there but you're not quite sure how to let it out.

C: Mm-hm

T: Okay. Well what do you feel like right now? 'Cause I can see the tears and I can see you trying really hard to push them back, but-

C: 'Cause you see right now I don't know why I'm crying (pause). I can't, you know, put my finger on it. Like, what is it about this? I'm talking about something that's not that difficult. Why am I crying? (sniffs).

T: Okay, well instead of wondering about the why, why don't we just look at what it is you're feeling right now.

C: Mm-hm.

T: Since that seems to be very alive, what's happening inside here?

C: (Sighs) (pause:00:00:08) I feel like an ache inside all the time like I'm not really happy.

T: Mm-hm.

C: (pause:00:00:05) Um, I'm very close to my sons and I miss them a lot 'cause they're not here.

T: Mm-hm.

C: And I'd like to spend more time with them and that's not, you know, feasible.

T: Mm-hm. Tell me about the ache that you feel.

C: I dunno, it's almost like a physical, you know

T: Mm-hm.

C: hurting.

T: Mm-hm.

C: And it's almost always with me.

T: That must be draining to have it always.

C: I guess that's why I'm so tired and exhausted all the time (03/1).

Also from the empirical analysis, a new component in the process of client performance was identified as 'Expression of opposition.' At this point in the process of interruption, clients describe an internal sense of opposition to the initial awareness/expression of emotional experience. They may describe awareness of a desire to oppose emotional experience. For example, one woman reported feeling "tearful" and "I don't want to feel tearful." Clients may express specific opposing beliefs and/or admonishments about emotion ("I should be in control"). They may also describe non-verbal opposition, such as physical/muscular opposition or they may sigh.

Furthermore, the component 'Express inhibition of emotion' was differentiated into two components: 'Awareness/expression of inhibitory/secondary emotion' (e.g., "I am embarrassed to be hurting"), and 'Express inhibitory behaviour' (e.g., Self-talk-"Keep the pain in"). Clients may engage in one or both of these means of inhibiting emotional experience or expression.

The refinement of the model at this stage makes clearer the distinction between two forms of interruption: the experience and/or expression of inhibitory emotions, such as fear and in one case shame, and the expression of inhibitory behaviour alone unrelated to an

inhibitory emotion, such as sighing, constricting muscles, and beliefs/self-talk. In addition, conceptualizing the components in this way facilitated inclusion of the analysis of the one case of interruption of fear that did not include awareness of inhibitory/secondary emotion, unlike all the others. The process for this one client involved awareness of fear followed by the performance of inhibitory behaviour, as illustrated in the example below.

C: (Sigh) (Crying) I'm getting scared of getting things done.

T: Mm-hm. So there's something very scary about completing all these papers.

C: Because I'm afraid that, oh I'm not up to the challenge and that things are going to change because then I will have all sorts of expectations...I can feel myself start to panic (19/#14).

The client and therapist continued to differentiate the client's fears, and then she expressed the suppression of panic by inhibitory behaviour.

C: Just don't say anything now. Just keep a lid on it for now...I do wish you'd just sit still and just keep quiet.

T: What happens over here when she says sit still and just keep quiet? Keep a lid on it?

C: I feel like I really want to but it feels like I'm swallowing the panic and I can't breathe anymore...and I'm really trying to sit still and I'm trying to be good. But the more I try to be good and the more I sit still it only lasts for such a little bit and I just get really panicky again and all of it explodes again.

T: Tell her what it's like to sit on that panic or sit on your fears.

C: It's just like drowning. It's like I'm gulping everything down (19/#14).

The process of interruption for this single case of fear was drawn with a dotted line to distinguish it from the dominant pattern of components. While the search for commonality is the main driver in the task analysis, it is also important not to lose sight of valid, idiosyncratic processes. The intention here was to encompass the tension between a nomothetic and idiographic approach to be inclusive of all clients' experience for all emotions. The limitation of a purely nomothetic approach is that the final model is not fully representative of all client's experience of all emotions, and clients who do not conform to it are at risk of not being fully understood and/or treated effectively by the clinician.

Finally, the component 'Express effect of interruption' was further refined to include both positive and negative effects at the endpoint of the process of interruption. The client may describe awareness of a tired, drained sense of self or a general sense of discomfort. For example, one woman put her anger in a "straight jacket," by a series of threats designed to induce fear of expression that left her feeling "tired." Another woman expressed awareness of a general pattern of controlling the expression of feeling in tears that in turn left her depleted ("It's draining"). Alternatively, one client expressed how she felt "good" after she stopped herself from showing painful feelings of sadness in an imaginal dialogue with her parents. She "disconnected" from them instead to guard against them seeing what was "inside" her and thereby, not "having some kind of control" over her in a vulnerable state.

The preliminary rational-empirical model of SIE at this stage is shown in Figure 6 below.

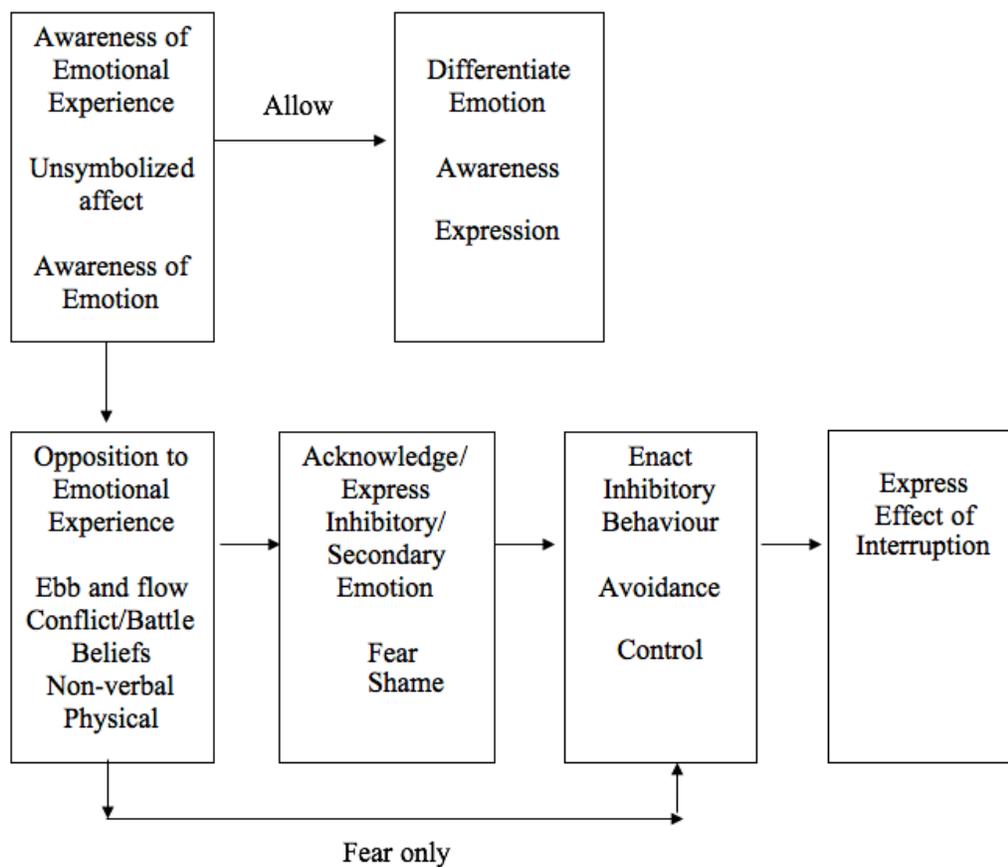


Figure 6. Preliminary rational empirical model.

***Refinement of the model.*** Following the iterative process of task analysis, the model was further refined following analyses of eight additional SIE events from seven clients, as shown in Table 5 below.

Table 5. Empirical Task Analysis Frequency Table.

<b>Client #</b>	<b>Session #</b>	<b>Therapy Type</b>	<b>Emotion</b>	<b># of events</b>
4	20	EFT	Hurt	1
5	8	EFT	Sadness	1
6	9	EFT	Anger	1
7	13	EFT	Anger	1
8	5	EFT	Sadness	1
	5	EFT	Hurt	1
9	11	EFT	Anger	1
10	11	EFT	Sadness	1

The method outlined above for the selection of transcripts varied slightly. One clinical transcript was selected following the method outline above. The remaining six clinical transcripts were obtained as part of a study of emotion focused therapy for depression that was in progress. Clients in this study had previously provided written consent to the use of material from their therapy session for research purposes. Therapists in the study

were recruited by the researcher to aid in identification of sessions where interruption of emotion occurred. They were oriented to the purpose of this research study. The definition of a marker of SIE was reviewed with them and illustrative examples provided. They were asked to advise the researcher immediately following a therapy session if a marker of interruption occurred. The researcher then listened to the therapy session audiotape to confirm the presence of a marker and these sessions were analyzed after their transcription following the method outlined above. Session numbers ranged from 5-13 and a variety of emotions were represented, including anger, sadness, and hurt.

Components of the process of interruption for each additional case were analyzed and drawn in a process diagram. Each diagram was compared to the preliminary rational-empirical model of SIE and the latter was revised accordingly. From this analysis and comparison, existing components were further differentiated by new descriptors. The decision to stop the analysis was made after no new information was gained after the analysis of the 14th SIE event derived from 10 clients.

The component 'Express inhibitory/secondary emotion' was further refined from these additional analyses. In the preliminary rational empirical model, this component included the emotions of fear and shame only. After the additional analyses, the component was re-written to include other types of secondary emotions. Fear remained the most commonly expressed inhibitory emotion. The other secondary emotions were single instances of shame, guilt, hurt, and anger. For example, one woman expressed anger toward her father in a two chair dialogue, followed by secondary guilt that functioned to inhibit the expression of anger (*"You should feel guilty when you say you're mad at him"*).

The results of this second round of analyses showed again that the component ‘Express Inhibitory/Secondary Emotion’ was not necessary for interruption of emotional experience to occur across all clients. Two options were considered here. This component could be eliminated from the model. However, in doing so a core element in the process of interruption for the vast majority of clients in the sample would be excluded. Alternatively, the model could be written to show two different patterns of SIE. The researcher/writer chose the latter as writing the model in this way allowed for a more inclusive representation of the process by which any given client can interrupt emotion.

The component ‘Effect of Interruption’ was further differentiated to include additional descriptors commensurate with the internal experience of a depleted, drained sense of self. There remained only two cases where a client described a positive internal experience of “relief.”

Empirical models for the two different paths of SIE that included all 14 events are shown in Figures 7 and 8 below.

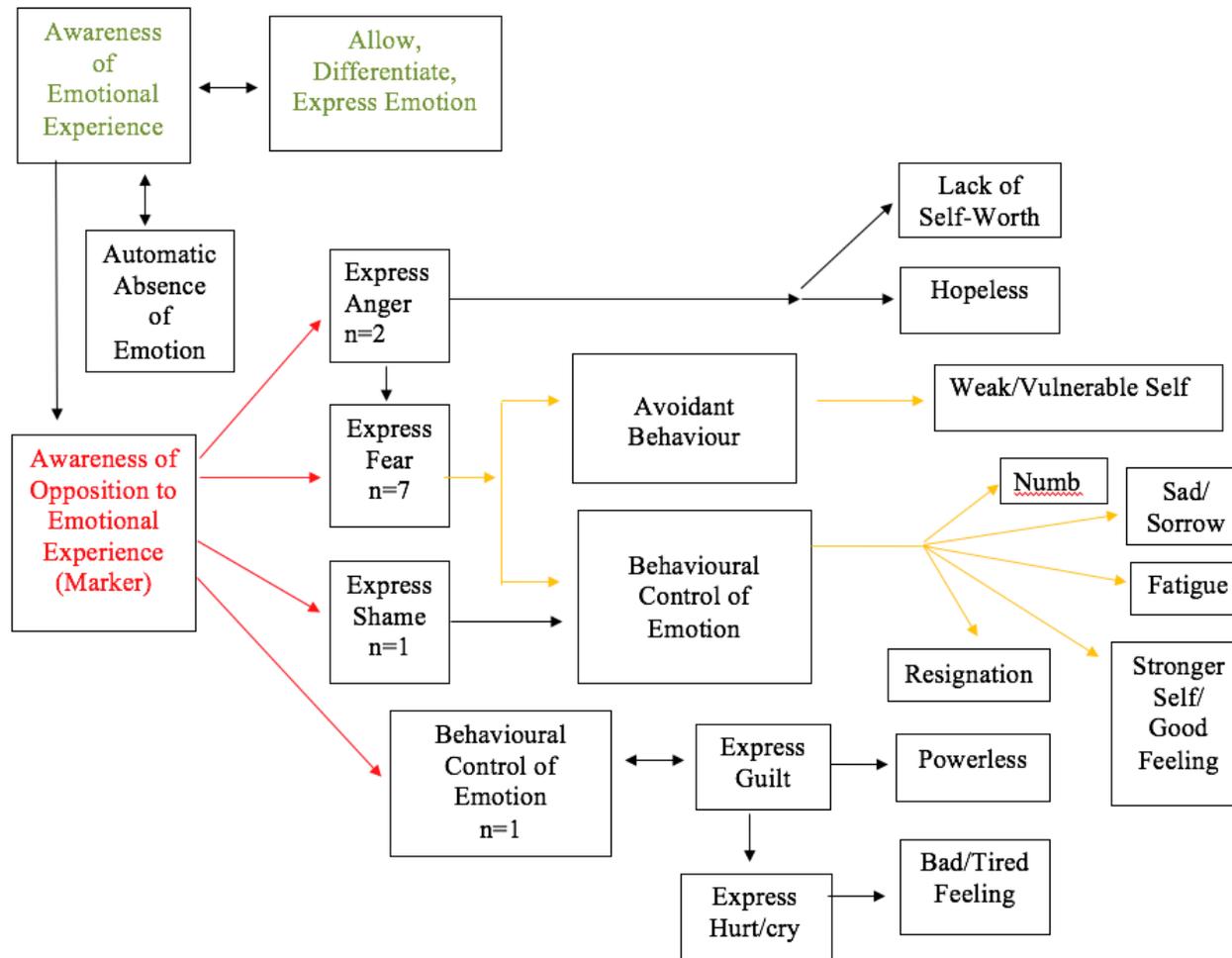


Figure 7. Type I: Inhibitory emotion & behaviour.

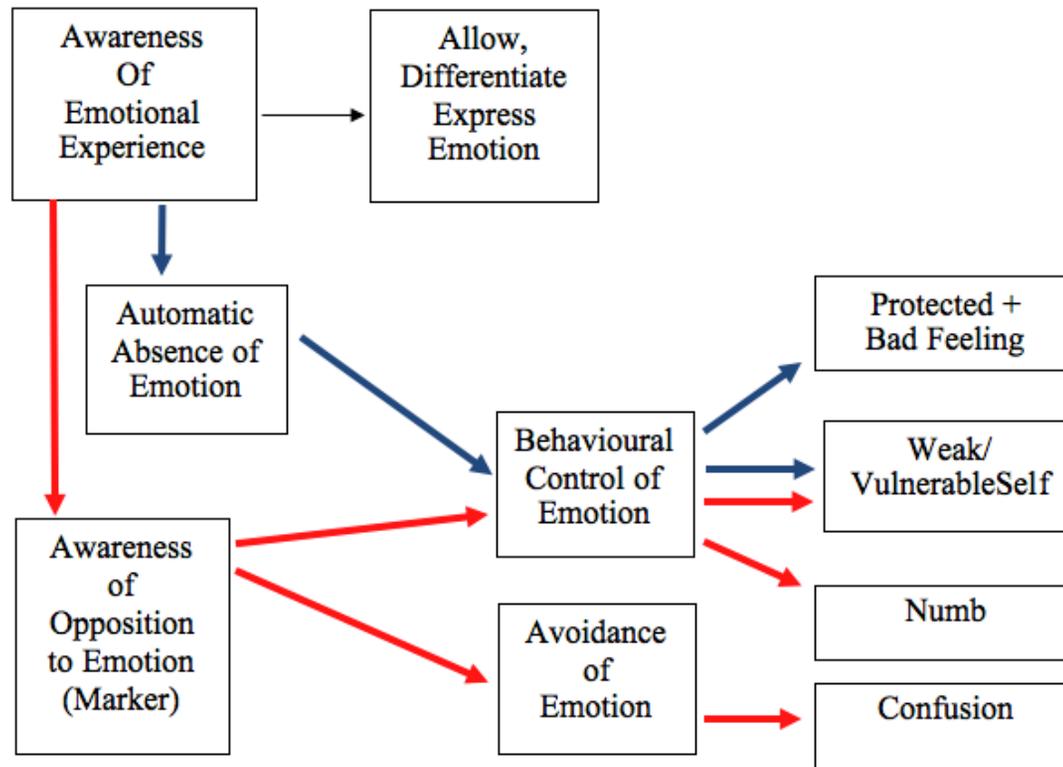


Figure 8. Type II: Inhibitory behaviour.

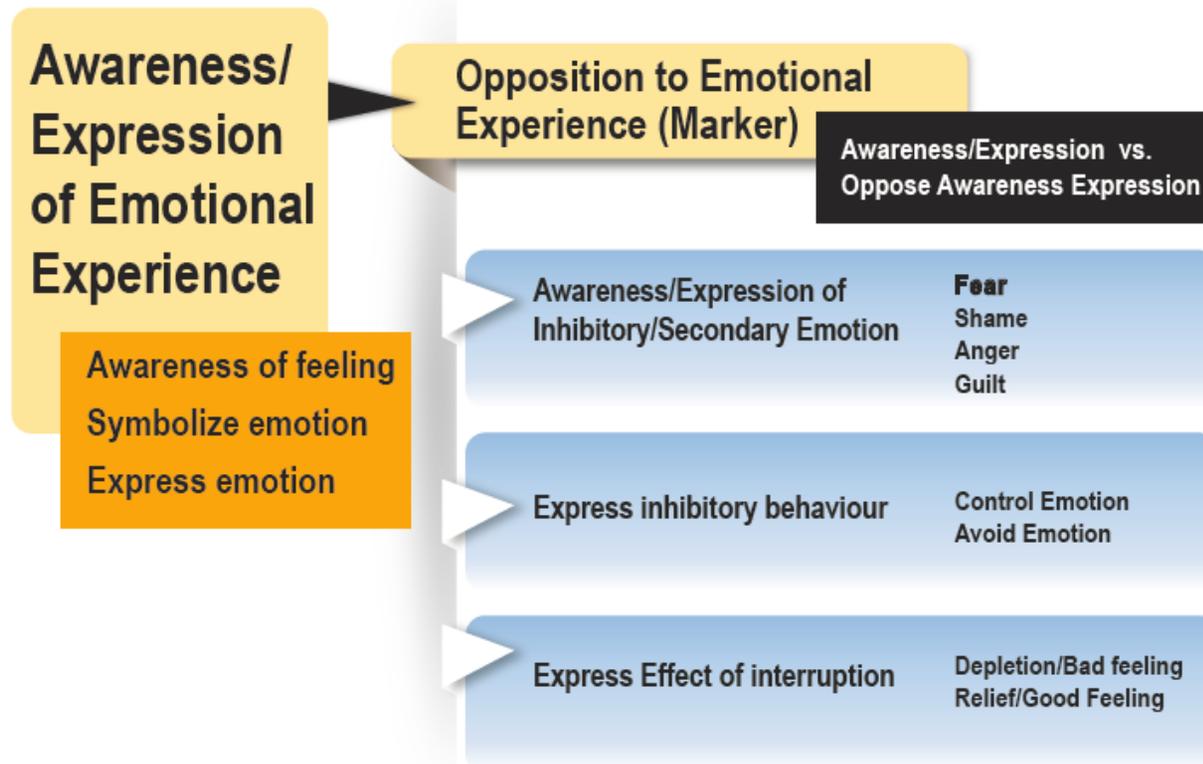


Figure 9. Final rational-empirical model of self-interruption of emotion.

After the completion of the analyses, the final rational-empirical model was drawn, as shown in Figure 9 above. This model encompasses two patterns of interruption that clients may follow. The two patterns are differentiated by the presence or absence of one component, '*Awareness/Expression of Inhibitory Secondary Emotion.*'

For the large majority of clients (n=7), who conformed to the pattern '*SIE Type I: Inhibitory emotion and behaviour,*' the process of SIE involved a shift from the *Awareness/Expression of Emotional Experience* to *Opposition to Emotional Experience* that is further differentiated in the form of *Awareness/Expression of Inhibitory Secondary Emotion* and/or the *Expression of Inhibitory Behaviour*. The final component or step in the model is to *Express the Effect of Interruption*. In contrast, fewer clients (n=3) conformed to the pattern '*SIE Type II: Inhibitory behaviour*' that was differentiated from *SIE Type I* by the absence of the component *Awareness/Expression of Inhibitory Secondary Emotion*.

While the model is presented as a sequence of steps, for both '*SIE Type I: Inhibitory emotion and behaviour*' and '*SIE Type II: Inhibitory behaviour,*' it is understood that clients may move through the process in patterns that are idiosyncratic. They may move back and forth between components or repeat particular sequences of steps. However, overall they will move sequentially through the steps.

The components in the final model of SIE will be described below, with illustrative examples of client dialogue from the therapy transcript. To demonstrate the common process of SIE across different types of emotions multiple examples involving a variety of emotions will be included.

### **Final Performance Model of the Process of Self-Interruption of Emotion**

The process of interruption begins with awareness of emotional experience in the present moment. Emotion types in this sample included anger, sadness, hurt, fear, crying, inchoate emotion or emotional pain.

There are multiple contexts for awareness of emotion. It may occur in a relational context where the client is focused on the exploration of internal experience related to a significant other that may include telling a story about an interaction, disclosing a memory of experience with a family member, or occurs during a two chair imaginal dialogue with a significant other. Awareness of emotion may also occur in the context of two chair work involving a dialogue between the self and its critic. It may occur when the client is in an empathic dialogue with the therapist about an internal experience. The client's experience in the therapy relationship itself may be a context for awareness of emotion.

#### **Awareness/Expression of emotional experience.**

Awareness of emotional experience may be described anywhere along a continuum of differentiation that includes: awareness of inchoate feeling or physiological arousal, emotional experience that is labelled as a specific type of emotion, expression of emotion that is non-verbal/paralinguistic or verbal in the form of related needs and/or personal significance/meaning. In the case of inchoate emotional experience, the client expresses awareness of an un-symbolized, meaningless feeling of arousal in the body. The client may express a vague or limited awareness of undifferentiated, meaningless bodily sensations or a general sense of physiological arousal. For example, one client cried and then asked, "*Why*

*do I do this*” in reference to crying and limited awareness of what she called “that feeling.” Inchoate, un-symbolized bodily felt affect may unfold in a process of differentiation/symbolization of emotional experience in awareness, culminating in the acknowledgement and identification of a specific emotional experience. An example of this process follows. One client described awareness that she was teary and “*choked up*” and then said “*I don’t know why.*” She differentiated this inchoate experience first as feeling “*upset*” and then as feeling “*very sad.*” However, not all clients will describe a process of changing awareness from inchoate feeling to specific emotion.

Alternatively, the client may express conscious awareness of emotional experience that has been differentiated, symbolized, and acknowledged as a specific emotion. For example, one therapist asked a client how she felt as she described how her parents were critical and unaffectionate toward her. The client reported “*I feel sad*” (62/#11). In this sample, clients identified specific emotions of anger, sadness, hurt/emotional pain, inchoate emotion or fear. There may be descriptions of an increase in arousal that is defined by physiological correlates of a particular emotion, such as: fear and related changes in breathing patterns; anger and a roiling, churning sense in the stomach; hurt and a feeling of physical pain, sadness and a physical sense of loss. For example, while engaged in a two-dialogue with his mother, one man reported awareness of intense feelings of hurt, as illustrated in the following excerpt from the therapy transcript.

C: It’s hurting. Uhhhhh, I feel a hurting inside.

T: Uh-huh. Uh-huh.

C: Too much.

T: Uh-huh.

C: Ahhhhhhhhh (silence) It's just a hurt.

T; There's too much of it.

C: Yeah. (17/20)

Awareness of emotion may also include expression of emotion. The form of expression of emotional experience may be non-verbal, such as crying. There may also be changes in vocal quality commensurate with a specific emotion, e.g., speaks loudly or yells in anger or speak softly when expressing sadness. It may involve the verbal articulation of bodily felt experience, related urges, needs or personal significance. Clients may communicate the desire or intention to express a specific emotion in words or actions. They may also express emotion in terms of specific verbal communications, including related desires, needs or urges. For example, one client expressed awareness of sadness, "*I feel sadness,*" and the related need "*I want to be accepted*" (02/#8). The intensity of the felt sense of emotion and a related urge to express or expression of it may vary from a minimal to an extreme amount.

Awareness of emotion may include explicit statements about a sense of vulnerability associated with emotional experience. As one client put it, "*I feel angry and vulnerable*" (33/#9). In another example, the therapist asked "It doesn't feel safe to be angry in here?" and the client responded "*No. I don't feel safe*" (19/#18). A client in a two chair dialogue with his mother expressed sadness and a related need for acceptance and then said, "*For me to tell you what I feel makes myself vulnerable and every time I do that you always attack*" (02/#8).

Illustrative examples of this component from the therapy transcript follow for crying and anger.

Awareness of emotional experience: Tearful feeling (06/#6)

T: So what's happening now as you speak?

C: Um (pause) I'm feeling kind of tearful.

Awareness of emotional experience: Anger: Feeling/urge to express (19/#18)

C: I know that the anger has a lot to do with (ex-boyfriend). I still haven't worked that out.

T: You're still feeling angry at (ex-boyfriend).

C: Ooh! I am furious at him...I can feel my tone...

T: What's happening inside now?

C: Ooh! I'm just (sigh) I'm, oh I want to scream at him so badly!

Awareness of emotional experience: Express anger/unmet need (10/13)

C: I deserve it...he wants me to call him once a week. He should call me.

T: I deserve something.

C: I do deserve it. I don't do anything wrong.

T: Put him back there. Tell him 'I deserve more from you.'

C: I deserve it and I want it.

.....

T: Tell him what you're angry at.

C: That he doesn't see it.

T: Try and actually see him. Tell him 'I'm angry that you-

C: I'm angry that you just think that everything is fine.

### **Opposition to emotional experience (Marker of SIE).**

The next component in the process of interruption is opposition to emotional experience.

An explicit statement of opposition to awareness of emotional experience serves as a marker of SIE.

Opposition may occur immediately on the heels of awareness of emotional experience or a short time thereafter. In the majority of cases, the client communicates verbally the conscious awareness of internal opposition to the initial feeling, related urges and/or expression of emotional experience or related needs. Paralinguistic behaviour may also be present in the form of sighing, silence or shaking the head from side to side to communicate a lack of agreement or 'no.' Overall, there is communicated a sense of struggle against or conflict inside with an initial experience of emotion. Illustrative examples of various forms of opposition are described below.

1. Descriptions of a sense of an internal conflict between a part of self that is aware/expresses emotional experience and another part that opposes it.

Internal conflict- Express vs. Control Inchoate Feeling/Crying (03/#1).

C: "Part of me [wants to] let it all out...Part of me feels I should be in control of it."

Internal Conflict- Sad Feeling vs. Frustrated About Sadness (62/#11)

T: And how does it feel when you're sort of thinking about all of this. Do you feel kind of sad for all the stuff that you missed?

C: Well I feel sad, yeah, I feel sad about that. But I feel even more frustrated that I continue doing it. When are you ever going to change?

2. Non-verbal behaviours that serve to oppose continuation of an initial feeling and/or expression of emotion (physical constriction, sigh, body posture, shakes head).

Opposition to anger expression: Sighs (19/#18)

T: What do you want to scream at him? Try.

C: He just (sigh), he won't, I mean he just walked out on everything! And now it's (sigh)

T: It doesn't sound angry.

C: I know it doesn't sound angry. It's (sigh)

T: You just abandoned, you just turned your back on us!

C: Completely! (sigh)

T: Can you tell him that?

C: Ooh. No! No that's the problem. I can't tell him that. I can feel my, I'm sucking it all in...

T: What does it feel like as you suck it all in?

C: Ordinary. I do it all the time...

T: What else?

C: Ooh! I can feel it's...tingling at the edge of every muscle trying to get out.

Opposition to Expression of Sadness/Need: Sighs (02/#8)

C: I feel (sighs) anger. Sadness she can never, I guess I want to be accepted.

T: I need to be accepted. Say that to her.

C: I needed you to accept me. See who I am. I suppose I still do.

T: Tell her what it's like.

C: (Sighs). For me to tell you what I feel makes myself vulnerable and every time I do that you always attack.

3. A stated desire or intention to stop the flow of feeling/emotion,

Opposition to emotional experience- Feeling Tearful vs. Don't Want to Feel (06/#6)

T: so what's happening for you now as you speak?

C: Um (pause) I'm feeling kind of tearful.

T: Hm. Can you stay with that [awareness of feeling], see what words come? Tearful, sad?

C: I don't want to feel tearful.

Opposition to feeling sadness: Feel Sad vs. Don't want to Feel (62/11)

C: "Well I feel sad...I want to cut it off. I don't want to deal with it."

4. Cognitions (beliefs/evaluations) that function to oppose emotional experience including negative evaluations of the experience of emotion, hopeless beliefs about expressing emotion.

Opposition: Inchoate feeling/crying vs. Negative evaluation (03/#1).

Client cries and then says "I don't like feeling this way."

Opposition: Express Anger vs. Hopeless Beliefs (10/#13)

C: I'm angry that you just think everything is fine and when it's not and you-he doesn't know how to give me what I need.

T: Tell him. Tell him what isn't fine.

...

C: I just want to feel like I'm worth the effort for picking up the phone or calling.

T: Why don't you tell him 'I'm angry at you for not-' What happens? You shake your head.

C: Because it's never going to happen.

In a few cases, opposition was not explicitly differentiated in awareness in every instance as an intentional act. In these cases, there was an automatic quality to the ebb and flow of emotional experience (n=3). Descriptions of fleeting emotional experience may include references to awareness/expression of emotion followed by reference to feeling “drained” of feeling or awareness of the loss of emotional experience. An example of the automatic loss of emotion is shown below.

C: I'm feeling really tight in my stomach and I'm feeling really sad because I've never been good enough. It doesn't matter what I do it's never good enough (cries).

T: Yeah just really sad.

C: (Cries) And I lose emotion. It's really hard so you better start talking (50/#5).

**Awareness/Expression of inhibitory secondary emotion.** For the majority of clients at this point in the process of interruption, opposition is differentiated in the form of secondary emotion that serves to further inhibit or block the flow of initial emotional experience and/or expression. Inhibitory secondary emotion will first be described below, followed by illustrative examples from the therapy transcripts.

Awareness of another emotion may include fear, shame, anger, or guilt, in order of frequency of client reports in this sample. Clients may describe the experience of these secondary emotions in terms of an internal awareness of feeling. Expression of feeling

may be verbal or non-verbal, e.g., hangs head in shame, raises voice in anger. They may communicate beliefs specific to particular emotions. Some may express specific fears about the consequences of allowing an initial emotion, such as they will lose a relationship, self-control or that they may not even survive the experience. Others may express shame or embarrassment about admitting or showing emotion because of a belief that it will negatively affect a relationship or they will be judged and found wanting by others. Beliefs about not living up to expectations or being ungrateful to another and related feelings of guilt may be expressed. Anger may be expressed in the form of harsh self-criticism for allowing emotion.

Overall, there is a sense that clients are vulnerable to significant personal and/or interpersonal losses, such as a loss of control or a loss of a relationship, should they allow an experience of emotion to continue. In the context of this sense of vulnerability, secondary emotion is evoked that serves to further inhibit or block the flow of emotional experience. Illustrative examples of therapy dialogue are included below for secondary fear, shame, anger and guilt follow.

Express Secondary Fear- Beliefs (17/#20- Hurt)

The client is explaining to his therapist that he felt hurt, and then he felt afraid of allowing hurt feeling to continue because he would be harmed.

C: It was hurting too much and then I was afraid of hurting myself physically.

T: Afraid that somehow if you stayed with the hurt...

C: If I stayed with that, physically I would hurt myself.

T: That the hurt would be too painful.

C: Yeah.

T: Or you would actually do something.

C: No. That the hurt would be too painful because now it spread all the way across, and it became much sharper and stronger.

Express Secondary Fear- Beliefs (19/#18-Anger)

C: I have images of wanting to take a knife to him and slash him up because I'm so angry with him.

T: Mm-hm.

C: And I don't really! But I know that I want to slash him up the way feel that he's slashed me open (voice shaky).

...

T: You don't want to express that rage in here.

C: No I think I'm really afraid of it.

T: What'll happen if you express it?

C: I don't know. Well, oh! I do. I'll be embarrassed or I'll lose control... Even small  
angers...I don't feel safe when the feelings of anger start coming up.

T: What are you frightened of? Break a chair? Hurt Me?

C: No, not hurt you. Um

T: Put a hole through the wall?

C: Yeah.

In another instance, fear was expressed in the context of contact with the therapist in the  
therapy relationship. The client had opposed an initial expression of crying however,  
contact with the therapist evoked fear of losing control of emotion and the therapist's  
devaluing of her.

Express Secondary Fear- Beliefs (03/#1- Crying/Inchoate feeling)

The client is engaged in an empathic dialogue with the therapist and she describes fear of  
allowing the expression of inchoate feeling and crying because it could negatively effect  
the relationship.

T: What are you feeling right now?

C: (sniffs) Well, looking at your face, you're sympathetic and you're encouraging  
me to let go and I feel like I'm going to lose it (cries).

T: Ok.

C: And

T: You're scared?

C: (Blows nose) Yeah. Scared and I think you'll think less of me...I'm almost afraid to look at you (therapist) because it's going to bring it (crying) on again.

Express secondary shame/embarrassment- Feeling (06/#4- Emotional Pain/Hurt)

The client's experience of shame may also interrupt the expression of painful hurt.

C: It's embarrassing to be hurting.

.....

T: Can you tell me about that pain?

C: I don't like it. I feel so stupid (soft voice) I can't even look at you. That's terrible (head hung).

Express secondary guilt- Censure (10/#13)

In this example, secondary guilt interrupts the expression of anger as the client engages in an empty chair dialogue with her father.

T: This is what's tearing you up. Tell her that you've got no right to be angry at him. Tell her what he's done for her. Let's give each side a voice.

C: He's taken you out of a home and let you live with him. He sent me away to school.

He's been there.

T: Right. He's been there for you so therefore-

C: You should feel guilty when you say you're mad at him.

Express secondary anger- Censure (62/#11)

The client is engaged in a two-chair dialogue where she expressed secondary anger toward herself for feeling sadness that she did not receive the kind of support she wanted from her parents.

C: Why can't you stop thinking they matter? You should know better. All of these things come into play and then I almost hate myself for them (exhales).

T: Right ok. So tell her how much, tell them what you hate actually. A part of you says-

C: I hate you being sad all the time. I think I've done this before. I hate looking at the sadness. I hate looking at the pathetic life you're leading.

In a small subset of clients, the component of secondary emotion was not present and therefore constituted a distinct process (Type II: Inhibitory behaviour, n=3). For example, one client did not report secondary emotion in the case of her experience fear, whereas she had done so in the context of awareness of anger and inchoate emotion. The process

of interruption for these clients did include the other three components of the model, as shown in Figure 8.

**Express inhibitory behaviour.** The component of inhibitory behaviour is included in each of the two paths of interruption, as opposition continues to unfold in the form of inhibitory behaviour that may include the repetition of earlier expression of inhibitory intentions and actions, and/or new behaviour that is further differentiated in awareness. For example, one client expressed sadness and a related need that was countered by a sigh and then expression of vulnerability in the form of secondary fear, followed by more sighing. At this point the therapist asked “What’s the sigh” and the client responded with awareness of the meaning of the sigh, “*I take back control of the emotions. That’s what the sigh is for me*” (02/#8). In pattern *Type I: Inhibitory emotion and behaviour*, subsequent to the awareness of secondary emotion clients consciously and actively engage in behaviours that further inhibit the feeling and/or expression of an initial emotional experience, such as constructing muscles, swallowing, or self-criticism. Illustrative examples of inhibitory behaviours will be provided below. Similar actions occur in pattern *Type II: Inhibitory behaviour*, as the behaviours of opposition to initial emotional experience are repeated and/or further differentiated in the absence of secondary emotion.

For inhibitory behaviour, the client’s description must be consistent with an experience in the present moment as opposed to a past occurrence or a general statement.

The example below is illustrative of the latter, where the client is talking in general terms about her awareness of a pattern of disallowing anger.

Behavioural Control of Emotion- General (19/#18- Anger)

C: I'm sure you've seen it. Every time when I try to express anger I can't do it.

T: Mm-hm.

C: I completely close off.

There is a difference in the quality of inhibitory behaviour as compared to the earlier stage of opposition to emotion, as there is no reference to a sense of a struggle or conflict inside between two parts of self. Rather, the experience of opposition itself is further differentiated in the form of behaviours of control or avoidance that dominate and serve to inhibit the initial experience of emotion. Clients may comment on how they are regulating an initial emotional experience to reduce or keep in check a sense of vulnerability in the self.

Control may be cognitive or physiological in nature. Clients may actively engage in cognitive control by invalidating emotional experience, self-criticism, expression of hopeless beliefs or prohibition against allowing emotion due to the belief that doing so will have a negative impact. They may also exert control over the feeling or expression of emotion by physiological means such as swallowing, sighing, choking or clenching muscles. Illustrations of the active control of emotion in the therapy session are shown below.

Behavioural/Cognitive Control of Emotion: Invalidation (06/#4- Emotional Pain/Hurt)

One client expressed shame secondary to hurt, and then invalidated the experience of hurt by questioning the veracity of her feelings.

C: (sniffs) Maybe I'm just making it all up.

T: Making up your hurt, that you've been hurt.

C: I don't know. I can't tell sometimes (blows nose).

T: I think it's important to just stay with your feelings and just let them come.

C: Sometimes I wonder if I'm just acting a part. Just looking for sympathy or something.

Behavioural/Cognitive Control of Emotion: Express Prohibitions/Beliefs-

Crying/Inchoate feeling (03/#1).

The client reported that she was trying to gain control of her emotions because she held the belief that if she did not do so it would affect her ability to work.

T: ...it's hard for you to give yourself permission (to cry). (pause:00:00:25) Do you feel like you're trying now to uh

C: Get myself together?

T: Yeah.

C: Yeah.

T: Yeah. 'Cause you look like you are.

C: I'm trying to get myself under control. Uh, if I don't I won't be able to go to work. Uh, if I'm not able to work, then that's going to add extra pressure.

Behavioural/Cognitive Control of Emotion: Express Prohibitions/Beliefs-Anger (19/#3).

The client expressed prohibitions against anger, including "a good girl can't be angry," and the belief that "people won't like you."

Behavioural Control of Emotion/Cognitive: Express Prohibitions/Beliefs (106/#6-Emotional pain/crying) in context of UFB/parents.

The client expressed the belief that she had to control emotional pain because if she allowed it her parents would be gratified and thereby have control over her.

C: So I'm stopping. I'll have to go over there and do this (changes chairs).

T: Ok.

C: I'm stopping her by saying that if I cry about it, even to a chair, I will be somehow or another allowing them to have some kind of gratification out of pain.

And by not letting the pain out, oh

T: So keep that pain in.

C: By keeping that pain in

T: Keep that pain in

C: and hidden, you'll keep them from influencing and having some kind of control over our life.

Behavioural Control of Emotion: Physiological control- Anger (19/#3; 52/#11)

One client expressed awareness that she was “choking down a lot of anger.”

Another gave voice to a choking feeling that controlled the expression of anger- “I’m the choker and I’m holding my breath so you can’t speak.”

In contrast to behaviours that serve to control emotional experience, some clients may engage in avoidant actions. Avoidance may take the form of an explicit expression of a general desire to avoid internal experience and/or its expression, as well as specific desires to hide or flee the session. It may go one step further and involve acting on these desires by engaging in actions that serve to avoid the feeling and/or expression of emotion and a related sense of vulnerability. Avoidant behaviour may take a variety of forms including: self-injunctions against expression, laughter, statements indicating an internal sense of disconnection from the perception of emotion or pushing away emotional experience, expressions of hopelessness or helplessness.

In the excerpt that follows, the client expresses how she moves from an experience of secondary fear that she will drown in her emotions to avoidance of them by withdrawing to “the surface” of emotional experience.

Avoidant Behaviour: Withdraw to the surface (19/#9- Inchoate Emotion)

C: I start digging down on the emotions...I start drowning in them...I am terrified if I drop into this (sigh) it does feel like I'm drowning when I drop into this...I'm just skimming the surface again. I'm not dealing with anything...the way of rescuing myself is to pull myself back up to the surface so that we just don't deal with that.

She also explained how she avoided getting close to emotional experience by engaging in rational thought.

Avoidant Behaviour: Analytical/rational thought (19/#9- Inchoate Emotion)

C: It feels like the minute you get close to anything that (sigh), that everything stops...It's like the part of the brain that you switch on when you try to deal with complex ideas. Nothing to do with emotions and it just clicks in.

T: You don't get close to it.

C: No. No it disappears completely.

Another client described how she avoided feeling hurt by expunging a sense of connection to her parents from her “brain.”

Avoidant Behaviour: Mentally disconnect from other (06/#6- Painful Emotion/Hurt)

T: What do you feel now when you think of them. 'I'm not going to let you know how I feel. I'm not going to let you know how you hurt me.'

C: Sighs (pause).

T: You'll never get to me.

C: I don't want to talk to you. You're out of my life...Goodbye.

T: Goodbye.

C: Still the same thing about I'd like to vacuum them out of my mind.

T: Do it. How would you like to, do that with a gesture. Get out of my life.

C: (Sounds of vacuuming). Vacuum them out of my brain (laughs)...If... another person would say 'What about your parents?' I'll say 'Well I've disconnected from my parents'....

Avoidant Behaviour: Intentionally loses concentration- (62/#11- Sadness)

One client expressed secondary anger toward her sad self which was followed shortly after by an intentional loss of focus on her experience of sadness.

C: I get a headache. My head becomes really foggy. Like I don't really want to concentrate on it.

T: You really start to distract yourself?

C: Yeah. Distract myself or not really comprehend anymore.

Avoidant behaviour: Express helplessness (10/#13-Anger)

Avoidance may also be expressed in the form of hopelessness, helplessness, or passivity.

One woman's expression of anger and a related unmet need for a meaningful expression of care by her father was interrupted by secondary guilt, and further inhibited by the subsequent inner sense of collapse and helplessness.

C: I can't defend myself with him.

T: You try to raise your voice and you can't...What's it feel like?

C: I feel like shit because I can't defend myself. That's why I want to be able to support myself so that I can turn around and he'll have no holds on me.

T: Uh-huh. So you feel trapped.

C: I do. It's a total control for him.

**Express effect of interruption.** The unfolding of the process of self-interruption of emotion culminates in the cessation of emotional experience. The effects of SIE are binary, in the form of either negative or positive feelings and sense of self.

In the majority of cases, clients describe the resulting subjective sense of a depleted, weakened self. Clients communicate awareness of this sense of self by making

verbal statements that describe an all-encompassing inner sense of depletion that is characterized by one or more of the following: weakness, numbness, fatigue or bad feeling, resignation, sadness, hopelessness or a lack of self-worth. Illustrative examples are described below.

After interruption of the expression of sadness by both expression of secondary anger and then distraction from emotional experience, one client was left feeling hopeless, numb and with a sense that she was not a “worthwhile” person (62/#11). Another client who thwarted the expression of anger by choking it down said “*I’m unhappy with myself because I feel like I was about to say something and I just can’t say it* (52/#11).” A third client interrupted the expression of sadness and related needs by secondary fear and physiological control (sighing), and he described the effect as “*The overall feeling is a sense of resignation*” that it is a “*sad situation*” that “*can’t be fixed*” (02/8). The following excerpt illustrates how the interruption of anger by secondary fear and subsequent inhibitory behaviour of swallowing the feeling of it had the effect of a weakened, vulnerable sense of self.

Effect-Weakened/Vulnerable Self (19/#18- Anger)

T: What does it feel like inside as you swallow it down? What is it doing to you?

C: Ooh... it is! just corroding is the right word. It’s destroying me.

T: Can you speak // those feelings that are destroying you inside.

C: Ooh (breath) it's more like fraying around the edges.

The effect of interruption of emotion may also be described in positive terms. There were only three instances of this type of outcome in this sample. One client expressed awareness of feeling stronger following interruption of anger. The process of interruption of anger included: opposition to an initial expression of anger, secondary fear and inhibitory behaviours in the form of hopeless beliefs and admonishments to “*get rid*” of feelings and “*be stronger*.” The effect of interruption was positive in that he felt “*more strength*” (04/#9). Another client described a sense of “*relief*” and “*good feeling*” following the interruption of painful emotion, as illustrated below.

Effect-Relief/Good Feeling (06/#6- Interrupt Crying/Painful Emotion)

C: Well I've disconnected from my parents. I will not be denying it or hiding it.

T: Hm.

C: That's all.

T: That's it. So how do you feel saying that?

C: That's good. I like that (laughs). That's not bad at all. That's pretty easy.

T: So that feels

C: An easy way to do it.

T: Take some control or?

C: Yeah...It's great. I thought I'd be weeping and wailing and howling and bawling and stuff like that (laughs).

She further reported a new awareness that she could "*chip away*" at "*this [painful feeling of sadness]*" "*a little bit at a time*" and that allowing weeping "*may even come too.*" A third client described how she felt "*under control*" and "*alright*" as an outcome of the process of interrupting anger (19/#3).

The effect of moving through the process of interruption may be described in terms of a newfound awareness of why it was so difficult to allow and express emotional experience. One client informed the therapist "*I won't allow myself to be vulnerable.*" She expressed the insight that when she was starting to cry she was "*really holding it back*" (50/#5). Another expressed her new understanding that she "*swallows*" all the time to "*get rid*" of a "*lump*" of inchoate feeling of something "*emotional*" caught in her throat (03/#2).

### **Summary of Results**

A rational-empirical model of self-interruption of emotion (SIE) in therapy was conceptualized following the descriptive phase of the method of task analysis (See Figure 9 above).

A marker of interruption of emotion was defined and used to identify that SIE was occurring in a given therapy session. As well, parameters for the identification of a self-interruptive event were defined. Thus, a method was developed for identifying and delimiting the occurrence of the process of interrupting emotion in a therapy session.

Following this method, 14 SIEs from transcripts of 10 therapy clients were identified and subjected to a task analysis. From these analyses, a final rational-empirical model of SIE was conceptualized.

The final rational-empirical performance model differed from the initial rational model in two main ways. First, the sequence in the rational model of the component un-symbolized affect that was then differentiated in awareness, symbolized, and expressed as a specific emotion was not validated. Consequently, these two components in the rational model were collapsed into one component 'Awareness of Emotional Experience' that was represented as a continuum, from un-symbolized affect to awareness and expression of emotion. Second, whereas the rational model was monolithic, the rational-empirical model encompasses two patterns of SIE. Four components were common to both patterns: 'Awareness of emotional experience,' 'Awareness of opposition to emotional experience,' 'Express inhibitory behaviour,' and 'Express effect of interruption.' The two patterns were differentiated by the presence or absence of a fifth component 'Awareness of inhibitory/Secondary' emotion that included fear, shame, anger or guilt, in order of frequency.

Finally, while the component of secondary emotion was included in the initial rational model, the empirical analyses showed that the secondary emotion of fear was by far the most common type and this information was represented in the final rational-empirical model.

## CHAPTER THREE

### **Study II: The Subjective Experience of Self-Interruption of Emotion in a Therapy Session**

The purpose of this study was to provide a representation of therapy clients' subjective experience of self-interruption of emotion (SIE).

#### **Overview of Method**

A multi-method design was used to gather and analyze information about the phenomenon of SIE. The method of Interpersonal Process Recall (Elliott, 1986) was used to obtain subjective reports from therapy clients about their experience of emotion in a therapy session. The "constant comparative method" of grounded theory (Glaser & Strauss, 1967) was followed to analyze these reports and provide a conceptual representation of SIE. Each of these methods will be described in detail below.

A common critique of qualitative research is that the researcher's subjectivity biases the findings (Guba & Lincoln, 1985; Kvale, 1994; Rennie et al., 1988). This critique is valid for all forms of research. Recognizing that "immaculate perception" exists only as a belief (Nietzsche, *1844-1900*, 2006), it is important for researcher's to be explicit about the biases and assumptions that they bring to their research so that this influence on perception is made as transparent as possible. Elliott, Fischer, & Rennie (1999) include "owning one's perspective" on their list of "Evolving guidelines for publication of qualitative research studies." They argue that by making explicit the theoretical assumptions and values of the

researcher, the reader is free to consider how they might influence the analysis and understanding of the data. In this study, the rational-empirical performance model developed from the task analysis, as described in the chapter above, served as an explicit statement of my biases and understanding of SIE prior to undertaking a grounded theory analysis of the subjective experience of this phenomenon.

### **The Grounded Theory Method**

Rennie, Phillips, & Quartaro (1988) adapted grounded theory, which has its origins in sociology (Glaser & Strauss, 1967), for use as a systematic approach to psychological inquiry into subjective experience. In later writings, Rennie (2012) described grounded theory as a method of methodical hermeneutics that is used to generate theories that represent the meaning of subjective experience, through interpretation of linguistic accounts. Given that it is not possible to directly access the experience of another person these natural language accounts provide a window into consciousness (Polkinghorne, 1983).

The grounded theory method has been used to study a wide range of psychological phenomenon, including metaphor in psychotherapy (Angus & Rennie, 1989), emotional pain in adult children of alcoholics (Bolger, 1995), therapy client deference (Rennie, 1994), cancer (Fergus, 2011; Shapiro, Angus & Davis, 1994), sadness in psychotherapy (Henretty, Levitt, & Matthews, 2009) and enduring marriage (Kagan, 2014).

The constant comparative method of grounded theory is an inductive, bottom up process characterized by iterative cycles of data collection, coding, categorization, and analysis. The ultimate goal is to identify the common or core aspects of a phenomenon across individuals that are grounded in observations of a phenomenon of interest.

**The constant comparative method.** There are several procedures involved in the constant comparative method. They are: data collection, open categorizing, memoing, delimiting the theory, and writing the theory (Glaser & Strauss, 1967).

The process of data collection is different from other approaches in that participants are selected according to a method of "theoretical sampling" (Glaser & Strauss, 1967). At first, participants are selected based on the criterion of homogeneity. Adherence to this criterion facilitates the conceptualization of categories and their properties that represent the underlying uniformity in the phenomenon across individuals. Sampling continues until the categories are "saturated." That is, when no new information is forthcoming that aids in developing new categories or their properties. When saturation has been determined for the first group under study, subsequent comparison groups are selected with an eye toward articulating variation within the phenomenon and developing categories and their properties more fully. This process of refining the distinctive dimensions or qualities of a phenomenon is facilitated by maximizing the differences between comparison groups. An analyst can be confident of the scope of the theory only when saturation has been achieved across relevant comparison groups.

This study is limited to analysis of data from one homogeneous group, i.e., clients who received experiential psychotherapy treatment for depression. Given the lack of diversity in the participants, this study may be considered an initial step in the process of generating a comprehensive theory of SIE by therapy clients.

As data is collected, units of analysis referred to as "meaning units" are compared to determine assignments to categories. A meaning unit is defined as a segment of text

containing a single idea, concept, theme, observation or process noted by the interviewee (Angus & Rennie, 1989). The process of comparison involves the generation of categories and their properties from initial interview data against which the data from subsequent interviews are compared. On the basis of this iterative process of comparison new data will either be subsumed under existing categories or, in the event that the data have not been represented previously, new categories will be conceptualized. At this stage in the analysis, the categories are descriptive and their labels stay close to the language of the participant. However, as the analysis progresses, constructed or more abstract categories are developed. These categories are both explanations of the descriptive categories and of their interrelationships.

The assignment of a meaning unit is not restricted to one category, as in content analysis. Rather, following a process of “open categorizing,” units are assigned to as many categories as are pertinent. This system facilitates the discovery of interrelationships among the categories.

Throughout the process of category generation, ideas, observations and speculations about the categories and their interrelationships are recorded as memos. These memos serve as conceptual blueprints that show the assumptions guiding the analysis and track the researcher’s process of conceptualizing the interview data. They are also used to help in the write up of the analysis.

Upon achieving saturation, the next step in the analysis is to delimit the theory. This endeavour involves the identification of central categories that represent the core features of a given phenomenon. Clusters of related categories are formed drawing from the

information recorded in the memos. The grouping of related categories into clusters results in a smaller set of categories. Each cluster is assigned an abstract conceptual label that represents the underlying commonality. In this way the original categories, which are grounded in the data, became properties of the abstract conceptualizations. Through this process of analysis, a core category is conceptualized that represents the central dimensions or aspects of the phenomena represented in the lower order categories. In a departure from Glaser and Strauss (1967), later writers expanded the conceptual framework beyond that of a “core category” to include the possibility of multiple core categories or a process model (Strauss & Corbin, 1990).

Finally the theory is written. The existing memos are analyzed and new memos generated as the major themes, supported by the categories, are developed. These memos are written up drawing on data from the related categories to support and illustrate the theory.

Further details of the specific application of the constant comparative method in this study are provided below in the data analysis section.

**Participants.** Participants were selected from the York Psychotherapy Clinic research study of experiential psychotherapy treatment for depression (York II; Goldman, Greenberg & Angus, 2006). Clients in the study were assessed for depression on the Structured Clinical Interview for DSM-1 (SCID I) and on the Beck Depression Inventory (BDI). Those with scores of 16 or greater on the BDI were judged to meet criteria for depression. After they were accepted into the study, clients were randomly assigned to either a 16-week client centered therapy (CCT) treatment or a 16-week emotion focused

therapy (EFT) treatment condition. In a few cases, clients received up to 20-weeks of treatment. For further information about the CCT and EFT treatments that the therapists provided to the therapy clients the reader is referred to Client Centered Therapy (Rogers, 1951) and Facilitating Emotional Change (Greenberg et al, 1993).

Clients gave informed consent to the use of their session audio and videotapes for research purposes, and to their participation in a recall interview about their experience in therapy (see Appendix A).

Homogeneity for this sample was defined according to the following criteria:

1. Clients were assessed as depressed, according to the SCID 1 and BDI.
2. Participation in a 16 to 20-week experiential therapy treatment trial for depression.
3. Clients interrupted their experience of emotion during a session of therapy as determined by the presence of a marker of interruption.

**Procedure.** Therapists in the York II Depression Study (Goldman, Greenberg and Angus, 2006) were recruited by the researcher to help identify potential participants. They were informed about the dissertation research on client's self-interruption of emotion in a therapy session. The definition of SIE was explained to them. The method of collecting information by IPR was also explained.

Therapists who expressed interest in recruiting clients were provided with more information about how to identify eligible participants. They were instructed by the researcher about how to identify markers of self-interruption that occurred in a therapy session. They were given the description of the characteristics of a marker of SIE, with examples, as outlined above in the section on task analysis. After each session with their

client(s), they were asked to indicate on a form whether or not the client interrupted emotion during the session, and approximately where in the session this phenomenon occurred. The researcher checked the forms daily to identify potential candidates to interview. In some cases, the therapist contacted the researcher directly after the session to give her the information or to ask for clarification.

The researcher reviewed the therapy tape, confirmed the presence of a marker of SIE and demarcated the SIE event according to the criteria described in the task analysis study described above:

1. The event must contain the context that the self-interruption is situated in.
2. The event must contain a marker of SIE.
3. Consideration of the context within which the marker is embedded will inform the decision about where the SIE event begins.
4. The decision where to end the SIE event will be informed by a change in topic (e.g., client is no longer dealing with SIE) or the client interrupts a different emotion (this would be considered a separate SIE event) or there is a shift in process to the allowing of emotion.
5. An SIE event may contain multiple interruptions of the same emotion.
6. Tangential material that appears within the event may be excluded.

Within 24 hours of the session, suitable candidates were contacted by their therapist to see if they were interested in participating in the study. They were advised that the study was being conducted by the writer, a doctoral student, as part of her dissertation research about client's experience of emotion in a therapy session. They were informed that it would involve viewing and commenting on a videotaped segment of their most recent therapy

session with the researcher. Clients had signed consent forms prior to participation in the depression study that included information about the possibility of being asked to participate in an interview while reviewing a therapy session tape during their treatment. They were informed that participation was strictly voluntary and that agreement or refusal to participate in the study would in no way effect their treatment.

If the client expressed interest, the therapist informed the researcher who contacted the client. Potential participants were given information about the study and the interview. They were informed that the interview would be conducted at York University and that it would be audio taped, transcribed, and analyzed. Confidentiality was addressed at this time. Potential participants were advised that their audiotape and transcript would be identified by a numeric code, and that all identifying information such as personal and place names would be removed from the transcript. It was explained that the therapy session would be transcribed and analysed and the results would be written up for inclusion in the researcher's dissertation. Any questions were answered at this time. If the client was interested, an interview time was confirmed. Signed consent to participate in the study was obtained, as shown in Appendix A.

Of the 16 clients who agreed to participate, one was a no-show for the IPR interview and another cried throughout the viewing of the therapy tape and could not comment. With respect to the latter participant, the writer offered support and validation of the difficulty in viewing the tape and the interview ended. The participant's therapist was informed about what happened during the IPR interview.

During the interview, participants were asked to recall their experience of emotion in therapy while viewing a segment of videotape of from their most recent therapy session that contained an SIE event. Accounts of their experience of interrupting emotion were gathered following the method of Interpersonal Process Recall (IPR).

### **The IPR method**

IPR has been recognized by psychotherapy process researchers as a method that yields clinically relevant and rich data (Elliott, 1986; Greenberg, 1999). The IPR method involves the replay of a taped therapy session or segment, where the client and/or therapist are asked to recall their experience of a particular phenomenon. This method has been used in two forms (Elliott, 1986): 1. unstructured, where the client is free to stop the tape and comment at will, and the interviewer acts as a facilitator, and 2) a more structured format where the interviewer controls the tape and gathers information by using rating scales or brief interview schedules. In this study, the unstructured, exploratory IPR method was used.

**The IPR interview.** To begin the interview, participants were informed that the researcher was interested in hearing about their experience of emotion in therapy in connection with her dissertation research. They were informed that the interview procedure involved viewing a segment of videotape from their last therapy session to help them recall their experience of emotion. They were asked to comment freely about their recalled experience of emotion to minimize experimenter effects.

Clients were given control of the remote. They were invited to stop the video tape if they so desired. They were informed that if needed, the taped segment or portions of it

could be rewound and reviewed. Participants were asked to distinguish between recollections of the therapy and newly experienced emotions and perceptions.

The writer responded to the participants' comments in a variety of ways including minimal encouragers, requests for clarification and elaboration, and summary statements.

One participant was interviewed twice due to a technical failure. In the first interview, only the first 30 minutes of the interview was recorded. By the time this omission was discovered it was well outside the 48-hour post-session parameter for the interview. Fortunately, the participant agreed to a second IPR interview of another session where he interrupted the same emotion. Information from both interviews was included in the analysis. Another participant was overcome with emotion for the better part of the interview and said nothing while watching the tape. The interviewer took a more active role in offering support and the option of stopping the interview. This interview was not included in the analysis. In two cases, participants remained silent for the most part and appeared transfixed as they watched the videotape. In these cases, the writer normalized this experience, reiterated the instructions and participants indicated their willingness to review the segment again and share their recollections.

Interviews were transcribed by the researcher and a fellow graduate student in the Ph.D. programme in Clinical Psychology at York University. Every effort was made to accurately transcribe the audible portions of the therapy videotape being viewed as well as the IPR interview dialogue. Established psychotherapy transcription standards were adhered to (Mergenthaler & Stinson, 1992).

**Sampling.** In this study, sampling continued until saturation was reached, i.e., no novel information was obtained that furthered the development of new or existing categories. No new categories or information that further refined existing categories was forthcoming from the analysis of the 12th IPR interview. A 13th IPR interview was analysed with the same result. At this point, the researcher made the judgement that saturation was reached after the analysis of the 13th IPR transcript.

**Analysis of the IPR transcripts.** To begin, the writer read the complete interview transcript to get a sense of the phenomenon of SIE in its entirety. Any general impressions or observations were recorded as memos. This step was important as it allowed for consideration of the whole context wherein the phenomenon occurred as well as any general themes prior to moving to analysis at the level of fractured narratives.

Next, the transcript was segmented into meaning units and coded. The end of the first and subsequent meaning units in each therapy transcript was marked by a topic shift, e.g., discussion of a new facet of the interruptive process, digressions involving unrelated information or the interruption of a different emotion. The size of the meaning units varied in length from a few lines to a few pages and included the relevant therapist-client talk turns where possible, to provide context, as well as the researcher-participant talk turns. Each meaning unit was assigned a code that identified the client number, session number, therapy type, meaning unit number and the line numbers where it appeared in the text.

The meaning of the text in the unit under analysis, as it related to the phenomena of self-interruption of emotion, was summarized and recorded on index cards or “property cards.” These summary statements are in essence descriptors or “properties” of as yet to be

conceptualized categories. Identifying information about the client, session number, type of therapy and meaning unit number was also recorded at the top of the index card. An example is shown below from the first interview transcript. Note that verbatim text from the transcript was included to demonstrate grounding in the participant's account of subjective experience.

Property Card: 33/#8/PE/MU3

During the session she “really wanted to leave” because the anger was “so deep,” “so like a monster” it was “scary” and it felt like there was “no hope of resolution” so “it was pointless” to “continue.”

Next, property cards were analyzed, compared, and thematically organized into categories. At this stage in the analysis, the categories were descriptive and their labels stayed close to the language of the participant, again to demonstrate grounding. In the case of the first interview transcript 33/#8/PE, all property cards were compared one to each other and clustered on the basis of commonality or left to stand alone if the meaning was idiosyncratic. Category titles were conceptualized that represented the meaning of the statements on these cards.

In the case of the property card described above, four categories were conceptualized to represent the aspects of meaning perceived by the researcher: Urge to Leave the Session; Anger Monster Felt Deep and Scary; No Hope of Resolving Anger; Process: Anger Monster Deep and Scary-Felt Hopeless-Wanted to Leave Session. The first three categories capture the language the participant used to represent their experience. The

fourth category represents the overall process of emotional experience described by the participant.

New properties from subsequent interviews was either subsumed under the existing taxonomy of descriptive categories conceptualized from the first interview transcript or, in the event that the property had not been represented previously, new descriptive categories were conceptualized.

A summary of the number of meaning units, property cards, and categories generated from each interview transcript in this first phase of the analysis is found in Table six below.

As the analysis progressed, constructed or more abstract categories were conceptualized by the researcher. These categories were “grounded” in the descriptive categories. In this way, there was a check on the ever-present possibility of inadvertent conceptual drift away from the phenomenon of the client’s subjective experience. The process of development of the abstract categories will be further described in the following section.

Table 6. Frequency of meaning units, property statements and descriptive categories conceptualized from each interview.

<b>Participant</b>	<b>SIE Event</b>	<b>Meaning Units</b>	<b>Property Statements</b>	<b>Descriptive Categories</b>
33	Anger Sadness Hurt	26 13 6	35 15 6	32 12 4
23	Emotional Pain Fear Inchoate	16 4 13	26 7 18	19 6 4
05	Anger Sadness Inchoate	25 26 9	29 34 9	19 22 5
02	Hurt Inchoate	8 26	11 28	8 34
78	Anger #1 Anger #2	35 20	44 38	35 20
50	Sadness Fear	55 3	56 3	30 2
54	Inchoate Hurt Sadness	19 9 19	25 10 23	8 4 7
10	Sadness Anger	24 15	33 27	20 10
25	Emotional Upset	16	21	10
04	Fear Hurt/Crying	13 19	16 26	8 18
27	Sorrow	16	19	15
07	Hurt	37	50	13
62	Sadness Hurt	14 8	18 9	12 7
<b>Total</b>	<b>27</b>	<b>494</b>	<b>636</b>	<b>384</b>

**Description of the development of the model.** In this phase of the analysis, higher order abstract categories were conceptualized. The 384 descriptive categories from the first sort of property cards were reviewed, compared, and sorted into clusters based on the perception of similarity in terms of content or themes and ideas noted in theoretical memos. This process involved three sorts and resulted in a smaller set of higher order conceptual categories.

In the first sort, the taxonomy of descriptive categories from the first sort was divided into two general domains, 'Therapy Experience' and 'IPR Experience'. These two domains differentiated recall of experience in therapy from descriptions of experience outside of therapy, such as memories and emotion experienced during the IPR interview. This distinction was important because some participants became emotional during the IPR and did not distinguish between what was felt in the therapy session and what was evoked in the IPR interview without clarification by the researcher.

In addition, 12 categories were omitted from the analysis for the following reasons: four categories were collapsed and properties were integrated due to duplication with another category, six categories were related to allowing sadness, and two categories contained general information not relevant to the research question.

All remaining 372 descriptive categories were sorted into the relevant domain. At this stage in the analysis, the domain 'Therapy Experience' contained 343 categories and the domain 'IPR Experience' contained 29 categories.

There was variability across the descriptive categories in terms of the number of property statements contained within each category and the number of participants and types of emotion represented within each category.

There were 287 categories that contained property statements from single participants about one emotion. There were 56 categories that contained property statements from more than one participant about one or more types of emotion. Within this group of 56 categories, 10 categories were perceived as the most central at this point on the basis that they represented the greatest number of participants and contained the greatest number of property statements. The 10 categories were: Conflict Inside, Confusion, Sense of Hopelessness, “Difficult” to Put Words to Unclear “Feelings,” Feeling of Fear, Felt Overwhelmed, Felt Very Vulnerable, Awareness of Physical Tension/Discomfort, Intolerance/Inner Judgement of Emotion, Therapist’s Reflection “Triggered” Bigger [Emotional] Reaction.”

This group of 10 categories were of particular interest at this early stage as they were viewed as potential candidates for a central role in the process of SIE. In particular, the category ‘Feeling of Fear’ contained the greatest number of property statements from the greatest number of participants across all types of emotion. A theoretical memo was written that noted the above and contained ideas about the possible relationships among the other 10 categories. This memo also contained speculations about the central role of the subjective experience of emotional incoherence and vulnerability in the process of interruption of emotion. It was also noted that none of these categories was inclusive of all participants across all emotions.

Next, all 287 categories that contained information about one emotion were sorted into emotion specific clusters, as I was interested in knowing if there were similarities and differences in SIE within and across a variety of specific emotions (e.g., sadness) and emotional experiences (e.g., emotional pain). This sort resulted in eight emotion categories: anger, sadness, hurt, inchoate emotion, fear, emotional pain, sorrow, and emotional upset. Some emotion categories represented specific emotions named by the participants and others were conceptualized by the writer. For example, the category ‘Inchoate Emotion’ was conceptualized by the writer to represent participants’ descriptions of the subjective experience of a formless, undifferentiated, unclear sense or feeling of emotion.

The information contained within each category facilitated the conceptualization of commonality within each type of emotion. From this analysis, more information was gained about the central qualities of each emotion and higher order categories were created.

For example, a new category ‘Emotion Metaphors’ was created. The information within this category contained both participant and researcher generated metaphors that represented the subjective experience of a specific emotion. For example, some participants described anger as a “monster” or sadness as “a wave.” Super-ordinate metaphors were conceptualized by the writer that represented the core qualities of the participant generated metaphors as well as descriptions of the qualities of their subjective experience of emotion. A theoretical memo was written to note that that theme of vulnerability was represented in each emotion metaphor.

In the next phase of analysis, the emotion categories were examined to determine commonality across all types of emotion. From this analysis, higher order categories were

conceptualized and existing categories were subsumed under them as relationships among the categories were perceived.

For example, the category ‘Awareness of Feeling in the Body’ was conceptualized to represent the participants’ awareness of feeling, or “getting into the body” as one man put it. Specific characteristics of visceral experience were identified across all emotion types. The descriptive categories sorted into this category were analyzed to identify central characteristics and identify patterns within and across emotions, and across participants. From this analysis, the central qualities of ‘Intensity of Feeling,’ ‘Deep Feeling,’ ‘All of a Sudden,’ and ‘Painful Feeling’ were conceptualized as sub-main categories. Relevant descriptive categories and properties were again sorted to ensure that all relevant data was included and to demonstrate that this category was grounded.

In addition, the category Therapist’s Reflection “Triggered” Bigger “Reaction” ’ was renamed ‘Therapist Empathic Reflection of Emotion,’ and subsumed under a broad category of ‘Therapist Behaviour’. In turn, the category ‘Therapist Behaviour’ was subsumed under a newly conceptualized higher order category ‘Feeling is Triggered’ after additional analyses made clearer that there were a variety of precipitants to the participants’ experience of the onset or sense of a release of emotion in the body.

The information contained in the descriptive categories in the domain IPR Experience was reviewed and the categories were clustered on the basis of common themes. Three categories were conceptualized from this process: Emotion Histories, Personal Theories of Emotion and General Reflections on Experience. The category ‘Emotion Histories’ was developed from analyses of descriptions of past experience of emotion,

vulnerability, and/or interruption of emotion that participants recounted during the IPR interview.

Upon further review, the category ‘Personal Theories of Emotion’ was considered as a participant-generated theoretical memo, as it represented post hoc conjecture about why or how they engaged in particular interruptive behaviour. Therefore, it was removed from the taxonomy of categories that were related to the in-session experience of emotion. The information contained in this memo was considered, along with information contained in the researcher’s memos, in the process of analysis and write up of the data. The category ‘General Reflections on Experience’ was not included in the analysis as the information contained within it was not relevant to the phenomenon of interruption of emotion.

In the third sort, the 10 central categories and the eight emotion categories were collapsed. Also, the two categories from the domain ‘IPR Experience’ and the theoretical memos (participant and researcher generated) were reviewed. It was perceived that the categories across both domains represented different aspects of the phenomenon of SIE and followed a temporal order, which was historical context (Emotion Histories) and in-session process. In view of the above, the two domains ‘Therapy Experience’ and ‘IPR Experience’ were collapsed.

At this stage in the analysis, core themes and higher order categories were conceptualized. The theme of vulnerability and a sense of threat in connection with the experience of emotion was central. Individual categories represented various elements in a process of experiencing and regulating vulnerability or a sense of danger to the self in the context of emotional experience. The role of vulnerability was also a dominant theme in the

theoretical memos. Given the significance of this theme of vulnerability, categories were assigned to higher order categories that represented a core or central aspect of the process of experiencing and regulating an emotionally vulnerable sense of self.

For example, the categories ‘Emotion Histories,’ ‘Feeling is Triggered,’ and ‘Felt Very Vulnerable’ were grouped together as each was perceived to represent a different aspect of the experience of vulnerability in connection with awareness of emotion. These three main categories were then subsumed under a higher order core category conceptualized as ‘Emotionally Vulnerable Sense of Self.’

Recall that early in the analysis the category ‘Feeling of Fear’, which contained descriptions of how participants reacted with fear to awareness of emotion, was a contender for a central role in the process of interruption. As the analysis progressed, other ‘reactive emotions’ were identified, such as shame, sadness, anger, and guilt. In addition, the quality of reactivity to an initial emotional experience was common to all. In view of this new information the category was renamed ‘Reactive Emotion’ and fear was described as the most frequently occurring type.

A third higher order category, ‘Provide Self-Protection’, was conceptualized to represent the activity of protection against the experience of vulnerability associated with the subjective experience of emotion. A variety of specific emotions and behaviours, voluntary or involuntary in nature, served to interrupt or stop the experience of vulnerability and thereby the initial experience of emotion.

The specific protective behaviours were represented by three main categories: ‘Control Emotional Vulnerability’, ‘Avoid Emotional Vulnerability’, and ‘Reactive

Emotion'. The category 'Control Emotional Vulnerability' represents the participants' descriptions of actions they took that served to regulate or control a sense of vulnerability related to the experience of emotion. The category 'Avoid Emotional Vulnerability' represents the participants' description of behaviours they engaged in to escape the experience of vulnerability associated with emotional experience. In both categories, participants' actions were voluntary and/or involuntary. For example, sadness was controlled intentionally by swallowing or unintentionally by constriction of muscles. The category 'Reactive Emotion' represents different emotional reactions to the awareness of vulnerability that served to interrupt the flow of an initial emotional experience. Finally, a third higher order category, 'Effect of Protection: Limited Emotional Awareness', represents the outcome of the various activities of protection. Relevant lower order categories were assigned to this category.

In keeping with the iterative process of analysis, lower order categories were further analyzed and defined in light of the conceptualization of the higher order categories. In some cases, these analyses involved property cards being grouped into separate clusters. These clusters represented different aspects of the experience represented by the category. For example, property cards assigned to the category 'Confusion' were sorted into two clusters. One cluster represented the experience of 'Confusion' as it related to the experience of 'Emotional Conflict Inside'. Another cluster represented the experience of confusion as an outcome or 'Effect of Protection.' Similarly, properties of the category 'Sense of Hopelessness' were grouped into two clusters. One represented the experience of hopelessness as it related solely to the experience of a 'Weakened State' ("No Hope"-

Weakened) whereas the other was related to the 'Effect of Protection' (Sense of Hopelessness-Effect). Assignment of property cards was made accordingly.

During the final sorting, a category x participant table was constructed and all of the property cards were sorted into relevant categories, as shown in Appendix C. This presentation of the results serves to demonstrate the grounding of the categories in the participants' experience within and across emotions.

The core category 'Protection from Dangerous Emotions' was developed from the information contained in the lower order categories and theoretical memos. Overall, themes of vulnerability, a threatened sense of self, and self-protection were central in participants' accounts of emotional experience. The client's experience of 'Protection from Dangerous Emotions' is defined by three interrelated higher order categories that represent three distinct phases of the subjective experience of interruption: 'Emotionally Vulnerable Sense of Self', 'Provide Self-Protection', and 'Effects of Protection: Limited Emotional Awareness'.

The final hierarchical model is illustrated in Figure 10 below and includes the core category, three higher order categories and respective main and sub-main categories. A taxonomy of categories showing the number of properties generated from each participant for each category is found in a table in Appendix C. In the table, quotation marks are used to show categories that are grounded in the language of the client. The model will be described fully in the results section that follows.

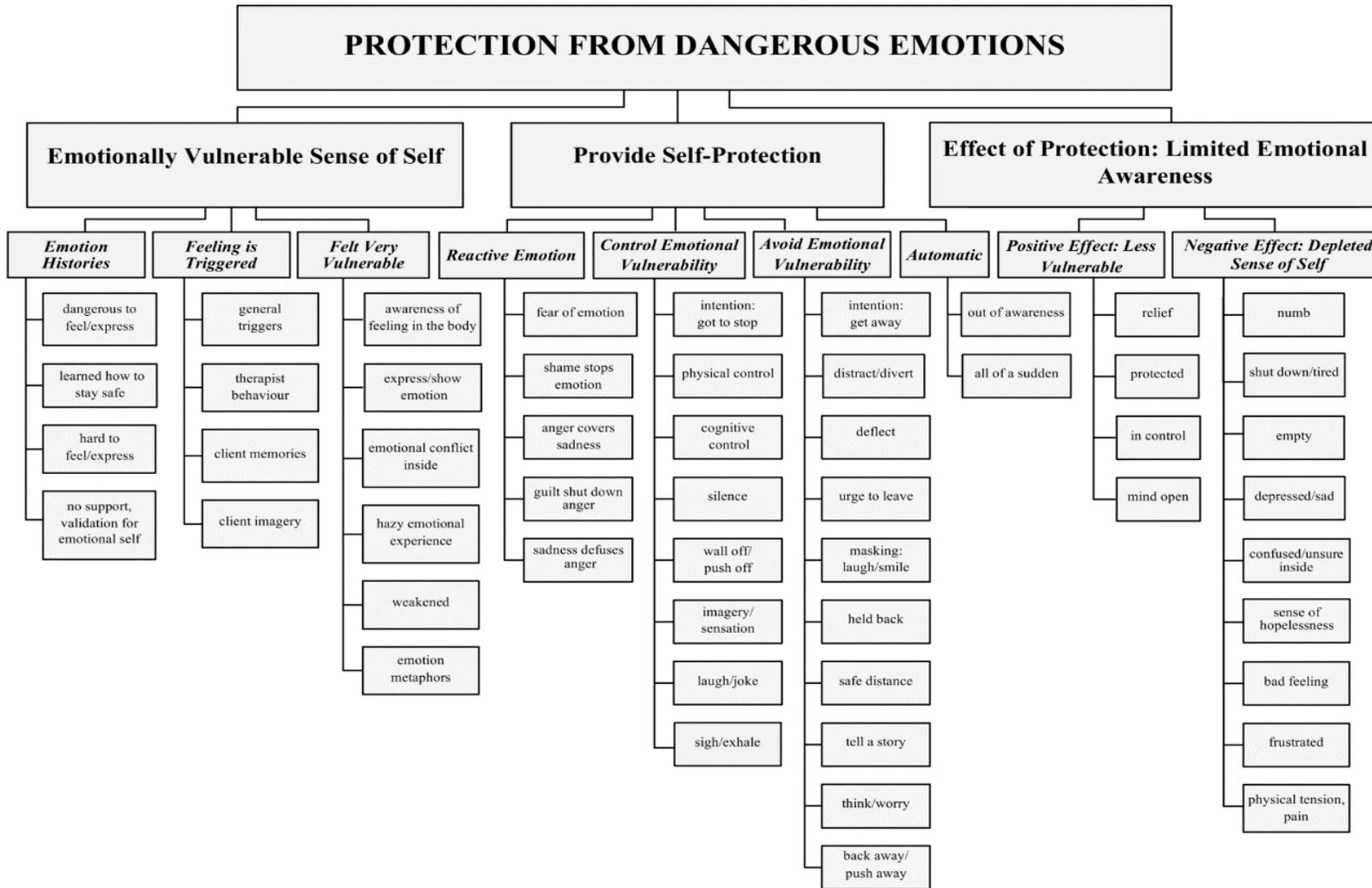


Figure 10. Subjective experience model of ‘Protection from Dangerous Emotions’

## Results

Thirteen depressed therapy clients participated in an Interpersonal Process Recall (IPR) interview. They were asked to view a videotaped segment of their most recent experiential therapy session that unbeknownst to them contained a marker of interruption of emotion, and recall their emotional experience. Eight clients viewed segments of a therapy session where they participated in emotion focused therapy (EFT). Five clients viewed segments of a therapy session where they participated in client centered therapy (CC).

From these 13 IPR interview transcripts, 27 self- interruption of emotion events (SIE) were identified. Nine SIEs were identified from the IPR interview transcripts of the five CC therapy clients. The average number of client SIEs was 1.8. Eighteen SIEs were identified from the IPR interview transcripts of the eight EFT therapy clients. The average number of client SIEs was 2.25.

Five client's IPR interview transcripts contained only one SIE that referred to one specific emotion or emotional experience. Accordingly, five SIE's were identified from these five clients. Four of these clients were in a CC therapy and one was in an EFT therapy. In contrast, eight client's transcripts contained multiple SIEs. For example, separate SIE's for anger, sadness and hurt were identified for one client. Six of these eight clients were in EFT therapy and two were in CC therapy. In total, 22 SIE's were identified from these eight clients. One client participated in two IPR interviews due to a technical failure. Two anger SIEs were identified for this one client.

The 27 SIEs involved eight different types of emotion: sadness (n=6), hurt (n=6), anger (n=5), inchoate emotion (n=4), fear (n=3), sorrow (n=1), emotional pain (n=1), and emotional upset (n=1).

All 27 SIEs were analyzed following the “constant comparative method” of grounded theory (Glaser & Strauss, 1967; Rennie, Phillips, & Quartaro, 1988). Results of this grounded analysis are described in the following section.

### **Description of a Model of Therapy Clients’ Subjective Experience:**

#### **‘Protection from Dangerous Emotions’**

The phenomenon of self-interruption of emotion (SIE), as the name implies, refers to a shift or change over time from the experience of an emotion to activity on the part of the self that serves to “interrupt” or stop this experience. Participants’ IPR accounts provided information about the subjective experience of interrupting emotion, and the development of the model of SIE focused exclusively on this subset of properties in their recalled experience.

From a grounded analysis of participant accounts, the essence of the client’s subjective experience of SIE was conceptualized as a core category: *Protection from Dangerous Emotions*. This core category represents the therapy client’s experience of satisfying an implicit or explicit need for protection from perceived threatening emotional experience and expression while in a vulnerable state. A central property of this category was the temporal nature of this experience, involving a change or progression over time from the client’s initial experience of profound emotional vulnerability associated with

awareness and/or expression of an emotion, to a related sense of danger that precipitated protective emotional reactions and/or actions of control and avoidance. In turn, these protective emotions and actions limited emotional awareness, and thereby the threat that it posed. While the immediate sense of emotional danger may have passed with these self-protective efforts that regulated a sense of vulnerability, many of the clients were ultimately left the worse for it as they now felt a sense of inner depletion in the form of emptiness, sadness, numbness, hopelessness, fatigue, or confusion.

The core category *Protection from Dangerous Emotions* is at the pinnacle of a hierarchical structure of categories that provides both a comprehensive representation of the participants' subjective experience, and also illustrates the grounding of the more abstract higher level categories in the language of the participants' accounts. The hierarchy of categories is represented in a tree diagram in Figure 10 above that shows the core, higher order, main, and sub-main categories.

Three higher order categories that directly underpin the core category represent the key features in the process of providing self-protection that were common to all clients: *Emotionally Vulnerable Sense of Self, Provide Self-Protection, and Effect of Protection: Limited Emotional Awareness*. Each of these higher-order categories captures both a temporal dimension and an essential aspect of the client's subjective experience. In addition, each of these categories subsume lower order categories that both define them and also represent the variability across participants' experience.

The category *Emotionally Vulnerable Sense of Self* represents the clients' common experience of self as emotionally vulnerable in a therapy session (When I was "sad" I felt

“very vulnerable.”). The subjective experience of emotional vulnerability occurred in connection with one or more of the following: awareness of the feeling of emotion in the body, expressing or showing emotion, awareness of emotional conflict inside, hazy emotional experience, and/or a weakened sense of self. The category *Provide Self-Protection* represents the desire, or need for protection as well as emotional reactions and actions of avoidance or control that all functioned to safeguard an emotionally vulnerable self. Finally, *Effects of Protection: Limited Emotional Awareness* represents the outcome brought about by engagement in these self-protective behaviours. In some cases, protection resulted in a positive experience of decreased vulnerability. More often, protection left participants with a negative experience of a depleted or drained sense of self.

While the three higher order categories represent the commonality of experience across participants, variability in subjective experience was also represented by information contained in the lower order categories that define them. For example, there were differences in participants’ accounts of: the visceral experience of emotion, the expression of emotion, hazy emotional experience, emotional conflict inside, and/or a sense of self in a weakened state that resulted in different signatures of emotional vulnerability. Similarly, there were variations in the subjective experience represented by the higher order categories *Provide Self-Protection* and *Effect of Protection: Limited awareness*. For example, different patterns of the subjective experience of protection for an emotionally vulnerable self were conceptualized. While all participants engaged in protective behaviours of control or avoidance, all but two participants also reacted to the sense of emotional vulnerability with another emotion.

In the following section, a representation of the client's subjective experience of *Protection from Dangerous Emotions* will be described in detail. Each higher order, main, and sub-main category in the hierarchical model will be described with illustrative excerpts from participants' accounts. To demonstrate grounding of the category across participants' accounts of different types of emotion, e.g., sadness, emotional pain, excerpts that refer to a variety of emotional experiences will be included.

**Emotionally vulnerable sense of self.** Across participant accounts, there was a common theme of a profound sense of vulnerability in the therapy session that was associated with the awareness and/or expression of emotion. The higher order category 'Emotionally Vulnerable Sense of Self' was developed from information contained in three lower order main categories that are subsumed under it: 'Emotion Histories', 'Feeling is Triggered', and 'Felt Very Vulnerable'. These three categories provide information about the origins of the therapy client's experience of emotional vulnerability, as well as the onset and experience of an emotionally vulnerable sense of self in the therapy session.

Participants explained that emotional vulnerability in the therapy session was situated within a historical context of emotional experience where allowing and/or expressing it was unsafe, difficult, and/or negatively evaluated by self or others. They described how awareness of vulnerability began in the session when feeling/emotion was initiated or "triggered" by particular types of therapist behavior and/or their own memories, stories, or imagery.

All participants shared a common experience of feeling vulnerable in the context of emotional awareness. The main category 'Felt Very Vulnerable' was conceptualized to represent the shared subjective sense of self as unsafe, threatened, defenseless, open to attack, or being wounded. However, there was variability across participants in terms of the qualities of this experience. Five sub-main categories were conceptualized to represent different aspects or concomitants of vulnerability: 'Awareness of Feeling in the Body', 'Express/Show Emotion', a sense of 'Emotional Conflict Inside', 'Hazy Emotional Experience', and existence in a 'Weakened' state. The heterogeneity of participants' experience of vulnerability is represented by the inclusion of their descriptions across all or some of these five sub-categories.

Each of the three main and associated sub-main categories that define the *Emotionally Vulnerable Sense of Self* will be described further in detail below.

***I Emotion histories.*** During the IPR interview, participants spontaneously gave personal accounts of emotion that provided a historical context for the experience of vulnerability in the therapy session (n=13). These accounts included: stories of emotion across various developmental periods, experiences in the family, long-held beliefs about emotion, views of self with respect to emotion, particular experiences and previous difficulties with emotion, and ways of coping with negative experiences of emotion.

None of the 13 participants recalled a positive experience of emotion. As one man explained, he had no memory of any positive feeling of emotion in childhood: "I've never, I can't sit down and say to you 'Oh yeah. I remember getting up one morning and

the Christmas tree was full of presents underneath.’ I don’t have feelings, thoughts like that” (04.PE.14).

The information obtained from these historical accounts of emotion was analyzed and represented by the main category ‘Emotion Histories.’ All participants accounts of emotion history were represented by information contained in this main category.

However, there was both commonality and variability across participants in terms of the qualities that defined this historical experience. These qualities were represented by four sub-main categories: ‘Feeling/Expressing Emotion is Dangerous’, ‘Learned How to Stay Safe’, ‘Difficult to Feel/Express Emotion’, ‘No Support/Validation for Emotional Self’.

The four sub-main categories were not mutually exclusive. For some participants, the history of emotion was represented across all four categories. For others, the salient aspects of emotion history were represented by fewer categories. Each of the four sub-main categories will be described below with exemplars from the IPR interview transcripts.

*Dangerous to feel/Express emotion.* Some participants gave descriptions of how the experience of emotion earlier in life was dangerous as it rendered them vulnerable to harsh consequences (n=7). They described how harsh consequences followed from allowing or expressing emotions such as anger, sadness, hurt/pain, crying, despair or emotional experience in general.

The experience of harsh consequences was varied and included: being beaten for showing emotion, feeling intense fear in connection with an initial emotion, losing

control and vomiting or suffering physical injury, depression, or being the subject of verbal attack.

Two participants described early experiences where the expression of emotion was dangerous in the context of the maternal relationship. One recalled how “it was just terrible feeling emotional” when she was a young child. She explained that she was beaten by her mother when she showed emotion.

Somehow way back when I quit feeling emotion, I wasn’t allowed to cry so obviously emotion must be a bad thing to feel. But I also equated feeling emotion with getting beaten. So it was bigger than crying. It was everything to do with emotion, anything. If I cried I got beaten. I wasn’t allowed to be angry because I’d be beaten for that. If I fell down and hurt myself and cried I got beaten for that so I wasn’t allowed to feel pain (50.PE.5).

Consequently, whenever she “allowed” herself “to feel emotion” it “always affected” her stomach (50.PE.5). She explained that she “usually always throws up” when she gets “really emotional.” The other participant reported, “I was rewarded for being happy. I was punished for being angry or upset or sad” (23.CC.18). Her account was unique in that she also described how she was afraid of her mother’s anger. She recalled, “I was very afraid of some things when I was very, very young. I remember my mother being very angry with me when I was in a crib” (23.CC.18). Given her overall experience, any expression of emotion was unsafe. She also described how she was not used to knowing what she was feeling, especially “negative things,” and that it was “frightening to get close to those feelings” (23.CC.18).

Other respondents did not describe explicit punishment for showing emotion. However, they did recall how they feared harsh or unpleasant consequences of allowing feeling or expressing emotion such as: losing control, feeling vulnerable, being criticized, feeling fear, or getting close to unknown feelings. One woman explained that her difficulty expressing feelings of hurt and betrayal toward her father in a two-chair dialogue was rooted in a history of vulnerability to attack in the relationship. She explained, “I don’t think I dealt with him very honestly at all. I don’t think I could because I was too vulnerable. Whenever I was vulnerable he jumped all over me” (54.PE.8).

Some participants described how emotion was associated with fear and loss of control. For example, one participant described his adolescent experience of emotion as one of being trapped in a “black hole” of “despair.”

It’s terrible. It’s a feeling of your worst nightmare and a tremendous amount of fear. You can’t control the situation and you just want to get the hell out of there. But the despair or something is holding you there and you can’t get away. It’s a prison and I guess the depression comes from knowing you can slip into it at any time. You don’t have any control over that. And it’s a very terrifying place because you feel physically sick, stomach gets into knots. I can feel nausea. (02.PE.8).

The fear of losing control of anger was described by one man who reported that he had been afraid of the “unpredictability” of it for as long as he could remember (78.PE.13). He recalled that 20 years earlier he “got into a state” of anger and punched a structure

with a pipe in it and he broke a small bone in his hand. He also recalled his negative experience of anger in a previous therapy.

One experience I had a long time ago, this was with another therapist, the whole room went black. I couldn't see anything except the face of the person that was sitting in front of me and that was a totally frightening experience. I mean, I couldn't see the floor, I couldn't see the ceiling, no walls nothing. And that's how it [anger] came on me that time (78.PE.6).

He explained how these past experiences coloured his experience of anger and a related sense of vulnerability in the current therapy session. Another participant reported a longstanding fear of showing sadness, even when alone, because it will "come out" unbidden and leave her embarrassed in public. She explained, "I'm afraid that if I start that pattern it's gonna come out everywhere...If I was gonna show my sadness I feel embarrassed" (62.PE.11).

*Learned how to stay safe.* Participants who described the experience of dangerous emotion earlier in life also explained that they understood the need to stay safe (n=7). They learned how to stay safe by employing a variety of means that served to control or avoid the feeling and/or expression of emotion. Participants described a number of safety behaviours including: distraction, isolation, intellectualization, silence, laughter, sleep, physical constraint, and/or blocking feeling/emotion.

Some participants recalled how they controlled emotional experience such as feeling hurt and the expression of tears or anger (Control Emotion, n=3). One woman recalled, "I know that for as long as I can remember, controlling my emotions and what I

felt was of paramount importance to me from the time I was very, very, very little” (23.PE.18). She described how she “learned to cut off” expression of emotion in the maternal relationship.

I learned to cut off. She used to hit me over the wrist with a strap or ruler or wooden spoon or something. I remember very clearly one day I wasn’t going to show her that it hurt because I was going to get it anyway. I had the sense that she liked the fact that I cried and didn’t like it. So I decided I wasn’t going to let her know that and I would laugh instead. I was probably six or something like that. So there was this thing I think from very early that feeling was to be controlled (23.CC.18).

Similarly, another woman recalled how she controlled her tears by holding her breath in the context of a physically punitive relationship with her mother: “When my mother was hitting me I wasn’t allowed to cry and if I held my breath really hard I could never cry” (50.PE.5). A third woman described a longstanding need to control the expression of anger. She explained,

I might look weak on the outside but I am full of it inside. It’s unresolved anger. And I’ve always had this need to keep it under control. I get busy with other things. If I’m at home alone I will just turn on the t.v. or open a book or wash the dishes...to get my mind and my belly off of things. “I’m under control all the time (33.PE.8).

Many participants reported how they learned to escape a sense of danger by engaging in various means of avoidance from emotional experience, such as distraction,

intellectualization or urging disengagement from feeling (Avoid Emotion, n=7). One woman described how she used to distract herself from feeling sad or bad by singing when she was a child. She explained that as an adult, she only likes pursuing the issue of how she is feeling “intellectually” (23.CC.18). Another woman explained her lack of motivation to engage anything hurtful and a tendency to avoid the feeling of hurt. She said “I tend to go away from things that hurt me. I don’t even want to get involved with that anymore...I’ve urged myself not [to] let myself feel that anymore” (33.PE.8). One man described how he learned to avoid intense fear of being beaten by kids chasing him in childhood by becoming numb to feeling.

If I was to draw feelings from the time I was running up the street with all these kids chasing me, it was just scared...you know you’re gonna get beaten up. Just take it. That was all the feeling, the numbness. There was no more scared there. Just get away from it. You know facing, even if they kicked your teeth in there wouldn’t be the pain you feel (04.PE.14).

Another respondent explained how avoidance of expressing emotion involved avoidance of her mother in childhood. She described how she stayed safe by being quiet and hiding from her mother to avoid punishment for showing emotion.

I wasn’t allowed to feel anything without being punished for it...I had to be very quiet. And the expression “Little children should be seen and not heard,” which is what I was raised with, was even bigger for me because if my mother saw me she’d beat me. So I tried very hard for her not to see me so I spent a lot of my life, my young childhood, hiding away from her as much as possible (50.PE.5).

She reported that this pattern of hiding persisted over the years into adulthood and generalized beyond the relationship with her mother. She described how she “gets in bed at night if I start to cry or anything where nobody could ever be around” (50.PE.5).

Moreover, she contrasted how she experienced emotion in childhood with how she stays safe in adulthood. She explained how she keeps her emotion and intellect separate both from each other: “They’re separate now from me, my emotion and my intellect. But they were integrated back then and it was like a full circle... [now] I have an intellect, I have an emotion” (50.PE.5). She also described how she experiences different emotions as different “parts” of herself that she can “jump” between or avoid altogether, as illustrated in the following excerpt.

There`s a part of me that`s angry. There`s a part of me that`s sad. There`s a part of me that`s depressed. There`s a part of me that`s happy. There`s a part of me that experiences love. But they`re all separate parts of me. I can bring them all together under one umbrella, you know what I mean, if I choose to and it`s okay. But I can separate these things out and if one thing becomes too painful I can jump to another thing or I could go away and watch those things from afar and not actually experience them anymore. But back then I was just learning how to do that (50.PE.5).

Another participant described how she avoided the danger of showing sadness in public by habitually not paying attention to sad feeling. She explained, “Rarely do I address it even when I`m alone...I don`t want to make it a pattern. I don`t want to be like

that... I don't want it to become a part of something I'm gonna do whenever I feel sad, is show it" (62.PE.11).

*Hard to allow/Express emotion.* Some participants described a history of difficulty allowing and/or expressing emotional experience (n=8). Unlike accounts represented in previous categories, descriptions did not include explicit references to fear or the sense that emotion was dangerous. Instead, participants described barriers that included: difficulty allowing and/or articulating feeling, specific beliefs, and various ways of controlling and/or avoiding the feeling and expression of emotion.

Some participants described longstanding difficulty allowing and/or describing emotional experience. (Hard to allow/label, n=5). One man explained how ongoing difficulty describing what he was feeling left him unmotivated to talk about it.

[T]hat's something that I've sort of been having problems with up to now... an old pattern of 'Well, if I can't label it then I don't want to talk about it. I know what I'm feeling because I'm feeling it but how the hell am I supposed to describe it to you? (05.CC.13).

Another participant explained how it was hard for her to allow sadness when anger came easier. She explained, "It's easier for me to be angry because I grew up in a very angry home. So it's a lot easier for me to be angry" (54.PE.8). One woman was also keenly aware of her great difficulty allowing and naming the feeling of emotion in the therapy session. She puzzled over the fact that her previous therapies had never focused on how she was feeling and asked "How can I have been through so much therapy before and never once worked on 'How are you feeling at this moment?'" (23.CC.18).

In some cases, participants described longstanding ways of coping with these difficulties by avoiding emotional experience (History: Avoid emotion, n=5). Avoidance took various forms, such as: shutting down or distancing from feeling, blocking feeling or engaging in rational thought. One woman reported that she does not like to show emotion and she avoids expressing sadness. She explained, “I kind of shut off...I’m trying to say it but I can’t...Somehow I think about it more and I try and block it off” (10.PE.13). One man explained that despite his desire to feel and express emotion, “getting back into the feeling of the emotion” during the session was hard. He described a long history of walling off his emotional experience with various “hurdles...barriers...doors” (02.PE.8). Moreover, he described how this pattern of emotional avoidance has left him struggling to understand his emotional experience and communicate what he feels because he has “a limited vocabulary” of emotion. Another man noted the similarity between his history of steeling against an emotional reaction to financial losses in his business dealings and how he does not allow himself to cry in the therapy session.

If a deal falls apart and you’ve lost 10-20,000 dollars in commissions, which can happened very easily, I will trust myself not to react to it...and sometimes I surprise myself how much I don’t react to it...that’s exactly what I’m doing now [in therapy session] (04.PE.14).

For some participants, difficulty expressing emotion was related to beliefs that there was no point in communicating what they felt to others or that doing so would negatively impact others (Beliefs, n=3). One woman expressed the belief that “let[ting] it out” will not help her to feel better (33.PE.8). Another participant reported that he did not think it

was appropriate to be “bringing up my feelings period” out of a concern for the impact on the other person. He further explained, “One thing with me is I never talk to anybody about my problems. Everybody talks to me about their problems but I won’t let anybody in because I end up feeling I don’t want to bother them with my problems” (04.PE.14).

*No support/validation for emotional Self.* Some participants described a longstanding experience of feeling unsupported, invalidated, and/or unaccepted by self or others when they were emotional (n=6). The chronic lack of validation and acceptance of emotional experience had negative consequences as these participants held perceptions of self as unacceptable, weak or even “crazy.”

One woman described self-invalidation of emotion as an “intolerant” attitude toward her “emotional lamenting.” She explained, “I find that very weak and non-accepted” (54.PE.8). The lack of emotional support or invalidation of emotion was especially poignant for some others (n=3), as the experience of emotion was central to a sense of self as “a bit of a weepy, sensitive person,” “an emotional person,” or “me.” One participant explained, “I don’t have the support. I think I don’t have the support to say ‘It’s ok to be sad. It’s ok to cry... To be me’” (62.PE.11). Consequently, showing sadness or crying brings feelings of shame because she holds the belief that “it’s not something acceptable” and she is unsure about “how people will take it” (MU8). Another woman explained “I like crying very much. I feel very comfortable crying. I’m an emotional person” (05.CC.13). However, she explained that she has been “so intimidated” and unsupported by her husband that “most of the time I’m thinking to myself, ‘Well then, I’ve got to be crazy or what I’m feeling is not valid.’” This invalidation of feeling carried

over to her therapy sessions where, she explained, it is “important” to her “self-esteem” to be able to talk about her emotions in a focused way as opposed to crying with abandon.

The lack of emotional support and understanding by others was also described in terms of a sense of alienation (Alienated, n=2). One participant expressed his belief that “nobody cares” about his feelings and emotions. He explained that no one can “really, really feel your hurt...And I’m not just talking about this [therapy] situation. I categorize everything into a situation like that” (04.PE.14). Another participant reported that she does not have anyone in her life to ask for help with experiencing her feelings (33.PE.8). She explained that her family was “not verbal about emotions” and she would go to her room when she was sad because there “was no use being sad in front of everybody” (33.PE.8).

In summary, the experience of vulnerability in the face of emotion in session was rooted in a history of negative experiences of emotion. Participants’ stories of emotion were dominated by themes of danger, the need to find safety, difficulty allowing feeling or expression, and/or invalidation of emotion.

In addition to descriptions of historical experience, participants recalled how vulnerability in the context of emotion was also experienced in the therapy session. The category ‘Feeling is Triggered’ was conceptualized to represent the client’s subjective experience at a point in the process of interruption, where feeling/emotion began in response to specific types of “triggers.” This category was included in the conceptualization of the process of SIE for without the triggering of feeling/emotion in the session, there would have be no emotional experience to interrupt. The category

'Feeling is Triggered' will be described below with illustrative examples from client accounts.

**II Feeling is Triggered.** The process of interruption of emotional experience began with a shift in awareness to the unintentional onset of feeling or emotional experience. Participants described the sense of a release or onset of feeling that was "triggered" automatically in various ways (n=12). For some, specific therapist responses, directions, or questions evoked emotional experience. For others, closeness in the therapy relationship, the perception of a memory, or vivid imagery precipitated the feeling of emotion.

Some participants spoke in general terms about emotion "triggers" (Triggers in general, n=2). One man described how "certain questions or triggers" had the effect on him of "slip[ping] into the whirlpool" of "the feeling of the emotion" (02.PE.9). Another participant explained that there are "certain things that trigger your anger" however, she did not elaborate further (10.PE.13).

In contrast, some participants described how specific types of therapist responses and directions initiated the onset of emotion (Therapist behavior, n=8). Overall, therapist's statements focused on emotional experience and included: empathic reflection of emotion, close attention and inquiry into feeling, direction of one form or another, or use of a metaphor to represent the client's emotional experience.

Therapist empathic reflection of emotion was the most frequent type of therapist response that evoked emotional experience, such as sadness, hurt, or emotional upset (Empathic reflection of emotion, n=6). One participant described how sadness was

evoked by the therapist's empathic reflection, "My sense is there's a lot of sadness that you still feel and I don't know if it's true." She recalled how this emotionally evocative empathic reflection had the effect of starting a feeling of sadness.

As soon as he said that like something happened within me. He said he sensed a sadness and...that kind of like just pushed a button in me where, yeah, the rest of the session I was just sad (10.PE.10).

Furthermore, she described a release of feeling in tears. She explained, "After he (Therapist) mentioned the sadness, I could feel that my eyes were watering, and then, as we talked further, I did start tearing a little." For another participant, the therapist's validation of hurt evoked intense feeling. The experience was one of the therapist hitting "a very vulnerable spot" within her. She explained, "Now she's validating what I feel in there and that starts me going again...she's hit a very vulnerable spot...Now what she's saying is exactly how I feel...I'm ready to cry" (07.CC.9). One woman described how she felt "emotional upset" and when she started to cry the therapist was "very empathetic," which left her feeling "more upset" as she experienced "a repeat of the initial wave" of feeling that was also more intense and deeper (25.CC.6).

Some participants described how the therapist's behavior of close attention and inquiry into feeling evoked emotion (Close attention, n=3). For one woman, the therapist's close attention elicited fear. She explained, "You can see, she's really attentive, she's listening, she's paying attention, which is an experience I've never really had before. And it feels somewhat frightening to me. There was a sense of fear or threat" (23.CC.18). A short time later the therapist asked "How are you feeling right now?" and

she recalled, “Whenever she asks me ‘How are you feeling right now at this moment?’ that’s very frightening, threatening” (23.CC.18). She also explained that when she was more aware of the therapist and they made eye contact it evoked a great feeling of the emotional pain of aloneness, as she experienced a deep sense of connection with the therapist.

I was looking at her (therapist) and I think what was happening was that I was getting a sense that she was listening she and was paying attention and I was connecting and yeah, that’s coming back to me right now, because it was feeling like (crying in IPR) somebody to listen and yeah it was a very deep sense of pain and grief (23.CC.18).

For another woman, the therapist’s close attention and inquiry into sadness initiated sad feeling. She explained, “He was just going near me and then I felt sad” (10.PE.10).

Emotional experience was also triggered by the therapist’s behavior of direction to express feeling or re-direction to focus on feeling. These types of therapist directions occurred only in the context of an EFT session (Direction, n=2). For example, one participant viewed a segment of the therapy tape where she expressed a sense of unworthiness. The therapist instructed her to give voice to this sense in a two-chair dialogue and “Tell her what’s undeserving about her.” She recalled, “This is where I got really sad, when she said ‘What is undeserving about her?’...just what she said about ‘Why shouldn’t you be deserving? That triggered that emotion” (33.PE.8).

Another participant recalled how she felt “raw emotion” after her therapist redirected her from “storytelling” about a work problem with a theme of betrayal to the

more central and evocative theme of her father's betrayal. She explained, "[W]hen [therapist] pulled it back to 'Well, you talked last week about your father and the betrayal you can hear it, my voice is upset. I'm starting to get upset again'" (54.PE.8).

One participant was unique in that she described how the therapist's use of metaphors evoked emotion. The therapist likened the woman's troubled marriage to a "tapestry woven together" to which she had taken "a knife and slashed through." The participant recalled that while she was discussing the metaphor with the therapist she felt "a great sense of loss" as well as "a shared intimacy" and "trust" (27.CC.8). She also recalled that when the therapist used the word "pure" to describe how her husband saw her it "hit a nerve." She explained, "When [therapist] used that word, that was a trigger word that within me gets a bigger reaction" emotionally (27.CC.8).

As they recalled emotional experience, some participants described how vivid imagery triggered the release of feeling (Imagery, n=4). One woman remembered that while she talked to the therapist about conflicting emotions related to her boyfriend, "there was some imagery there." She explained, "I kind of have, whether it's a movie screen in my mind or whatever it is...you kind of have images of people that perhaps even drum up those feelings in you as well" (25.CC.6). Another woman described the onset of intense fear as she envisioned her harsh and critical mother in a two-chair dialogue. She recalled, "The feeling that I had there was a total feeling of fear...a vision of my mother popped in and I remember feeling like I wanted to throw up" (50.PE.5).

Some participants described how recalling and recounting memories of distressing experiences evoked a feeling of emotion like they had at that time (Memories,

n=3). Visual memory was a trigger for another woman. She viewed a segment of the therapy tape where she sobbed and described a painful feeling in her stomach. She recalled that during this passage she had been entranced by positive feelings evoked by visual memories of her family that were quickly followed by the feeling of loss.

I could see the pictures and then I could feel the sense, almost like music through a church...you start to believe you're there and then you immediately know you're not...that's where the sadness comes... It's nothing more than a memory (54.PE.8).

Another participant described how recounting memories as he told stories to his therapist evoked feelings of intense fear and hurt. At one point in the therapy session he told a story of being unable to find his wife at a mountain chalet during a rocky period in their marriage. He recalled that while telling the story "I picked up on all the emotions of that day...there were many scared feelings actually in that conversation, that minute there...the tears were scared tears. I know that I felt for a couple of minutes there the cry that I had on that mountain" (04.PE.14). At another point he described to the therapist another memory of being bullied at school that involved a physical assault by another student. In the IPR of this passage he recalled that while remembering and describing the assault "all of a sudden" he felt like he was "in the body of that child" and he felt the "feelings of that time" (04.PE.14).

***Summary of feeling is triggered.*** The process of client interruption of emotion was initiated at a point in a therapy session where a therapist response or direction, or a client's memory or visual imagery, precipitated the unintentional onset of emotional

experience. Participants described how the therapist's empathic reflection, validation, use of metaphor, inquiry into feeling, or direction "triggered" the onset and awareness of feeling emotion. Client's also recalled how their own memories or imagery evoked feelings. Overall, whether in a client-centered or emotion focused therapy session, participants described an almost mechanical sense of the onset of feeling/emotion in the context of dialogue with the therapist that focused on emotional experience.

Subsequent to the various ways in which feeling/emotion was triggered, participants described how they felt very vulnerable. The experience of extreme vulnerability in the face of emotional experience is described by the information contained in the main category 'Felt Very Vulnerable'. This category will be described in detail below with illustrative examples.

***III Felt very vulnerable.*** After emotional experience was released or "triggered" at a point in the therapy session, each participant was aware of a sense or feeling of self as quite vulnerable (n=13). One participant described a sense of sorrow as "vulnerability, loss, I would say something at the very core" (27.CC.8). She recalled "how deep the emotion is and how vulnerable I feel". Another recalled how she felt "very vulnerable" when she was sad (50.PE.5). Other participants described awareness of feeling exposed, unprotected, or at the mercy of a powerful force they might not survive intact if at all. Overall, the experience of vulnerability in the context of emotional experience encompassed a sense or feeling of a threat to physical self-integrity, psychological self-cohesion, and/or existence.

Five sub-main categories were conceptualized to represent different facets of the subjective experience of vulnerability: ‘Awareness of Feeling in the Body’, ‘Express/Show Emotion’, ‘Emotional Conflict Inside’, ‘Hazy Emotional Experience’, and ‘Weakened’ state. While the experience of vulnerability in the context of emotion was common to all there were differences in the configuration of these sub-main categories across participants, in keeping with individual differences. In some cases, the subjective experience of vulnerability included membership in all five sub-main categories whereas in others it did not. The five sub-main categories that define the experience of self as emotionally vulnerable will be described below, with illustrative excerpts from the IPR interviews that demonstrate grounding in participant accounts across a variety of emotions.

*Awareness of feeling in the body.* Across all participants, awareness of feeling in the body was a central feature of the experience of vulnerability (n=13). The most commonly described visceral experience was intensity of feeling or sensation, most frequently in the torso or stomach area. Less common, and in equal frequencies, were qualities of deep feeling, sudden onset of feeling, and painful feeling.

In a few cases, participants had also reported during the therapy session itself that they felt vulnerable in connection with awareness of the feeling of emotion. For example, one woman reported to her therapist “I feel angry and vulnerable” (33.PE.8). During the IPR of this segment she elaborated on the qualities of anger that were associated with vulnerability. She described awareness of physiological arousal as well as the subjective sense of something “deep” and “heavy” in her body that was like “a monster.” However,

explicit descriptions of vulnerability during the therapy session were in the minority in contrast to recall of vulnerability across all IPR accounts.

Several participants used metaphoric language to represent the visceral experience of emotion. These metaphors were sorted into researcher generated categories of super-ordinate metaphors. Each quality of emotion and super-ordinate emotion metaphors that represent the qualities of specific emotions will be described in a later section.

The subjective experience of awareness of the four visceral qualities of emotion will be described further in the next section, with illustrative examples that cover the spectrum of participant recalled emotion.

*Intensity of feeling.* As participants recalled an experience of emotion in a therapy session, they described an internal awareness of intense feeling in the body (n=13). Across emotions, participants described the intensity of feeling using terms like “very,” “so,” “really, really,” “so much” and adjectives like “a great sense,” “a myriad,” “total,” “strong” and “heavy.” Most common were descriptions of the intensity of a specific emotion, such as sadness, anger, hurt, fear or sorrow, though awareness of intensity also applied to inchoate emotional experience and “emotional upset.”

The quality of intense feeling of sadness was evident in all participants’ descriptions of feeling “so sad,” “really, really sad” or “very sad” (n=6). One man described how he felt overall “pangs of sadness” in his body (05.CC.13). One woman described the subjective experience of intense sadness related to various losses in terms of vivid visual imagery and feelings. She recalled the transition from inchoate sensation to intense sadness that emerged in connection with vivid imagery as follows,

Well the colour changed to green. All of a sudden there were memories, there were colours, but it was all green. I remember that, specifically seeing the trees which made it clearer [whereas before] it was very dark and I was seeing pillow, shapeless, formless now it's formed. I can see the leaves, I could see the branches very, very clearly...that's what I was feeling. I mean obviously I can't see my [deceased] mother but I can feel her. It's interesting because the image that I had at the time was the scenery but it was clouded completely with impressions of my family and my history...I didn't see faces of them. It was like you feel a presence (54.CC.8).

Some participants recalled awareness of how they felt an extreme sense of hurt (n=3).

One woman described feeling "how much" she was hurt by her mother (54.PE.8).

Another participant recalled how he felt a "strong, strong hurt" while recalling a childhood incident where he was bullied. He explained, "This is where I really started getting into the body. I'm getting into the feelings of what's happening ... I heard all the laughter around me in my head...I hurt so much" (04.PE.14).

Anger was also described in terms of awareness of intense feeling. One man recalled, "I'm aware of having those angry feelings...It's high intensity" (78.PE.13).

For some, extreme feelings of fear were also recalled (n=3). One woman described a "sense of fear or threat" that was "slightly less than panic." She explained "It feels very frightening" (23.CC.18). Another woman recalled, "the feeling I had there was a total feeling of fear" (50.PE.5).

Some participants described intensity associated with undifferentiated emotion or an emotional state when feeling a sense of pain or emotional upset (n=6). All participants who described an incoherent, meaningless sense or feeling recalled the intensity of this inchoate experience (n=4). They described awareness of a “very dark...very negative sense (54.PE.8),” “a big thing...this consuming thing” (05.CC.8), “very emotional” feeling (02.PE.8), “so much” feeling or a “very distressing feeling (23.CC.18). Intensity of feeling was also described in accounts of the single cases of emotional upset, emotional pain, and sorrow. In the case of emotional upset, the quality of intensity was described by one woman in terms of feeling a “jumbled mess” of conflicting “strong emotions” (love, anger, sadness) about her partner (25.CC.6). Another woman described a “burst” of emotional pain that was associated with the subjective experience of aloneness (23.PE.18). A third woman described a sense of vulnerability associated with great sorrow over the loss of her marriage. She recalled “a great sense of loss” that she further described as, “vulnerability...something at the very core” (27.CC.8).

In summary, the examples included above demonstrate that awareness of the intensity of feeling of emotion was common across all participants and all types of recalled emotion.

For some participants, intensity was experienced as a feeling of a sudden change in the body from quiescence to increasing sensation (Intensity: Rush, n=8). In these instances, there was awareness of a feeling of churning, spreading, or growing sensation that “rushes up” in the body. This rush of intense feeling was associated with the experience of sadness, anger, hurt, inchoate emotion, or emotional pain. One participant

recalled feeling a rush of intense sadness as she viewed a segment of the therapy tape. “There I was feeling it in my chest coming up to my brain” (62.PE.11). Anger was described in terms of the qualities of a powerful and aggressive force in motion. One man recalled the feeling of anger “coming on” and described it as a “thrust” from inside his abdomen (78.PE.6). The sense of a moving force was also recalled for the experience of inchoate feeling. One participant described how an “unknown sense of it” was “coming up in my face” (05.CC.13). The qualities of rising, growing intensity were also present in descriptions of hurt, emotional upset, and emotional pain. One woman recalled awareness of hurt and how she “felt it coming up” from her “gut” to her throat and she was “ready to sob” her “heart out” (07.CC.9). Another woman explained that when she was emotionally “upset” she “sort of feel[s] a wave of that coming on. It kind of rushes up” (25.CC.6). A third woman recalled awareness of the increasing intensity of the emotional pain of aloneness. “It was so explosive. I remember that feeling of it coming...this feeling that was growing in me” (23.CC.18).

Some participants described intensity in terms of feeling heaviness or weighed down by the feeling of emotion (Intensity: Heavy, n=3). For example, one woman explained “It’s in my stomach. I just feel the weight, the sadness” (410.PE.9). Another woman recalled a “very heavy” feeling of anger (33.PE.8).

While all participants described intensity of feeling related to the experience of one or more specific emotions, a few did not report intensity for all experiences of emotion. In the four cases of anger, three participants described an intense feeling in the area of the stomach or upper body whereas, the fourth participant acknowledged a non-

specific awareness of uncomfortable anger. He did however recall intensity of feeling in his body in connection with awareness of other emotional experience, such as inchoate feeling and sadness.

Two of the six descriptions of hurt were unique in that the participants reported that they did not allow or feel hurt at all. One woman described intensity associated with awareness of anger and sadness. However, she recalled that when the therapist coached her to express unmet needs associated with feeling hurt, as soon as she heard the therapist say the word “hurt” she “automatically clicked” into “keep that away from me” (33.PE.8).

In summary, intensity of feeling, across a wide range of emotional experience, was the most commonly described visceral experience that was associated with a vulnerable sense of self (n=13). Intensity was defined from participants’ descriptions as awareness of extreme, strong, heavy, and/or powerful feeling in the body. Some descriptions also included the quality of a surfacing or fast moving sensation that rushed upward in the body.

In addition to intensity, some participants also described the qualities of deep feeling, painful feeling, and/or a sudden onset of feeling. Each of these qualities will be described below with illustrative examples.

*Deep feeling.* Some participants described emotional experience that included awareness of the feeling of emotion located “deep” within the body (n=9). For example, one woman recalled feeling “really deep” sadness (33.PE.8). Another woman described awareness of feeling “a very deep sense” of emotional pain (23.PE.18).

In some instances, the deep feeling of emotion was located in the area of the stomach (Deep in my stomach, n=5). One participant recalled that when he felt hurt, “I was drawing up from my stomach” (04.PE.14). With respect to anger, one woman reported “It’s so deep...It’s in my belly” (33.PE.8). Another woman described awareness of sadness that she noted was “always in my stomach. That’s where it goes to me, in the stomach” (50.PE.5).

Descriptions of the subjective experience of deep emotion were not necessarily specific to a physical location in the body. For example, one participant described sorrow as a feeling of loss that was “deep,” at the “very core” (27.CC.8). Another recalled feeling “a very deep sense” of emotional pain (23.PE.18). In other cases, participants described the feeling of emotion surfacing from the depths of the body. For example, one man recalled the feeling of inchoate emotion as “something bubbling to the surface” (02.PE.8).

*Painful feeling.* At times vulnerability involved the physical sensation of painful feeling associated with the experience of an emotion, such as sadness, anger, hurt, fear, sorrow, or emotional pain (n=9). In some instances, participants described awareness of painful feeling in specific physical locations, such as the “stomach,” throat, head or “solar plexus,” or a “core...tender spot.” Others described a more global feeling of physical pain.

Painful feeling was described most frequently in connection with the awareness of feeling hurt or emotionally wounded by another (Painful wound, n=4). One woman described how the feeling of being hurt by critical or indifferent family members

involved intense physical pain in her stomach. She reported that she had complained about this stomach pain to her family doctor, who was unable to help resolve it. Another woman watched a section of the therapy tape where she discussed how she was hurt by her father's betrayal and recalled, "I'm feeling this very painfully" (54.PE.8). One participant recalled that while he was recounting the story of childhood bullying to his therapist, he experienced painful feelings of hurt like he had at the time. He explained, "It was really, really strange because I felt pain really, really as if it happened two minutes ago" (04.PE.14).

Awareness of physical pain was reported in some instances of other types of emotion, such as anger, sadness, inchoate feeling, fear, sorrow, and emotional pain. For example, some participants recalled how anger felt physically painful (Painful anger, n=2). One man described the feeling of anger and physical pain as a "mixture" that cannot be separated. He explained,

The anger doesn't come from the head it comes from here (pointed to solar plexus) It's still the pain. It's still this gas pressure building up and it's right in here, in the solar plexus. And it's stronger than I recollect it ever feeling...I don't recall it ever being that painful...It makes breathing difficult (78.PE.13).

For others, the feeling of sadness was physically painful (painful sadness, n=3). One woman described awareness of sadness that included feeling "a lot of pain" in her stomach (54.PE.8). Another woman recalled that she had "a glimpse" of "the pain of the stomach ache" that formed part of her experience of inchoate feeling (54.PE.8). With respect to fear, one man recalled that when he felt "many scared feelings...I was

hurting...I was really hurting” (04.PE.14). Painful feeling was also described in the single cases of sorrow and emotional pain. One woman recalled how the experience of great sorrow involved awareness of “the tender spot... it’s always painful” (27.CC.8). Another explained that the emotional pain of aloneness included the physical feeling of pain in her body (23.PE.18).

*All of a sudden.* Many participants described a sudden onset of feeling in the body associated with the emotions of sadness, anger, hurt, fear, and emotional pain (n=10). One woman recalled the immediate onset of sadness. She described how “[t]here was nothing and then it [sadness] came on...it kind of jumps up” (10.PE.9). There were no descriptions of sudden onset for inchoate feeling, sorrow, or emotional upset.

Participants described how the feeling of emotional experience came on without warning to startling effect. As one man observed a segment of therapy tape where he recounted a childhood experience of bullying he recalled,

I remember crying the exact cry from that time...all of a sudden, it was the weirdest thing. I put my body right now into that body of that child...It came out of nowhere. I was surprised that I put myself into that little boy again (04.PE.14).

Another man recalled how the feeling of anger was akin to an alien creature that “suddenly, destructively” burst out of his body (78.PE.13). One woman explained that when she experienced emotional pain “the crying sort of burst out and I didn’t expect it” (23.CC.18).

In summary, participants’ sense of vulnerability in the context of emotional experience involved awareness of the visceral experience of intensity of feeling, deep

feeling, sudden onset of feeling, and/or painful feeling. In describing this experience, participants also used a variety of emotion metaphors that were analyzed and subsumed under super-ordinate categories of metaphors that were generated by the writer. The category Emotion Metaphor will be described further below.

*Emotion metaphors.* Some participants used metaphors to represent the experience of emotion when recalling sadness, anger, hurt, inchoate feeling, and in the single cases of emotional upset, sorrow, and emotional pain (n=9). None of the participants' descriptions of fear contained metaphors. In addition, some participants used a metaphor of a "black hole" to describe their experience of depression (n=3).

Super-ordinate metaphors were conceptualized that captured the essence of all client descriptions of the experience of emotion, as well as specific client-generated metaphors across a variety of emotions. The metaphor for emotion as 'fast moving water' encompasses the client generated metaphors of a "wave," "tide" or "overflow" as well as other descriptions that conveyed the sense of emotion as a forceful, water-like entity in motion. The metaphor for emotion as a 'malevolent force' represents client-generated metaphors of emotion as a "monster," "alien" or "explosion" as well as descriptions that communicated a sense of a threatening, large, and powerful force in the body. The metaphor 'emotion is darkness' draws from a participant generated metaphor for inchoate feeling as "the darkness emotion" and descriptions of the experience of depression as "the black hole" (n=4). Emotion metaphors will be described further below with illustrative examples.

*Emotion is fast moving water.* Participants frequently described the visceral

experience of emotion using water metaphors (n=7). The super-ordinate metaphor ‘emotion is fast moving water’ was conceptualized to capture the essence of the subjective experience of visceral activation as unbidden surging or fast moving sensation in the body.

The use of water metaphors was most common in descriptions of sadness as a force or sensation progressing upward in the body, like the surging force of a wave moving upward from a body of water (Sadness like a wave, n=4). One participant described how she felt sadness like “a wave coming up” from her “belly” that crested in tears (033.PE.8).

The metaphor of a wave was also used to describe the visceral experience of inchoate feeling in one case and emotional upset in another. One man described inchoate feeling as “this wave thing...that keeps coming up in my face” (05.CC.13). Another participant described an experience of emotional “upset” as deep feelings in her body that “welled up” like a wave. She explained, “I feel a wave of that coming on, it kind of rushes up...It’s just a repeat of the initial wave but then it just intensifies and gets deeper” (25.CC.6).

The metaphor of emotion as fast moving water also captures the essence of other descriptions such as: emotion is a “whirlpool” (02.PE.9), welling tears of sadness is “an over flow” or “spill over” of emotion (50.PE.5) or “pouring” emotion (04.PE.14).

*Emotion is a malevolent force.* Participants also used metaphors to represent the experience of emotion as a dangerous, harmful force in some descriptions of anger, hurt, inchoate emotion, and in the single cases of emotional pain and sorrow (n=7).

The sense of a malevolent force was especially salient in descriptions of anger. Some participants described their subjective experience of anger using the metaphor of a “monster” or “an alien.” One woman described anger as “so deep and so like a monster” to convey the sense that something unnatural, abnormally large and powerful was in her body (33.PE.9). Another participant described anger as an “alien,” powerful and dangerous force within his body that he referred to as “this creature.” He described the feeling of anger “coming on” as a “thrust” from deep inside his body (78.PE.6). He likened his experience of the dangerous, explosive quality of anger to that of the character in the science fiction movie *Alien*, who has an extra-terrestrial creature growing in his belly that burst out and killed him. One woman described the visceral feeling of emotional pain as an “explosive” force in her body, capable of producing intense pain and self-destruction should it fully detonate

The experience of intense and painful emotion was also described in terms of a wound or injury to the heart (Wounded heart, n=2). One woman used the metaphor of a broken heart to describe the impact of intensely painful feeling of deep sorrow over the loss of both her marriage and identity as a married woman. Another participant described the intense pain of feeling alone and wounded by the hurtful behavior of family members. On the therapy tape she described the pain like “a knife to my heart.” During the IPR of this segment she recalled a related urge to “sob my heart out” (07.CC.9).

*Emotion is darkness.* The metaphor of emotion as “darkness” or like being in a “black hole” was used by some participants to represent their experience of inchoate feeling or depression (n=3). One participant described the sense of inchoate feeling that

she named “the darkness emotion.” She recalled, “I remember feeling very um, tunnelly, like dark...very dark, no direction, just very cloudy, very, you know, like an ominous evening” (54.PE.8). While the metaphors of “darkness” and “a cloud” were not explicit in the other descriptions of inchoate emotion, participants did make reference to an “unclear sense” or feeling.

In some cases, the experience of depression was one of being in a “black hole” (n=3). As one woman recalled, “I’m feeling like it’s a black hole and I can’t understand why. I can feel that I’m really depressed” (07.CC.9). One man described how he felt depressed knowing he could “slip into” the feeling of being trapped in a “black hole” of emotion unexpectedly at any time (02.PE.8).

Overall, emotion metaphors shared a similar theme of emotion as a dangerous, ominous, threatening force or sensation.

***Summary of felt very vulnerable: Awareness of feeling in the body.*** Participants’ awareness of feeling in the body was a central feature of the subjective experience of a vulnerable sense of self. Visceral experience of emotion included the sense of intense, heavy, powerful feeling that was also deep and/or painful in some instances. Descriptions also included accounts of a sudden awareness of surfacing, progressing, or fast moving sensation that rushed upward in the body. Participants used a variety of metaphors across different types of emotion to represent awareness of vulnerability in the context of the visceral experience of emotion: sadness is a “wave” that rushes up in me, anger is “a monster” inside me. These metaphors were subsumed under researcher generated super-ordinate emotion metaphors such as ‘emotion is fast moving water’ and ‘emotion is a

malevolent force' that represent the general themes across client metaphors. A third metaphor "emotion is darkness" represented some participants accounts of feeling lost or trapped in a meaningless void or "dark hole" of depression or the "darkness" of inchoate emotional experience.

In addition to the subjective experience of self as vulnerable in the context of awareness of feeling in the body, some participants also described how vulnerability was associated with the expression or showing of emotion. The category 'Express/Show Emotion' will be described below with illustrative excerpts from participants' accounts.

*Express/Show emotion.* The experience of vulnerability was frequently related to the overt expression or showing of emotion in various forms (n=13). Emotion was expressed by crying, revealing inner feelings, or voicing emotion and related needs. Each of these aspects of emotional expression associated with the experience of vulnerability will be described below, with illustrative examples.

Participants described crying as an expression of intense, deep, painful and/or sudden feeling of emotion that was part of an overall experience of vulnerability (Crying, n=10). There were no descriptions of crying for anger or inchoate feeling, nor was it apparent in the corresponding segments of the therapy tapes. The intensity of crying ranged from feeling "tearful" to sobbing. At the extreme end, one woman explained "I could just keep on crying and crying and crying" (07.CC.9).

There was often an automatic quality to crying with no sense of purpose other than a visceral release. One woman recalled, "I'm so sad and I have all of this stuff coming out of me. I have a feeling in my stomach and it rises and comes out" (10.PE.13).

Another described crying as a wave of sadness and a “release of some kind” in her neck (33.PE.8).

In contrast, two participants described the meaning of crying, which for both was related to a sense of loss. As one woman explained, when she sobbed “It’s a sense of lamenting. It’s over...loss and disillusionment” (54.PE.8).

Descriptions of the subjective experience of crying conveyed the sense of self as unprotected, threatened, or unsafe. One woman recalled how she felt intense, deep sadness like “a wave coming up” from her “belly” and “tears were starting to form” (33.PE.8). At this point on the therapy tape she cried as an expression of this intense feeling of sadness and wiped her face with a Kleenex. During the IPR she recalled that while she did so, “I felt very soft, very sort of vulnerable. Yeah vulnerable.” Another participant described how she felt that her life was in danger at a point where sudden, intense and painful feeling was unleashed and expressed in tears. She explained, “The tears come up unexpectedly and for that split second I have this feeling like I’m dying or just drowning” (23.CC.18).

One man recalled how he felt vulnerable as he expressed “scared tears” at one point and tears of hurt at another. He described awareness of an undesirable sense that he was vulnerable to “break down,” continue to cry and “Los[e] whatever dignity I have left” (04.PE.14).

For some participants showing or voicing emotion evoked a sense of vulnerability (Show/Voice emotion, n=4). The nature of the sense of vulnerability varied, and included being open to attack, judgement, pity, and/or an internal sense of doubt or dys-control.

Vulnerability was experienced in the context of the therapy relationship, or in relationship to an imagined other during a two-chair imaginal dialogue in an EFT session.

One woman described how she was reluctant to show sadness to the therapist as it did not feel safe to do so. She explained that when she felt the rising sensation of intense sadness in her body, “It feels very uncomfortable in front of somebody...I don’t want to show sadness” (62.PE.11). She described how her discomfort emanated from a pervasive concern about being judged by others should she show her feelings, which was rooted in her family history of invalidation of emotion. She explained, “It’s not something acceptable and how will people take it? I don’t have the support. I’ve never really had the environment where I could do that.” Another participant explained to the therapist that she did not want to “show that I’m sad” because she did not want to be vulnerable to self-pity or to be pitied by her therapist. She explained,

I just don’t want to pity myself. We’re all dealt a deck of cards and live our life and whatever’s happened in mine, I don’t want people to be like ‘Oh poor [client name]...I don’t feel sorry for myself and I don’t want other people to feel sorry for myself...I feel like I was defensive when I was talking to him [therapist]” (10.PE.9).

A third woman commented about a segment of the therapy tape where she struggled to express intensely painful feelings of betrayal to her father in a two-chair exercise. In the IPR interview she explained that she had great difficulty doing so because she felt vulnerable.

C: I can’t confront him vulnerably.

Int: So right there was some feeling of vulnerability?

C: Yes (54.PE.8).

Some participants described how they felt vulnerable when they verbally expressed emotion and/or related needs. These verbal expressions occurred in the relational context of dialogue with an imagined other during chair work in an EFT session (Express need, n=4). They recalled difficulty expressing or describing the experience of an unmet need related to a specific emotion of hurt, anger, or sadness that was associated with a feeling of vulnerability. One woman struggled when she expressed anger and a related need for “emotional attention” in a two chair dialogue with her father. On the therapy tape she reported “I can’t defend myself with him...I feel like shit because I can’t defend myself” (10.PE.13). In the IPR she further explained that when she expressed the need, “I’m really not sure of myself...I know the feeling’s there and I feel it but maybe I’m not confident enough to really believe it. Like I’m not confident with myself...I’m just not sure inside.” One man explicitly reported vulnerability at a point in the therapy session where he expressed sadness and a related need for acceptance during an empty chair exercise with his mother. An excerpt from the therapy session is quoted below.

“T: If she were here what would you say to her? What are you feeling inside?”

C: Sadness she can never, I guess I wanted to be accepted.

T: I needed to be accepted. Say that to her.

C: I needed you to accept me. See who I am. I suppose I still do.

T: Tell her what it’s like.

C: (Sighs) For me to tell you what I feel makes myself vulnerable and every time

I do that you always attack.”

In the IPR of this passage the participant described his subjective experience of vulnerability as,

The old reactions to the old hurts...the physical reactions...in the chest, occasionally stomach. And I feel a flush in the face and my eyes start to tear a little and also it's a case of...starting to lose control (02.PE.8).

In addition to the experience of vulnerability associated with the overt expression of emotion in the form of crying, showing, or voicing, vulnerability was also related to emotion that was consciously realized and symbolized privately in language (Private Realizations, n=6).

Some participants described how the expression of emotion took the form of consciously, privately acknowledging intense, sudden, deep, and/or painful feelings or images and then and putting them into words. This realization of emotion was associated with a sense of self as vulnerable to defeat, depletion, or emotional wounds. One participant explained that when she expressed sudden, deep feeling of sadness and cried, “The tears would be part of the feeling of never being good enough and the realization ‘I’m never going to be good enough.’ And ‘I’m defeated’” (50.PE.5). Another recently separated woman recalled the painful realization of a “core” sense of sorrow over the loss of her marriage and awareness of a wound to her sense of self-identity. She explained,

I realize ‘Oh yeah, this really is the tender spot’...and it’s always painful...it’s vulnerability, loss, it’s something at the very core...sort of how I see myself...I’ve always been a married partner so it’s very core (27.CC.8).

A third participant described intense feelings of hurt while recalling a traumatic memory and the surprising realization that he was still vulnerable to feeling emotionally wounded.

He recalled,

It was as if my body had got into that body automatically. I was back in grade eight...It made me think quickly that that whole day still hurts me. Made me start to think like that. I was really, really surprised that I got those feelings out of it...Kind of more of a realization, like say 'Wow' you know. 'This is still hurting me. This still hurts.' (04.PE.14).

In summary, some participants described a sense of self as vulnerable when they showed or expressed emotion to the therapist or to a significant other in an imaginal two-chair dialogue. Others recounted vulnerability in the form of realizations about emotional experience that were symbolized privately. Overall, the overt or covert expression or realization of emotion was associated with awareness of an emotionally vulnerable sense of self.

As well as vulnerability in the context of expressing or showing emotion, some participants recalled the subjective experience of unclear and/or unsymbolized feelings and emotions. The category Hazy Emotional Experience will be described below, with illustrative examples from participant accounts.

*Hazy emotional experience.* For the majority of participants, the subjective experience of vulnerability was, at times, related to a lack of clarity about various aspects of emotional experience (n=12). Some participants described emotional experience as vague and cloudy, and they struggled to differentiate and/or symbolize feelings and

specific emotions. For others, the purpose or meaning of symbolized emotion was a hazy unknown. This lack of emotional clarity was associated with an emotionally insecure, hazy sense of self that often involved confusion about internal experience.

Difficulty in differentiating and putting words to emotional experience was described in all accounts of inchoate feeling (Cloudy feeling, n=4). The subjective experience of an unclear emotional sense was represented in words such as “it,” “something” or “cloud-like.” One woman explained her experience of an unclear sense in the following passage: “I know I was feeling but I was not aware of what I was feeling...I don’t know how to separate them [feelings]. I don’t know what it is” (23/#18.CC.MU3, 5). Another participant recalled his experience of an “unknown sense of it” and his desire to “define it” (05/#13.CC.MU6). He explained, “It’s an unknown thing that I’m having a hard time dealing with. What is it? Can’t define it” (MU5). A third participant described inchoate feeling as “the darkness emotion (54/#8.PE). She recalled, I just remember there was no sense of direction. It’s pervasive. It’s inarticulate. It’s like a cloud...I don’t know.” (54.PE.8)

Other participants were able to clearly identify what emotion they were feeling, such as sadness or anger. However, they described how it was difficult to explicitly describe it because they lacked a concise vocabulary of emotion that would allow clarity of expression (Hard to put words to/Express, n=9). One woman described difficulty putting words to the “preverbal” sad feeling she felt deep in her body. She explained,

It’s so old in me that I don’t even have words for it...There are no words for this kind of sadness and I didn’t have the words for that kind of sadness and almost

neglect. Now I'm speechless. It really seems to be really deep. It sort of overtakes me (33.PE.8).

One man viewed a segment of tape where the therapist directed him to express his feeling of intense, painful anger, and a related need in a two-chair dialogue. He described the feeling of anger that he had at that time as "this thing," which conveyed the sense of something alien and undefined in his body. At one point on the tape where the therapist directed him to "put words about the anger" he explained, "I'm thinking about an answer and forming an answer in my mind. And it's very difficult for me to talk about that because I don't know much about it" (78.PE.6).

In some cases, the subjective experience of hazy emotion involved a sense of confusion (Confusion, n=8). There was variation in participants' descriptions of confusing emotional experience. One woman described her experience as one of feeling "discombobulated...pulled apart and almost looking at more questions than answers" (27.CC.8). Another participant described her experience of emotional confusion as she talked about her feelings of anger while recounting family history.

...emotionally, time is non-linear. I mean, I'm bouncing around here. I'm past. I'm future. I'm mixed up because emotionally I'm trying to wade my way through it...it's very, very confusing emotionally because they're all...basically mixed together (54.PE.18).

The sense of confusion involved an interpersonal dimension for another participant. She commented on a moment on the therapy tape where she shrugged as she was talking about feeling chronically alone and deeply wounded by the hurtful way she perceived

that her family treated her. She explained the shrug as an expression of her bewilderment that she is in a “black hole” and “it’s just so painful. I don’t understand why people can’t see it” (07.CC.9).

While some participants could differentiate and identify the feeling of a specific emotion they were confused about its purpose and personal meaning. One participant recalled how she struggled with a sense of emotional incoherence.

[I] was just trying to connect my brain to this feeling to be able to like say something coherent... I don’t know, I just couldn’t... my mind was blank... I have the feeling. It’s in my stomach, like I just feel the weight, the sadness. But I just can’t tell you why...It’s just there’... I had very few words to say the rest of the session because I just don’t know what it is, what brings on this [sad] feeling. ...I don’t even know what to say. I can’t even put it into words (10.PE.9).

Another participant watched a segment of the therapy tape where he described a traumatic childhood memory coloured by the feeling of intense fear. During the IPR he described how he was confused about why he was “feeling scared.” He recalled, “I kept saying to myself ‘Why is this (feeling of fear) happening?’ yesterday during this (therapy session) time. I can’t explain it” (04.PE.14).

In summary, participants recalled the subjective experience of vulnerability associated with an internal sense of hazy emotional experience. This lack of emotional clarity was defined by one or more features, such as cloudy feeling, symbolized feeling and emotion that was hard to express in words, and/or unclear emotional experience that engendered a confused sense of self.

In addition to a vulnerable sense of self that was associated with a hazy emotional experience, some participants also described vulnerability characterized by awareness of an internal experience of emotional conflict. The category ‘Emotional Conflict Inside’ will be described below, including exemplars from participant accounts.

*Emotional conflict inside.* For many participants, recollections of the subjective experience of various emotions contained descriptions of an internal sense of emotional conflict, which was central to a sense of self as vulnerable(n=11).

Emotional conflict was defined by the internal experience of a fragmented self that consisted of opposing “parts.” In some cases, emotional conflict inside also involved an internal sense of confusion or a threatened sense of identity. Across accounts, participants described one or more of these qualities of internal conflict in the context of recalling emotional experience.

Many participants recalled emotional experience that included the subjective experience of diametrically opposed “parts” or “sides” of self. They described an experience of internal conflict, where one part/side wanted to allow a feeling and/or expression of emotion and another part/side stood in opposition to this desire (Opposing parts of me, n=8). In some cases, participants described the feeling of emotional conflict by using metaphors of an internal “battle” or “fight.” One man explained that while he was trying to be more open to his emotional experience in general, he felt like he was “battling...fighting...the old me” to “deal with this in a different way” than he was “normally used to” (05.CC.13). Another man described how he felt conflicted about “trying to consciously step back into the whirlpool of emotion.” He described this inner

battle as “fighting myself” where “part” of him was saying “Are you crazy? We just got out” and another “part” was saying “Well, you gotta do it” (02.PE.8). Others recalled the sense of internal conflict in the context of an experience of a specific type of emotional experience. One woman described a “kind of a battle inside” when she felt painful feelings of hurt, which she explained was a back and forth of “Go-No keep tight” (62.PE.11). Another man explained that his therapist “tried to...lead” him “to say ‘It’s okay to cry, let it out,’” but he was “fighting” himself “inside”; he wanted to but his “body” was “fighting” him “saying ‘No you shouldn’t’” (04.PE.14). One participant described a conflict between her head and her heart when it came to allowing very sad feelings. She recalled that she was “opposing” allowing very sad feeling it as it was “foreign” (50.PE.5). She further explained, “I have to feel emotion which I don’t want to do. So it’s against each other...I mean I want to do it intellectually but in my heart I don’t. I don’t want to face it.”

A few participants described confusion related to awareness of emotional conflict inside (Conflict confusion, n=3). As one put it,

It was confusing as well because on one side I’m saying “So what” and “Stop this already” and on the other side I’m saying “This is feeling right. This is what I should be feeling. Sadness for myself (33.PE.8).

Descriptions did not all contain explicit references to an internal sense of conflict. However, they described awareness of disparate parts of self in the context of emotional experience. One woman watched herself on the therapy tape during the IPR and commented on the incongruence between what she was feeling inside and how she

expressed herself in rational terms. She reported, “I can hear the insecurity...Like I’ve got the intellectual side and the emotional side” (07.CC.9).

For some participants, internal conflict posed a threat to self-identity (Threatened Identity: Not Me, n=3). These participants were able to name or express an intensely felt emotion in words, and the personal meaning of the emotion was clear. However, it was this awareness of emotional meaning that left them feeling vulnerable because it did not cohere with the participants’ beliefs about themselves. As a result, conflict in emotional experience posed a threat to an aspect of self-identity. One man described a conflict between his emotional identity and his emotional experience when he realized that his feeling of anger contradicted his self-perception “I’m not an angry person” (05.CC.13). For another participant the intensity of emotion was described in a way that conveyed a sense of vulnerability at one point and at another point the meaning of expressing emotion threatened her self-identity. She first described the intense feeling of anger as “not a good feeling to have. Like it kind of comes and grasps you” (10.PE.13). On the therapy tape she was coached by the therapist to express anger toward her father in a two-chair dialogue, which she did to a degree in the following excerpt from the therapy session.

C: My grandmother was not nice to me at all...and I told my dad ‘I can’t handle it anymore’...and he goes ‘You are going to suffer financial consequences’ and I was just like ‘What the fuck is that?’

T: Tell him how angry you are. Tell him I resent you controlling me in that way.

C: It’s no way to control somebody.

In the IPR of this segment she explained that the expression of anger threatened her self-identity.

It felt like a little anger while I was saying how my father affects me or has that grasp on me...and then I just start talking about that whole thing with my grandmother and I think there's a lot of anger towards her. But...I don't want to be that kind of person...I'm not really an angry person (10.PE.13).

Another participant described how the expression of painful hurt in tears threatened his identity as a man. As he put it, "You're not a man if you do it" (04.PE.14).

In summary, vulnerability was associated with an internal experience of emotional conflict, defined by a sense of self divided into two opposing parts or sides. For many, this conflict was one of a "battle" inside with respect to allowing emotion. In some cases, this internal experience of conflict also involved a sense of a threatened identity, and/or emotional confusion.

In addition to awareness of an internal sense of emotional conflict, participants described vulnerability characterized by a sense of self in a weakened state. The category "Weakened" will be described below, including illustrative examples from participant accounts.

*Weakened.* All participants recalled at least one experience of vulnerability in the context of emotional experience that included the perception of a weakened sense of self (n=13). This experience was represented by the category 'Weakened'. Participants described how they felt overwhelmed, like they were losing control, defenceless, or

hopeless in the face of the visceral experience of emotion and/or while they expressed emotion.

Some participants described how a weakened sense of self involved feeling overwhelmed by the intensity and/or expression of emotion (Overwhelming emotion, n=9). Sadness was the only emotion where all participants described the experience of feeling overtaken by feeling (Overwhelmed by sadness, n=6). There were also some recollections of feeling overwhelmed by the experience of other forms of emotional experience, such as hurt, inchoate feeling, or emotional upset.

In some cases, the feeling of being overwhelmed related solely to the quality of intensity of emotion (Overwhelmed by intense feeling, n=7). One woman viewed a segment of therapy tape where she talked about sadness over a poor relationship with her mother. She recalled “It’s very sad and it’s overwhelming. Too much for me to address” (62.CC.11). Another described her experience of “emotional upset” as “a myriad of emotions” that felt “heavy, like it’s too much on you...like another overwhelming wave” (25.CC.6).

Many participants described the sense of being taken over by a powerful force inside the body (Overtaken, n=7). One woman described her experience of being taken over by an overwhelming feeling of sadness. She recalled,

I was tearing because I was sad...I know the tears are just about to come out... like you have that overwhelming feeling and you could either just cry and cry and not stop crying...it kind of like spreads...I automatically start tearing more...the

feeling kind of takes over everything...there's tears streaming down my face"  
(10.PE.10).

Other participants described how they felt overtaken by the "growing" or increasing intensity of emotion. One woman described how "really deep" sadness rose like "a wave" from her "belly" that crested in tears and "overtakes me" (33.PE.8). Another recalled the experience of how she felt overwhelmed by inchoate feeling. She described how she felt overwhelmed by a "wave" of "unknown" emotion that was a "big...consuming thing... this feeling that was growing in me...takes over" (23.PE.18).

A few participants reported that at times they felt overwhelmed by both the powerful feeling and expression of emotion (Overwhelmed by feeling/expression, n=3). One woman viewed a segment of therapy tape where she felt intense sadness and cried while she was talking about the past. She recalled how her experience of sadness "became overwhelming" at this point in the session (54.PE.8). Another woman recalled feeling overwhelmed as she expressed extreme pain in tears and in words as she talked about feeling emotionally alone and unsupported by her family. She described how "The overwhelming pain just kind of comes up, physically comes up, physically gets up to here (pointed to her throat) and then comes out" (07.CC.9). She further explained that the therapist's empathic reflections perpetuated the overwhelming feeling that threatened her sense of wholeness: "I could just break up...she's just repeating what I feel and it's just overwhelming for me" (07.CC.9).

For other participants, the experience of a weakened sense of self was described as a feeling that they were losing control of intense emotion (Losing Control, n=4). One

woman recalled that when she felt intense sadness she felt “so vulnerable” and she had “a set feeling within” that she “did not have control of it anymore” (10.PE.13). One man explained that when he experienced intense anger he had a feeling of losing control of it and that he “wanted to break something” (78.PE.13).

The experience of vulnerability was unpalatable for another participant because it involved a weakened, degraded sense of self. She explained,

I don't like having this pain. I don't like feeling like this. I don't like being vulnerable and I don't like being in this situation. I would rather be in [Therapist's] shoes. I would rather be listening to someone and helping somebody than be the person somebody has to help. ...It's very degrading to me (07.CC.9).

For some participants, emotional vulnerability was experienced as a sense of self as defenseless in the face of either powerful emotion or a powerful other in a two-chair dialogue (Without defenses, n=3). One woman recalled feeling intense sadness and that she felt “defeated...very weak and without defenses, just for a second” (50.PE.5).

Another woman described how she felt a deep and painful feeling of sorrow and a sense of “vulnerability...at the very core,” and “pretty much like a victim ...like where is this inner strength that I need?” (27.CC.8).

One man's unique description of a weakened state involved the experience of hopelessness in the face of intense and painful feelings of hurt (No hope/Helpless, n=2). He watched a segment of therapy tape where he was crying while he recalled the experience of being physically and emotionally bullied as a child and explained, “I hurt

so much...I really got a feeling...there's no hope...That was such a strong, strong hurt. Strong and I literally felt like 'I give up' right there" (04.PE.14).

**Summary of emotionally vulnerable sense of Self.** The category *Emotionally Vulnerable Sense of Self* was conceptualized to represent the participants' subjective experience both in a historical context and during a therapy session. In recalling past experiences of emotion, some participants described how feeling and/or expressing emotion was dangerous and they learned how to stay safe by various means of avoidance or control. In some instances, the historical experience of emotion was not coloured by a sense of danger. However, participants recounted longstanding difficulty allowing or expressing emotion due to problems identifying or voicing feelings, inhibitory beliefs, or coping by avoidance of emotional experience.

In the context of the therapy session, participants described the subjective experience of awareness of feeling emotion that was "triggered" without intention. The initiation of feeling/emotion followed from specific types of therapist responses that focused on the internal experience of emotion and its expression, as well as the client's own awareness of emotionally laden imagery and memories.

Participants described a shared experience of vulnerability in the context of emotional experience that was characterized by one or more qualities including: awareness of intense, deep, painful, and/or sudden feeling in the body (Awareness of feeling in the body); the overt or covert expression of feeling by verbal or non-verbal means (Express/Show emotion); an internal sense of a divided self, or parts in conflict over allowing emotion, and/or in connection with a threatened emotional identity, and to

a lesser extent a sense of confusion (Emotional conflict inside); difficulty symbolizing and/or expressing unclear emotional experience, and a related sense of emotional confusion (Hazy emotional experience); a sense of self as overwhelmed, losing control, defenseless, or hopeless in the face of intense emotion and/or an imagined powerful other (Weakened).

The experience of vulnerability in the context of emotional experience was intolerable for participants and they felt the need to find protection against it, which they did by various means. The process whereby participants moved from a sense of self as emotionally vulnerable to one of protection against vulnerability was conceptualized as 'Provide Self-Protection'. This category will be described below with illustrative examples.

**Provide Self-Protection.** In the context of an experience of self as emotionally vulnerable, participants described an explicit or implicit need for self-protection that was met by engagement in various responses and actions. The higher order category *Provide Self-Protection* was conceptualized to represent this process. It is defined by information contained in three sub-main categories that share a common theme of a means of self-protection: 'Reactive Emotion', 'Control Emotional Vulnerability', and 'Avoid Emotional Vulnerability'.

All participants recalled how they responded to an overarching sense of vulnerability in ways that shielded or stopped them from experiencing the visceral sensations of emotion, warded off the expression of emotion, safeguarded against an

internal sense of hazy emotional experience and emotional conflict, and/or bolstered a weakened sense of self.

The categories ‘Control Emotional Vulnerability’ and ‘Avoid Emotional Vulnerability’ represent the main ways that participants protected against a vulnerable sense of self in the context of emotional experience. Participants described how they provided self-protection by controlling and/or avoidant actions. For some protective behaviours were “automatic” or not consciously intended whereas for others they were deliberately enacted. Each category will be described further in later sections.

In addition, all but two participants described how they also reacted with another emotion to an experience of self as emotionally vulnerable (Reactive Emotion, n=11). The two exceptions were participants in a client-centered session who did not react with another emotion to awareness of vulnerability associated with sorrow, emotional “upset,” or fear. The category ‘Reactive Emotion’ was conceptualized to represent the subjective experience of reacting with another emotion to awareness of vulnerability in the context of an emotional experience. Reactive emotion served to elevate the need to provide self-protection and in some cases also satisfied that need.

The quality of reaction to awareness of emotion with emotion is illustrated by one participant who recalled how she felt a “nervous reaction” of fear/anxiety to awareness of the great “weight” of sadness in her stomach (10.PE.10). While fear was by far the most frequently reported reactive emotion, some participants also recalled reactive shame, guilt, anger, and/or sadness.

There were differences in the types of reactive emotion reported by participants in a client-centered therapy (CC) session as opposed to an emotion-focused therapy (EFT) session. Three of the five participants in a CC therapy described how they reacted to emotion with another emotion. Two described reactive fear only, and a third recalled reactive fear at one point and reactive shame at another point. In contrast, all eight participants in an EFT session reported reactive emotion of one kind or another, including fear, shame, guilt, anger, or sadness. Some described a single reactive emotion, whereas others reported multiple reactive emotions. For example, one participant reported how she reacted with fear to an initial experience of sadness (33.PE.8). Another described reacting to anger with guilt and sadness (10.PE.10). A third participant recalled how sadness was followed by a reaction of fear and shame (50.PE.5).

Overall, single reactive emotions were most common in both CC (n=3) and EFT therapy sessions (n=5). In addition, fear was the most common type of reactive emotion across CC and EFT therapies (n=10).

The subjective experience of all reactive emotions will be described further below.

***Patterns of Self-protection from dangerous emotions.*** From analysis of information contained in the main category ‘Provide Self-Protection’, two patterns were conceptualized that represented the client’s experience of both needing and providing self- protection when they felt emotionally vulnerable in a therapy session.

The most common pattern included the experience of vulnerability related to awareness and/or expression of sadness, anger, hurt, inchoate emotion, or emotional pain,

followed by reactive emotion and actions taken to control and/or avoid vulnerability (Pattern 1: Awareness of Emotionally Vulnerable Sense of Self-Reactive Emotion-Control/Avoid Vulnerability, n=11). A less frequent pattern did not include reactive emotion (Pattern II: Awareness of Emotionally Vulnerable Sense of Self-Control/Avoid Vulnerability, n=5). Rather, participants described awareness of vulnerability followed by actions to control and/or avoid emotional experience. This pattern includes single cases of sorrow, fear, and emotional upset for two CC clients, as well as two cases of fear and one of inchoate emotion for three EFT clients.

These three EFT clients were members in both pattern classes, as they reported differences in how they provided self-protection across different types of emotion. For example, one woman described how she felt a “total feeling of fear” that was evoked by images of her physically abusive mother and then she would “look for escapes” to avoid it (Pattern 2-Fear). At a later point in the session she recalled feeling intense, painful, and overwhelming sadness related to the belief that she would “never be good enough.” She described how she reacted to this experience with fear (Pattern 1-Sadness). She explained that in this state of vulnerability and reactive fear “I need something to protect myself.” She satisfied this need by distracting herself and concentrating on the sound of a Kleenex box being opened in the room (50.PE.5). Each pattern of protection will be described further below with illustrative examples.

***Pattern 1: Awareness of emotionally vulnerable sense of Self-Reactive emotion-Control/Avoid vulnerability.*** Participants descriptions conformed most frequently to a pattern where they: felt vulnerable while experiencing or expressing emotion, reacted to a

sense of emotional vulnerability with another emotion, and then acted in a manner that controlled or avoided the experience of emotional vulnerability (Pattern 1, n=11). For example, one woman recalled awareness of intense and overwhelming feelings of sadness that were followed by fear of losing control over them and losing her mind, and then she swallowed the sad feeling to control it and alleviate the experience of emotional vulnerability.

Acts of protection included behaviours of control and avoidance that occurred in equal numbers across participants. All of the participants in an emotion focused therapy and three of the five participants in a client centered therapy were included in this pattern.

There was variability both with respect to the type of initial emotion that was associated with a sense of vulnerability and the type of reactive emotion that followed it. Participants described awareness of initial emotional experience that included one or more of following types of emotion: sadness, anger, hurt, emotional pain, and/or inchoate emotion. As well, they described a variety of corresponding reactive emotions such as fear, shame, guilt, sadness, or anger. Many participants recalled fear of sadness, anger, hurt, inchoate emotion, or emotional pain. Some reported shame about admitting or expressing anger, sadness, or hurt. A few described guilt about expressing angry feelings and related needs and/or sadness in reaction to the feeling of anger. Others gave accounts of being angry about sadness.

Overall, fear was the most frequently reported reactive emotion (n=10) followed in order of frequency by shame (6), anger (4), sadness (2) and guilt (2). Each of these types of reactive emotion will be described in separate sections below, including

illustrative examples for a variety of emotions to demonstrate that the concept of reactive emotion is grounded in participant descriptions of subjective experience.

*Fear/Afraid of emotion.* The category ‘Fear/Afraid of Emotion’ represents many participants experience of self as vulnerable in the context of an emotional experience, followed by a reaction of fear (n=10). They described reactive fear in response to all types of recalled emotion with one exception, there were no descriptions of fear of fear.

Participants reported that fear followed awareness of a specific emotion or emotional experience, such as anger, sadness, hurt, emotional pain, or inchoate emotion. Some participants reported fear in connection with only one type of emotion, e.g., anger. Others reported fear of more than one type of emotion, e.g., anger and inchoate emotion.

The perception of an emotion or emotional state as dangerous or threatening occurred in the context of an experience of vulnerability as defined previously in the category ‘Felt Very Vulnerable’. For example, one participants’ experience of vulnerability was defined by: awareness of the visceral experience of hurt, such as deep and intensely painful feeling, the expression of hurt in tears and metaphor, emotional conflict in the form of opposing urges and confusion about why she felt the way she did, and a related sense of self in a weakened state by virtue of her overall experience of a “totally overwhelming feeling.” She described reactive fear that should she continue to express how she was feeling in this vulnerable state she could lose control and “just break up” (07.CC.9).

All participants recalled an experience of vulnerability that evoked a reaction of fear that was associated with the subjective experience of emotion in the body, especially

the perception of a physical sense of intensity. There was variability across participants and emotions in terms of the specific aspects of vulnerability alone or in combination that evoked or preceded fear. Whereas all experienced awareness of intensity of feeling, there were individual differences in terms of patterns of the other visceral qualities of painful, deep, and sudden onset of feeling.

In addition to the visceral experience of emotion, participants gave idiosyncratic descriptions of how all or some of the other aspects of vulnerability, such as the expression of emotion, emotional conflict inside, hazy emotional experience, and a sense of self in a weakened state were also associated with reactive fear. The following excerpt is illustrative of fear of allowing and expressing emotional pain that involved all five aspects of emotional vulnerability.

I was overwhelmed with emotion then...It was a very deep sense of pain and grief and I remember stopping and crying...you can see that crying sort of burst out and I didn't expect it...it was so explosive...I couldn't remember what I was crying about... One part of me would like to have let go but the other part of me said 'No this is not safe. I might break...when I explode all at once I have this sinking feeling and the tears come up unexpectedly and for that split second I have this feeling like I'm dying or just drowning or sinking...If I let go of the way I feel it will never stop and I'll lose it. I don't know what I'm afraid of. I just think it will be disastrous (23.CC.18).

In contrast, some participants' experience of reactive fear involved fewer qualities of vulnerability. One man recalled how he was aware of "battling" inside about allowing

and expressing anger, which in turn brought on a sense of confusion. He explained that the prospect of acknowledging anger brought on "...more of a fear thing...I wanted to say 'Oh yeah, the fear thing' and get away" (05.CC.13).

Sadness was the only emotion where those individuals who recalled reactive fear could be differentiated from those who did not recall it by the presence or absence of emotional clarity (Hazy emotional experience). While all six participants recalled how they felt overwhelmed by the visceral qualities of sadness, such as a deep, intense feeling in the body, the three who recalled reactive fear also described a lack of emotional clarity in the form of un-symbolized emotional intensity. A fourth participant in the fear of sadness group was unusual in that she was able to ascribe meaning to her sadness. She explained that her sadness and "the tears" flowed in connection with the "realization I'm never going to be good enough and...I'm defeated" (50.PE.5). During the IPR interview she described how she was beaten in childhood when she showed emotion. Her fear of sadness makes sense in the context of a history of learned associations between the expression of emotion and physical abuse. This example may be considered a stand-alone case of reactive fear of sadness that is a conditioned response.

In contrast to the examples of reactive fear described above, fear was not recalled by two participants who reported that the meaning of sadness was clear. They described how they reacted to sadness with shame and/or anger, which will be discussed further in a later section.

*Four kinds of reactive fear.* Participants' recollections of reactive emotion contained explicit references to fear or descriptions commensurate with the experience of fear. The subjective experience of reactive fear varied across participants.

Some participants described how fear involved either a visceral sense or "underlying feeling" only (n=4). They recalled awareness of fear that was palpable and characterized by various physical sensations. One woman described a nervous reaction to a "really sad" feeling in her body. She recalled feeling "really anxious" in her stomach and that she had a "big lump" in her throat (10.PE.10). One man recalled that when he felt anger "coming on" he felt "threatened, a lot of apprehension and a lot of anxiety" in his "solar plexus" (78.PE.13). A third participant described awareness of reactive fear when she focused on inchoate emotional experience. She reported "It feels frightening...I feel that kind of fear or threat" (23.CC.18).

For others, reactive fear involved beliefs and thoughts only (n=4) or a combination of feeling and cognition involving thoughts or beliefs about the catastrophic consequences of allowing emotion to flow unabated (n=3).

Descriptions of the feelings and/or cognitions involved in reactive fear were analyzed and four subtypes of 'Fear of Emotion' were conceptualized. They are listed here in descending order of frequency: fear of losing control, fear expression of emotion, fear of the unknown, and fear of dying. Fear of expressing emotion was unique in that it represented the experience of participants in an EFT therapy session only.

Some participants described only one type of fear whereas others described more than one type. For example, one man recalled an initial reaction of fear of losing control

that followed awareness of the feeling of intense, deep and painful anger. At a later point, he was afraid to express anger by raising his voice because of its unpredictable, unknown course.

Participants described fear of losing control following a sense of self as vulnerable in the context of emotional experience (fear losing control, n=7). They recalled the visceral qualities of extremely intense, deep, and/or painful feeling and then a sense or feeling of fear that in some cases also included catastrophic beliefs. Participants described specific fears that included: losing their sanity, losing control of an explosive force or strong impulse, or ending up trapped in a “black hole.”

In some cases, participants described fear of losing their mind in the face of deep, intense emotion (fear loss of sanity, n= 3). One woman described awareness of deep, intense anger in her “belly” followed by a fear that it would be unleashed in an explosion at the expense of her sanity. She recalled,

It’s “so deep, so like a monster. It’s scary...I felt it several times. What’s the use of going on with this and then the fear that ‘Oh my god it’s gonna explode right here in this room and they’re going to have to take me away in a white jacket’ ” (33.PE.8).

Another participant described how she felt fear of allowing “so much” painful sadness and crying. She held the related belief that if she did so she would lose control of her faculties and end up in a senseless state. She explained,

I'm scared to let it come...I'm really scared to do that...I felt scared right there... my biggest fear is that if I let all my emotion I'll become catatonic. I won't be able to face all that is in there. It'll be just too overwhelming for me (50.PE.5).

One man's description of vulnerability was unique and poignant as he recalled how he felt helpless in the face of a "strong, strong feeling" of hurt to the point where he felt hopeless and lost his will to live. He recalled the fear that he would lose control and commit suicide in this weakened state (Fear losing control of strong impulse, n=1).

I hurt so much right there I didn't want to continue anymore. Not the conversation but I didn't want to live anymore. I really got a feeling, and I haven't been like that for a little while. Not that drastic. There's no hope. That's what I was telling (therapist) because I was scared that I wanted to commit suicide right at that moment (04.PE.11).

He disclosed his suicidal feeling to the therapist and it passed as he expressed his awareness of the distress this act would cause his family.

Two participants described the fear of losing control of an explosive, dangerous force (Fear unleashing explosive force, n=2). They recalled a feeling of fear in reaction to changes felt in the body associated with anger. One man (78.PE.6) recalled, "When I feel the anger coming on I feel threatened. I feel a lot of apprehension and a lot of anxiety." Initially, his fear was in response to the "thrust" or surging quality of explosive, extremely painful anger. He described how he was afraid to allow this unpredictable burst of feeling that was rooted in a series of negative experiences in the past where allowing anger involved physical violence and/or vulnerability. He noted that difficulty allowing

anger was “the big nut to crack,” with the caveat “if I can get into that somehow safely, where I’m not going to hurt somebody and I’m not going to hurt myself.”

Fear of losing control was especially strong for one man. He described an “underlying fear” that should he allow or express intense, at times inchoate emotional experience he could become trapped in a kind of hell he called “the black hole” (02.PE.8). He viewed a segment of therapy tape involving a two-chair dialogue with his mother where he expressed sadness and a related need for acceptance. On the tape he acknowledged vulnerability and the fear that she would hurt and attack him if he told her how he felt. During the IPR of this segment, he reported that he “was feeling very emotional at that moment” as he now struggled to express surfacing inchoate feeling. (02.PE.8). As he viewed a section of the therapy tape where his therapist coached him to express hurt in a two chair dialogue with his mother, he recalled how it was an effort to “get back” into “the whirlpool” of intense feelings. While he expressed hurt and a related need for his mother to understand and apologize, he recalled “an underlying fear the whole time” of losing control and ending up in the grip of “despair.” He described the “black hole” of despair as, “a feeling of your worst nightmare. And a tremendous amount of fear you can’t control the situation and you just want to get the hell out of there but the despair or something is holding you there.”

For other participants, fear was a reaction to the unknown qualities, meaning and/or course of intense and overwhelming emotional experience (fear of the unknown, n=3). Fear of sadness or inchoate emotion was described in reaction to awareness of

deep, intense, incoherent, and overwhelming feelings. One man recalled how he reacted with fear to an incoherent “big wave” of intensity.

It’s an unknown thing that I’m having a hard time dealing with. What is it? Can’t define it...and for me it’s sort of a scary thing because I want to know what it is. This fear, it makes me, yeah it scares me. I don’t know what ‘it’ is, so how can I deal with it? ‘It’ is unknown...how can I deal with it if I don’t know what it is yet it keeps coming up in my face (05.CC.13).

In some cases, reactive fear was precipitated by the therapist’s empathic reflection of emotion or inquiry into feeling. One participant described how she felt fear in reaction to her therapist’s close attention and inquiry into what she was feeling, at a point where she was emotionally “upset” and overwhelmed by unclear feeling. She explained,

I’m not used to knowing what I’m feeling, especially the negative things and that’s very frightening to me. If I were feeling sad and somebody asked me that, that wouldn’t bother me to say I’m feeling sad. But she was getting close to something uncomfortable...When she said ‘How are you feeling right now?’ I didn’t know...there’s this other feeling that takes over that at first I was labelling ‘upset’...I don’t know what it is ...I was just totally overwhelmed. Whenever she asks me ‘How are you feeling right now, at this moment?’ that’s very frightening, threatening...it feels frightening (23.PE.18).

She further described how a growing awareness of difficulty identifying frightening feelings was “very distressing.”

It's very distressing to me as I'm working with [therapist] and I'm starting to realize that there are a lot of feelings I can't name, separate. And I want to because if I'm feeling grief or sadness or happiness or something and I can identify those to myself then they don't frighten me. I can feel full of grief and I'm still okay (23.PE.18).

In one case, fear of anger involved a reaction to emotional conflict inside that was characterized by a sense of confusion and difficulty expressing acknowledgement of anger. This man's subjective experience of reactive fear is described in the excerpt below, as he viewed a segment of the therapy tape where he acknowledged the therapist's reflection "So a sense of feeling angry too then."

C: It's hard for me to say "Yeah I do get angry...for me to acknowledge that I am angry about where I am at... [is] very hard.

I: So when you are talking [on therapy tape] about anger, what are you experiencing emotionally?

C: It was more of a fear thing than anything else. I had some reluctance to talk about it (anger)...I just wanted to say 'Oh yeah, the fear thing.' I just remember feeling very strange...more a confused kind of state...it [anger] was obviously there and I just barely acknowledged it. So [two sides] battling themselves, sort of confusing (05.CC.13).

He further described how fear was defined by a number of uncertainties including confusion about the meaning of his emotional identity.

It goes back to acknowledging that I am angry and the fear of 'Okay, I just

acknowledged that and I've also said I'm not an angry person. So what does that really mean? Where is the anger? Where is it now? Where does it come from? Am I capable of wherever that could take me and where is that?' So that's sort of like the fear...to it (05.CC.13).

Some participants in an emotion focused therapy session described how fear followed the therapist's direction to express emotion because they felt very vulnerable (Fear expression of emotion, n=4). One woman described fear of expressing how much she felt hurt and betrayed by the actions of her father in the distant past. She explained that while she was telling the therapist about her father's betrayal she was "feeling this very painfully," it was "raw emotion," and "the story and emotion are in sync" (54.PE.8). She reported fear of expressing her feelings to her father in this vulnerable state that included a belief that she would be defenceless in the face of his usual attack. She recalled, "I'm quite nervous here. Yes, very nervous...because I have to confront my father...as soon as the therapist says 'Well I think you need to tell him' I'm right on edge" (54.PE.8). This example illustrates how a client reacts with fear when they are coached to express emotion to a powerful other when they are already in an emotionally vulnerable state.

One man, with a history of bad experiences of feeling and expressing emotion, reported that when he followed the therapist's direction to express anger by saying "I hate you" in a two chair dialogue he was concerned because "yelling...just gets me off track somehow" (78.PE.6). He also recalled how he reacted with fear when his therapist coached him to express anger that he experienced as an extreme, painful, and incoherent

feeling in his abdomen. He explained, “I really didn’t feel like yelling it...I was afraid of something happening...I was afraid to let it [anger] go right over the top...not knowing what it would do or what it was like...the unpredictability of it.”

For some participants, existential fear was central (fear of dying, n=3). There were no descriptions of specific fearful cognition. Rather, participants recalled a wordless, visceral sense that should emotional experience be allowed or expressed they could die. Fear was rooted in a profound sense of aloneness or abandonment as they grappled with seemingly life-threatening emotional experience.

Two participants described awareness of an intense, painful, and overwhelming feeling of emotion and a familiar deep sense of aloneness in dealing with it. One woman viewed a segment of the therapy tape where she told the therapist “I’m frightened,” and recalled that she was experiencing a feeling of “preverbal fear” in response to awareness of a wordless “wave” of “really deep...really sad feeling” (33.PE.8). She explained, “There was a kind of churning in my belly. I guess my heart was racing” and she had a sense that she could die. She likened her experience to the fear she has felt when she senses that she is going to have a seizure, a symptom of her potentially life threatening seizure disorder, and no one is going to help her manage it.

Another participant described reactive fear as a strong sense that allowing an unsafe painful, overwhelming feeling of aloneness, and expressing it in tears, was “dangerous.” She likened the experience to an old familiar “feeling of dying.”

I was overwhelmed with emotion then. I’m trying to explain that. I remember the feeling and the feeling was like that I remember so well as a young child in the

crib calling for my mother. That feeling of just dying because you were totally alone and abandoned and there was nobody there (23.CC.18).

Moreover, she recalled how the therapist's encouragement that it was safe to allow painful feeling was at cross purposes with her feeling like she could die from the pain.

She kept saying 'Let it go. It's ok. Let it go.' My feeling at that time was if I let this feeling go and I really cry I will break...Like I might die because I won't be able to stand it, the pain. So that's what I was feeling (23.CC.18).

She was careful to note that that fear of allowing and expressing emotional pain did not involve cognition and she explained, "The feeling is, it's not going through my head but the feeling is I will die of the pain...That's the feeling, that this is dangerous."

In summary, the category 'Fear/Afraid of Emotion' represents participants' descriptions of how an experience of vulnerability in the context of emotional awareness was followed by feelings and/or cognitions that served to hold them in the grip of fear and alert them that danger was at hand. Across participants, there was variability in the number and kind of qualities that defined vulnerable experience that was followed by a reaction of fear. Four subtypes of reactive fear were conceptualized according to variability in participants' recall of subjective experience: fear of losing control; fear of the unknown; fear of expression of emotion, and fear of dying.

In tandem with reactive fear, participants recalled how they both needed and provided self-protection. They did so by engaging in a variety of behaviours in an effort to control or contain, avoid or escape the experience of emotion and thereby the sense of

vulnerability and danger. The inter-relationship of reactive fear and control and/or avoidance of emotional experience will be described further below.

*Reactive fear*  *Control/Avoid emotional vulnerability*. The categories ‘Control Emotional Vulnerability’ and ‘Avoid Emotional Vulnerability’ represent participants’ descriptions of self-protective behavior in the face of fear of an initial emotion that parallels the fight or flight responses to fear. When participants acted to control vulnerability, intentions and behaviours involved movement toward and control over the aspects of emotion that evoked fear. When they acted to avoid vulnerability, urges and actions were characterized by escape or an internal sense of movement away from the feared experience of emotion. These behaviours were consciously intended in some instances and “automatic” or out of awareness in others. Moreover, there was variability within and across participants in terms of both the number and kind of protective behaviours they engaged in.

The categories emotionally ‘Control Emotional Vulnerability’ and ‘Avoid Emotional Vulnerability’, as they relate to reactive fear, will be described further below with illustrative examples.

*Control emotional vulnerability*. Participants sought protection by acting to regulate the sense of emotional vulnerability that evoked reactive fear. They did so by containing or controlling the visceral experience and/or expression of emotion, hazy emotional experience, emotional conflict inside, and/or sense of self in a weakened state (Control Emotional Vulnerability, n=13). Protective behaviours were audible, visible, or private. In some cases, control was a singular act, whereas in others it was recurrent.

Efforts to control vulnerability, associated with the experience of sadness, hurt, inchoate emotion, anger, or emotional pain, were intentional in some cases and unintentional or “automatic” in others. Some participants recalled how they consciously intended to control emotional experience that evoked reactive fear (intention/got to stop, n=5). One woman recalled an intention to control a sense of life-threatening pain; “I remember the feeling of it coming and I didn’t want it too...I wanted to keep it controlled” (23.CC.18). She made a point of clarifying that while she needed and intentionally acted to protect against the experience of vulnerability by stopping herself from crying, she did not always have specific thoughts running through her mind. Rather, she described a wordless “inner message” that she could not allow herself to cry.

I really wanted to sob and I couldn’t let myself...I’m not thinking ‘I’ve got to stop this’ but that’s what my purpose was. I’ve got to stop this and control it...I wasn’t consciously saying ‘I must stop crying’ but that was my whole inner message, like inner knowledge that I could not cry and I did stop it (23.CC.18).

For another participant, the explicit need for control was also linked to the overarching importance of a sense of emotional coherence in the therapy relationship. She explained how she did not want to lose control of the “totally overwhelming feeling” of hurt and end up “going over the deep end,” which she feared, as she “need[ed] the affirmation” of her therapist.

When I’m talking to [therapist] and I’m saying these words it makes me feel very good that I’m being focused...It’s important to me and my self-esteem because I question what I say and I’m always questioning my feelings because I don’t think

they're valid...I'm listening very carefully to what [Therapist] is saying because I need the affirmation...for someone to understand that what I'm saying makes sense (07.CC.9).

However, the therapist's validation was a mixed blessing as it both affirmed the sense of what she was saying and left her feeling emotionally vulnerable. She explained how she intentionally acted to physically "contain" what she was feeling in her body by doubling over (physical control: posture, n=2).

C: (Points to therapy tape) See I'm holding my, my

I: Oh yes. Holding your arms across your gut.

C: That's right.

I: And you sigh. So what's happening there?

C: Well, I'm holding it back...like double over...that's so intense pain, I'm in a black hole. People won't see it. I don't understand. I'm confused, I'm in pain and I'm talking.

I: As you reach for the Kleenex.

C: I'm really trying to contain so that I can keep talking. I contain it and then I can go on and it's alright. I don't have that overwhelming feeling for a couple of minutes...then I'm containing it again because she's [therapist] hit a very vulnerable spot (07.CC.9).

Most frequently, participants described how they held in or contained the physical feeling and/or expression of emotion by tensing muscles, choking, swallowing, or breath control

(Physical control: n=9). One man recalled muscular control over a frightening feeling of intense, painful, and explosive anger.

It's sort of like every muscle is tensed to keep the opposite one from moving. It's like...a paralysis of exertion somehow. No mental images at all that I can remember...It's just every muscle is competing against every opposite muscle and I feel that through most of my body...mostly in my arms and in my legs and also in my stomach (78.PE.13).

In some instances, participants described how feared emotional experience was throttled by swallowing or choking the feeling rising in their bodies. One woman described how she wanted the intense wave of rising sadness that overwhelmed her to “go away” and she tried to “push down” the feeling by swallowing and she felt “choked” and “cut off.” She recalled,

When I was talking I had this huge feeling in my throat...it stopped me from talking...Something's stopping me from saying something. Like a block, it's like a lump. Physically I felt like something was stopping me, cutting me off (10.PE.9).

Another woman described how she was “gulping down” a painful feeling of hurt and tears and “tightening” her stomach muscles in an effort to contain it (07.CC.9). One participant described how she felt overwhelmed by intense, painful sadness and reactive fear to the point that she felt the sense “like my head was gonna explode. Everything was gonna explode me apart. It was really trying to get out hard and I really held it in” (50.PE.5). She described how she felt choking tightness in her throat, “I could feel it just

like a constriction. Like a vice grip here [points to her throat]. And I'm sweating like hell. I'm really sweating. And I'm aware of my breath not being there." Constriction occurred unintentionally for another woman who recalled "a choking feeling" that left her "cut off" from intense and painful feelings of sadness that were overwhelming. She recalled, "It's very much a choking feeling for me like you can't breathe. Like you're being choked...It's very much in my throat. It's resisting it...stopping how sad it is" (54.PE.8).

Some participants described how they controlled emotional experience and a related sense of threat by consciously or automatically controlling their breath. They did so by sighing or holding their breath. One woman described how she "exhaled" to stop the threatening feeling of pain. While watching a segment of the therapy tape where she exhaled loudly she commented, "Right there, especially there. Blowing it away to stop this feeling" (23.CC.18). She explained that "blowing it away" was not entirely in her awareness; "I was just out to lunch right there." In contrast, at another point when she started to cry she consciously took a breath. She explained, "I took a bit of a breath there (on the therapy tape), if you noticed, I sort of (inhales) because...I wanted to keep it controlled."

Sighing also controlled threatening emotional experience. One man described how he automatically sighed to control emotional vulnerability and fear of expressing hurt while engaged in a two chair dialogue with his mother.

I was feeling it and then the sigh is a cut off...I only allow it to come to the surface to a certain level a few seconds ... I'm not consciously aware that I'm

sighing...It's not containing, it's controlling. Usually the feeling is allowed to dissipate with the sigh and it slips away (02.PE.8).

Another participant commented at a point on the therapy tape where she sighed. She explained that she was "holding the emotion in check" by holding her breath, and she sighed because she "hadn't taken in air for a long time...It's like being underwater, you've gotta come up for air sometime" (50.PE.5).

Overall, participants described how by engaging in voluntary and/or involuntary protective behaviours of muscular tension, choking, swallowing, or breath control the body served as a vise or container of feared emotional experience.

In contrast to physical control, some participants described various cognitions that served to control the feeling and/or expression of intense and painful emotion, in the form of beliefs, imagery, or intellectualization of experience (Cognitive control n=11). They described how cognitive control included beliefs that were active in the session, such as it is "weak" or "unproductive" to allow or express emotion or they could not tolerate it and "had to control it."

In one case, the participants' expressed the belief that it was "just not productive to let it out while I'm in this session." She explained that "She [the therapist] is there to listen to what I have to say" and expressing emotion would get in the way of being heard (07.CC.9). Another woman explained, "You can see the crying sort of burst out and I didn't expect it and I didn't want it and I thought I couldn't stand it and I had to control it" (23.PE.18). One man described more generally how he controlled the feeling of intense, painful, and frightening anger by intellectualizing it. At one point he explained

that he “put a lid on” his anger, the “lid” being the machinations of his thoughts. He explained, “as soon as my brain takes over, mind takes over, I’m not aware of it being there at all...I intellectualize things so by the time this stuff gets out it’s nothing like what it was when it started” (78.PE.6). The metaphor of mind as a “lid” on emotion was also invoked when he described the process whereby his therapist directed him to express anger loudly. He explained that his “mind” kept his anger “down” so he would not lose control of it, which he feared. He recalled that whenever the therapist directed him to express anger, “my mind focuses on keeping that down, keeping it from getting out of hand, and it takes away from this somehow.”

Two participants described awareness of a voice of protection that functioned as a guardian against threatening emotional experience. One participant viewed a segment of the therapy tape where she expressed sadness in a two chair dialogue and then admonished herself sternly, “You can’t ever show those feelings. It is really bad to show those feelings.” During the IPR of this segment she recalled, “I was thinking to myself at that point ‘Wow. Oh I’m blocking. I’m really blocking big time’ ” (50.PE.5). Furthermore, she had a significant insight, which she did not disclose to the therapist, that this voice was not malevolent but rather her “protector.” She explained, “What I’m saying to you now is what I was feeling then and what I’m saying to you is that I’m, I became aware of being a nurturer, nurturing this small child. This is the protector.”

In addition to the voice of “the protector,” she recalled protective imagery and sensations. She explained, “My mind was taking over and I go into double protection mode...There’s a part of me that builds walls with bricks, I can feel those bricks going

up...this part of me is trying to protect me.” She further described imagery of “bricks going up” around her,

As I’m sitting there I’m feeling that emotion and in my peripheral vision, I can see them going up all over the place. They are being thrown up and I’m not stopping them. I can watch them happening and I’m allowing it to happen (50.PE.5).

As well as protective imagery, she also described a variety of other sensations associated with the imagery of bricks enveloping her. She recalled,

I felt them over my eyes, like my eyes were going to explode. I remember that. And there’s a sound I hear too. It’s like the subway going through a tunnel and I can hear it as my bricks are going up. I can hear the sound (50.PE.5).

Some participants described how they intentionally stopped talking and silence served to control the feeling or expression of feared emotion (Silence n=4). One man described how he felt a wave of intense sadness and then he paused and fell silent in an effort to stop the feeling and expression of it. While watching the segment of the therapy session where he sighed, he recalled, “I was just afraid to say ‘Well yeah it is sad’ and I caught myself doing that. And then there’s that sort of weird pause there... I was sort of trying to stop myself from feeling sad. It’s a strange emotion” (05.CC.13).

Smiling or joking was another way to control emotional experience (Laugh/Smile, n=2). One woman recalled how she was afraid that she was going to lose control and vomit at one point during an empty chair dialogue when “a vision” of her mother “popped in” and she felt an intense emotional reaction. She explained,

I'm not really willing to release [the feeling of emotion] because I'm afraid I'll embarrass myself. But I felt it come up. Did you see I made a joke and I laughed? That was to push it down...I feel it coming this way [points upward in body] and then I start to joke to bring it back down again (50.PE.5).

Some participants engaged in a variety of protective behaviours to control the sense of vulnerability, as exemplified in the following account. One woman described how she felt emotionally vulnerable and afraid that she could lose control over intense and painful feelings of hurt. She described fear that she would “break up” and become a “bumbling idiot” if she allowed herself to cry. She recalled a conscious intention to control the expression of tears; “I was holding myself back” from “sobbing” to “suppress,” “contain it.” She described how during a period of silence she was “gulping down whatever was coming up until I can't do it anymore, then the tears come.” She explained that when she sighed on the therapy tape, which she was unaware of in the session, and hunched over with her arms held across her stomach, which she was aware of, “I'm holding it back...hunched over to make sure it doesn't come up.” In addition, she described at a later point how she was “containing it again because she's [therapist] hit a very vulnerable spot... this tightening comes...a tightening of the muscles in your stomach...just trying to contain it.” She also reported that she holds the belief that expressing painful emotion by crying “is not beneficial, not productive for what we're doing,” though she clarified that she was not consciously thinking this way in the session.

In summary, as participants recalled emotional experience they described a related sense of self as vulnerable and a reaction of fear. Following this experience of

reactive fear, they engaged in a variety of intentional or unintentional, overt or covert, protective acts that served to control the experience of emotion and thereby regulated the sense of vulnerability. These protective actions were physical, cognitive, or expressive in nature.

In addition to descriptions of controlling feared emotional experience, participants also recalled how they engaged in behaviour that served to avoid the experience of vulnerability that evoked reactive fear. The category 'Avoid Emotional Vulnerability' will be described below with exemplars from participants' accounts.

*Avoid emotional vulnerability.* Participants recalled how they protected themselves by various acts of avoidance when they felt threatened by the inner experience or expression of emotion (n=11). The subjective experience of avoidance was described as awareness of an internal sense of backing away, moving away, "side stepping," or the urge to get away from feared emotional experience.

Overall, participants described how they intentionally or automatically avoided feared emotional experience and a related sense of vulnerability by engaging in one or more actions, such as: distancing, distracting, joking/laughing, worrying, and/or by having an urge to escape from inner emotional experience or the therapy room. The avoidance of emotional vulnerability will be described further below, with illustrative examples from participants' accounts.

Some participants recalled how they intentionally sought to avoid the subjective experience of vulnerability associated with awareness of an emotional experience of sadness, hurt, anger, or inchoate emotion (Intention: Get away, n=6). Two men described

how they wanted to “side step” feared anger. One man, in an EFT session, explained it was like he was “the matador side stepping the thrust” of intense anger. He recalled,

When I feel anger coming on I feel threatened. I feel a lot of apprehension and a lot of anxiety...It’s like a bullfight. I’m the matador sidestepping the thrust. I move out of the way. I disappear. I do something that permits me not to have to deal with it (78.PE.6).

The other man, in a CC session, recalled his intention to avoid acknowledging and expressing unknown anger, which he feared. He said,

I had some reluctance to talk about it, to acknowledge it. I didn’t want to. I just wanted to say ‘Oh yeah the fear thing’ and get away...I really felt like avoiding it [anger]. I really wanted to sort of side step it...in my mind (05.CC.13).

One woman described her reluctance to heed the therapist’s suggestion that she express intensely painful feelings of hurt to a parent in an empty chair exercise. She recalled how she felt “very nervous and vulnerable.” She explained, “I’m too vulnerable...and I’m on edge...I’m getting nervous here and I’m trying to back my way out of the situation” (54.PE.8).

Some participants described how they avoided the feeling of deep, intense, and/or painful feeling by distracting attention away from bodily sensations and thereby, away from a related sense of vulnerability that evoked fear (Distract/Divert, n=4). One man explained that when he started to feel intense and painful feelings of explosive anger in the session, “I divert my attention elsewhere...It’s almost like it wants to move the focus away from here [points to torso] to here” [points to head] (78.PE.13). For others,

distraction involved a shift in attention away from awareness of emotional experience to something external, such as an object or sound in the room, or fiddling with clothing. One participant recalled fear of sadness and explained “I need something to protect myself so I use something in the room to concentrate on to get away from, to go outward instead of inward.” She described how distraction afforded protection from the intense, painful and overwhelming feeling of sadness.

I use cues, something in the room or something tangible to distract me. And when she [therapist] broke open the Kleenex box I heard it and I was able to get rid of the feeling quickly by concentrating on that. It just totally distracted me...the sound of the Kleenex box being broken open. And that was the end of the emotion...it was gone (50.PE.5).

Worrying also functioned as a means of avoiding uncomfortable emotional experience (Worry, n=2). One man explained how the more he worried the more he “got away” from powerful feelings of anger.

I start to worry about who was outside the door. I was worried about, I mean here I am in some building which I don't know and I'm expected to let all of this stuff out. I don't feel comfortable doing that so I started worrying about that. And the more I did that, the further I got away from this [points to torso] (78.PE.13).

There were also some descriptions of intentional avoidance that involved urges to leave the therapy session (Urge to leave, n=3). As one man recalled, “I really wanted to get out of there, get out of the room to avoid feelings of intense and frightening anger” (78.PE.13).

In some cases, avoidance took the form of distancing from the perception of an emotional experience that evoked reactive fear (Safe distance, n=6). Participant descriptions conveyed a sense of self as safely detached from the intense and overwhelming feeling of emotion. In contrast to distraction, there was more of a sense of depersonalization, even dissociation, present in descriptions of 'safe distance.' One man described how he kept himself safe by distancing from the "overwhelming sense" of sad feeling that kept "hitting" and "washes over" him (05.CC.13). He described this experience as a "sort of strange thing where I can kind of watch myself...it seems a little fail-safe thing kick in where I'm just watching myself...it's sort of removing myself." He further described how there was an element of aggression toward his sadness that served to keep it at bay. He explained,

I just start to feel sad and then there's something that kicks it...it sort of kicks it away...it does creep in a bit. I sort of throw it out there and instead of me saying 'That's very sad' (05.CC.13).

Another emotionally vulnerable man explained how he avoided hurt by trying "to go off track, not be in this scenario." He described how he encouraged himself to let go and move away from the frightening feeling of hurt in his body.

When I tell myself to 'Let it go' it's tight here [points to his chest] but I don't get into the other body anymore...I just sort of see the whole scenario at a distance...I'm up there looking down on the situation...up in that corner looking down on instead of in that body feeling (04.PE.14).

He also described how avoidance involved becoming “numb” to feeling (Shut down/Numb, n=2).

A few participants described “masking” emotion by laughing, smiling, or joking (Masking: laugh, smile, n=3). For example, one woman recalled a “nervous reaction” to the feeling of intense and unknown sadness in her body and outwardly she smiled to mask its expression (10/#10.PE.MU5). Another man described how he deflected anger by joking. He explained,

That’s the big thing that I do...when things start to get a little close I tend to make a joke out of it and do a lot of laughing...deflecting. Just part of my reluctance to get myself into whatever headspace is going on, some emotion or feeling (05.CC.13).

Less frequently, avoidance of feared emotional experience occurred out of awareness (Automatic, n=3). One woman recalled that while she consciously intended not to feel intense, painful, and overwhelming sadness and a related sense of self in a weakened state, her use of distraction as a means of avoidance was “all subconscious.” She explained that distraction included getting the therapist “off track” by derailing the conversation. As she watched the therapy tape she commented,

See look what I’m doing there. My eyes hit the ceiling. Do you see that? Right after I hit [the clock] I diverted it. It was relief that I diverted the conversation away from where she was going because I didn’t want to feel anymore. She [Therapist] was trying to bring me back and I wasn’t prepared to do that. I was

finished now and she wasn't so I had to get her off track. But I didn't do this knowingly. This is all subconscious (50/#5.PE.MU23).

In summary, feared emotional experience was avoided by acts of distraction, distancing, joking/laughing, worrying, and/or by having an urge to escape from inner emotional experience or the therapy room. Avoidance was predominantly intentional across emotions of sadness, hurt, anger, and inchoate emotion. Less frequently, avoidance was described as unintentional in the face of feared emotion.

Across accounts of reactive fear there were some common protective behaviours that served to avoid or control the experience of emotional vulnerability, such as participants' recollections of intentionality, specific types of beliefs/thoughts, smiling/laughing, or automatic actions. Unique to the category 'Control Emotional Vulnerability' were descriptions of physical control, such as muscular tension, breath control, and posture. As well, internal dialogue involving prohibitions against allowing emotion that in some cases included a voice of "the protector" or silence as a means of control were both unique to this category. In contrast, unique to the category 'Avoid Emotional Vulnerability' were descriptions of distancing/detaching, numbing feeling, diverting attention, and worrying.

While fear was the most commonly described type of reactive emotion, some participants recalled other types, such as shame, anger, guilt, and/or sadness. Each of these types of reactive emotion will be described further below.

*Shame stops emotion.* Six participants reported that they reacted with shame to awareness of vulnerability in the context of an emotional experience of sadness, anger, or

hurt. Five were in an EFT session and one was in a CC session. Three of the five also described reactive fear, as described in a previous section, as well as reactive shame.

The main difference between reactive fear and reactive shame was that fear often occurred in reaction to awareness of the visceral experience of an initial emotion, whereas that was never the case with shame. Rather, shame was evoked primarily in reaction to one or more of four specific aspects of the experience of self as emotionally vulnerable: showing/expressing an initial emotion, an experience of emotional conflict inside, hazy emotional experience, or a weakened sense of self. All participants described related beliefs and concerns about violating social or personal values and norms, and/or being exposed and subjected to negative evaluation by others.

Differences between reactive fear and shame are illustrated below in the case of one woman who described both reactive fear and shame in the context of a general feeling of sadness. She described awareness of an overwhelming physical feeling of the “weight” of sadness in her “stomach” that “jumped up,” followed by a “nervous reaction/anxiety” and the feeling of a “lump” in her throat (10.PE.9). In contrast, her inability to “describe” or “name” the incoherent feeling of sadness left her feeling “stupid” and embarrassed. Moreover, she did not want to express or “show” sadness because she did not want to be pitied by others.

Some participants described how the overt expression of emotion left them vulnerable to perceived judgement or criticism by others, and the related sense of shame served to protect against this experience by stopping it (Shame stops expression, n=5).

In some instances, shame involved beliefs that it was not “right” or “socially acceptable” to express emotion, such as hurt or anger (Beliefs, n=3). One woman reported shame in the context of a two-chair dialogue where she was coached by the therapist to express how much her mother’s critical comments hurt. She recalled that while her mother’s criticism caused her intensely painful feeling, she believed it “wasn’t really right” for her to “be critical” and express “how much she hurt me” and she felt “ashamed” (62.PE.11). She further speculated about how shame and the belief that she was a “bad person” served to guard against painful feelings of hurt. She explained, “Let me think of me, that I’m really the bad person so I don’t feel the hurt...Let me put myself down so that, that’s much easier to do than feel the pain or tell somebody else” (62.PE.11). Another participant recalled feeling intensely angry and then feeling a “kind of embarrassment,” with the end result that her anger was “shamed away” (33.PE.8). She explained that she “know[s] it’s not socially acceptable” to express anger. In the IPR interview she also gave voice to shame with the admonitions “Be the good girl. Don’t be angry. Who are you to get angry?” However, it was not clear if she actually experienced the voice of shame during the therapy session. Another participant described how he “felt ashamed” after he cried in the session while recalling an emotionally intense and painful traumatic experience of hurt when he was bullied in childhood. He recalled how shame about showing emotion involved an experience of a punishing voice, “I felt ashamed. I started to feel there for a minute that, ah, you know ‘Come on grow up...sort of ‘stop it. So I kept sort of slapping myself with verbal [comments]” (04.PE.14).

Some participants described how they felt embarrassed about showing or expressing emotional experience to the therapist. One woman commented on a segment of the therapy tape where she told the therapist that she was embarrassed because she had shown her “a weak part of me” that was very sad, and rooted in harsh childhood experience. She explained that by controlling intense and overwhelming feeling,

I don't have to show anybody, including the therapist, what's truly, truly deep down inside. It's like when you have a skeleton in the closet that's really, really like a dirty little thing and you don't want anybody to know that's kind of like the way I feel. It's kind of like a shame...My face was feeling red and my cheeks were red. Like you get red in the face, you know (50.PE.5).

One man uniquely recalled how he reacted with shame to awareness of an experience of emotional conflict that he likened to “lying.” He described how shame followed awareness of the contradiction between his experience of anger and his self-perception as someone who was not an “angry person.” He recalled,

[T]here was a part of me that was ashamed to admit that I was angry and why I was angry...there was a reluctance to even talk about it...after I sort of recognized the anger, because I don't necessarily consider myself an angry person and the fact that I maybe was angry was making me feel sort of shame, it was like I'm sort of lying, 'well yeah I'm angry but I'm not an angry person' ” (05.CC.13).

In addition to reactive shame, some participants in an EFT session described reactive anger, guilt, or sadness. Participants in CC therapy sessions did not report these

additional types of reactive emotions. Each of these other types of reactive emotion will be described below with examples.

*Anger covers sadness.* Some participants in an EFT session described how a harsh, “invalidating voice” of anger followed a feeling of intense, overwhelming sadness, and a weakened sense of self (n=4). They explained that reactive anger functioned to “cover” or “shut off” these threatening feelings of sadness. Three of the four also recalled the experience of another reactive emotion, such as fear or shame as described in previous sections.

One woman described how she felt a wave of deep, overwhelming sadness expressed in tears and then an “invalidating voice” of anger took “over.” She explained that “it was like the sadness and the anger were playing each other” (33.PE.8). She described how the intense, deep, “preverbal,” feelings of sadness were related to “picturing or feeling little me so different from all the other kids” and she felt “very soft, very sort of vulnerable.” She explained that the “automatic” anger that followed was “the ancient voice” of her parents saying, “Get on with” it and “What right do you have to feel so sorry for yourself?.” She offered her interpretation of the function of anger as a “cover” over sadness and the related sense of vulnerability, “[the] anger is covering up the sadness...with sadness I don’t cut things off. It’s like it never ends...whereas anger’s very quick, very fast and it just covers things up.”

While another participant also described an invalidating voice of anger, she described a different pattern of reactive emotion where she first felt embarrassed about showing extreme feelings of sadness and then expressed anger toward her “sad self.”

While viewing a segment of the therapy tape where she expressed “hate” toward her sad self in a two-chair enactment (“I hate you being sad all the time. I hate looking at the sadness”), she recalled feeling intense and overwhelming sadness. This emotional experience was followed by embarrassment about showing sadness and an intention to “eradicate” it, which she did by expressing “hate” toward her “sad self.” She explained that showing sadness rendered her vulnerable to external invalidation and therefore prompted a desire to get rid of it.

I show much more anger here than before...because I’m so embarrassed about the sadness because I don’t have the support to feel sad. Then I want to totally eradicate it. I hate myself for being sad. I actually hate myself for having a sad life (62.PE.11).

*Guilt shut down anger.* For two participants in an EFT session, the expression of anger toward a parent(s) in a two-chair exercise was followed by guilt (n=2). For both, anger was about perceived emotional neglect and unmet emotional needs. However, they described how the expression of angry feelings and unmet needs to a powerful other, from an internal sense of an emotionally vulnerable disempowered self, proved difficult.

When each began to express needs for attention, love, and care they experienced guilt and anger was “shut down.” One participant described guilt as a feeling in her body that “shut down” the expression of sudden, intense feelings of anger and a related need for her father to show that he cared about her. She explained,

I shut down or can’t express my anger [because] I feel guilty so therefore I don’t

feel good inside...I felt guilty for what I was saying. Like I shouldn't be saying this...It was more of a feeling than more of me thinking 'Ok. You shouldn't be saying this right now (10.PE.13).

She further described how in concert with the feeling of guilt she also automatically controlled the expression of anger by holding her breath.

I try to stop myself, like holding my breath...See (points to videotape playing) I'm holding my breath for so long...When I restrict myself in breathing, you're holding back and you can feel it, the tightness (points to solar plexus area)...like a pressure, you know, it pushes down...this is how I'm feeling physically inside but I don't think about it. Like I'm not thinking 'Okay hold your breath right now (10.PE.13).

In contrast, the other participant described guilty thoughts that served to stop the expression of deep, intense feelings of anger. She explained:

My brain kicks in and says 'Hold on, hold on. I'm gonna hurt a lot of people that's unnecessary you know. Don't talk to your mother about this. Don't ever ask her about this.' In the back of my mind it would be my fault for ruining her life (33.PE.8).

*Sadness defuses anger.* For two participants in an EFT therapy session the urge or action of expressing angry feelings was followed by sadness (n=2). This experience of reactive sadness served to stop the flow of unsafe angry feelings and the expression of related needs. Sadness was described in terms of a physical feeling only and descriptions contained references, implicit and explicit, to the quality of safety in sadness.

One participant described how he felt intense and painful anger followed by a feeling of sadness. He reported that he consciously wanted “to stay with sadness rather than go” with his desire to express intense anger (78.PE.6). He explained that in contrast to his experience of allowing anger, which he felt as a painful “thrust” in his body, he felt “safe” staying with sadness “because there’s no element of anger or rage in it” (78.PE.6).

Another participant reported that when she expressed a need for attention from her father in an empty chair exercise she was aware that she felt angry. She described how anger came “up and grasp[ed] her” in the region of her shoulders and upper body and that it was “not a good feeling to have” (10.PE.13). She recalled that she expressed anger verbally only to immediately feel sadness take its place. At one point on the therapy tape the therapist coached her to express anger to her father and she said “It’s no way to control somebody. It’s not nice.” She explained how this expression of anger engendered an internal sense of emotional conflict in the form of a threat to her identity that was defused by sadness.

While I was saying that, how I feel my father affects me or has that grasp on me...as soon as I say ‘and that’s not nice,’ that’s just sadness because I don’t want to be that kind of person. I don’t want to have the anger...as soon as I said ‘not nice’ it’s just total sadness, like there’s no anger anymore (10.PE.13).

As with the previous participant, there was a sense that sadness was a safe emotion whereas anger was dangerous and could be kept at bay by allowing sad feelings.

In summary, participants most frequently conformed to a pattern of protection that included reactive emotion(s) and behaviours of control and/or avoidance of initial

emotional experience. In addition to this dominant pattern, a minor pattern was also conceptualized that involved only engagement in behavior that served to control and/or avoid the experience of an emotionally vulnerable sense of self. This second will be described below, with illustrative examples.

**Pattern 2: Emotionally vulnerable sense of Self- Control/Avoid emotional vulnerability.** A second, minor pattern was conceptualized to represent how emotional experience was interrupted or stopped in the context of a sense of self as vulnerable (n=5). Unlike pattern 1 described above, this less frequent pattern did not include reactive emotion. Instead, emotional experience was controlled or avoided by various actions that promoted a feeling or perception of safety.

Of 13 total participants, two in a client-centered therapy session were unique in that they did not describe reactive emotion at all for any type of emotional experience. Rather they recalled how they engaged in “automatic” or unintentional behaviours, such as physical constriction or laughter that served to control or avoid a sense of emotional vulnerability associated with awareness of emotional upset or sorrow. One woman described how her experience of emotional upset included awareness of a “jumbled mess” of emotions that she experienced at times as a sudden, overwhelming “wave” of “strong,” incoherent feeling that rushed up from her torso to her throat, and then was expressed in crying. She explained how she controlled this emotional experience and expression through “physical resistance.”

I think I take a breath in and then...it's like a bearing down... not necessarily resistance on my part consciously, but a physical resistance almost... it's like

trying to hold the floodgates back without realizing that you're doing it. An automatic response without even really being conscious that you're fighting it (25.CC.6).

Another woman explained that when “something is really painful” in the session she “deflects it” and “It’s not something really conscious.” At one point while she and the therapist were exploring her deep and painful feelings of sorrow and she felt weak “like a victim,” she automatically laughed. She explained how laughter served the function of “masking” how emotionally vulnerable she felt.

When I sort of laugh...it’s just because it’s a sensitive area. That was definitely a response that is a defensive sort of mechanism. It’s actually camouflaging how deep the emotion really is and how vulnerable I do feel...It’s more just masking my vulnerability (27.CC.8).

There were also no reports of reactive emotion from participants in either an EFT or CC session who recalled an initial experience of fear ( $n=3$ ). Rather, similar to the examples of emotional upset and sorrow above they avoided or controlled the experience of emotional vulnerability.

Participants described either involuntary, “automatic” actions that served a protective function by stopping the experience of fear or recalled voluntary or intentional actions that served the same purpose. In contrast to how they responded to an initial feeling of fear, these same participants did describe reactive emotion associated with other types of emotional experience such as hurt, sadness, and/or emotional pain.

Avoidance/control of vulnerability in the context of an initial feeling of fear took the form of seeking escape or safe distance from emotional experience and/or the surroundings (safe distance, n=3). One woman described how enactment of her harshly critical mother in a two-chair exercise evoked a feeling of intense fear and confusion that prompted a shift into “escape.” She likened this experience to childhood behavior when she would run away from her irate mother to avoid being beaten. While she did not run away in the session, she interrupted this “total feeling of fear” and urge to escape by automatically holding her breath. She explained that when she was sighing on the therapy tape it was because she had “not taken in air” and needed to breathe (50.PE.5). One man recalled that when he cried “scared tears” in connection with awareness of sudden, painful, “many scared feelings” he tried to “go off track” by diverting his attention and becoming numb.

I tried to find somewhere I could go in my head because I was hurting...I was just trying to go off track. Not be in this scenario...I just kept getting number and number as we went along (04.PE.14).

There was also no evidence of reactive emotion in one woman’s description of inchoate emotion during an EFT session. She recalled both controlling and avoiding physically painful feeling and incoherent sensation that she called “the darkness emotion.” At times she did so intentionally and at other times she did so out of awareness. At one point she felt like she was holding herself back from her feelings (held back, n=4). While she was aware of feeling choked and breathless she reported that she did not intentionally engage in this avoidant behavior.

I can't breathe, like you're being choked. That's the way it feels for me,  
like I'm cutting myself off... under the chin... I guess I just don't want to go there.

Maybe it's I don't want to feel things... it's like holding myself back (54.PE.8).

At another point she started to avoid experience of "the darkness emotion" by dissociating from it to "the comfort zone," which she described as "a very, very safe place for me... it's literally like vegging out" (Safe distance, n=3). She described how she felt disconnected from her body, the therapist, and the room. She explained, "Going to the comfort zone rather than really getting to the feeling... I've just [snaps fingers] switched into the other channel. I'm in the comfort zone. I remember a conscious decision there, making the 'click'."

In summary, a minor pattern was perceived where some participants described how they only engaged in behaviours of control or avoidance that functioned to protect against an emotionally vulnerable sense of self. The need for protection and satisfaction of this need was "automatic" or out of awareness at some points and intentional or in awareness at others. Protection was achieved by means of physical or breath control, laughter, or keeping a safe distance by dissociating from the perception of feeling in the body, the therapist, and/or the therapy room.

**Summary of provide Self-protection.** All participants described how, in the context of an emotionally vulnerable sense of self, they sought and/or provided self-protection from dangerous emotion. Three main categories subsumed under 'Provide Self-Protection' represent different facets of the provision of protection: 'Reactive Emotion', 'Avoid Emotional Vulnerability', and 'Control Emotional Vulnerability'.

In 'Reactive Emotion', participants reacted to an experience of emotional vulnerability with another emotion. Reactive emotion functioned to communicate the presence of danger to the self, and/or served to interrupt the experience of the initial emotion itself. In order of frequency, participants described reactive emotions that included fear, shame, anger, guilt, or sadness.

There was variability across participants' descriptions of the particular qualities of vulnerability that were associated with reactive emotion. Awareness of the visceral experience of emotion was central to the reaction of fear. In addition, participants gave idiosyncratic descriptions of how all or some of the other qualities of vulnerability, such as the expression of emotion, hazy emotional experience, emotional conflict inside, and a sense of self in a weakened state also gave rise to fear. Four classes of fear were conceptualized that represent different client concerns: fear of losing control, fear of the unknown, fear of the expression of emotion, and fear of dying. Less frequently, participants described how other reactive emotions, such as shame, anger, guilt, or sadness, were safe emotions that offered protection by suppressing the dangerous feeling and/or expression of an initial emotion.

Reactive emotion usually, though not always, gave rise to behaviours of emotional avoidance or control that also provided protection by alleviating the sense of vulnerability in the self. For example, the reaction of fear itself in the face of the dangerous experience or expression of intense, deep, and overwhelming sadness served to interrupt the experience of sad feeling. Additional behavior such as swallowing down sad feeling and expression ensured control over this internal emotional threat (Control

Emotional Vulnerability). In contrast, awareness of intense and volatile anger followed by the soothing feeling of reactive sadness itself brought about a sense of safety.

In ‘Control Emotional Vulnerability’ and ‘Avoid Emotional Vulnerability’, protective behaviours that regulated the experience of an emotionally vulnerable sense of self included: intention to control or avoid, physical control, cognitive avoidance or control, silence, laughter, or going “off track.”

Two patterns of ‘Provide Self-Protection’ were conceptualized from analysis of information contained in the three main categories: ‘Reactive Emotion’, ‘Control Emotional Vulnerability’, and ‘Avoid Emotional Vulnerability’. The major pattern that represented the greatest number of participants included awareness of a vulnerable sense of self in the context of emotional experience, followed by reactive emotions and behaviours of avoidance or control that served a protective function (Pattern 1: Awareness of Emotionally Vulnerable Sense of Self-Reactive Emotion-Control/Avoid Emotional Vulnerability). A minor pattern of protection was also perceived that did not include reactive emotion (Pattern 2: Awareness of Emotionally Vulnerable Sense of Self-Control/Avoid Vulnerability). However, all participants who conformed to this pattern described how they sought or engaged in behaviour that served to control or avoid emotional experience that in turn protected against the experience of an emotionally vulnerable sense of self.

Across participants, the outcome of self-protection was varied. The category ‘Effect of Protection: Limited Emotional Awareness’ represents the experience of self that followed protective reactive emotion and/or behaviors of avoidance and/or control.

This category will be described in the following section, with examples from participants' accounts.

**Effect of protection: Limited emotional awareness.** As participants recalled how they acted to protect themselves while vulnerable in the face of emotional experience or expression, they also described various outcomes of these efforts. In general, protection in the form of reactive emotion, avoidance, and/or control served to stop or diminish threatening emotional experience by limiting emotional awareness (Limited Emotional Awareness, n=13).

**Negative effect: Depleted, drained.** Many participants described how engagement in protective behavior(s) that served to limit emotional experience ultimately had a negative effect, as the suppression or avoidance of emotion left them with an encompassing sense of depletion or that they were drained of energy (Negative Effect: Depleted, Drained, n=11). Some recalled how physical control over intense, overwhelming, and dangerous feeling and/or expression left them with an internal sense of emptiness (Empty, n=2). One woman described how “squashing down” the angry “monster” that she felt in her body left her feeling “kind of empty...like a void...not a good feeling” (33.PE.8).

Some participants described how the suppression or avoidance of angry or hurt and painful feeling left them feeling depressed or sad (n=5). One man recalled that the effect of dissociation from intensely painful feelings of hurt was that he felt numb and “depressed even more. I wanted to give up” (04.PE.14). One woman explained how holding back painful feeling that evoked fear left her depressed at the end of the session.

C: Physically, to hold back tears and such pain, it doesn't hurt...and I'm not tired after I finish, but...it takes a lot of strength to hold it back. It's a lot of effort and energy...to hold this back for the amount of pain that I have...and I'm not tired after this.

I: You don't feel depleted or tired. What do you feel?

C: Nothing. To be honest I walk out of there and I don't remember half the things that went on in there two seconds after I've left there. I get in the car and drive off.

I: You feel...

C: Just a depression. Just that total depression...nothingness (07.CC.9).

Another woman described how after she felt guilt about expressing anger to her father in a two chair dialogue and held her breath, she felt "the feeling of sadness coming on" and she felt "bad" (10.PE.13).

One man reported a recent insight that when he feels like he is "starting to lose control" and protects himself by "taking a tighter grip" on his feelings he is vulnerable to feeling more depressed. He explained, "For me it's become a coping mechanism...maintaining [it] is wearing me out, a lot of physical energy, a lot of mental energy. And I also realize that I'm not winning the battle which adds to the depression" (402/#8.PE.MU6).

Some participants described how avoiding emotional experience, by dissociation from the perception or physical experience of it, left them in a disembodied or alienated self-state (n=5). As one woman recalled after she reacted to awareness of sadness with

shame and anger, “A foggy feeling [came] in. It’s like I don’t exist. I’m oblivious” (62.PE.11). Another woman recalled how she avoided intense, deep, and feared emotional pain by “blowing it away,” with the result that she “wasn’t aware of anything” (23.CC.18). She described the effect of avoiding an overwhelming feeling of “distressing” inchoate emotion by withdrawing from contact with the therapist; “[M]ainly it’s a feeling of disconnected with her” (23.CC.18).

For some, the effect of detachment from the perception or bodily feeling of unsafe emotion was one of numbness (n=3). One man explained, “As you can see I’m just sort of saying what I see [inside] but I don’t feel it...I kept getting number and number as we went along. Especially in the end there” (04.PE.14). He described how this state of numbness persisted at the time of the IPR 24 hours later. “I know I kept feeling a numbness right there [in therapy session] and I still feel it right now.”

In addition to the uncomfortable effects of protection by avoidance of emotional experience, some participants described the physically uncomfortable outcome of control over it. They recalled how the physical “constriction” of or “resistance” to feelings of sadness or anger left them feeling like their body was squeezed in a vise, often with painful consequences (physical tension, pain, n=3). One woman described how she felt a “torso up kind of constriction” of sadness that left her with a sore throat (25.CC.6).

Another participant described the effects of physically controlling feared anger as,

a lot of tension through my whole body...I’ve been noticing what I call a tingling in my extremities, my hands my arms usually from my elbow down and my leg

usually from my knee to my feet. I think the only part that is free from it is my head somehow (78.PE.6).

In some cases, the avoidance or control of emotional experience left the participants feeling confused or uncertain (confused, unsure inside, n=3). This was the case for three of the four instances of interrupted anger. One man described how he was left feeling confused after he joked to “deflect” his emotional experience of feared anger. He recalled,

I did my little jokey thing, and so as soon as I started to talk about it I realized I wasn't sure what the hell I was talking about...I just remember feeling this weird confused state, but I didn't want to say 'I don't know what I'm talking about right now' so I kept talking...I just remember feeling that at the time (05.CC.13).

Another participant described how “squashing down” the feeling of feared anger left her feeling bewildered, “kind of a confusion ‘Now what do I do?’ ” (33.PE.8).

Some participants described how the effect of “resisting” or controlling the feeling and expression of emotion made it hard to experience or express it (Frustrated, n=3). One man described his awareness that “there's something going on deeper inside that is not being released” (78.PE.6). He recalled,

I got the feeling I'm getting a piece of it but not all of it. Like maybe 40% of it or maybe 50%, but not the 100%. I can't get the 100%. I know I can't. It's just not going to be allowed and I'm feeling this while this is going on here (78.PE.13).

Sometimes the sense of protection that was gained by control over emotion was transient. One woman described how reactive anger about sadness left her feeling “in

total control.” However, the feeling of control was fleeting and she was left in a state of “hopelessness” that she described as “Resignation. It doesn’t really matter. Nothing matters” (54.CC.8). Another explained how physically controlling the feeling and expression of intense and painful emotion that evoked reactive fear brought about a sense of temporary relief from a weakened, overcome sense of self. She said, “I contain it and then go on and it’s alright. You know, I don’t have that overwhelming feeling for a couple of minutes” (07.CC.9).

***Positive effect: Less vulnerable.*** In contrast the negative effect of protection, some participants recalled how the avoidance or control of emotional experience they felt less vulnerable (Positive Effect: Less vulnerable, n=8). One woman described how she felt safe and protected following avoidance of the dangerous sense of intense, painful, and overwhelming sadness that also served to stop her tears.

It’s gone. There’s nothing. It’s like all of a sudden it’s like total peace. Like being wrapped in cotton and totally protected. There is nothing that can penetrate that...

It’s relief. I’m okay now. My whole body is different now (50.PE.5).

Other participants recalled how various means of control over emotional experience left them with a strengthened sense self that was more “in control.” One woman explained how cognitive control over her emotional experience of profound sorrow involved a shift from a sense of self as vulnerable, “a victim” to more of an active agent “somewhat in control of my emotions” (27.CC.8). Another woman described how disengaging from contact with the therapist left her feeling “more in control” of her distressing experience of emotion (23.CC.18). A third participant described how he controlled the intense and

overwhelming feeling of emotion that evoked reactive fear by sighing at various points. In turn, he recalled how the feeling of physiological arousal and a sense that he was losing control abated; “The tightness is gone. The flush is gone from the face. All the physical stuff is dissipated. [I am] uncomfortable but not emotionally overwrought. The emotions are not in control” (02.PE.8). He also explained that while protection against vulnerability brought relief, he has come to realize the high long-term cost to his sense of well-being as he remains depressed.

One woman described how she felt less vulnerable when the painful and overwhelming sad feeling she struggled to articulate was stopped when she suddenly felt “choked,” “cut off,” and breathless (54.PE.8). She labeled this process as “the resistance” to the expression of sad feeling. In this state of “resistance” she described how she felt a “surge of confidence” while “story telling” in “professional mode,” as if she was at work.

I’m into...professional mode...I’m not as vulnerable. Look at my body (points to video). My hands are open and all of a sudden I’m not covering up my face and my throat’s not choking here. I mean that’s gone ‘cause it’s all shut off now (54.CC.8). .

At another point she described how reactive anger diminished the intense and painful feeling and realization of sadness, leaving her feeling in control and less vulnerable. She explained, “In the end I don’t feel the pain the same way. The pain comes from the sadness. It doesn’t come from the anger. When I’m in anger I’m in total control!” (54.CC.8).

**Summary of effect of Self-protection: Limited emotional awareness.** Overall, the effect of self-protection was to limit awareness of threatening emotion. Participants described how emotional experience was diminished, controlled, avoided, or stopped altogether. Moreover, many participants described how subsequent to various means of protection that served to limit emotional awareness, they were left with an overall negative sense of self characterized by one or more of the following: numbness, detachment, alienation, sadness, confusion, physical tension/pain, emptiness, depression, uncertainty, or an overall bad feeling. In contrast, a smaller number of participants recalled a more positive effect where they felt protected and less vulnerable. This shift to a less vulnerable state was characterized by a sense of relief and a feeling that they were now “in control” of emotion as opposed to an earlier experience of self as emotionally vulnerable. In some cases, the positive sense of protection was transient.

**Summary: Subjective Experience Model ‘Protection from Dangerous Emotions’**

*Feeling is Triggered → Emotionally Vulnerable Sense of Self → Provide Self-Protection  
→ Effect of Protection: Limited Emotional Awareness*

The client’s experience of protecting against threatening emotion in a therapy session was nested within a historical context of difficulty allowing and/or expressing emotion. This shadow of the past was ever present in the therapy session as clients struggled with awareness of emotional experience. For some, the feeling and/or expression of emotion were associated with a long standing sense of danger and ways of coping that were learned to stay safe. For others, the history of emotional experience included outright invalidation of emotion or a general difficulty allowing the feeling or expression of

emotion. The legacy of these emotion histories was manifested in various ways in the therapy session as participants became aware of emotional experience.

The process of protection began with awareness of feeling that was initiated in the body by specific emotion “triggers,” such as: the therapy client’s own memories or vivid imagery, the therapist’s empathic responses, use of metaphor, direction to attend to and/or express emotional experience. A subjective sense of vulnerability soon followed.

Vulnerability in the self was associated with one or more of five defining features or properties of emotional experience. One property was awareness of the visceral experience of emotion, such as intense, deep, painful, and/or sudden feeling in the body. Another property was the expression or showing of emotion in the form of crying, expression of related needs, and/or private realizations. A third property was the perception of emotional conflict or a battle inside that was defined by one or more of the following: awareness of opposing parts of self with respect to allowing emotion, a threatened identity, and/or confusion. A fourth property was awareness of hazy emotional experience. This lack of emotional clarity was characterized by difficulty describing and/or expressing either the subjective experience of meaningless intensity or a specific emotion, and in some cases entailed an internal sense of emotional confusion and/or a hazy sense of self. Finally, a fifth property was a weakened sense of self, defined by one or more of the following features: feeling overwhelmed, a sense of losing control or being stuck in a black hole, hopelessness, or lacking self-protection.

The profound sense of self as vulnerable was the catalyst for a related implicit or explicit need for protection. The process whereby self-protection was provided took two

forms. In the majority of cases, awareness of an emotionally vulnerable sense of self was followed by reactive emotion(s) and behaviours of avoidance and/or control that served to stop or shut down the initial emotional experience. These reactive emotions and behaviours served to protect against the experience of an emotionally vulnerable sense of self by stopping the visceral sensations of emotion, warding off the expression of emotion, safeguarding against an internal sense of emotional conflict, providing relief from hazy emotional experience, and/or strengthening a weakened sense of self.

Reactive emotions include fear, shame, anger, guilt or sadness. Fear was the most common form of reactive emotion, and it involved a physical sense and/or specific cognitions. Four specific classes of fear included: fear of losing control, fear of the unknown, fear of expression of emotion, and fear of dying.

In contrast to the dominant pattern described above, a second, minor pattern did not include reactive emotion. Rather, awareness of vulnerability was followed by avoidant or controlling behavior alone that served to protect against the experience and/or expression of emotion. In both patterns, the effect of self-protection was either negative for those who were left with a “bad” or “drained,” sense of self or, to a lesser extent, positive for others who felt less vulnerable and more in control.

Overall, the process of providing protection left clients with limited emotional awareness. Emerging feelings, urges, needs, expression, and/or meaning were met with countervailing reactive emotions, avoidant or controlling behaviours that served to interrupt the initial flow of emotional experience. In turn, these protective acts left some

clients with a negative, depleted sense of self and others with a more positive experience of self as less vulnerable and protected.

Illustrative participant profiles that exemplify the two patterns of protection from dangerous emotions will be described below, for emotions of hurt, sadness, and emotional upset. Examples are drawn from both EFT and CC therapy sessions. To demonstrate that the two patterns of protection are grounded in a variety of emotional experiences, additional profiles of protection from anger, inchoate emotion, emotional pain, sorrow, and fear are included in Appendix B.

#### **Profiles of protection from dangerous emotions.**

**Profile of Mary: Pattern 1- Protection from hurt (07.CC.9).** Mary described her experience of vulnerability in the context of hurt in the 9th session of client centered therapy, as she talked with the therapist about how her husband and children treated her poorly.

*Emotionally vulnerable sense of Self.* In the therapy session, Mary talked about how her mother told her “from infancy” that other people were better than her and that she was “the worst...horrible person.” In the IPR she reported that the impact of this message was “I’m always questioning my feelings because I don’t think they’re valid” (Emotion Histories- No Support/Validation for Emotional Self). She also described how her husband picked up where her mother left off. The impact of his harsh invalidation of her thoughts and feelings was that, “Most of the time I’m thinking to myself “Well then I’ve got to be crazy or what I’m feeling is not valid” (Emotion Histories: No Support/Validation for Emotional Self).

The therapist validated Mary's feeling of hurt which, in turn, struck a chord inside and evoked intense and physically painful feelings. She explained, "Now she's validating what I feel in there and that starts me going again...she's hit a very vulnerable spot." As the therapist validated hurt exactly it brought her to the point of releasing feeling in tears. She explained, "Now what she's saying is exactly how I feel...I'm ready to cry" (Feeling is Triggered-Therapist Behavior: Empathic Reflection/Validation).

As Mary told the therapist about how she felt rejected by her husband and children, she was privately aware of intense and painful feelings of hurt located deep in her body, "my stomach, my gut" (Felt Very Vulnerable-Awareness of Feeling in the Body). She expressed these extreme feelings in tears (Felt Very Vulnerable-Expression of Emotion). Her metaphor of existing in a "black hole" represented the agony of her experience of hurt (Emotion Metaphors). Vulnerability also included the subjective experience of unclear and conflicted emotional experience. The profound lack of clarity in the context of hurt was defined both by a feeling of confusion about why she was feeling the way she did and inner conflict between her emotional experience and doubt about what she was expressing (Felt Very Vulnerable-Hazy Emotional Experience, Emotional Conflict Inside). Moreover, Mary described the sense that she was assailed by a "totally overwhelming feeling" (Weakened).

*Provide Self-protection.* Mary reported that in this emotionally vulnerable state she was afraid of losing control should she to continue to express intense, deep and painful feelings of hurt. She explained, "I'm afraid that if I continue talking I'm just going to lose it...It's very easy for me to just go over the deep end...I could just break

up” (Reactive Emotion-Fear). While the need to protect herself was implicit, she explicitly described the various ways that she protected herself from threatening emotion by maintaining control over what she was feeling.

At a point where she sighed and stayed quiet on the therapy tape Mary pointed out how her arms were folded across her abdomen and she explained, “I’m holding myself back...I’m just gulping down whatever’s coming up...physically to hold back tears and such pain...it takes a lot of strength to hold it back...a lot of effort and a lot of energy to hold this back for the amount of pain that I have” (Control Emotional Vulnerability).

*Effect of protection: Limited emotional experience.* Control over feared emotional experience served to impede the feeling and expression of hurt as well as the perpetuation of vulnerability. Mary explained that physically controlling what she was feeling brought some relief; “I contain it and then I can go on and it’s alright...I don’t have that overwhelming feeling for a couple of minutes” she said (Positive Effect- Less vulnerable). However, a sense of relief was fleeting and she reported that when she left the session “the pain [wasn’t] gone” and she felt “just a total depression. You know, nothingness” (Negative Effect- Depleted, Drained).

In contrast to the example above, there were multiple reactive emotions in some profiles of pattern 1. This pattern of multiple reactive emotions will be illustrated in the following example of protection from vulnerability in the context of sadness.

***Profile of Eleanor: Pattern 1-Protection from sadness (62.PE.11).*** Eleanor was a woman in her 11th session of EFT. She participated in an IPR of a therapy segment where she talked to the therapist about how the history of a difficult relationship with her

critical mother negatively impacted her self-esteem. She reported feeling sad about the lack of validation and support from her mother and then criticized herself for feeling sad. She also expressed sadness in the context of a two-chair dialogue with a harsh internal critic.

In the IPR interview, Eleanor described vulnerability in the context of her experience of sad feeling. Protection against vulnerability involved reactions of both shame and anger, as well as avoidance by involuntary loss of focus and attention.

*Emotionally vulnerable sense of Self.* Eleanor reported that she rarely addresses feelings of sadness even when she is alone because she does not want to get into the habit of showing it. She explained that she is afraid that if she does show sadness in front of others she will be embarrassed because “it’s not something acceptable and how will people take it.” She clarified that she does not have the “support to be me” and say it’s ok to be sad and cry (Emotion Histories-No Support/Validation for Emotional Self).

In the therapy session, Eleanor acknowledged the therapist’s empathic reflections about how she felt unaccepted by her mother and needed reassurance that she was “a good person.” In the IPR she explained that she felt “really sad” throughout this passage as the therapist accurately reflected her experience of invalidation by her mother and an unmet need for affirmation and resolution with her mother (Feeling is Triggered-Therapist Behaviour- Empathic Reflection/Validation).

A sense of vulnerability was related to awareness of feeling “really, really” sad. Eleanor recalled the visceral sense of this intense feeling “in my chest coming up to my brain” (Felt Very Vulnerable- Awareness of Feeling in the Body). She explained that the

sad feeling was related to an unmet need “to fix things” in the relationship with her mother (Felt Very Vulnerable- Expression of Emotion).

Eleanor described how the strong feeling of sadness continued to the point where it was “overwhelming...Too much for me to address.” She described the sense of overwhelming sadness as a “distressing feeling” that “becomes more tight around my neck” (Felt Very Vulnerable- Weakened).

*Provide Self-protection.* The implicit need for protection and the satisfaction of this need took a variety of forms, including reactive emotions and avoidant behaviours.

Reactive emotion was associated with a sense of vulnerability in the context of an historical experience of a lack of support for expressing emotion. Shame served to protect against censure for showing sadness. At one point Eleanor recalled that she felt embarrassment about showing strong feelings of sadness as she was vulnerable to the disapproval of others. At another point on the therapy tape she enacted the harsh critic of her sad self (“I hate you being sad all the time”). In the IPR she described how self-critical anger followed on the heels of a private experience of reactive shame. She explained, “I was so embarrassed about the sadness, because I don’t have the support to feel sad. Then I want to totally eradicate it and I hate myself for being sad. I hate myself for having a sad life” (Reactive Emotion: Shame Stops Emotion, Anger Covers Sadness). In effect, angry self-censure was a proxy for social censure and served to interrupt the expression of sadness and protect against the possibility of public humiliation.

In addition to reactive emotions of shame and anger, Eleanor also described other means of protection against either acknowledging or allowing the overwhelming feeling

of great sadness. She described how she avoided “feeling really sad” by falling silent because “I really don’t want to address it”...It’s an emotion I can’t deal with” (Avoid Emotional Vulnerability). At other times avoidance was unintentional and her attention drifted away from what she was feeling as it was “too much for me to address.” She recalled, “It’s very sad and it’s overwhelming so my mind begins, my thoughts begin to wander as the distressing feeling” intensified. She further explained, It’s involuntary. I almost have to bring myself back to where I’m at” (Avoid Emotional Vulnerability). Eleanor also described how her focus shifted away from internal experience and she started to pick at her sweater.

*Effect of protection: Limited emotional experience.* The effect of reactive shame and anger was to suppress the expression of strong feelings of sadness and thereby stop the threat of censure. Avoidance of the overwhelming visceral sense of sadness by shifting the focus of attention to other thoughts or externally left Eleanor feeling “[L]ike I don’t exist kind of thing. I’m oblivious...I knew I wasn’t really feeling the sadness” (Negative Effect- Depleted, Drained).

In contrast to the examples of Pattern 1 described above, the process of protecting an emotionally vulnerable self was different for a minority of participants. In this second pattern of protection, the differentiating feature was that the subjective experience of needing and providing protection did not include Reactive Emotion. The profile of Holly described below exemplifies Pattern 2.

***Profile of Holly: Pattern 2- Protection from emotional upset (25.CC.6).*** Holly participated in an IPR interview of a videotaped segment of her 6th session of client

centered therapy (CC). In this taped segment, she was explaining to the therapist that she had doubts about her relationship with her boyfriend. She cried on and off throughout the segment as she elaborated on her concerns. Holly also expressed confusion about why she was “getting upset.”

*Emotionally vulnerable sense of Self.* The backdrop to Holly’s interruption of emotional experience in the session was a history of difficulty both staying with feelings and expressing how she feels. The following passage illustrates these difficulties and a tendency to rationalize her emotional experience.

How to just be connected to how I really do feel about something and not get bombarded with rationalizing forty different sides of an argument. How I really feel...I don’t know how to do that very well...There are ramifications of it, of your emotion...I have a lot of needs to express myself...but you’re not always feeling you can (Emotion Histories: Hard to Allow/Express Emotion).

Holly recalled that she was talking to her therapist about problems in the relationship with her boyfriend when she suddenly felt a wave of intense emotion in her body. “I had to release this,” she explained. She also described how she inexplicably started to cry.

Holly recounted how the perception of imagery served to elicit feeling, “There was some imagery there...whether it’s a movie screen in my mind or whatever it is, you kind of have images of people that perhaps even drum up those feelings as well” (Feeling is Triggered- Client Imagery). She also explained that her therapist was “very empathetic” and it precipitated “a repeat of the initial wave” that intensified and deepened and she felt “more upset.” She identified one therapist reflection about her

boyfriend in particular, “So you see his woundedness,” that “really hit” home emotionally (Feeling is Triggered- Therapist Behavior).

Holly described how her experience of “emotional upset” included the visceral sense of a sudden “wave” of “strong” feeling that “rushes” up from her torso (Felt Very Vulnerable- Awareness of Feeling in the Body). She reported that “this wave of emotion that was upsetting” took her “totally by surprise.” This intense feeling was expressed in crying (Felt Very Vulnerable- Express Emotion-Crying). Though taken aback by the awareness and expression of the visceral sense of emotion, she was also struck by the significance of it. Holly recalled, “It made me realize that a lot of these strong emotions that I was really having, that I don’t think I recognized before, this matters. It’s important” (Felt Very Vulnerable- Express Emotion-Realization). Moreover, she was aware that a related sense of hazy emotional experience left her speechless. “I knew I was starting to cry and I thought ‘Why am I crying? I have no idea...I couldn’t speak on it because I just didn’t know why I was so upset,’” she explained (Felt Very Vulnerable- Hazy Emotional Experience). She further described how this inchoate emotional experience progressed to awareness of “a myriad” of “upsetting emotions that “welled up,” such as sadness, love and anger. There was a cumulative effect of the repeated experience of a wave of strong, “upsetting” visceral sensation and crying, which was a weakened sense of self caught in a “jumble” of overwhelming feeling. Holly explained,

Like you kind of feel heavy, like it’s too much on you...It continues, feeling the overwhelming feeling. It’s just like a little spark that spurs on this whole reaction, different emotions. But then it just comes back to like another overwhelming

wave. There's no real way out of that...it seems like a jumbled mess of emotions (Felt Very Vulnerable-Weakened).

*Provide Self-protection.* Holly explained how she controlled the experience of “emotional upset” through an “automatic response” of “physical resistance” (Provide Self-Protection: Control Emotional Vulnerability- Physical Control).

There's a little bit of resistance when you...sort of feel a wave of that coming on. It kind of rushes up, constricts your throat, the back of your eyes or wherever you can feel it. So a kind of constriction through the body.” “My torso and my stomach...I don't even think I breathe. I think I take a breath in and then...it's like a bearing down ... not necessarily resistance on my part consciously, but a physical resistance almost... it's like trying to hold the floodgates back without realizing that you're doing it. An automatic response without even really being conscious that you're fighting it.

Effect of protection: Limited emotional experience. Involuntary physical constriction served to interrupt both the feeling and expression of emotion. She recalled that “from the torso up kind of constriction” made it hard for her to talk as the feeling was caught in her throat; “I can't get across what I'm trying to say so I sort of get stopped” (Effect of Protection: Limited Emotional Experience).

## **CHAPTER FOUR**

### **Integration of Performance and Subjective Experience Models of SIE**

Two studies were undertaken for the purpose of understanding both the performance and subjective experience aspects of therapy client's self-interruption of emotion (SIE). In Study I, a task analysis of client performance of SIE in an experiential therapy session was conducted and a performance model outlining the components of the process of SIE was developed. In Study II, a model of the subjective experience of SIE in an experiential therapy session was conceptualized from a grounded analysis of client accounts.

The comparison of the performance and subjective experience models of SIE will be organized as follows. First, each model of SIE will each be summarized briefly. These summaries will provide context for a later discussion of the similarities and differences between the two models, and the description of a final integrated performance/subjective experience process model of SIE.

### **Summary of Final Rational-Empirical Performance Model of SIE**

Components of SIE: Awareness/Expression of emotional experience -> Opposition to emotional experience -> Awareness/Expression of secondary emotion -> Express inhibitory behaviour -> Express effect of interruption.

The development of the final performance model of SIE was an iterative process of task analysis, where an initial rational model of the components of SIE was refined through comparison with empirical models derived from analyses of client performance in therapy transcripts.

In the final rational-empirical model, the process of interruption began with the conscious awareness and/or expression of emotional experience or various types of emotion, including sadness, anger, crying, hurt, fear, inchoate emotion, or emotional pain. This emotional experience occurred in the context of empathic dialogue with the therapist or during an imaginary two-chair dialogue with a significant other or an internal critic.

The first component in the model, *Awareness/Expression of Emotional Experience* represents the client's perception and expression of internal experience that may or may not be differentiated along a continuum ranging from: awareness of feeling/physiological arousal, to the symbolization of feeling/arousal in words identifying it as a specific emotion ("I feel sad") that is then further differentiated in terms of needs and/or meaning ("I wanted to be accepted"). Alternatively, expression of emotional experience may be non-verbal, such as crying. The intensity of this emotional experience may range from a minimal to an extreme degree. Clients may explicitly describe a sense of vulnerability related to awareness of emotional experience, ranging from reports of feeling "overwhelmed" by emotion to "I don't feel safe" allowing emotion.

The next component in the model is *Opposition to Emotional Experience*, which serves as a marker that the interruptive process is occurring. Clients communicate awareness of internal opposition to the initial experience of feeling and/or symbolization of emotion, related urges, and/or emotional expression. Opposition may take the form of explicit expression ("I'm feeling kind of tearful...I don't want to feel tearful") or non-

verbal/paralinguistic communication, such as sighing, shaking of the head ‘No,’ or silence.

In the majority of cases, interruption is further differentiated as clients become aware of and/or express another emotion, such as fear, shame, anger, or guilt that further inhibits the experience and/or expression of the initial emotion. As represented by the component *Awareness/Expression of Secondary Emotion*, these secondary emotions may be described in terms of an internal awareness of feeling and/or the expression of related beliefs that are primarily related to the threat of loss (control, relationship) should the initial emotion be allowed. Fear was the most commonly expressed secondary emotion.

The process of interruption continues to unfold as clients engage in further inhibitory behaviour. *Express Inhibitory Behaviour* stands in contrast to the earlier experience of opposition to emotion, as there is no sense of a conflict or struggle between different ‘parts’ of self with respect to allowing emotional experience. Rather, behaviours of avoidance and/or control over emotional experience dominate. Engagement in avoidant behaviours may take the form of expression of a desire to flee the session, self-admonishments, disengagement from the perception of emotional experience, laughing, and/or expression of helplessness or hopelessness. Alternatively, clients may engage in cognitive or physiological control over the feeling or expression of emotion.

The final component in the model of SIE is *Express Effect of Interruption*. Effects were bi-directional in terms of outcome. In the vast majority of cases, clients expressed how interruption of emotional experience left them with an all-encompassing sense of depletion or bad feeling. As one client who interrupted anger put it, “It’s destroying me.”

Another client who interrupted sadness expressed how it left her feeling hopeless and that she was not a “worthwhile” person. In contrast, only a few clients expressed relief, or a positive feeling. For example, one man who interrupted anger was aware of feeling “more strength.”

Overall, two patterns of the performance of SIE were perceived and named: Type I-Inhibitory Emotions and Behaviours, which represented the greatest number of clients, and Type II-Inhibitory Behaviours. Four components described above were common to both patterns: ‘Awareness of Emotional Experience’, ‘Awareness of Opposition to Emotional Experience and Expression’, ‘Express Inhibitory Behaviour’, and ‘Express Effect of Interruption’. The pattern Type I differed from Type II in that it also included a 5<sup>th</sup> component, ‘Awareness/Expression of Secondary Emotion’, as described above.

### **Summary of Subjective Experience Model of SIE: Protection from Dangerous Emotions**

A representation of the subjective experience of SIE was conceptualized from a quasi grounded theory analysis of therapy client’s accounts of emotional experience, where a marker of SIE was present in an experiential therapy session.

From this analysis, a core category was conceptualized: **Protection from Dangerous Emotions**. This category represents the essence of the therapy client’s subjective experience of SIE, which was one of providing protection from the internal experience and/or expression of emotion that posed a threat or danger to the self. Three main categories that are subsumed under the core category each represent commonalities in different aspects of the subjective experience of SIE: *Emotionally Vulnerable Sense*

***of Self, Provide Self-Protection, Effect of Protection: Limited Emotional Awareness.***

Together, these three categories represent the overall process whereby clients interrupted an experience of emotion in a therapy session.

For the majority of clients, the experience of self as emotionally vulnerable in the therapy session echoed historical experience of emotion (*Emotionally Vulnerable Sense of Self: Emotion Histories*). Participants described a history of difficulty allowing emotional experience and longstanding coping strategies that served to interfere with the awareness and/or expression of emotion. In some cases, emotion was experienced as dangerous to emotional and/or physical well-being earlier in life, and participants had developed ways of handling emotion that allowed them to feel a sense of safety. For others, the problem was one of struggling to allow, label, and/or express emotional experience and they habitually engaged in emotional avoidance. Another theme in emotion histories was the chronic invalidation of emotion by self and/or others.

In the context of the therapy session, participants became aware of the onset of feeling that occurred in the course of interactions with the therapist (*Emotionally Vulnerable Sense of Self: Feeling is Triggered*). Particular types of therapist and/or client behaviours served to initiate the onset of feeling, such as the therapist's empathic reflections and/or directions to focus on and/or express emotion, as well as the client's internal images or memories. The internal experience of unbidden emotion was followed closely by a sense of self as extremely vulnerable (*Emotionally Vulnerable Sense of Self: Felt Very Vulnerable*).

This great sense of vulnerability in the context of emotional experience was characterized by one or more of five features. The first and most frequently described was awareness of the visceral experience of emotion, such as intensity of feeling, deep feeling, sudden onset of feeling, and/or painful feeling. Vulnerability also was associated with the expression of emotion in words or crying, awareness of emotional conflict inside, hazy emotional experience, and/or a sense of self in a weakened state.

This all-encompassing sense of self as vulnerable precipitated emotional reactions and/or behaviours that served to interrupt the initial internal experience and/or expression of emotion and provide a sense of self as safe or protected (*Provide Self-Protection: Reactive Emotion, Control Emotional Vulnerability, Avoid Emotional Vulnerability*). For the majority of participants, reactive fear in the face of emotional vulnerability interfered with the continuity of an initial emotional experience, and was followed by behaviours of emotional avoidance or control. Four different classes of fear were identified: fear of losing control, fear of the unknown, fear of expression of emotion, and fear of dying.

Less common were reactive emotions of shame, anger, sadness, or guilt. These emotions served the same function as reactive fear, which was to run counter to an initial experience of unfettered emotion. Similarly, they were followed in the main by behaviours of emotional avoidance (dissociate, distract, worry) and/or control (squeeze muscles, silence, beliefs- “weak to show emotion”). In some cases, the reactive emotion itself provided protection by overriding the initial emotional experience, e.g., the feeling of sadness calmed and soothed the dangerous visceral experience and/or expression of intense anger.

Overall, reactive emotions and behaviours of avoidance and/or control served as protection against the sense of vulnerability in an emotional self, by shutting off the visceral sensation of emotion, stopping the expression of emotion, ending a sense of emotional conflict inside, alleviating the discomfort of hazy emotional experience, and/or bolstering a weakened sense of self.

In contrast to the most common pattern of SIE described above, a second, less common pattern did not involve reactive emotion. Rather, the experience of an emotionally vulnerable self was followed by avoidant and/or controlling behavior only.

In both patterns of self-interruption, the process of self-protection resulted in limited awareness of emotional experience (*Effect of Protection: Limited Emotional Awareness*). In the majority of instances this outcome was described in negative terms, such as a depleted, drained sense of self. In a smaller number of cases, limited emotional awareness was a more positive experience of self as protected and less vulnerable.

In summary, all participants described in various ways how they “felt very vulnerable” following awareness of feeling that was “triggered” inside. Vulnerability was associated with awareness of the visceral experience of emotion, the expression of emotion, a sense of emotional conflict inside, hazy emotional experience, and/or a weakened state. In many cases, accounts of this experience of vulnerability in the context of in-session emotional experience mirrored the narrative of their emotion history.

Overall, two patterns were perceived in the client’s subjective experience of **Protection from Dangerous Emotions**. In the major pattern of SIE, participants reacted to vulnerability in the context of initial emotional experience with another emotion and

behaviour of control or avoidance. In contrast, in the minor pattern of SIE, participants did not experience reactive emotion and the experience of emotional vulnerability was followed by behavioural control or avoidance only. In each pattern, the outcome of interruption was limited emotional awareness. In the majority, limited emotional awareness was associated with a negative sense of self that was drained of feeling and energy.

### **Comparison of Performance and Subjective Experience Models of SIE**

Overall, the subjective experience model both confirmed the components of the performance model and fleshed it out by providing additional information that enhances understanding of the process of SIE. Similarities and differences between the performance and subjective experience models, summarized in Table 7, will be described below.

The latent element of emotion history in the process of SIE, as narrated in the participant's personal accounts, was unique to the subjective experience model of SIE. As one woman explained her emotional experience in the therapy session, "I'm past. I'm present." Clients described a history of emotional experience in terms of longstanding difficulty and/or vulnerability associated with allowing and expressing emotion. The subjective experience of vulnerability or negative experience in the context of emotional experience was a central theme across historical accounts of emotion, and this leitmotif was apparent throughout the in-session experience of SIE.

With respect to similarities, central features of the process of SIE in the performance model were also present in the subjective experience model. Information about the

subjective experience of SIE provided a more differentiated understanding of the components in the performance model, and emphasized the client's experience of vulnerability in the context of awareness and expression of emotion, as described below.

Similar to both models, awareness of internal emotional experience was precipitated by specific types of therapist behaviour, such as: the empathic reflection of emotion, inquiry into feeling/emotion, direction to attention inward to emotion and/or express emotion, and in some instances by the use of metaphor. From the subjective experience model it was learned that this initial phase of emotional awareness may also be initiated by the client's private memories, imagery, or an unspoken sense of closeness to the therapist. Whether precipitated by therapist behaviour or client private experience, the internal sense is one that feeling/emotion is "triggered" automatically in the body (Feeling is Triggered).

The 'Awareness/Expression of Emotional Experience' is the first component in the performance model of SIE. This component is defined along a continuum of experience from awareness of feeling, to symbolization of emotion, to expression of emotion and/or related needs. Participants may describe how awareness of emotion involves a sense of self as overcome or overwhelmed. The process of SIE for individual clients begins anywhere along this continuum.

While this continuum of emotional experience also holds for the subjective experience model there is an important difference, which is that a sense of vulnerability was pivotal in the interruptive process for all clients. In the main, while expression of vulnerability was described in the performance model for many clients, the subjective experience of vulnerability in the context of emotional experience was universal. In

addition, the subjective experience model provides a rich description of the subjective experience of emotion and a related sense of self as vulnerable, as represented in the category 'Emotionally Vulnerable Sense of Self.' Information in this category makes clear how the client's experience of profound vulnerability is specifically associated with awareness of the feeling and/or expression of emotion. This sense of vulnerability in the emotional self is defined by five features: awareness of the visceral experience of emotion, expression or showing emotion, emotional conflict inside, hazy emotional experience, and a weakened state. Across clients, there are different patterns or signatures of vulnerability in the context of emotional experience, involving one or more of these features. A notable difference between the performance and subjective experience models is that in the former intensity of feeling ranged from minimal to extreme levels, whereas in the latter clients described awareness of the great intensity of visceral experience.

The difference in emphasis on the role of an emotionally vulnerable sense of self, between the performance and subjective experience models, may be accounted for by the different methods used in each study. The method of task analysis was used to identify how the client interrupted emotion during a therapy session, e.g., the observable performance of self-interruption. In contrast, the grounded theory analysis of client accounts of emotion while engaging in self-interruption provided additional information about what the experience of emotion itself was like, and what it was about this experience that precipitated self-interruption.

**Marker of SIE.** An explicit statement of opposition to emotional experience or expression is considered a marker of the occurrence of self-interruption of emotion in the

performance model (T: “A sense of feeling angry then too?” C: “Yeah. Although I’m trying to keep that checked.”). This marker of SIE corresponds to one of the five features of vulnerability in the subjective experience model, as described in the category ‘Emotional Conflict Inside.’ The subjective experience of the client at the marker of SIE is one of a sense or perception of “opposing parts” of self that are engaged in an internal “battle,” with one side allowing emotional experience and expression and another side of self that manifests in opposition (“battling myself”). This internal conflict may also take the form of the perception of a ‘Threatened identity,’ where the meaning and/or expression of emotion conflicts with a view of self that is related to personal identity (“I feel angry” vs. “I am not an angry person”). In some instances, awareness of internal conflict can also involve a sense of emotional “Confusion” (“All these things battling themselves, sort of confusing”).

While markers of SIE typically involved explicit statements or internal awareness of opposition to emotional experience or expression, there were instances of pre-conscious conflict for a few clients who also described an “automatic” experience of emotion that was there one moment and gone the next (Automatic Stop, n=4).

**Secondary reactive emotion.** In both the performance and subjective experience models, the process of interruption further unfolds with awareness of secondary reactive emotions. The term “secondary” denotes the order in which the emotion occurred, e.g., second to an initial emotion. The term “reactive” is consistent with information in the subjective experience model that explains how secondary emotion occurs as a reaction to

another emotion, in accordance with the related experience of an emotionally vulnerable sense of self.

The performance model includes information about how opposition to emotion is differentiated as clients become aware of a secondary emotion that serves to further interfere with or inhibit an initial emotional experience (*Awareness of Inhibitory/Secondary Emotion*). Secondary emotions include fear, shame, anger or guilt, in descending order of frequency. Secondary emotions occur along a continuum from feelings to verbal or non-verbal expression. Expressed beliefs and admonishments across secondary emotions of fear, shame, and guilt have a common theme of concern about either loss of control or loss of a significant relationship should an initial emotion be allowed or expressed. Fear of losing self-control is a dominant concern. Secondary anger and contempt may also be expressed toward an emotional self.

In contrast, the subjective experience model provides more information about the relationship between a sense of vulnerability in the emotional self and the protective function of ensuing secondary emotional reactions. These reactive emotions function both to interrupt awareness and/or expression of initial emotional experience that is experienced as threatening to the self in some way, and motivate engagement in protective behaviour that will satisfy an unmet need for safety (*Provide Self-Protection- Reactive Emotion*). In some cases, the experience of reactive emotion itself may satisfy the need for protection. For example, the feeling of reactive shame serves to stop the expression of anger that is sensed as a threat to a relationship. Or, the feeling of secondary anger provides safe harbour in the face of overwhelming waves of sadness. Likewise, the reaction of a feeling and

acknowledgement of sadness to the perception of the malevolent force of anger provides a sense of safety in the body. In short, reactive emotion interrupts a preceding emotion when the latter is experienced as threatening.

Similar to the kinds of secondary emotions included in the performance model, reactive emotions included fear, shame, guilt, or anger. Also similar across the two models, fear was by far the most common type of secondary/reactive emotion. In contrast to the performance model the class of secondary or “reactive” emotions was more varied in the subjective experience model, as sadness, exclusively in reaction to anger, was also included. Moreover, additional classes of fear of emotion beyond that of ‘losing control’ were described (Fear expression of emotion, Fear of the unknown, Fear of dying).

The subjective experience model also provides more information about the interrelationship of particular aspects of vulnerability and specific secondary/reactive emotions. For example, reactive fear is associated with one or more of the five qualities of vulnerability in the context of emotion, especially visceral experience, whereas reactive shame is associated with awareness of all but the visceral experience of emotion. In contrast to fear and shame, reactive guilt is only associated with vulnerability related to the expression of emotion and related needs to a significant other. Reactive anger is related to the visceral experience of sadness and sense of self in a weakened state, whereas reactive sadness is related to the subjective experience of unsafe visceral feelings of intense anger and expression of related needs.

**Interruptive behaviour: Avoidance, Control.** In both the performance and subjective experience models, opposition to emotion was further differentiated in the

form of interruptive behaviors of emotional avoidance and/or control. At this stage in the process of interruption, clients may express conscious intention to avoid emotional experience, as well as engage in cognitive and/or physiological acts that serve to inhibit feeling and/or expression. Across both models, the difference between avoidance and control was that while both involve agency on the part of the self, the former is defined by actions that move away from emotional experience and have a quality of escape from bodily experience (distract, dissociate), whereas the latter involves moving toward and actively tangling with or controlling aspects of emotional experience (tense muscles to manage feeling in the body/expression). The subjective experience model further accounts for how the enactment of these protective behaviours of interruption functions to inhibit the feeling and expression of emotion, and thereby the related sense of vulnerability in the self.

New information from the subjective experience model broadened the class of inhibitory behaviour. Avoidant and controlling acts also included pauses or silence during the therapy dialogue, overt postures (hunching over, arms folded across stomach), dissociation, and worrying.

**Effect of interruption.** The final outcome of the interruptive process is similar across both the performance and subjective experience models. In the vast majority of cases, interruption of the experience and expression of an initial emotion left clients with a limited awareness and experience of emotion. The subjective experience of limited emotion is an internal sense of depletion and “bad” feeling. Less frequently, clients

expressed how they felt a positive effect, such as a feeling of relief or a less vulnerable sense of self, which was also fleeting for some.

**Patterns of Self-interruption of emotion.** Two different patterns of interruption are represented in both the performance and subjective experience models of SIE. The most common pattern includes awareness and/or expression of initial emotion, followed by secondary reactive emotion and enactment of related inhibitory behaviour (Type 1: Secondary Reactive Emotions and Inhibitory Behaviours). A smaller number of clients conform to a minor pattern of SIE that does not include secondary reactive emotion. In this pattern, protection for the vulnerable self is solely ensured by behaviours of emotional avoidance and/ or control (Type 2: Inhibitory Behaviour).

As shown in the subjective experience model only, there are contextual factors at play here as the mode of therapy plays a role in the prevalence of the minor pattern. Those participants in a client-centered session are more likely than those in an EFT session to follow this pattern.

In the minor pattern of SIE that did not include secondary emotion, two of the five CC clients were represented exclusively in this pattern (40%) whereas, there are no clients in an EFT session who conformed only to this pattern. Five of eight clients in an EFT session conformed only to the major pattern of SIE (62%), while the other three were mixed in that they were included in both the major and minor patterns of SIE (37%) as there were differences in how they handled different emotions.

With respect to the type of emotion that was interrupted in the minor pattern (Type 2-Inhibitory Behaviour), the process of interruption of an initial experience of fear

was unique as compared to other emotions, across the performance and subjective experience models. It was the only emotion that clients did not react to with a secondary emotion. In the performance model, the minor pattern of SIE (Type 2-Inhibitory Behaviour) included four clients in an EFT session, each of whom interrupted a different emotion (fear, sadness, anger, or hurt). In the subjective experience model, this minor pattern included five clients who interrupted emotions of fear, emotional upset, sorrow, or inchoate emotion. Two of the participants in this pattern were in an EFT session and interrupted an initial experience of fear. Similarly, in the performance model, the one case of initial fear did not involve secondary emotion.

Given that these three cases of initial fear all conformed to the minor pattern of SIE (Type 2-Inhibitory Behaviour), it is possible that there is something unique about fear that does not readily elicit secondary reactive emotions. From an evolutionary perspective, secondary emotional reactions to fear under conditions of threat may not readily enhance survival as they muddy the waters of perception and slow down response time. Of interest here is that clients engaged in fight/control or flight/avoid behavior to interrupt the emotion of fear itself, suggesting another possibility that reactive fear of fear occurred out of the client's awareness. The fact that the two EFT clients who did not recount secondary reactive emotion to awareness of initial fear did report secondary emotional reactions to other initial emotions lends support to the proposition that fear is unique with respect to the process of interruption. However, further sampling of cases of fear is required before any definitive conclusions can be drawn about the interruption of fear as a unique process compared to other emotions.

Each of the major and minor models of SIE could also be considered as distinct processes of SIE, perhaps representative of individual differences in therapy clients, differences in specific types of emotion, or therapy contexts. Alternatively, they could represent different phases of the process of interruption in the context of therapy overall. Recall that the unit of analysis in this study was an SIE event that was identified for each client in one therapy session. It is possible that a client at an early stage of awareness of SIE in therapy is not consciously aware of secondary emotion. Or the reverse could also be the case. As secondary emotions are experienced and processed in awareness they recede over time, and only the performance of related behaviours of control and/or avoidance are consciously enacted. Further study of the process of SIE is needed to clarify this question.

In summary, there are similarities and differences between the performance and subjective experience models of client SIE in a therapy session. Information in the subjective experience model of SIE supports the central components of the performance model, and also adds to it by highlighting how the client's experience of an emotionally vulnerable sense of self plays a central role in the early stages of the process. Furthermore, the subjective experience model provides a representation of the interrelationship of an emotionally vulnerable sense of self and subsequent secondary reactive emotions and interruptive behaviors that impede the client's awareness/expression of emotion, in the service of self-protection. Across both models, two similar patterns of SIE were perceived; one included secondary reactive emotion and one did not. Fear was the prevalent type of secondary reactive emotion in both the performance and subjective experience models. In addition, the outcome of the process of

SIE was similar across both models, as the majority of clients were left with an overall bad feeling of depletion. Finally, information about the client's prior history of difficulty allowing and/or expressing emotion was only described in the subjective experience model.

Table 7. Similarities and differences between performance and subjective experience models of SIE

Performance of SIE	Subjective experience of SIE
Historical context of in-session performance of interruption not present.	Emotion history was a latent element of in-session emotional experience.
Process of SIE began with awareness/and or expression of feeling/emotion, in context of therapy dialogue. Client emotion/feeling precipitated by therapist empathic reflection of emotion, inquiry into feeling/emotion, direction to attention inward to emotion and/or express emotion, in 2-chair imaginal dialogue, metaphor. Client tells a story, memory.	Process of SIE began with sense that feeling is “triggered” in context of therapy dialogue. Client emotion/feeling precipitated by therapist behaviour: empathic reflection of emotion, inquiry into feeling/emotion, direct attention to emotion, direction to express (two chair), metaphor. Also initiated by client’s undisclosed memories, imagery, or private sense of closeness with therapist.
Awareness of vulnerability by many clients.	Strong sense of self as vulnerable in context of emotion common to all clients. Five defining features of vulnerability: awareness of feeling in the body, express/show emotion, emotional conflict inside, hazy emotional experience, weakened state.
Secondary emotion followed awareness and/or expression of an initial emotion, and included: fear, shame, guilt, or anger.	Clients reacted to an initial emotional experience and related sense of vulnerability with another emotion. These reactive emotions included: Fear, shame, guilt, anger, sadness.
Fear most common secondary emotion.	Fear most common reactive emotion. Four types of reactive fear were conceptualized (Fear of losing control, fear of the unknown, fear of expression, fear of dying).
Clients inhibited emotion by performing behaviours of avoidance, control.	Clients engaged in self-protective behaviour of emotional avoidance, control.
Result of performance of interruption is predominantly a negative sense of self (depleted, bad feeling). Relief/Good feeling in a small number of cases.	Effect of protection is limited emotional awareness. Majority of clients described a depleted, drained sense of self, negative feeling. A few described positive effect of feeling less vulnerable.
Two patterns of SIE: Type I – Most frequent, included secondary emotion. Type II- Less frequent, did not include secondary emotion.	Two patterns of SIE- Most common pattern included “Reactive emotion,” less frequent pattern did not.

In the following section, a final integrative model of SIE will be presented that is a synthesis of the performance and subjective experience models. The model represents the therapy client's process of change in emotional experience from awareness and/or expression of emotion, to emotional reactions and enactment of behaviours that in turn serve to interrupt or limit emotional experience. An illustration of the final integrative process model of SIE is shown below in Figure 11. A description of each of the phases shown in the process model is provided in the following section.

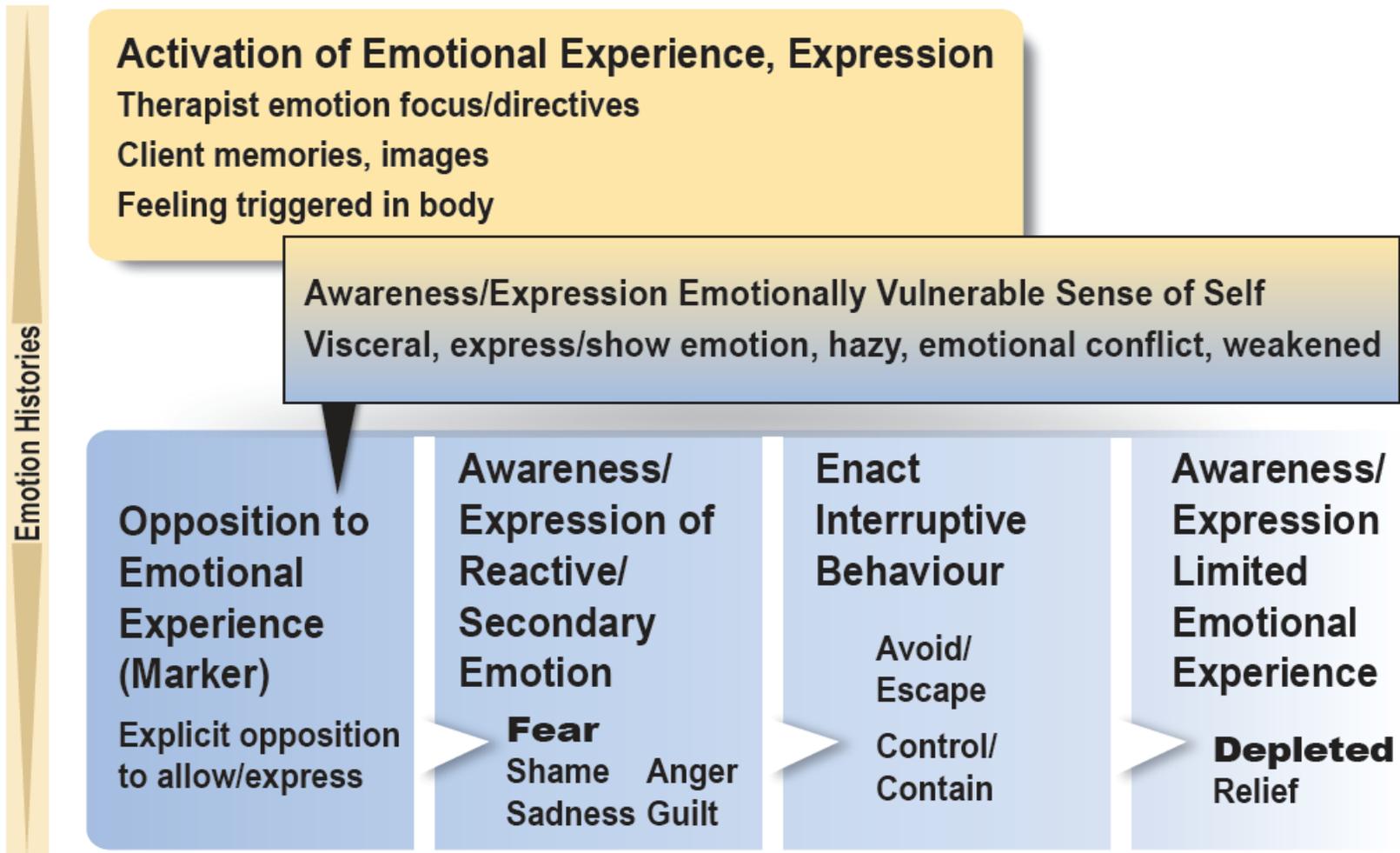


Figure 11. Integrative model of ‘Protection from dangerous emotions: Process of Self-interruption of emotion in a therapy session.’

### **Integrative Model of ‘Protection from dangerous emotions: Process of Self-interruption of emotion in a therapy session.’**

The integrative model of SIE is represented in Figure 11 above. A brief summary of the model is provided below, followed by a more detailed description of each component in the model.

The client’s process of self-interruption of emotion in the therapy session is informed by their historical experience of emotion (Emotion Histories). The process of SIE in the therapy session begins with the ‘Activation of Emotional Experience, Expression,’ that is soon followed by the clients’ ‘Awareness/Expression of an Emotionally Vulnerable Sense of Self.’ Awareness of emotional vulnerability then gives rise to ‘Opposition to emotional experience,’ which is a marker indicating the presence of SIE. Opposition to emotion is further differentiated as clients’ experience ‘Awareness/Expression of Secondary Reactive Emotion’ and/or they ‘Enact Inhibitory Behaviour.’ Finally, the process of SIE culminates in the clients’ ‘Awareness of Limited Emotional Experience.’

**Historical context of SIE.** For those clients who interrupt emotion in a therapy session, there is typically a personal history of difficulty allowing and expressing emotion. Historical experience of emotional experience may include dangerous consequences to allowing and/or expressing emotion, such as: physical abuse by a caregiver, suffering verbal attack by another, loss of control (vomiting up feelings, lashing out in anger resulting in physical or interpersonal injury), or feeling depressed.

Emotion histories may include descriptions of behaviour that served to keep clients safe from emotional and/or physical injury in the face of `dangerous` emotional experience. Safety behaviors include controlling or avoiding the feeling and/or expression of emotion by various means. Emotion is controlled by physical constraint, distraction, silence, or laughter. Avoidance of emotion involves escape behaviours, such as: sleeping, isolation, intellectualization, disengagement and not paying attention to feeling.

Alternatively, some emotion histories may not include descriptions of vulnerability to harm if emotion is allowed or expressed. Rather, the problem is one of difficulty allowing or articulating feeling, along with various means of coping that include: distancing from or blocking feeling, controlling emotional reactions, engagement in rational thinking, beliefs about the futility of expressing emotion or that doing so would negatively impact others.

Emotion histories may also include descriptions of self-invalidation of emotion, or invalidation of emotion by others, where feelings and expressions of emotion are explicitly discounted or unattended to. There may be a related view of self that is described in negative terms, such as beliefs that `I am unacceptable to others,` `unstable,` or `weak.`

In summary, the client's emotion history provides information about an entrenched experience of emotional vulnerability and related difficulties allowing and/or expressing emotion, as well as longstanding coping strategies of regulating unsafe emotional experience that foreshadow interruption in the therapy session.

**Activation of emotional experience, expression.** The client's emotional experience is activated or "triggered" in the therapy session in response to specific types of therapist communication, or client cognition, perception, and expression, in the course of therapy dialogue.

The onset of emotional experience may be activated at a point where the therapist offers an empathic reflection ("My sense is that there's a kind of sadness that you still feel"), pays close attention to and inquiries about feelings ("What does it physically feel like in your body?"), directs the client's attention inward to emotional experience or outward to the expression of emotion ("There's a sadness there. Somehow, we need to find words to put to that. I'm sad that..."), or offers a metaphor or image to capture emotional experience (Pain of divorce- "The image that comes to mind is of a tapestry woven together...a co-created effort and it's as if you took a knife and just slashed through it").

Alternatively, emotion may be activated in connection with the client's subjective sense of closeness or contact with the therapist ("He was just going near me and I felt sad"), as well as memories or vivid imagery that may or may not be disclosed. Memories were most often related to loss, or traumatic experiences in childhood or adulthood.

The onset of emotional experience may also occur in the context of two chair work, where the client is exploring internal experience while engaged in dialogue with a significant other or between the 'self' and its 'critic.'

The subjective experience of emotional activation is one of a shift in awareness to a release of feeling. As clients describe it, there is an automatic quality to the subjective

sense of feeling that is “triggered” in the body (“This is where I got really sad, when she said ‘What is undeserving about her.’ That triggered that emotion.”; “He said he sensed a sadness and...that pushed a button in me where the rest of the session I was sad.”). These bodily feelings are related to a specific emotion (e.g., sadness, anger, fear, hurt, or emotional pain) or a more diffuse sense of undifferentiated emotional experience.

(Integration of: Performance model- Awareness/Expression of emotional experience;  
Subjective experience model- Emotionally vulnerable sense of self: Feeling is triggered).

**Awareness/Expression of emotionally vulnerable sense of Self.** At this stage in the process of SIE, clients are aware of emotional experience that can be described along a continuum of conscious apprehension and expression: awareness of un-symbolized affect, symbolization of a specific emotion, verbal and non-verbal expression of emotion, related needs and/or personal significance. An individual client’s emotional experience and expression may be described anywhere along this continuum. Clients may explicitly express a sense of vulnerability in connection with awareness of emotional experience. The subjective experience of an emotionally vulnerable sense of self is universal.

The concept of vulnerability in the context of the process of SIE is defined as a sense of danger to the self in a moment or period of time in a therapy session that is associated with awareness of the visceral experience of emotion, an internal sense of emotional conflict, hazy emotional experience, an overall weakened sense of self, and/or an urge or explicit action of expression of emotion.

The most common visceral quality associated with vulnerability is awareness of the high intensity of feeling in the client’s body. Less frequently, and still prominent,

vulnerability is also described in connection with one or more of three other visceral qualities, such as, the location of feeling deep within the body, painful feeling, or the sudden onset or surfacing of feeling. There are also idiosyncratic patterns of the four visceral qualities (intensity, deep feeling, painful feeling, and sudden onset) across individuals and emotions. Three metaphors represent the client's visceral experience of emotion as the embodiment of danger: Emotion is fast moving water; emotion is a malevolent force, and emotion is darkness.

Vulnerability is also frequently associated with expressing or showing emotion. Crying is the most common form of expression associated with a sense of self as vulnerable. Other forms of client expression associated with a sense of vulnerability are explicitly showing or voicing emotion, stating related needs, or realizations about emotion that are expressed in private dialogue ("I realized 'This still hurts me'.").

An emotionally vulnerable sense of self may also be related to awareness of emotional conflict inside. The client does not feel safe to allow or express emotion and consequently there is internal opposition to emotion. The subjective experience of vulnerability is one of an internal sense of an embattled self that is divided into opposing parts or voices ("This sadness feels right" vs. "Don't feel sad"). The sense of vulnerability in the self may also involve the perception of a threatened emotional identity ("I feel angry" vs. "I'm not an angry person"), and/or a sense of emotional confusion. As described below, the explicit expression of opposition to feeling or expressing emotion in the therapy session constitutes a marker of SIE.

Vulnerability may also be associated with an internal awareness of hazy emotional experience, where emotion is inchoate, unknown, or identified as a specific emotion that is then hard to fully express because the client does not have words for it. For some, this lack of clarity involved a sense of great confusion and a hazy sense of self related to a lack of understanding about the purpose and meaning of emotion.

Finally, vulnerability may be associated with a sense of self in a weakened state. This global sense of weakness is associated with feeling overwhelmed by one or more of the following: The visceral experience or expression of emotion, a sense of losing control, feeling defenceless in the face of emotion, or the expression of emotion to a powerful other in imagination or explicitly in chair work.

In summary, in this phase of the process of SIE awareness and expression of various forms of emotional experience (inchoate feeling, specific emotions, or emotional experiences) is married together with an emotionally vulnerable sense of self. The sense of all-encompassing vulnerability in the emotional self is pivotal in the process of SIE, as it sets the stage for the next phase of opposition to emotion that includes reactions and behaviours that serve to interrupt an initial emotional experience.

(Integration of: Performance model component- Awareness/Expression of emotional experience; Subjective experience model category- Emotionally vulnerable sense of self: Felt very vulnerable).

**Opposition to emotional experience (Marker of SIE).** As clients allow the experience and/or expression of emotion, they become aware of a related sense that they

are vulnerable to harm. This sense of self as unsafe in the face of emotion promotes opposition to allowing the feeling and/or expression of it.

One type of SIE marker is an explicit statement of opposition to an initial experience of emotion that indicates self-interruption of emotion is occurring. Examples of a makers of SIE are shown below.

Marker of SIE: Hurt/crying 06/4/PE UFB Mother

T: So what's happening for you now as you speak?

C: Um (pause) I'm feeling kind of tearful.

T: Can you stay with that, see what words come? Tearful? Sad?

C: I don't want to feel tearful.

In another example, a client expressed sad feeling and a related need for acceptance from his mother, in a two chair dialogue. However, he almost simultaneously countered this expression of sadness by sighing, and said "For me to tell you what I feel makes myself vulnerable and every time I do that you always attack (Marker of SIE: Sadness 02/8/PE UFB Mother)."

While markers of SIE are present, they are not always explicitly stated. In some cases, clients are aware of internal opposition to emotion, or the sense of an "automatic" shut off of emotion, however, they do not always report these implicit markers to the therapist.

In addition, vulnerability may not be described overtly at a marker of interruption. However, the subjective experience of a vulnerable sense of self as emotional experience is allowed and/or expressed is ubiquitous in the self-interruptive process, and precipitates opposition to emotional experience.

Opposition to feeling and expression that serves to interrupt emotion, and thereby the sense of vulnerability in the emotional self, is further differentiated in the form of subsequent protective emotional reactions and behaviours, as described below.

**Awareness/Expression of secondary reactive emotion.** For the majority of therapy clients, the process of interruption of emotion continues to unfold with awareness and/or expression of secondary emotional reactions to initial emotional experience, in the context of a profound sense of vulnerability in the self. These secondary emotions serve a protective function, as they interrupt and in some cases override the initial feeling and expression of emotion and/or related needs. For example, secondary reactive fear and the perception of threat stops the emotionally vulnerable client from expressing anger and related needs to his mother in a two-chair exercise. In some instances, self-protection may be provided by the experience of secondary emotion itself. For example, the feeling of reactive sadness calms and soothes an intense feeling of anger in the vulnerable self.

Secondary reactive fear is the most common reaction to initial emotion and/or expression of related needs. The therapy client's reaction of fear is a response to one or more of the five aspects of vulnerability: awareness of feeling in the body, expression of emotion, hazy emotional experience, emotional conflict inside, weakened state. Other

secondary reactive emotions include shame, guilt, anger, and sadness. These less common protective emotions are responses to a narrower range of emotional experiences associated with vulnerability in the self. For example, secondary reactive shame is associated with all features of vulnerability except for awareness of the visceral experience of emotion. The main client concerns in the case of reactive shame are that allowing or expressing emotion will have negative social consequences or personal values will be violated. Secondary reactive guilt thwarts the expression of emotion and associated need. Reactive sadness occurs in response to awareness of the visceral experience and expression of intense anger and a related feeling of vulnerability to physical harm or loss. The reaction of secondary anger follows awareness of the visceral experience of sadness and a weakened sense of self.

In summary, the experience and/or expression of secondary reactive emotion interrupts or overrides the initial emotional experience, thereby providing protection for a vulnerable self in need. However, in the majority of instances, the client's need for self-protection is fully met through additional performance or enactment of controlling or avoidant behaviour that will be described further below.

**Enact interruptive behaviour.** At this stage, the process of interruption further unfolds with the differentiation of previous inhibitory behaviour. Whereas earlier in the process there was a sense of a struggle or conflict inside between two opposing parts of self (allow/express emotion vs. don't allow/express), now the opposing force is dominant in the form of control or avoidance of emotional experience. Avoidant acts are characterized by flight or escape behaviours that serve to disengage from emotion,

whereas acts of self-control involve moving toward emotional experience with the intention of controlling it.

The therapy client's intention to avoid or control emotion is expressed in words or is un-symbolized in the form of a "bodily felt sense." Avoidant behaviours include: an urge to flee the session or hide, joking, laughter, worrying, distraction, or dissociation from the perception of emotional experience or physical surroundings, expressed hopelessness or helplessness, or rational self-talk. Behaviours of physical control include: tightening muscles, posture (hunch over, fold arms), swallowing, breath control (hold, sigh), or silence that serves to contain or suppress the visceral experience or expression of emotion. Acts of cognitive control include invalidation of emotion and/or the emotional self (attack, criticize, question) as well as negative beliefs/prohibitions about emotion (hopelessness, negative consequences to self and/or relationships), all of which serve to suppress emotional experience.

**Awareness/Expression of limited emotional experience.** The process of self-interruption of emotion culminates with an experience of limited emotional awareness that is described primarily in terms of an overall "bad," depleted, numb, sad, or depressed sense of self. A small minority of clients will experience an immediate feeling of "relief" from an earlier experience of emotional vulnerability, which may also be fleeting for some. These clients may describe the subjective sense of feeling "protected," or "in control."

### **Summary of Integrative Model of SIE**

Information from the performance and subjective experience models of SIE was compared, contrasted, and synthesized. Categories in the subjective experience model both confirmed the central components in the performance model and added new information, such as clarifying the central role and features of vulnerability and a threatened sense of self in the context of emotional experience. As well, the interrelationship of vulnerability and self-protective secondary reactive emotion and inhibitory behaviour was explained. For example, awareness of intense feelings of sadness evoked a sense of vulnerability in the physical self that was followed by a reaction of fear (lose control), and related behaviours of avoidance and/or control.

In addition, the in-session experience of SIE was understood in a historical context of emotional experience that was characterized by a sense of vulnerability in the emotional self, and longstanding coping strategies to mitigate a variety of perceived threats or challenges. The client's history of emotion, such as past difficulties and negative experiences related to allowing and/or expressing emotion, foreshadowed the interruption of emotion in the therapy session.

Two patterns of SIE were conceptualized. The vast majority of clients conformed to a pattern of SIE that included the awareness and/or expression of secondary emotional reactions and the enactment of interruptive behaviour (Type 1: Secondary Reactive Emotion and Behavioural Interruption), whereas an infrequent pattern did not include secondary emotional reactions (Type 2: Behavioural Interruption).

In the following discussion section, the final integrative model of SIE will be compared to the relevant empirical and theoretical literature. In addition, suggestions will be given for clinical practice, to help therapists know how to address the client's experience of emotional vulnerability and secondary reactive emotion in therapy. Finally, limitations of the study will be addressed and suggestions for future directions will be offered.

## CHAPTER FIVE

### Discussion

The review of the empirical and theoretical literature in the first chapter of this dissertation established that the inhibition or interruption of emotion is associated with a variety of psychological problems and disorders. Therefore, interruption of emotion is an important focus of treatment in therapy. This study is the first to systematically examine the phenomenon of self-interruption of emotion in depressed therapy clients.

The overall goal of the study was to identify and understand the defining features of the client's self-interruption of emotion in an experiential therapy session. More specific goals were to examine how clients interrupt emotion in therapy through the performance of overt behaviours, and to understand the client's subjective experience of interrupting emotional experience. To these ends, two studies of SIE were conducted. In the first study, the performance of SIE by 10 therapy clients in an experiential therapy session was examined using the method of task analysis. From this analysis, key components of the process of SIE were identified and then represented in a performance model of SIE. In the second study, a model of the client's subjective experience of SIE in a therapy session was developed from a qualitative analysis of interviews with 13 clients, following the "constant comparative method" of grounded theory (Glaser & Strauss, 1967; Rennie et al, 1988). Information from the performance and subjective experience models was integrated, and a final model of SIE was proposed.

In this integrated model of performance and subjective experience, SIE is represented as a process of providing self-protection that is initiated at moments in a therapy session where clients experienced a sense of threat or danger in the face of emotional experience or expression. The client's awareness of self as vulnerable in these moments was a central feature of the interruptive process that was followed by self-protective secondary emotional reactions and/or self-protective acts of control or avoidance.

The discussion will be organized as follows. First, the conceptualization of vulnerability in the process of SIE proposed here will be compared with the EFT literature. Second, the role of secondary reactive emotion in the interruptive process will be discussed. Finally, implications for clinical practice, limitations of the study, and future directions will be addressed.

### **Vulnerability in Self-Interruption of Emotion**

Greenberg and colleagues have written extensively about therapy client's experience of vulnerability and the importance of therapists "providing empathic affirmation of the vulnerable self" (Greenberg, Rice, & Elliott, 1993, p.271). They argue that it is essential for therapists to attend to client's communication of intense vulnerability and respond with genuine "empathic affirmation" to facilitate the client's acceptance of internal experience and emotion, and foster a strengthened sense of self (Greenberg et al, 1993, p.274).

According to Greenberg et al (1993), therapy clients often experience intense vulnerability as they allow and express "self-relevant negative emotions," such as deep and often painful feelings of shame, hurt, isolation, or despair. They explain that

vulnerability in the self that involves difficulty showing and expressing “extremely painful self-relevant emotions” is often rooted in fear of being judged or rejected by the therapist.

Although the negative emotions are intense, clients may be reluctant to reveal them in their full intensity. In fact, it is often the intensity of these feelings that leads the clients to fear them. Clients often fear that if they reveal themselves and fully express these painful emotions, or other seemingly unacceptable aspects of themselves, that the therapist will judge them, feel alienated from them, or even reject them... There is thus often an attempt to close down, or hold off, dreaded feelings or aspects of self and to avoid dealing with them (p.271-272).

In contrast to this relational type of vulnerability, they also describe another type of vulnerability that is rooted solely in an internal experience of self at risk.

For some clients there is even the fear that if they fully acknowledge these dreaded negative feelings, these emotions will be bottomless and engulfing, and they will lose control and will, themselves be overwhelmed by them (p.272).

The proposed integrative model of SIE provides empirical support for each of these propositions, while also highlighting that fear of internal emotional experience was of equal and in many cases a greater concern than relational fear of negative evaluation by the therapist. Furthermore, for clients in an EFT session, fear of expressing emotion also went beyond the therapy relationship as it was also related to showing emotion and/or expressing related needs to a significant other in the context of a two chair dialogue. Fear of emotion will be discussed further in a later section.

In the present study, the concept of vulnerability as it occurs specifically in the process of SIE was differentiated and defined by five features, any one or more of which occurred in connection with the subjective sense of self as unsafe or threatened. Each of these five features will be summarized briefly below.

**Awareness of feeling in the body.** Awareness of specific qualities of the visceral experience of emotion, such as intense, deep, painful, or the sudden onset of feeling, were associated with a sense of self as extremely vulnerable. The intensity or sense of extreme feeling in the body was the most frequently reported aspect of visceral experience that was associated with a sense of self as vulnerable.

**Express/show emotion.** Vulnerability in the self was also experienced in connection with the verbal or non-verbal expression of emotion. Crying was the most common form of expression associated with a sense of vulnerability. Other forms of expression included explicitly showing or voicing emotion to the therapist or an imagined significant other in a two-chair exercise and/or articulating related needs, or private realizations about emotion, such as those related to a wounded sense of self or threats to identity.

**Hazy emotional experience.** Emotional experience was often unclear and confusing due to the client's struggle to symbolize inchoate feeling or describe and express symbolized emotion, or uncertainty about the meaning of symbolized emotion. This hazy emotional experience was also associated with an emotionally unsure and confused sense of self.

**Emotional conflict inside.** Vulnerability in the face of emotional experience was associated with awareness of an internal conflict between a part of self that allowed the experience of feeling and emotion and another part of self that opposed it. The subjective sense of vulnerability here is one of a fractured self, engaged in an internal emotional conflict or battle with no sense of the possibility of resolution or a sense of emotional self-cohesion.

**Weakened.** In the context of awareness of the visceral experience of emotion or expression of emotion, there was a sense of self in a weakened state. This weakened sense of self was characterized by a feeling of being overwhelmed, defenseless, hopeless, and/or loss of control.

When the client is experiencing vulnerability in connection with one or more of these five forms of emotional experience, it is an indicator that the stage is set for the interruption of emotional processing. Given that the client's experience of vulnerability in the context of emotional experience is central to self-interruption, markers of emotional vulnerability are important to identify as they are precursors of subsequent emotions and actions that interrupt the initial experience and/or expression of emotion. Recognition that the client is experiencing emotional vulnerability is an essential first step toward intervening in the interruptive process.

Greenberg and colleagues (Greenberg et al, 1993; Goldman & Greenberg, 2015) discuss the importance of attending to markers of client vulnerability in therapy. They define a marker of vulnerability as, "a feeling in the present, and involves feeling

depleted, hopeless, like giving up, or ashamed and deeply hurt. It has a quality of fragility” (L. Greenberg, 2013, personal communication).

The proposed model of SIE provides information that can be used to refine and expand the class of markers of the interruptive process, to include markers of vulnerability in the self that are specific to the process of SIE.

The existing marker of SIE as defined in this study corresponds to one of the five features of vulnerability, ‘emotional conflict inside,’ where the client experiences an embattled, fractured sense of self that is divided between allowing and opposing emotional experience. The other four qualities of vulnerability in the emotional self may also be considered as important markers in the interruptive process. For example, ‘awareness of feeling in the body’ is a marker of vulnerability related specifically to arousal, where there is evidence that the client is having difficulty maintaining awareness of the intensity, depth, pain, and/or sudden onset of feeling, and perceives a threat to the self at a visceral level. Attention to this marker of difficulty handling visceral experience would be useful given how often clients struggled with this problem early in the process of SIE, and ended up solving it by shutting down emotional experience altogether.

From therapy clients’ reports of subjective experience in this study, it is clear that difficulty allowing and tolerating the sense of physiological arousal in the context of emotional experience is a central feature of vulnerability in the process of SIE. This problem is significant given the role of arousal as a mediating variable in therapy outcomes. As Greenberg & Pascual Leone (2006) concluded after a review of the empirical literature,

...the evidence suggests that emotional processing is mediated by arousal. For effective emotional processing to occur, therefore, the distressing affective experience must be activated and viscerally experienced by the client. Arousal appears to be essential but not necessarily sufficient for therapeutic progress (pg.612).

Fosha (2000) also proposes that for change to occur in therapy, it is essential that it involve visceral experience of emotion. She argues that “Visceral experience is the center point of core affect, the indispensable element of the affective model of change” (2000, p.24).

A more differentiated understanding of arousal has also been discussed in the literature following studies that demonstrated that “too little” or “too much” arousal did not promote emotional processing. Levels of “optimal” or “productive” arousal that are associated with good therapy outcomes for depressed clients have been identified (Greenberg, Auszra, & Herrmann, 2013; Carryer & Greenberg, 2010; Greenberg, Auszra, & Herrmann, 2007; Misserlian, Toukmanian, Warwar & Greenberg, 2005).

The proposed model of SIE provides additional insight into the problem of unproductive arousal. In many instances, clients experienced an extreme sense of vulnerability as they became aware of intense, deep, sudden, and/or painful feeling in the body that was perceived as overwhelming, foreign, uncontrollable, and even life threatening. Another form of unproductive arousal occurred when the client experienced vulnerability in connection with awareness of heightened visceral experience that proved too difficult to tolerate, symbolize, and express. In both instances, secondary/reactive

emotion and related behaviours of avoidance or control functioned to inhibit or interrupt the visceral experience or expression of emotion, and thereby the sense of self as vulnerable.

In view of the above, the therapist's close attention to how clients are handling visceral experience is essential. As one would expect, clients' subjective reports indicated that there was much more going on internally with respect to the onset of emotion than was expressed to the therapist in the session. In this study, "triggers" of the subjective experience of a sense of visceral "release" of emotion were identified. These precipitants of visceral experience included therapist behaviours such as, empathic reflection of emotion and/or directions to express emotion, as well as client internal experience of memories and visual imagery. Assessment of how clients are tolerating the visceral experience of emotion will involve inquiry into the effect of therapist empathic statements about emotional experience as it is experienced in the body, as well as the impact of private memories or images that have been activated in the course of discussion about emotionally charged topics. As the client discloses awareness of a visceral "release" of emotion in the body, the therapist can assess whether or not visceral experience is being tolerated and allowed. In doing so, the process of interruption can be addressed in its earliest stages if needed.

### **Secondary Reactive Emotion**

As clients became aware of a sense of self as vulnerable, emotional experience was most often interrupted by another emotion. These secondary reactive emotions served to protect against the sense of threat posed by the continuation of the initial experience of

emotion. In some cases, the client was aware of this function. As one woman explained, she was aware in the session that reactive anger protected against sadness, and she thought to herself, “This is the protector.” More often, there was a more automatic quality to the onset of reactive emotion. The interruption of emotion by another emotion is a central feature in the proposed model of SIE.

In the EFT literature, the problem of secondary emotion as a barrier to emotional processing of “global distress” has been discussed by Pascual-Leone and Greenberg (2007). In their model, global distress is characterized as,

a state of high expressive arousal (e.g., tears, emotional voice etc.) and low specificity in meaning (i.e. the object of distress is often unknown, the client has no sense of direction...global distress emerges suddenly, the person becomes dysregulated, and the specific concern at hand is often very vague and global (p.877).

This description of a state of global distress is similar to the description of the category ‘Hazy Emotional Experience’ in the proposed subjective experience model of SIE. As described above, hazy emotional experience involved the client’s awareness of intense, inchoate feeling and a sense of overwhelm and confusion that was related to the client’s difficulty symbolizing it. In some cases, e.g., a sense of great sadness, the problem in emotional processing was one of uncertainty about the meaning of symbolized emotion. Overall, in ‘Hazy Emotional Experience’, clients experienced a sense of vulnerability that was related to this emotionally unsure, confused sense of self. Also similar in the models of global distress and SIE, ensuing secondary emotion such as

fear or shame served to further obfuscate the initial emotional experience. Whereas the model of global distress explains shame and fear in terms of a global sense of self as “I am defective bad” or “I am weak, insecure” respectively (Pascual-Leone & Greenberg, 2007), the model of SIE highlights how clients felt fear or shame that was specifically related to the experience and/or expression of emotion. For example, the initial experience of inchoate emotion itself was perceived as threatening in terms of losing control over the overwhelming feeling of it or not knowing the course it might take. Shame on the other hand, was related to a sense of inadequacy about not being able to name and/or clarify the meaning of emotional experience.

Overall, the model of SIE proposed here explains what it is about the initial experience of emotion, including hazy, distressing emotional experience that is associated with a sense of risk or danger to the self, and clarifies the patterns of specific types of secondary protective emotional reactions that follow.

Secondary emotional reactions in the proposed model of SIE include fear, shame, guilt, anger, and sadness. Conceivably, there could be other types of secondary emotion. The concept of secondary emotion as an open class that potentially includes any and all types of emotion is in keeping with the experiential perspective of Greenberg and colleagues (Greenberg & Safran, 1987; Greenberg et al, 1993; Goldman & Greenberg, 2015). In addition, the proposed process model further refines the existing EFT model of SIE.

Greenberg et al (1993; 1997; 2006) have described self-interruption of emotion in terms of the client’s engagement in action against the self, such as physiological control over the visceral experience and expression of emotion, negative beliefs and self-talk that serve to

quash emotion, or avoidant behaviours like laughing or joking to ward off painful emotion. In addition, secondary emotion can obscure the experience, expression, and meaning of an initial emotional experience. The proposed model adds to the conceptualization of SIE in the EFT model by explaining the interrelationship of a sense of self as vulnerable in the context of an initial emotional experience, provision of self-protection through both the activation of secondary reactive emotion that serves to interfere with the continuation of the initial emotion and engagement in related avoidant/controlling protective behaviour.

Moreover, the proposed model provides a differentiated understanding of the types of secondary emotion that are experienced in the context of an emotionally vulnerable sense of self. For example, fear was by far the most frequently described type of secondary reactive emotion, as described further below.

**Fear of emotion.** In the proposed final integrative model of SIE, fear was the most common type of emotional reaction to emotion. Four classes of secondary reactive fear were conceptualized to represent differences in the object and meaning of fear across participants: fear of losing control, fear of expression of emotion, fear of the unknown, and fear of dying. Fear of losing control of the internal bodily experience of intense, deep, and/or painful feeling, that was often sudden, was of greatest concern. At the extreme, the intense and painful experience of emotion was so threatening that some client's feared death. In the following discussion, the concept of 'fear of emotion' described here will be compared to the existing literature.

Fear of emotion has been studied previously in the non-clinical, experimental literature. Taylor & Rachman (1991) assessed the validity of the construct 'fear of

sadness' in a non-clinical sample of 753 university undergraduate students. The students completed a 12-item questionnaire that was developed to test the hypotheses that sadness is feared, and that fear increases as the intensity of sadness increases. Results showed that fear of sadness was as common as the fear of snakes and spiders. Also, as predicted, levels of fear increased along with increases in the intensity of sadness. In a subsequent study by Taylor & Rachman (1992), the construct validity of 'fear of sadness' was also established as a type of fear that is discrete from other, more general types of fear, such as social anxiety, agoraphobia, and fear of bodily injury. It was also demonstrated that fear of sadness encompasses two aspects: the fear of the subjective experience of sadness itself, and a related fear of sadness cues.

In another experimental study, Williams, Chambless, & Ahrens (1997) validated the construct 'fear of emotion' that included fear of: anger, fear, positive emotion, and depression in a non-clinical sample of 75 undergraduates. The results showed that those participants who demonstrated fear of emotion as indicated by their responses on the Affective Control Scale (ACS; cited in Williams et al, 1997)), a measure of the fear of losing control of emotion or behavioral reactions to emotion, were also more fearful of bodily sensations, as measured by the Bodily Sensations Questionnaire (BSQ; as cited in Williams et al, 1997), following an induction exercise designed to increase autonomic arousal. Participants had been screened for a history of panic attacks to control for this potentially confounding variable. Williams et al (1997) concluded that these findings support the view that individuals who fear the symptoms of autonomic arousal are more

fearful of emotion and concerned about loss of control over inner experience than are those individuals who are less fearful of emotion.

The Taylor & Rachman (1991, 1992) and Williams et al (1997) findings from studies of university students are similar to the findings of the present study of depressed therapy clients in that fear of emotion was associated with awareness of intense visceral experience. Taylor & Rachman (1991) also noted a direct relationship between intensity of sadness and levels of fear, e.g., as ratings of intensity increased so did ratings of fear. It is possible that while fear of emotion is a phenomenon among university students that varies by degree according to within group variation in level of intensity, fear of emotion in a clinical sample is more likely extreme as it is related specifically to the subjective experience of high levels of intensity/arousal. The model of SIE developed in the present study supports this speculation, as awareness of intensity of feeling in the body was associated with the subjective experience of high levels of fear, e.g., fear of dying, fear of losing control. Also, the concept of fear of emotion in the present study also extends beyond the subjective experience of intensity/arousal to include fear of the unknown nature and course of emotion, as well as fear of the expression of emotion.

In the clinical literature, the suppression of emotion in Major Depressive Disorder was examined in one study, and fear of emotion was proposed as an underlying cause (MDD; Beblo, Fernando, Klocke, Gripenstroh, Aschenbrenner, & Driessen, 2012). Findings of this study showed that patients diagnosed with MDD engaged in higher levels of suppression of negative and positive emotions as compared to healthy non-patients. Examples of negative emotion included sadness, anger, anxiety, and depressed

mood. Positive emotions included pleasurable emotional experience, such as joy. Emotion suppression was measured by the following instruments: Emotion Acceptance Questionnaire (Beblo, Scheulen, Fernando, Grispentroh, Aschenbrenner, Rodewald, & Driessen, 2011; as cited in Beblo et al, 2012), Difficulties in Emotion Regulation Scale (Grazt & Roemer, 2004, as cited in Beblo et al, 2012), and Emotion Regulation Questionnaire (Gross & John, 2003, as cited in Beblo et al, 2012). Suppression in the MDD group was associated with symptom severity. Also of interest, the patient group endorsed higher levels of fear of negative emotions as compared to the non-patient group. This finding led the investigators to speculate that “fear of emotion might be one reason why MDD patients suppress emotions (p. 478).” They also called for more experimental studies and additional data collected using methods other than questionnaires to explore this hypothesis, as well as “to clarify the relations between emotion regulation, fear of emotion, and emotional experience (p.478).”

The results of the present study of SIE in depressed therapy clients is an initial step toward making clear the interrelationship of emotional experience, fear of emotion, and emotion regulation. First, the proposed model of SIE supports the proposition that fear of emotion plays a central role in the experience of depressed clients, though it is limited to the context of a therapy session. The interrelationship of a sense of emotional vulnerability in the self, fear of emotion, and acts of control (suppress/inhibit emotion) or acts of avoidance (distance or detachment from emotional experience) was explained. Furthermore, it was learned that specific aspects of emotion were feared, such as the

private visceral experience of emotion, inchoate emotional experience, or the public showing/expression of emotion.

Going beyond the proposal that fear of emotion is behind the suppression of emotion in depression, the present model of SIE in depressed clients also shows that some clients do not experience fear of emotion. Rather, other secondary emotions, such as shame, guilt, sadness, or anger may be involved. A pattern of multiple reactive emotions was also identified in a few cases. Whether this more varied class of reactive emotion is an artifact of the therapy context or extends more broadly to a general pattern of suppression of emotion by emotion among depressed individuals is an empirical question that requires further study

The present model also explains how secondary emotional reactions occurred in response to specific qualities of an emotionally vulnerable sense of self in therapy. Reactive fear was associated with one or more of all five aspects of vulnerability in the self (awareness of feeling in the body, expression of emotion, emotional conflict inside, hazy emotional experience, weakened state) across sadness, anger, hurt, inchoate emotion or emotional pain. In contrast, other reactive emotions were limited to a narrower range of the qualities of vulnerability. Reactive shame was not associated with awareness of feeling in the body. Rather, it was particularly related to admitting or expressing strong feelings. In all cases of secondary reactive shame, participants described related beliefs and concerns about violating social or personal values and norms or being exposed and subjected to negative evaluation by others. For example, the expression of anger evoked a feeling of

shame and related concerns about transgressing personal or social norms or values and thereby being vulnerable to censure.

Reactive sadness was also linked to anger, as it was evoked in connection with awareness of urges or actions to express strong angry feelings. Reactive guilt was only associated with expression of anger and related needs.

In addition, the proposed model of SIE provides a differentiated understanding of secondary reactive anger. An experience of vulnerability in the context a “wave” of intense sadness, and an overwhelmed and weakened sense of self, gave rise to secondary anger. The function of secondary anger was an intentional act in the service of providing “cover” or a means to “shut down” or “eradicate” sad feeling and its expression. Secondary anger was expressed as harsh self-judgements of sadness and a “sad self,” or on other occasions the feeling of reactive anger alone interrupted the visceral sense of sadness.

There are very few published empirical studies that describe and explain how an initial emotional experience or expression is arrested by the onset of a different emotion. Three studies that address the issue of secondary emotion will be summarized below.

As described previously above, Pascual-Leone and Greenberg (2007) propose a model of global distress developed from a task analysis of depressed clients in EFT. The model explains how secondary emotions of fear, shame, or rejecting anger serve to keep clients “stuck” in terms of progression on the path of emotional processing. Those clients who were able to move past secondary emotion, through a synthesis of needs and negative evaluations associated with fear, shame, and rejecting anger (“ ‘I still don’t’

have what I need' and 'I miss what I deserved,'" p.878) were able to move on to experience more adaptive emotion states, such as expressing assertive anger and self-soothing.

In a qualitative study of clients' "experience of moments of sadness in psychotherapy," the function of anger as a means of avoidance was described (Henretty, Levitt, & Mathews, 2008, p.244). Participants with a variety of presenting problems and disorders engaged in an IPR interview where they recalled their experience of sadness while listening to an audiotape of a recent therapy session. These interview were analyzed following the method of grounded theory (Glaser & Strauss, 1967). The therapists' psychotherapy orientations included cognitive behavioural, humanistic, and integrative.

In half of the clients' accounts of moments of sadness, there were descriptions of how reacting in anger, often by blaming self or others, was "more powerful and less painful than sadness" (p.250). These results are consistent with the concept of secondary reactive anger in the model of SIE proposed here, where the angry verbal critic (of self or other) provides protection for clients who are experiencing the sense of a vulnerable sad self. Similarly, protective anger did not necessarily involve cognition, as the powerful feeling of anger alone interrupted the threatening visceral experience of sadness.

According to Henretty et al (2008), fear was even more central in the client's experience of sadness, as represented by the core category: "In therapy, the experience of sadness is a struggle against the fear of becoming trapped within the painful, existential question, 'Who am I.'" The "fundamental struggle" for clients was between facing and

avoiding sadness that involved a “deep fear of becoming stuck in their sadness” (p.246). Three means of avoidance were identified: humour, anger (as described above), and topic evasion. While all three of these means of avoidance of sadness were also identified in the present study, the class of avoidance was broader than described by Henretty et al (2008) as it also included ‘safe distance’ from internal experience, in the form of detaching/dissociating from the perception of internal experience, and shame. In addition to avoidance of sadness, the proposed model of SIE in the present study also explained how clients engaged in means of control over sadness by muscle constriction, breath control, or silence.

The interruption of emotion was not a focus of study for Henretty et al (2008) as it was in the present study, where therapy clients viewed a pre-selected portion of a videotaped therapy session that contained a marker of SIE. In contrast, Henretty et al (2008) used a method that involved free recall of sadness while listening to an audiotape of a full session of therapy. Also, in contrast to the present study of a homogeneous group of psychotherapy clients in terms of a common diagnosis of depression, the participants in the Henretty et al (2008) study were a heterogeneous group as they suffered from a range of diagnoses and disorders. It is interesting that despite these methodological differences, the phenomenon of interruption of emotion was described by all clients in the present study and all but one in the Henretty et al (2008) study. This finding lends support to the proposition that interruption of emotion is a common phenomenon in psychotherapy that clients struggle to resolve. Furthermore, the subjective experience of SIE as a phenomenon irrespective of the therapy context is supported by the fact that

there was more diversity in the therapists' psychotherapy orientation in the Henretty et al (2008) study (cognitive behavioural, integrative, humanistic) as compared to the experiential psychotherapy orientation of all therapists in the present study.

The phenomenon of coping with an emotion by engagement in a subsequent emotion has also been described in a qualitative study of emotional inhibition (EI; Coggins & Fox, 2009). In this study, highly avoidant university students participated in an interview about their experience and understanding of emotion that included a developmental perspective.

In one of the main categories conceptualized from the analysis of student interviews entitled "Current strategies for coping with emotion," Coggins and Fox describe a central theme of "emotional coupling" that they define as "switching from painful to less painful emotion" (2009, p.65). They explain emotional coupling as a way of coping with difficult emotions that was rooted in the childhood experience of emotions as harmful or damaging to themselves or others in the family. This method of coping with threatening painful emotion, that was learned in childhood, was similar to the description of one participant in the present study. In describing how she learned to cope with painful emotion as a child she explained,

There's a part of me that's angry. There's a part of me that's sad. There's a part of me that's depressed. There's a part of me that's happy. There's a part of me that experiences love. They're all separate parts of me. I can bring them all together under one umbrella,,if I choose to and it's okay. But I can separate these things out and if one becomes too painful I can jump to another thing...But back then I

was just learning how to do that (50.PE.5).

Coggins and Fox (2009) also found that “emotional coupling” was particularly evident for anger, which was coupled with sadness as means of emotional inhibition. This sequence of anger and subsequent sadness was also described in qualitative accounts in the present study, where participants described how sadness served to defuse the feeling of intense and dangerous anger that was associated with a vulnerable sense of self.

In summary, in addition to explaining the role of vulnerability associated with difficulty allowing physiological arousal, symbolizing arousal, and/or expressing the meaning of emotion and related needs, the proposed model of SIE also provides a differentiated understanding of the form and function of various secondary/reactive emotions as protection against dangerous emotional experience by depressed therapy clients. Moreover, the proposed model of SIE both confirms and adds to existing knowledge in the small body of published qualitative literature containing descriptions of emotion sequences by participants in clinical and nonclinical samples, where one emotion serves to interrupt or inhibit another. While the occurrence of secondary reactive emotion appears to occur in both clinical and non-clinical samples, it remains for future comparative studies involving clinical and non-clinical samples to determine the differentiating features of this process between these two groups.

Overall, the findings from the present study show that the main processing difficulties that give rise to secondary reactive emotion in the process of SIE can be categorized under two main domains of vulnerability in the context of emotional experience:

1. Problems in allowing the internal experience of emotion and the subjective sense of high

arousal that also included a weakened sense of self and/or hazy emotional experience, and 2. Difficulty related to the outward expression or showing of emotion in words (including the expression of related needs in some cases) or expressive actions (crying). As described above, specific types of secondary emotion are related to one or both of these problems in emotional processing. There were no differences across these two domains in terms of related behaviours of emotional avoidance or control.

### **Comparison with Other Psychotherapy Models**

There are similarities and differences between the concept of secondary reactive emotion in the proposed model and McCulloughs' concept of "inhibitory affects" (1999). The terms affect and emotion are both defined here as referring to the conscious experience of emotion. There are similarities between McCulloughs' concept of inhibitory affect and that of secondary reactive emotion in the proposed model of SIE, as they both serve to impede an initial emotional experience. Also, emotions of inhibitory/secondary fear, shame and guilt are common to both. However, there are differences in the conceptualization of pain.

Initially, McCullough (1999) identified five types of inhibitory affects that serve to inhibit affective experience, especially those related to adaptive attachment needs: Anxiety/panic/fear, shame/humiliation, guilt, emotional pain/anguish, and contempt/disgust. As she further refined the model she explained that "anxiety" was an overarching term that encompasses any and all inhibitory affects (McCullough, Kuhn, Andrews, Kaplan, Wolf & Hurley, 2003). This refinement was in keeping with the parallel she drew between the classic model of phobia, where fear is evoked to external cues, and the concept of internal affect phobia that became a central concept in her model of psychopathology. It is also

similar to Freud's concept of signal anxiety that is activated when there is a perception of an internal or external threat, though the content of the threat differs in keeping with the change from drive based id impulses to affective experience in McCullough's model.

Whereas McCullough describes pain as an inhibitory affective response to an initial affective experience, the subjective experience of pain in the proposed model was experienced as part of the initial visceral experience of emotion rather than as a response to it. For example, one participant experienced emotional pain as a bodily felt experience of profound aloneness that she described as an "explosive" force of painful feeling in her body, to which she reacted with a great fear of dying. Another client reported how intense, deep feelings of anger involved a sense of physical pain in his abdomen like a "gash." These painful feelings of intense emotion were perceived as damaging to the physical self, and it was this perception of threat that evoked inhibitory fear. In short, pain was part of an initial experience of emotion, not a secondary reaction to an emotional experience.

In addition to differences regarding pain, the class of secondary reactive emotion in the proposed model also includes anger and sadness, whereas these emotions are not included in the class of inhibitory affects in McCullough's model. These differences may be accounted for by methodological differences. McCullough's affect phobia model was derived primarily from a priori rational/logical method of theory construction that involved the integration of existing theories and concepts. In contrast, the proposed model was developed using a rational/empirical method, where an initial rational model was revised in light of information from empirical task analyses of therapy transcripts and grounded theory analysis of interview transcripts.

Similarly, Fosha's (2000) AEDP model was constructed using a rational/logical method of theory integration involving concepts from four theories: short-term dynamic psychotherapy, attachment theory, emotion theory, and experiential theory. In the AEDP model, the concept of "secondary affective reactions" to "core affective experience" is a class of affects limited to shame, anxiety and loneliness in the context of attachment. In addition, she proposes that these affective reactions are followed by "red signal" affects of fear or shame that function to activate defenses against emotional experience. In contrast, the proposed model of SIE includes a more varied range of secondary reactive emotions that goes beyond fear/anxiety and shame to include anger, sadness, and guilt. Again, these variations in the class of secondary emotions may be attributed to methodological differences in theory generation. Moreover, the focus on attachment in the model may also contribute to a more circumscribed class of "secondary affective reactions."

Common to Greenberg, McCullough and Fosha's models, secondary or inhibitory emotion is conceptualized theoretically as maladaptive or defensive, as it serves to block primary adaptive or core emotion and action tendencies that promote well-being (Greenberg et al, 1987, 1993; 1997, 2015; McCullough et al, 1999, 2003; Fosha, 2000).

The subjective experience of the therapy clients in the present study was that secondary reactive emotions arose in the context of vulnerability in the emotional self and promoted a sense of self-protection. The self-protective function of secondary emotion is consistent with the EFT perspective of Greenberg and colleagues (Greenberg, L. S., 2015; Goldman & Greenberg, 2015).

In some cases, such as reactive fear, shame, or guilt, the subjective experience of secondary emotion was one of an emotional warning that danger to the self was at hand, either from within the body at a visceral or perceptual level, or from the external world should emotional experience be shown or expressed. The subjective experience of these protective emotions was that they served to alert the self to both a sense of impending danger and gave rise to an implicit or explicit need for protection. In many cases this need was then met by avoidant and/or controlling behaviour. In some instances, the visceral experience of the protective emotion itself served to override the initial experience of emotion and soothe or strengthen the vulnerable self in the short term. Such was the case of secondary reactive sadness that soothed the unbearable force of anger in the body, or anger that empowered a weakened emotionally wounded self.

Protective secondary reactive emotions may also occur in sequences that function to warn of danger followed by emotions that serve to mitigate danger. An example from the proposed model illustrates this point. Reactive fear was evoked in response to awareness of the visceral experience of intense, deep and overwhelming feelings of sadness and a sense of self in a weakened state. This reaction of fear was followed by the feeling and expression of anger that served to “shut off” or “cover” the initial sense of sadness. Alternatively, shame about showing intense feelings in a weakened state, while feeling overwhelmed and unsupported, may be followed by expressions of angry self-criticisms that function to “eradicate” a “sad self.”

In summary, the basic idea that it is “good” to experience and express emotions in therapy is often at odds with the client’s sense that it is existentially dangerous to do so. It is

important for both the therapist and client to understand the validity of entrenched ways of reacting to threatening emotional experience as they foster a sense of safety and protection for the vulnerable self, as well as to recognize the longer term negative consequences to psychological and emotional health as emotional experience that may enhance well-being is blocked. As the therapist and client work together to name and bring into clearer focus the experience of vulnerability in all its forms, it will both help the client make order or meaning out of a multiplicity of evolving features of emotional experience, and provide clarity in terms of identifying which aspects of vulnerability might be a focus of support and change.

### **Comparison with Process Models that Include Interruption of Emotion**

Interruption of emotional experience in therapy clients is described in one study of the process of transformation through emotional pain (Bolger, 1996), and in another study of the resolution of hopelessness in EFT therapy (Sicoli, 2005). Each of these studies is summarized below, and comparisons with the conceptualization of interruption in the proposed model of SIE are discussed.

In a qualitative study of transformation through the experience of pain, Bolger (1996) proposed a process model that represents how group therapy clients who were not able to work through emotional pain by “Allowing brokenness,” and “Staying with Brokenness” and related painful emotions, did not experience positive self-transformation. The model includes a category “Alarm” that represents the subjective experience of fear/anxiety, shame, panic, and/or shock in response to the painful sense of “Brokenness” and loss of control. In Bolger’s conceptualization, these emotional “alarms” occurred in

both those who worked through, and those who did not work through, pain. However, those who were successful vs. unsuccessful in working through pain could be differentiated at a choice point of either “allowing” or “covering” it. “Covering” of pain involved engaging in behavior that served to “interrupt”, “hide,” or hold” onto pain. The concept of “interrupt” in Bolger’s model refers to behaviours of detaching, stopping or controlling feelings, disallowing or denying feeling, or stopping the sense of breaking.

In another study, Sicoli (2005) developed a process model of the resolution of hopelessness in depressed clients from a task analysis of hopeless events in an EFT session. She found that those therapy clients who interrupted emotional experience were unable to complete the process of resolution of hopelessness. The component “Interruption” in the model explains how that those who interrupted an experience of emotion: had problems tolerating the feeling of emotion or accepting emotion, expressed contempt for emotional experience, complained, changed the subject, or engaged in intellectualization. Sicoli also reported that the suppression of anger differentiated resolvers and non-resolvers of hopelessness more so than the suppression of sadness or pain. The process of anger suppression was not elaborated. The model also includes a component “Secondary emotional reactions” to hopelessness. This component was not written in the model to show any relationship to “Interruption.”

In both Bolger’s model of transformation through emotional pain and Sicoli’s model of the resolution of hopelessness, the interruption of emotional experience was a barrier to the transformation or resolution of a negative emotional experience. Furthermore, in both models, the concept of interruption was limited to

avoidant/controlling behaviours such as, physically pushing emotional experience down or away, or cognitive control. Emotional reactions to emotion were also included as components in both models (“alarm”-Bolger, “secondary emotional reactions”-Sicoli).

However, in contrast to the proposed model of SIE, these emotional reactions were not conceptualized as central features of the interruption of emotional experience itself. Instead, both models are consistent with the proposed minor model of SIE described previously (Type II- Inhibitory Behaviours), where interruption involved behaviours of avoidance or control only. The proposed model of SIE explains how, most frequently, interruption is a process involving the interrelationship of vulnerability in the self, secondary reactive emotion, and related behaviours of avoidance or control. In other words, the experience of secondary emotions in and of themselves serve to “interrupt” awareness and allowing of an initial emotional experience while in a vulnerable state, as do often related behaviours of avoidance and control.

In the present model, the concept of secondary reactive emotion, in the form of fear or shame, is similar to that of an internal sense of “alarm” in response to awareness of emotional experience as it is described in Bolger’s model. Likewise, secondary reactive emotion also included fear or guilt, as outlined in Sicoli’s model. However, secondary reactive emotion was more broadly defined in the model of SIE proposed here as it also included anger and sadness. Also, the proposed model of SIE includes a wider variety of initial emotions and emotional experiences beyond emotional pain and hopelessness, including sadness, hurt, anger, fear, sorrow, and emotional upset. One explanation for these differences is that the process of interruption for emotional pain or

hopelessness has its own signature, where more circumscribed reactive emotions occur. This hypothesis is supported by the one case of emotional pain in the present study where, similar to Bolger's model, fear (of losing control, not surviving) was the sole "alarm" or reactive emotion.

These differences between models may also be accounted for by the fact that the main focus in the prior studies was to develop a model of the resolution or "working through" of specific emotional experiences, whereas the primary focus of the present study was to understand more broadly the process of self-interruption of emotion itself. In addition, methodological differences may have contributed to differences in the conceptualization of interruption. The proposed model of SIE included both the methods of grounded theory and interpersonal process recall used in Bolger's study, and the descriptive phase of the task analytic method used in Sicoli's study. Furthermore, the sample used in the proposed study differed from the one used by Bolger. Whereas participants in the present study were adult males and females who participated in short-term experiential psychotherapy for depression, Bolger's sample consisted of adult women in an ongoing support group for adult children of alcoholics, whom she interviewed after group sessions.

### **How to Address Secondary Reactive Emotion in Vulnerable Therapy Clients?**

It has been suggested that deepening the experience of secondary emotion is not therapeutic given that it interferes with the processing of adaptive emotion that is more central to well-being (Greenberg & Paivio, 1997, Greenberg & Pascual-Leone, 2006). Instead, it has been recommended that the therapist recognize "secondary emotions in the

moment, so that they can be validated and bypassed by the therapist (Goldman & Greenberg, 2015, p.27),” and the focus can shift to exploration, acknowledgment, and expression of underlying feelings and needs in words.

This strategy could be most effective in cases of vulnerability in the emotional self that is associated with awareness of the visceral experience of intense, unfamiliar, and/or un-symbolized emotional experience that is perceived as threatening, and in turn evokes reactive fear or shame. There were a number of clients in this study who fit this profile of vulnerability, as described in the category Hazy Emotional Experience. The importance of facilitating the naming and expression of emotional experience to circumvent threat based secondary reactive emotion and related avoidant behaviour is supported by the findings of one experimental fMRI study. In this study, involving a non-clinical sample, it was found that “putting feelings into words” during an emotion naming task was associated with reduced activity in the amygdala, the part of the brain involved in perceiving threat and related body responses (Lieberman, Eisenberger, Crockett, Tom, Pfeifer & Way, 2007). In another study of individuals who scored high on the Spider Phobia Questionnaire and who were repeatedly exposed to a live spider, it was found that affect labelling in the form of anxiety and fear words resulted in lower levels on measures of skin conductance, a physiological measure of arousal, as compared to reappraisal, distraction, or straight exposure (Kircanski, Lieberman, & Craske, 2012)

However, the strategy of encouraging the articulation of emotional experience may not suffice in all cases of self-interruption of emotion where initial, self-relevant emotion is perceived as dangerous and the level of threat high, as in the present study. By

doing an end run around secondary emotion and refocusing the client on the experience of initial feelings and emotions, without also helping them to address the problem of managing the profound sense of vulnerability in the face of intense emotional experience, the therapist runs the risk of perpetuating the interruptive process. In effect, secondary emotion may be thought of as a marker of vulnerability in the process of SIE that must be attended to and processed fully at times, to bring to awareness its protective function for a vulnerable self before moving on to more primary and often threatening emotional experience.

Many clients in this study described how the therapist's focus on, empathic reflection of, and directions to express in words an initial emotional experience served to "trigger" visceral arousal, which in turn was too intense to bear and left them with a sense of self as emotionally vulnerable. In turn, they reacted to this experience of vulnerability with secondary protective emotions and related emotionally avoidant or controlling behaviours. It is reasonable to suggest that focusing exclusively on deepening the emotional experience that 'primed the pump' of secondary reactive emotions and related motivation to engage in avoidant and controlling behaviour could lead to the same result.

In short, while redirecting attention to the emotion underlying secondary reactive emotion could be a useful and productive strategy for some clients and at some times, it could also promote a negative emotional experience akin to flooding for others that serves to precipitate and perpetuate the self-interruptive process. In keeping with the results of the spider phobia exposure study described above (Kircanski, Lieberman, and Craske, 2012), it may be more productive to encourage clients to put words to the feeling

and meaning of secondary fear of an initial emotion, that in turn regulates arousal, as a stepped approach to fully allowing and expressing underlying emotion.

However, as was the case in this study, therapists were not always aware that the client was privately experiencing secondary emotion, and they continued to encourage allowing and expressing in words more obvious emotional experience. An example from an IPR interview in the present study illustrates this point.

During the IPR interview, one woman explained that she and her therapist had determined in a previous session that she often stopped emotion during their session by deeply exhaling and “blowing it away.” During the segment of therapy tape she was shown in the IPR interview that contained a marker of SIE, the therapist asked her “How are you feeling right now?” She replied “Overwhelmed.” As she proceeded to explain why to the therapist, she started to cry. During the IPR interview she recalled that at this point in the therapy session she was feeling “a very deep sense of pain and grief. I remember stopping and crying. She (therapist) was telling me to keep going...she kept saying ‘Let it go and really cry. It’s ok. Let it go’... and I couldn’t remember what I was crying about but I remember stopping it because I had a feeling at that time if I let this feeling go and I really cry, I will break, I will just break because, I might die because I won’t be able to stand it, the pain...When I explode and all at once I have this sinking feeling like I’m dying or just drowning or sinking and I have to stop it...this is dangerous (MU2,8,21).” Her sense of fear about allowing herself to keep crying served to interrupt the initial experience of emotional pain. However, this secondary reactive fear of intensely painful feeling was not apparent to the therapist nor was the client expressing it

overtly. The end result here was that the client could not “Let it go” as she felt overwhelmed and unsafe in the face of intense, deep feeling, and so she ultimately stopped feeling altogether.

In summary, while deepening the experience of secondary protective emotion may not be helpful, though empirical support for this assertion is lacking, it is also plausible that bringing to awareness and expressing the experience of secondary emotion and related avoidant and controlling behavior, clarifying both the nature and protective function it serves in the context of a vulnerable sense of self, is an important step toward allowing more adaptive emotion. In the case of reactive fear, which was the most common type of secondary emotion in this study, allowing and expressing in words fearful feelings and beliefs may serve to reduce the perception of threat and thereby fear in the safe space of an empathic therapy relationship. As a sense of vulnerability in the self is regulated, processing of the initial emotional experience can take place. The approach here is more one of ‘peeling the onion’ as opposed to ‘cutting to the core.’”

Given that secondary emotion may not always be apparent to the therapist, or even the client, it is important to assess for the presence of secondary emotional reactions to initial emotion when a marker of SIE is observed. In cases where secondary emotion is expressed explicitly, one EFT strategy for working with secondary emotion is to engage the client in a two-chair dialogue where they enact the interruptive split between the experience of initial emotion on the one hand and the ensuing secondary emotional reaction on the other hand, in the context of an empathic therapy relationship (Greenberg et al, 1993; Greenberg, 2015). In doing so the client has the opportunity to gain an

experientially grounded understanding of the process of self-protection that they engage in, including knowledge of what it is about the experience of emotion that leaves them feeling vulnerable as well as understanding that they are not victims of emotion but rather they have agency in this process. As well, the client will gain an experiential understanding of the outcome or consequence of limited emotional awareness, which in many cases in the present study was predominantly a negative sense of depletion. The example provided below illustrates how the therapist works with the client in a two-chair dialogue to make clear how secondary reactive emotion plays a role in the self-interruptive process. In this example, secondary guilt interrupts the expression of anger as the client engages in an imaginal empty chair dialogue with her father.

T: This is what's tearing you up. Tell her that you've got no right to be angry at him. Tell her what he's done for her. Let's give each side a voice.

C: He's taken you out of a home and let you live with him. He sent me away to school. He's been there.

T: Right he's been there for you so therefore,

C: You should feel guilty when you say you're mad at him (10/#13).

This secondary reactive guilt can then be further explored and expressed in chair work, to bring to awareness how it functions to silence assertive anger, with the ultimate goal of validating and strengthening the expression of related unmet needs in the relationship.

In another example, the client and therapist are exploring how he interrupted sadness in the session. The therapist coaches the client to enact the suppression of sadness. Through this enactment, the client became aware of how he “squelched” sadness and that is was related to fear of embarrassment by showing his feelings to others.

C: I was sad.

T: You were sad just before you cut off?

C: Just before, yeah...I feel nothing until it just escapes, whatever it is that's being squelched, and then I just feel really, really bad until I pack it down again.

At this point the therapist instructs him in an experiential exercise that involves the enactment of squelching sadness by packing down Kleenex into a box, to bring to the interruptive process to awareness.

T: Let's see if we can just pack it in, can you try? ...Just pack it in the way you do. You're the squelcher, just packing in those feelings

C: (Sounds of client “packing” the Kleenex)

T: What's happening to you now?

C: I think I need to keep things all tidy and in their place. I don't want to make a mess or something.

T: Mm-hm, mm-hm, you don't want to make a mess. You've got to keep things neat and tidy. Is that the way someone would speak to you?

C: I don't know.

T: Is that your mom? 'Make sure to stay neat and tidy. Don't make a mess.'

C: Oh I'm sure she must have said something like that.

T: It doesn't have that feeling to it now?

C: No because I just feel free to ignore her (laughs).

T: Mm-hm. So what are you doing with the Kleenex now? You're packing it in.

C: (Laughs) I guess I'm almost trying to pack the Kleenex in to the shape of a rectangle.

T: Do you have the sense as you're doing that of being the squelcher, the packer-in, to pack in these feelings?

C: A bit. It kind of feels like trying to keep everything together to prevent it from spilling out.

T: I see. But if you weren't there doing that, what might happen?

C: Maybe embarrass myself. Maybe let on to other people that I'm unhappy or that other things that they do bother me.

T: So it feels very unsafe somehow...you've got to keep it all in...better to say nothing than to really let yourself be known. But if you do speak, somehow there's a real fear that you'll embarrass yourself. You'll make a fool of yourself.

C: Yeah. (52.PE.11)

In summary, engaging the client in a two-chair enactment of SIE serves to increase the client's awareness and lived understanding of the self-interruptive process, as well as the therapist's understanding of specific aspects of the client's interruptive

process that need attention and provide a focus for further work in therapy. The quality of safety in an empathic therapy relationship is essential for the client so that vulnerability can be acknowledged and addressed, and the client will feel motivated to take the risk of allowing emotional experience that is experienced as threatening. It is important for the therapist to be aware of the client's level of comfort in allowing emotional experience, as there is always the possibility that they are 'ahead of the client' and may be inadvertently pushing for allowing when the client is not ready. This mismatch of client and therapist pursuit of emotional experience was illustrated in the example above, where the therapist was unknowingly going beyond the client's level of comfort in coaching her to "let it go" and cry, with the end result that the client shut down feeling completely.

Gendlin's (1978) focusing method is also a useful way of addressing secondary protective emotion. He uses the metaphor of "a cage full of snakes" to describe the sense of horror some clients feel about approaching inner feelings. Recall that in the present study of the subjective experience of SIE, clients used metaphors to describe emotion such as a "monster," "alien" or a "wave" of tidal proportions, felt inside the body.

Gendlin explains how therapists can work with a client who is afraid to focus on a "felt sense" as follows,

[I]n focusing you can treat yourself gently. Take yourself by the hand and say, "It's all right, we will not force you to go where you don't want to go. If you're afraid of that place, we'll keep our distance. We'll stay right here and see what the fear is. All right? What does this 'fear' feel like from here? If I don't want to go into it I am not going to. But I won't back off either. I'll just stay right here,

where I don't want to focus, and I'll see: what is this feeling of not wanting to? Scared. OK, let's just stay right here, with this 'scared.'" What is this 'scared'? What kind of 'scared' is it? What is the whole feel of it? (1978, p.93).

In this way, Gendlin argues that avoidance of feelings can be overcome by approaching "what is" in awareness, which in turn allows for a new experience. He explains,

[F]ocusing allows the body to change what has long been stuck and unchanging in us. This means we need not be scared of what is in us-for there are no 'its' in us. Rather our feelings are newly produced each moment (1978, p.95).

The proposed model provides information about the specific aspects of vulnerability, or "what is," that give rise to secondary emotion. In the case of difficulty tolerating the sudden awareness of intense, deep and/or painful feeling, the therapist can work with the client to stay focused on bodily based experience and just notice secondary emotional reactions and related urges to avoid or control this visceral experience. If arousal is experienced as unbearably high and threatening, the client can be instructed in the use of self-soothing methods such as, regulating breathing, calming imagery, and self-empathy/validation, to promote tolerance and acceptance of this distressing emotional experience (Greenberg, 2015; Greenberg & Pavio, 1997). As Greenberg explains, the function of instruction in self-soothing is,

to help people cope with highly overwhelmed feelings to help them calm down and cope better rather than become dysregulated emotionally or behaviorally... to regulate secondary feelings, and fundamentally involves psycho-education to teach the client to deliberately perform and to practice efforts to down regulate

emotion by soothing self-talk or by evoking a safe place to get a positive or calming feeling (L. Greenberg, personal communication, January 17, 2013).

Garfinkel and Critchley (2016) discuss how in the processing of fear, signals from the heart inform the brain about how strong and fast it is beating, which in turn promotes “a general inhibitory effect” on perception, cognition, and the processing of pain (p.41, p.43) in preparation for the “fight or flight” response. Accordingly, it would be especially helpful for therapists to use strategies that soothe the body by focusing directly on reducing heart rate, such as coaching the client to use paced breathing or to use an ice pack, as well as providing safety in the relationship by providing empathic understanding and reassurance.

However, it is also important to assess if self-soothing has become another means of interruption as the ultimate goal is for the client to be able to allow emotion, with the reassuring understanding that they have the ability to step in and out of emotional experience.

In essence, if a client has had an experience of ‘surviving’ emotion at a visceral level, this new experience of safety will serve to circumvent the activation of protective secondary/reactive emotion and related avoidant and controlling actions, and promote taking the risk of working on fully allowing and processing emotional experience.

### **Secondary Emotion and Role of Therapy Context**

While results from this study provided empirically grounded information about the role of secondary reactive emotions in the process of SIE, there were differences between emotion focused (EFT) and client centered (CC) therapies. Whereas clients in EFT therapy reacted

with one or more of the full range of secondary emotions to an initial sense of vulnerability related to a particular emotion or emotional experience, clients in CC therapy reacted primarily with fear/anxiety.

These differences can be accounted for by differences in how and what the therapist does in terms of directing the client's attention to internal experience. In EFT therapy, the therapist explicitly targets emotion and actively directs the client's attention to awareness, symbolization and expression of emotion in terms of related needs and meaning. Moreover, expression in an interpersonal context, such as in the unfinished business model of EFT where clients engage in two-chair dialogue with significant others, gives rise to secondary 'social' emotions of shame and guilt.

In contrast, in keeping with the CC model the therapist is not as active in directing the client's attention to specific emotion, related needs, and expression. As a result, awareness of emotional experience may be more circumscribed. These differences in secondary emotion across therapy modalities, both within the present study and across the different therapy models outlined above, point to the importance of considering the context within which interruption of emotion occurs and the possibility that the client's subjective experience of the interruptive process may vary across different therapies.

For example, the emotion of anger was unique in that there was a greater variety of secondary protective emotions for clients who interrupted it in the context of an EFT session. Whereas secondary fear and/or shame was evoked in reaction to sadness, anger, hurt, inchoate emotion, or emotional pain across both client-centered and EFT therapies, secondary guilt and sadness were only associated with an initial experience and/or

expression of anger in the context of an EFT session. There was one case of interruption of anger in a client-centered session and it involved reactive fear only. This difference could be attributed to a heightened sense of vulnerability in response to encouragement by the EFT therapist to express anger that necessitated more complex emotional reactions to shut down the expression of a strong sense of anger and related needs in chair work. For example, one man reported awareness of an intense “thrust” of painful anger that evoked reactive fear and a related sense that he might not survive should it be allowed out. He struggled with this experience as the therapist encouraged him to express what he needed in a two-chair dialogue. However, it was his experience of reactive sadness that soothed the sense of a life-threatening “alien” beast inside him and left him feeling “safe.” In contrast, the CC therapist did not engage in these types of tasks and directives. Given this difference of a less pointed sustained focus on anger and its expression, a related sense of vulnerability might not be as great. Gender may also play a role here, as reactive guilt in the face of anger only applied to female clients.

Unique to EFT was the interruption of emotional expression at a point where the therapist coached the client to both identify and express related needs. This difference is accounted for by the fact that the explicit expression of needs is a component of the EFT model only.

### **Emotion History and Case Formulation for Self-interruption of Emotion**

From accounts of the subjective experience of SIE, it was learned that participants’ in-session experience was situated in a historical context that predisposed them to feeling vulnerable in connection with awareness and/or expression of emotional experience. It was

also learned that that they coped with vulnerability by engaging in longstanding strategies and behaviours in the service of controlling and/or avoiding the internal experience of emotion. Therefore, emotion history is a latent element in the process of in-session SIE that is significant. As one participant put it while describing an internal experience of emotion, “I’m past, I’m present.”

The developmental aspects of emotional inhibition have been described in a qualitative study of emotional inhibition that was summarized in more detail in a previous section (Coggins & Fox, 2009). There are similarities and differences between the category “Experience of emotions in childhood” described in the study and the category ‘Emotion Histories’ that was conceptualized in the present study.

A common theme in both studies was the occurrence of a traumatic experience in childhood that left participants with the sense that emotions were dangerous to express. However, the experience of a traumatic event was described by all of the participants in the Coggins and Fox (2009) study, whereas it was only reported in 54% of the participants in the present study. This difference may be accounted for by the fact that in the Coggins and Fox (2009) study, there was a deliberate focus on the developmental aspects of emotional inhibition and more probing questions specific to this interest were included in the interviews. Another difference is that in the present study, the legacy of traumatic experience went beyond the perception that expression of emotion was unsafe and included the sense that the feeling of emotion itself was also dangerous. Differences in the characteristics of the participants between the two studies is likely a factor here as the Coggins and Fox (2009) study involved a non-clinical sample of university students,

whereas the present study involved a clinical sample of depressed clients who interrupted emotional experience in a therapy session. Finally, in both studies, the theme of a lack of emotional support in the family was present, though once again this theme was identified in all participant accounts of experience in the family of origin in the Coggins and Fox (2009) study only. Inquiry into the developmental history of emotion suppression and avoidance in future studies of therapy clients would allow for further development of the present model of SIE.

Consideration of emotion history can provide therapists with useful information about how client's experience and cope with emotion. In many approaches, the therapist takes a psycho-social history at the outset of treatment, and this information informs an initial case formulation. These interviews do not typically include a focus on how clients have historically experienced and handled emotion. This type of information is useful in terms of early case formulation about the types of emotional processing difficulties, such as difficulty or fear of allowing feeling and expressing emotion, that clients might be expected to experience over the course of therapy, especially in therapies where emotional experience is a central focus. Participants in the IPR interviews spoke freely and unsolicited about their history of difficulties allowing and/or expressing emotion, and in many cases, the features of the interruptive process that was active in the therapy session were foreshadowed in these accounts. In view of this observation, it is suggested that deliberate inquiry into the historical experience of emotion be included as a matter of course in an initial psycho-social history.

### **Limitations and Future Directions**

The generalization of results from this study is limited due to the nature of the sample and the type of psychotherapy involved. The sample consisted only of depressed clients participating in experiential psychotherapy. This lack of diversity in the sample raises the question of whether it can be said that “theoretical saturation” was reached in this study. According to Glaser and (1967), the analyst “goes out of his way to look for groups that stretch diversity of data as far as possible, just to make certain that saturation is based on the widest possible range of data on the category” (p.61). Given the lack of diversity in the present sample, further study involving diverse comparison groups is required before a determination of theoretical saturation can be made.

Given that the interruption or inhibition of emotion has been identified as a central problem underlying many psychological problems, it is suggested that future studies of SIE include clients with a diverse range of diagnoses/psychological difficulties where emotion regulation is a debilitating problem, such as generalized anxiety disorder, trauma, eating disorders, and borderline personality disorder (BPD).

While the proposed model of SIE explains the relationship between vulnerability, the perception of emotion as dangerous, and interruptive/inhibitory emotions and behaviours, and these findings are consistent with the Henretty et al study (2008) that had a more diverse sample, it is still possible that different results would be obtained from the study of interruption in different clinical disorders. There are a few empirical studies that report a relationship between the perception of threat from specific emotions and particular inhibitory behaviours. In two studies of disordered eating, perceived threat of emotion was

associated with emotional inhibition. In the first study, the perception of threat from anger in women with a range of eating disorders (ED; anorexia nervosa, binge eating, bulimia nervosa, and ED not otherwise specified) was singularly associated with inhibition of emotion (Ioannou & Fox, 2009). In a later study of a homogenous group of individuals seeking treatment for obesity, sadness was predictive of binge eating that functioned to suppress the expression of sadness (Fox, Msetfi, Johnson, & Haigh, 2016). Given that in the present study the phenomenon of SIE was not explored in clients with diagnoses other than depression, such as eating disorders, the proposed model of SIE is best thought of as a step toward the development of a comprehensive theory that is representative of clients suffering from a wide range of diagnoses.

With respect to diagnostic diversity, participants in the present study did not have a diagnosis of BPD. As described previously in the method section, they were selected from a pool of participants in two larger studies on the treatment of depression, all of whom did not meet diagnostic criteria for a diagnosis of BPD as it was one of the rule-outs for eligibility to receive treatment. However, there are similarities between this depressed sample and the characteristics of the emotionally vulnerable and “exquisitely sensitive” individual with BPD, in terms of difficulty managing the intense, painful, deep, and/or sudden onset of feeling and emotion, though the interruption of emotion in those with BPD often takes more extreme forms, such as self-harm and suicidal behaviour (Linehan, 1993, 2015). It is proposed here that the common core problem of over-regulation, or “interruption” of the visceral activation of emotion or arousal and/or its adaptive expression, is one type of emotional processing difficulty that may transcend

diagnostic categories, with differences in terms of the degree of severity in behaviors of control or avoidance used to regulate it. The validity of this proposition will only be determined by further study of interruption of emotion with individuals diagnosed with BPD.

While a variety of different emotions and emotional experiences were included in the sample, it was not an exhaustive list. Future analyses of different types of emotions, including both positive (e.g. joy, love) and negative emotions (e.g., sadness), could provide additional information about patterns of SIE across and within emotion types. The possibility that client's process of SIE may vary according to the type of emotion is supported by the fact that in the three cases of SIE where vulnerability was associated with an initial awareness fear, none involved secondary reactive emotion. Whether this is a meaningful result or not, or applies to other emotions as well, can only be determined by the study of additional cases of SIE.

Finally, diversity in terms of cultural differences was not addressed in the present study. Future studies are required that involve culturally diverse samples to both understand what role, if any, culture plays in the process of SIE and to ensure saturation of the categories in the model.

An attempt to mitigate researcher bias was made in a number of ways in the task analysis. Initial assumptions about the interruption of emotion were made explicit, and the marker and components of the model that were conceptualized by the writer were reviewed by an expert in the method of task analysis. In addition, with respect to the subjective experience model, the performance model served as an explicit statement of

assumptions about SIE prior to undertaking the grounded analysis. The categories conceptualized by the writer in the grounded analysis were also subjected to external review and feedback by an expert in the area of self-interruption of emotion (L. Greenberg). This feedback was considered and changes to the conceptualization of categories was made accordingly. As well, the researcher's conceptualizations were validated by the words of the participants themselves, in the form verbatim quotes. Moreover, evidence of commonality in participants' self-reports served as a check on the internal validity of categories. However, participants could have been involved by asking them to review the categories the writer conceptualized to see if they accurately represented their experience of interrupting emotional experience in the therapy session.

In the proposed model of SIE, the client's experience of SIE occurred in the context of a therapeutic relationship. The client's experience and expression of emotion was influenced throughout the process of SIE by various therapist empathic statements, directions, and strategies. However, the transactional nature of SIE was not adequately studied. Therefore, examination of the therapist's performance and subjective experience during a period in therapy when the client engages in interruption of emotion is needed.

The present study focused on understanding the phenomenon of SIE. The process whereby interruption is resolved was not addressed. Accordingly, further study of the resolution of SIE is required. Based on the proposed model, it is hypothesized that resolvers of SIE will be clients who successfully relinquish engagement in protective secondary reactive emotions and/or avoidant/controlling behavior, and who are able to tolerate the underlying sense of vulnerability and fully embrace emotional experience and

its expression. In addition, keeping with the second minor pattern of SIE, it is hypothesized that for some clients, resolution will involve the ability to tolerate vulnerability without resorting to behaviours of emotional avoidance and control.

### **Conclusions**

This research study was undertaken to develop a model of self-interruption of emotion (SIE) as it occurred for clients during a session of experiential therapy. A model of the process of self-interruption of emotion was proposed that explains how emotional experience and expression is interrupted. Two patterns of SIE were identified that represent the main ways in which clients engaged in a process of protection for an emotionally vulnerable Self. While each pattern included central elements of ‘Awareness/Expression of Emotionally Vulnerable Sense of Self,’ ‘Enact Interruptive Behavior’ and ‘Awareness/Expression of Limited Emotional Experience,’ they were differentiated by the presence or absence of a fourth element of ‘Awareness/Expression of Reactive Secondary Emotion’.

The concept of vulnerability in the context of interruption of emotional experience was differentiated and defined. An emotionally vulnerable sense of self in the face of awareness of emotion was defined in terms of the perception of a threat to the self in connection with one or more of the following features: awareness of feeling in the body, an internal sense of emotional conflict, hazy emotional experience, a weakened sense of self, and/or at a point where there is an urge or action to express emotion and/or related needs. In turn, in the majority of cases any one or more of these qualities of

vulnerability evoked a variety of secondary emotional reactions, with fear the most predominant type.

One of the key features of vulnerability in those who feared emotion was difficulty in allowing the experience or expression of physiological arousal that was experienced as intense, deep, painful, and/or had a sudden onset. Also, for some fear was related to difficulty symbolizing and/or overtly expressing emotional experience and/or related needs in words.

While studies have shown that arousal is and of itself not predictive of positive therapy outcomes, it has also been demonstrated that it is a necessary element in the overall processing of emotion. In short, while arousal is necessary but not sufficient, it is still necessary. Difficulty in allowing the experience of arousal and/or expressing visceral experience in words may be understood as a particular types of emotional processing difficulty that must be targeted directly in therapy. Further development of markers of vulnerability associated with awareness of visceral experience is essential, as well as a model of the resolution of this emotional processing difficulty.

In addition to secondary reactive fear, there were other reactive emotions that were associated with vulnerability, such as shame, anger, guilt, and sadness. Secondary reactive emotions were activated when there was an internal sense of imminent threat to the self in a physical or existential sense or when there was a threat to relational bonds in the case of expression of emotion to a significant other. Specific secondary reactive emotions corresponded to these two types of threat.

Clinical implications of the results of the study were also discussed. It was suggested that a psycho-social history interview at the outset of treatment include the client's emotion history, as it can provide information about emotion processing difficulties that is useful in early case formulation. The importance of attending to markers of interruption and inquiry into secondary reactive emotions was also emphasized. A marker of SIE that denotes the occurrence of SIE at a moment in a therapy session was defined, to help therapists identify when the interruptive process is active in the session. Inattention to a marker of emotional vulnerability in the therapy session is a missed opportunity to help the client who is struggling to process emotional experience, and resorts instead to old ways of dealing with emotion that often perpetuate a negative cycle of limited emotional awareness and self-depletion. Relevant clinical practices and strategies were suggested for therapists working with clients who interrupt emotional experience: empathic attunement to the client's experience of emotional vulnerability to foster a sense of understanding and safety in the relationship, self-soothing to regulate a vulnerable sense of self and calm an anxious body, focusing to help clarify inchoate emotional experience, and two-chair imaginal dialogue to make explicit the self-interruptive process.

The proposed model of SIE also explains the outcome of interruption, which is 'Awareness/Expression of Limited Emotional Experience.' While limited awareness of emotion provided a sense of relief from vulnerability in a minority of cases, most often it entailed a subjective sense of a bad feeling of depletion, sadness, cognitive confusion, hopelessness, fatigue, and/or numbness. Given the overlap of the experience of limited

emotional awareness and some of the symptoms of depression that brought these clients in to treatment, it is vital that the self-interruptive process is front and centre in the case formulation and treatment plan for depressed clients.

The design of the study was unique as data was gathered from both the perspective of overt performance of SIE through a task analysis, and the subjective experience of SIE through a grounded analysis of clients' self-reports. This multi-method approach resulted in a rich representation of the process of SIE, as the subjective experience model both corroborated components of the model derived from the task analysis and enhanced it by providing additional information about the private experience of interruption. In view of these results, future process studies would benefit from incorporating methods beyond the typical analysis of therapy transcripts, such as qualitative analyses of IPR interview data.

Suggestions for future research included further refinement of the micro-processes of SIE, study of the resolution of SIE, and replication of the results with other clinical populations, such as those with BPD, as well as other types of psychotherapy. It was hypothesized that clients who resolve SIE will have successfully worked through the opposition to emotional experience in its myriad forms, such as opposing parts of self with respect to allowing/expressing emotion, secondary reactive emotions, and inhibitory behaviours, by addressing the features of underlying vulnerability that serve to manifest and sustain the need for self-protection. It was also recommended that future research include inquiry into the transactional nature of SIE through examination of the therapist's role in the process of SIE.

In summary, the proposed model of SIE explains how therapy clients interrupt emotional experience in the context of an experience of vulnerability for the purpose of self-protection. Also, the model adds to the theoretical literature as it provides a more differentiated understanding of the process of SIE, including the various attributes of vulnerability, and the relationship between particular aspects of vulnerability and types of secondary reactive emotions and/or related avoidant/controlling behaviour.

## REFERENCES

- Agnew, N. & Pyke, S. (1987). *The Science Game*. New Jersey: Prentice-Hall.
- Aldao, A., Nolen-Hoeksema, S., Schweizer, S. (2010). Emotion-regulation strategies across psychopathology: A meta-analytic review. *Clinical Psychology Review*, 30 (2), 217-237.
- Angus, L., & Hardtke, K. (2007). Margaret's Story: An Intensive Case Analysis of Insight and Narrative Process Change in Client-Centered Psychotherapy. In L.G. Castonguay (Ed); C. Hill, (Ed), *Insight in psychotherapy* (pp. 187-205). Washington, DC, US: American Psychological Association.
- Angus, L.E., & Rennie, D.L. (1989). Envisioning the representational world: The client's experience of metaphoric expression in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, Vol 26 (3), 372-379.
- Atwood, G. & Stolorow, R. (1984). *Structures of Subjectivity: Explorations in Psychoanalytic Phenomenology*. Hillsdale, NJ: The Analytic Press.
- Auszra, L., Greenberg, L.S., & Herrmann, I. (2013). Client emotional productivity: Optimal client in-session emotional processing in experiential therapy. *Psychotherapy Research*, Vol.23, (6), 732-746.
- Bakan, D. (1967). *On method: Toward a reconstruction of psychological investigation*. San Francisco, CA: Jossey-Bass.

Barlow, D. H., Allen, L. B., & Choate, M.L. (2004). Toward a unified treatment for emotional disorders. *Behavior Therapy, 35* (2), 205-230.

Beblo, T., Fernando, S., Klocke, S., Gripenstroh, J., Aschenbrenner, S., & Driessen, M. (2012). Increased suppression of negative and positive emotions in major depression. *Journal of Affective Disorders, 141*, 474-479.

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4*, 561-571.

Behar, E., DiMarco, I., Hekler, E., Mohlman, J., & Staples, A. (2009). Current theoretical models of generalized anxiety disorder (GAD): Conceptual review and treatment implications. *Journal of Anxiety Disorders, 23*, 1011-1023.

Bolger, E. A. (1996). *The subjective experience of transformation through pain in adult children of Alcoholics*. Unpublished doctoral dissertation, York University, Toronto, Ontario, Canada.

Borkovec, T. (1976). Physiological and cognitive processes in the regulation of anxiety. In G.E. Schwartz & Shapiro, D. (Eds), *Consciousness and Self-Regulation* (pp. 261-312).

Borkovec, T.D., Roemer, L., & Kinyon, J. (1995). Disclosure and worry: Opposite sides of the emotional processing coin. In J.W. Pennebaker (Ed), *Emotion, disclosure, and health* (pp. 47-70). Washington, DC: American Psychological Association.

Borkovec, T.D., Alcaine, O., & Behar, E. (2004). Avoidance theory of worry and generalized anxiety disorder. In R.G. Heimber, C.L. Turk & D. S. Menin (Eds),

*Generalized anxiety disorder: Advances in research and practice* (pp. 77-108). New York: Guilford Press.

Breuer, J. & Freud, S. (1961). *Standard edition of the complete psychological works of Sigmund Freud (Vol. 2)*. Ed. J. Strachey. London: Hogarth Press. (Original work published 1923).

Carrier, J. R., & Greenberg, L. S. (2010). Optimal levels of emotional arousal in experiential therapy of depression. *Journal of Consulting and Clinical Psychology, 78*, 190-199.

Choi, B., Pos, A., & Magnussen, M. (2016). Emotional change processes in resolving self-criticism during experiential treatment of depression. *Psychotherapy Research, 26*, 484-499.

Coggins, J. & Fox, J. (2009). A qualitative exploration of emotional inhibition: A basic emotions and developmental perspective. *Clinical Psychology and Psychotherapy, 16*, 55-76.

Coombs, M.M., Coleman, D., & Jones, E.E. (2002). Working with feelings: The importance of emotion in both cognitive and inter-personal therapy in the NIMH treatment of depression collaborative research programme. *Psychotherapy: Theory, Research, Practice, Training, 39*, 233-244.

Diener, M.J., Hilsenroth, M. J., Weinberger, J. (2007). Therapist affect focus and patient outcomes in psychodynamic psychotherapy: A Meta-analysis. *The American Journal of Psychiatry, 164* (6), 936-941.

Elliott, R. (1986). Interpersonal Process Recall (IPR) as a psychotherapy process research method. In L. Greenberg & W. Pinsof (Eds). *The psychotherapeutic process: A research handbook*. Guilford clinical psychology and psychotherapy series (pp. 503-527). New York, NY: Guilford Press.

Elliott, R., Fischer, C., & Rennie, D. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215- 229.

Elliott, R., Watson, J., Greenberg, L., Timulak, L., & Friere, E. (2013). Research on humanistic-experiential psychotherapies. In M.J. Lambert (Ed.), *Bergin & Garfield's Handbook of psychotherapy and behavior change (6<sup>th</sup> ed.)* (pp.495-538). New York: Wiley.

Fergus, K. (2011). The rupture and repair of the couples' communal body with prostate cancer. *Families, Systems, and Health*, 29, 95-113.

Foa, E. B., & Franklin, M. E. (2000). Psychotherapies for obsessive-compulsive disorder: A review. In M. Maj, N. Sartorius, A. Okasha, & J. Zohar (Eds.), *Obsessive-compulsive disorder* (pp. 93-115). New York: Wiley.

Foa, E. B., Rothbaum, B. O., & Furr, J. M. (2003). Augmenting exposure therapy with other CBT procedures. *Psychiatric Annals*, 33 (1), 47-53.

Fosha, D. (2000). *The transforming power of affect: A model of accelerated change*. New York: Basic Books.

Fox, J. R. E., Msetfi, R. S., Johnson, R. S., & Haigh, E. (2016). The perception of threat from emotions in predicting binge eating behaviours in people who are obese and seeking treatment for their weight. *Clinical Psychology and Psychotherapy*, 23, 452-459.

Franklin, M. E., & Foa, E. B. (2011). Treatment of obsessive compulsive disorder. *Annual Review of Clinical Psychology*, 7, 229-243.

Freud, S. (1915/1986). The unconscious. In *The Essentials of Psychoanalysis*. London: Penguin.

Freud, S. (1926/1957). Inhibitions, Symptoms, and Anxiety. In: J. Strachey (Ed) *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol. XX*. Hogarth Press.

Freud, S. (1949). *An Outline of Psychoanalysis*. New York: W.W. Norton.

Gendlin, E. (1978). *Focusing*. New York: Everest House.

Garfinkel, S. & Critchley, H. (2016). Threat and the body: How the heart supports fear processing. *Trends in Cognitive Science*, 20, 34-46.

Giorgi, A. & Giorgi, B. (2003). *The Descriptive Phenomenological Psychological Method*. Lingualeo.com.

Glaser, B. & Strauss, A. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine Publishing Company.

Goldman, R., Greenberg, L., & Pos, A. (2005). Depth of emotional experience and outcome. *Psychotherapy Research*, 15, 248-260.

Goldman, R., Greenberg, L., & Angus, L. (2006). The effects of adding emotion-focused interventions to the client-centered relationship conditions in the treatment of depression. *Psychotherapy Research, 16*, 537-549.

Goldman, R. & Greenberg, L. (2015). *Case formulation in emotion focused therapy*. Washington: American Psychological Association.

Greenberg, L. S. (1976). *Task analytic approach to the study of psychotherapeutic events*. Unpublished doctoral dissertation, York University, Toronto, Ontario, Canada.

Greenberg, L. S. (1979). Resolving splits: The two-chair technique. *Psychotherapy: Theory, Research, and Practice, 16*, 310-318.

Greenberg, L. S. (1986). Change process research. *Journal of Consulting and Clinical Psychology, 54*, 4-9.

Greenberg, L. S. (1999). Ideal psychotherapy research: A study of significant change processes. *Journal of Clinical Psychology, Vol 55 (12)*, 1467-1480.

Greenberg, L. S. (2006). Emotion-focused therapy: A synopsis. *Journal of Contemporary Psychotherapy, 36*, 87-93.

Greenberg, L. S. (2007). A guide to conducting a task analysis of psychotherapeutic change. *Psychotherapy Research, 17 (1)*, 15-30.

Greenberg, L. S. (2010). Emotion-Focused therapy: A clinical synthesis. *Focus, VIII (1)*, 1-11.

Greenberg, L.S. (2015). *Emotion Focused Therapy: Coaching clients to work through their feelings, 2<sup>nd</sup> ed.* Washington, DC, US: American Psychological Association

Greenberg, L., & Angus, L. (2004). The contribution of emotion processes to narrative change in psychotherapy: A dialectical constructivist approach. In L. Angus & J. McLeod (Eds.), *Handbook of narrative psychotherapy*. Thousand Oaks, CA: Sage.

Greenberg, L. S., Auszra, L., & Herrmann, I. (2007). The relationship among emotional productivity, emotional arousal and outcome in experiential therapy of depression. *Psychotherapy Research, Vol.17* (4), 482-493.

Greenberg, L. S., & Foerster, F. S. (1996). Task analysis exemplified: The process of resolving unfinished business. *Journal of Clinical and Consulting Psychology, 64*, 439-446.

Greenberg, L. S. & Johnson, S. (1988). *Emotionally focused therapy for couples*. New York: Guilford Press.

Greenberg, L. S., & Malcolm, W. (2002). Resolving unfinished business: Relating process to outcome. *Journal of Consulting and Clinical Psychology, 70*, 406-416.

Greenberg, L. S., & Paivio, S. C. (1997). *Working with emotions in psychotherapy*. New York: Guilford Press.

Greenberg, L. S., & Pascual Leone A. (2006). Emotion in Psychotherapy: A practice-friendly research review. *Journal of Clinical Psychology: In Session, 62*, 611-630.

Greenberg, L. S., & Pedersen, R. (2001, November). *Relating the degree of resolution of in-session self-criticism and dependence to outcome and follow-up in the treatment of depression*. Paper presented at conference of the North American Chapter of the Society for Psychotherapy Research, Puerto Vallarta, Mexico.

Greenberg, L. S., Rice L., & Elliott, R. (1993). *Facilitating Emotional Change: The moment by moment process*. New York: Guilford Press.

Greenberg, L. S., & Safran, J. D. (1987). *Emotion in psychotherapy: Affect, cognition, and the process of change*. The Guilford clinical psychology and psychotherapy series. New York: Guilford Press.

Greenberg, L.S., & Watson, J. (1998). Experiential therapy of depression: Differential effects of client-centered relationship conditions and emotion focused interventions. *Psychotherapy Research*, 8, 210–224.

Greenberg, L. S. & Watson, J. (2006). *Emotion-focused therapy of depression*. Washington, DC: American Psychological Association.

Gross, J. J., & John, O. P. (2003). Individual differences in two emotion regulation processes: Implications for affect, relationships, and well-being. *Journal of Personality and Social Psychology*, 85 (2), 348-362.

Gross, J. J., & Levenson, R. W. (1993). Emotional suppression: Physiology, self-report, and expressive behavior. *Journal of Personality and Social Psychology*, 64, 970-986.

Gross, J. J., & Levenson, R. W. (1997). Hiding feelings: The acute effects of inhibiting negative and positive emotion. *Journal of Abnormal Psychology*, 106 (1), 95-103.

Hayes, S. C. (1987). A contextual approach to therapeutic change. In N. S. Jacobson (Ed.), *Psychotherapists in clinical practice: Cognitive and behavioral perspectives* (pp. 327–387). New York: Guilford Press.

Hayes, S.C. (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavioral and cognitive therapies. *Behavior Therapy, 35*, 639-665.

Hayes, S. C., Pistorello, J., & Levin, M. E. (2012). Acceptance and commitment therapy as a unified model of behavior change. *The Counseling Psychologist, (40) 7*, 976-1002.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: The Guilford Press.

Hayes, S. C., Strosahl, K. D., Wilson, K. G., Bissett, R. T., Pistorello, J., Toarmino, D., Polusny, M., Dykstra, T., Batten, S., Bergan, J., Stewart, S., Zvolensky, M., Eifert, G., Bond, F., Forsyth, J., Karelka, M., McCurry, S. (2004). Measuring Experiential Avoidance: A Preliminary Test of a Working Model. *The Psychological Record, Heidelberg, 54.4. (Fall 2004)*, 553-578.

Hayes, S. C., & Wilson, K. G. (2003). Mindfulness: Method and process. *Clinical Psychology: Science and Practice, 10*, 161–165.

Hayes, S. C., Wilson, K. G., Gifford, E. V., Follette, V. M., & Strosahl, K. (1996). Experiential avoidance and behavioral disorders: A functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology, 64*, 1152–1168.

Henretty, J., Levitt, H., & Mathews, S. (2008). Clients' experiences of moments of sadness in psychotherapy: A grounded theory analysis. *Psychotherapy Research, 18*, 243-255.

Ioannou, K. & Fox, J. (2009). Perception of threat from emotions and its role in poor emotional expression within eating pathology. *Clinical Psychology and Psychotherapy*, 16, 336-347.

Kagan, F. (2014). *Untying the knot: A qualitative inquiry into the enduring marriage*. Unpublished doctoral dissertation, York University, Toronto, Ontario, Canada.

Kircanski K, Lieberman M. D., & Craske, M. G. (2012). Feelings into words: Contributions of language to exposure therapy. *Psychological science*, 23 (10):1086-1091.

Kvale, S. (1994). Ten standard objections to qualitative research interviews. *Journal of Phenomenological Inquiry*, 25, (2), 147-173.

Lane, R. D., & Schwartz, G. E. (1987). Levels of emotional awareness: a cognitive-developmental theory and its application to psychology. *American Journal of Psychiatry*, Apr; 144 (4):542.

Lieberman, M., Eisenberger, N., Crockett, M., Tom, S., Pfeifer, J., Way, B. (2007). Putting feelings into words. *Psychological Science*, 18, 421-428.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.

Linehan, M. M. (1993). *Cognitive-behavioural treatment of borderline personality disorder*. New York: Guilford Press.

Linehan, M. M. (2015). *DBT Skills Training Manual, 2nd Ed*. New York: The Guilford Press.

McCubbin, R. A., & Sampson, M. J. (2006). The relationship between obsessive-compulsive symptoms and appraisals of emotional states. *Anxiety Disorders, 20*, 42-57.

McCullough Vaillant, L. (1997). *Anxiety-Regulating Psychotherapy for Restructuring Defenses, Affects, and Attachment*. New York: Basic Books.

McCullough, L., Kuhn, N., Andrews, S., Kaplan, A., Wolf, J., & Hurley, C. L. (2003). *Treating affect phobia: A manual for short term dynamic psychotherapy*. New York: Guilford Press.

McMain, S., Links, P., Gnam, W., Guimond, T., Cardish, R., Korman, L., Streiner, D. (2009). A randomized trial of dialectical behavior therapy versus general psychiatric management for borderline personality disorder. *American Journal of Psychiatry, Dec; 166 (12):1365-74*.

Mergenthaler, E. & Stinson. (1992). Psychotherapy transcription standards. *Psychotherapy Research, 2 (2)*, 125-142.

Misserlian, T., Toukmanian, S., Warwar, S., & Greenberg, L. (2005). Emotional arousal, client perceptual processing, and the working alliance in experiential psychotherapy for depression. *Journal of Consulting and Clinical Psychology, 73*, 861-871.

Nietzsche, Friedrich Wilhelm, 1844-1900. (2006). *Thus spoke Zarathustra : a book for all and none*. Cambridge: Cambridge University Press.

Paivio, S. C., Hall, I. E., Holowaty, K. A. M., Jellis, J. B., & Tran, N. (2001). Imaginal confrontation for resolving child abuse issues. *Psychotherapy Research, 11*, 56-68.

Pascual-Leone, A., Greenberg, L. (2007). Emotional processing in experiential therapy: Why “the only way out is through.” *Journal of Clinical and Consulting Psychology, 75* (6), 815-887.

Pascual-Leone, A., Greenberg, L., Pascual-Leone, J. (2014). Task analysis: New developments for programmatic research on the process of change. *Quantitative and qualitative methods in psychotherapy, 249-73*.

Pennebaker, J. W. (1997). *Opening up: The healing power of expressing emotions*. New York: Guilford Press.

Pennebaker, J. W., & Beall, J. (1986). Confronting a traumatic event: Toward an understanding of inhibition and disease. *Journal of Abnormal Psychology, 95*, 274-281.

Perls F., Hefferline R.F., Goodman P. (1951). *Gestalt Therapy*. New York, Dell Press.

Polkinghorne, D. (1983). *Methodology for the human sciences*. New York, SUNY Press.

Pos, A. & Greenberg, L. S. (2007). Emotion-focused therapy: The transforming power of affect. *Journal of Contemporary Psychotherapy, 37*, 25-31.

Pos, A., Greenberg, L. S., & Warwar, S. (2009). Testing a model of change in the experiential treatment of depression. *Journal of Consulting and Clinical Psychology, 77*, 1055-1066.

Pos, A., Greenberg, L. S., Goldman, R., & Korman, L. (2003). Emotional processing during experiential treatment of depression. *Journal of Consulting and Clinical Psychology, 71*, 1007-1016.

Pos, A. E., Paolone, D. A., Smith, C. E., Warwar, S. H. (2017). How does client expressed emotional arousal relate to outcome in experiential therapy for depression? *Person-Centered & Experiential psychotherapies, Vol.16, (2), 173-190.*

Rennie, D. (1994). Client's deference in psychotherapy. *Journal of Counseling Psychology, 41, No. 4, 427-437.*

Rennie, D. (2012). Qualitative Research as Methodical Hermeneutics. *Psychological Methods, Vol.17, (3), 385-398.*

Rennie, D. L., Phillips, J. R., & Quartaro, G. K. (1988). Grounded theory: A promising approach to conceptualization in psychology? *Canadian Psychology, 29, 139-150.*

Rice, L. & Greenberg, L. S. (1984). *Patterns of Change: An intensive analysis of psychotherapeutic process.* New York, NY: Guildford Press.

Rogers, C.R. (1951). *Client-centered therapy.* Boston: Houghton Mifflin.

Schanche, E., Stiles, T. C., McCullough, L., Svartberg, M., Nielsen, G. H. (2011). The relationship between activating affects, inhibitory affects, and self-compassion in patients with Cluster C personality disorders. *Psychotherapy, Vol 48 (3), 293-303.*

Scherer, A., Boecker, M., Pawelzik, M., Gauggel, S., & Forkmann, T. (2017). Emotion suppression, not reappraisal, predicts psychotherapy outcome. *Psychotherapy Research, Vol. 27 (2), 143-153.*

Shapiro, S., Angus, L., Davis, C. (1997). Identity and Meaning in the Experience of Cancer: Three Narrative Themes. *Journal of Health Psychology, Vol 2 (4), 539-554.*

Sicoli, L. (2005). *Development and testing of a model of hopelessness in experiential therapy of depression*. Unpublished doctoral dissertation, York University, Toronto, Ontario, Canada.

Spitzer, R., & Williams, J., Gibbons, M., First, M. (1989). *Structured Clinical Interview for DSM-III-R*. Washington, DC: American Psychiatric Association.

Stein, R. (1991). *Psychoanalytic theories of affect*. New York: Praeger.

Stolorow, R., & Atwood, G. (1992). *Contexts of being: The intersubjective foundations of psychological life*. Psychoanalytic inquiry book series, Vol. 12. Hillsdale, NJ: Analytic Press, Inc.

Strauss, A. & Corbin, J. (1990). *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Newbury Park: Sage.

Taylor, S. & Rachman, S. (1991). Fear of sadness. *Journal of Anxiety Disorders*, 5, 375-381.

Taylor, S. & Rachman, S. (1992). Fear and avoidance of aversive affective states: Dimensions and causal relations. *Journal of Anxiety Disorders*, 6, 15-25.

Warwar, S. (2003). *Relating emotional processes to outcome in experiential psychotherapy for depression*. Unpublished doctoral dissertation, York University, Toronto, Ontario, Canada.

Whelton, W.J. (2004). Emotional processing in psychotherapy: Evidence across therapeutic modalities. *Clinical Psychology and Psychotherapy*, 11, 58-71.

Williams, K., Chambless, D., & Ahrens, A. (1997). Are emotions frightening? An extension of the fear of fear construct. *Behavior Research and Therapy*, 35, 239-248.

## Appendix A

### CLIENT CONSENT FORM

I hereby voluntarily consent to participate in the research project studying the experience of emotion in therapy. The nature of the research has been explained to me. I understand that I will be asked to recall my experience of emotion in therapy with an interviewer while viewing a videotape of one of my therapy sessions. It has also been explained to me that the recall interview will be audiotaped, transcribed, and used for research purposes under the supervision of Dr. Leslie Greenberg Ph.D. and by Ms. Janice Weston, doctoral candidate. All material will be kept strictly confidential. Any and all identifying information will be removed to protect your anonymity.

Signed \_\_\_\_\_

Witness \_\_\_\_\_

Dated \_\_\_\_\_

Dated \_\_\_\_\_

## Appendix B

### Profiles of ‘Protection from Dangerous Emotion’

#### 1. Profile of Carol: Pattern 1- Protection from Sadness (50/#5.EFT).

The participant in this example is a woman, ‘Carol,’ who protected against a sense of vulnerability in the context of her experience of sadness in the 5<sup>th</sup> session of emotion focused therapy (EFT).

*Emotionally Vulnerable Sense of Self.* Carol described a history of emotion where “it was just terrible feeling emotional” when she was a young child because she was beaten by her mother when she showed what she was feeling (Emotion Histories-Dangerous to feel/Express emotion). She learned that she was not allowed to cry or harsh consequences would follow. Staying safe involved holding her breath “really hard” so she “could never cry” (Emotion Histories-Learned to Stay Safe). She explained,

Somehow way back when I quit feeling emotion, I wasn’t allowed to cry so obviously emotion must be a bad thing to feel. But I also equated feeling emotion with getting beaten. So it was bigger than crying. It was everything to do with emotion, anything. If I cried I got beaten. I wasn’t allowed to be angry because I’d be beaten for that. If I fell down and hurt myself and cried I got beaten for that so I wasn’t allowed to feel pain.

Consequently, whenever she “allowed” herself “to feel emotion” over the years it “always affected” her in the stomach and she would almost always “throw up” when “really emotional.”

When Carol realized sadness in the therapy session, at the point where she told the therapist “I’m never going to be good enough,” she felt a release of sad feeling in her body (Feeling is Triggered- General Triggers). She became aware of intense and painful feelings of overwhelming sadness. In turn, these profound feelings were expressed in tears. Carol described her experience of sadness as “an over flow” or “spill over” of emotion. Moreover, she recalled her internal experience of feeling “defeated, very weak. Weak and without defenses just for a second” (Felt Very Vulnerable- Awareness of feeling in the body, Expression of emotion, Weakened sense of self, Emotion metaphors).

***Provide Self-Protection.*** Initially, Carol reacted internally with fear to this experience of sadness and vulnerability. She explained “I’m scared to let it come...I’m really scared to do that. I felt scared right there” (Reactive Emotion- Fear). In the therapy session, she voiced a part of herself that sternly forbade the expression of her feelings of sadness and said “You can’t ever show those feelings. It is really bad to show those feelings.” During the IPR of this segment she explained that at this point in the session she realized this was the voice of what she called “the protector” (Control Emotional Vulnerability). This insight was not shared with the therapist. Carol also recalled protective imagery of bricks going up around her that encased her body (Control Emotional Vulnerability).

***Effect of Protection: Limited Emotional Experience.*** The voice of protection and imagery of bricks going up around her served to provide reinforcement to a vulnerable sense of self. The visceral experience of emotion stopped and she felt safe. Carol explained, “It’s like all of a sudden it’s like total peace. Like being wrapped in cotton and

totally protected. Nothing can penetrate that. It's relief. I'm okay now" (Positive Effect: Less vulnerable). She also recalled, "When I walked out of there I felt fine. It was finished. I was feeling very tired, drained. It's like a void, emptiness" (Negative Effect: Depleted, Drained). She made an analogy to lancing an infected tissue, "There's skin there and there's emptiness...some poison came out and the pressure of the puss on you isn't as great."

## **2. Profile of Sarah: Pattern 1- Protection from Sadness (33/#8.EFT).**

This profile illustrates the process of protection from an emotionally vulnerable sense of self for a participant, Sarah, in her 8<sup>th</sup> session of EFT. In contrast to the previous illustrative example, Sarah described how protection involved two different types of reactive emotion, fear and anger.

*Emotionally Vulnerable Sense of Self.* The family environment in which Sarah grew up was one where emotion was neither attended to nor verbalized. Sarah recalled that it was "No use being sad in front of everyone" as she would not be noticed or comforted. Instead, she was expected to "be grown up." Avoidance of visceral, non-verbalized feeling was her primary means of coping with sadness. She recalled, "I would run away. I would be in my own little world in my room with my books and microscopes and stuff" (Emotion Histories-No Support/Validation for Emotional Self)

Sarah's experience of emotion began in the therapy session with the therapist's direction to describe a sense of unworthiness. This direction had an unexpected effect of releasing a visceral sense of sadness, as illustrated in the following excerpt.

I got really sad when she said ‘What’s undeserving about her?’ Something happened in my neck where I felt I got a release of it of some kind. Just what she said about ‘Why shouldn’t you be deserving?’ that triggered that emotion (Feeling is Triggered-Therapist Behavior: Direction).

Sarah reported that this physical “release” of sadness “was surprising.” Furthermore, she described it as a visceral sense of a fluid force moving upward “like a wave coming from my belly...the tears were starting to form.” She recalled the sense that sadness extended far down in her body; “It really seems to be really deep” (Felt Very Vulnerable-Awareness of Feeling in the Body; Emotion Metaphors).

Sarah struggled to find words to express the feeling of deep, emergent sadness. She described how “It’s kind of a preverbal thing. It’s so old in me that I don’t even have words for it...there are no words for this kind of sadness and I didn’t have the words for that kind of sadness, almost neglect. Now I’m speechless” (Felt Very Vulnerable-Hazy Emotional Experience). This experience of ancient, preverbal, intense sadness was overwhelming. Sarah described how “It really seems to be really deep...it sort of overtakes me” (Felt Very Vulnerable- Weakened Sense of Self).

She also described a sense of emotional confusion that followed from an internal conflict between validation and invalidation of sad feeling.

[It] was confusing as well because on one side I’m saying ‘So what and stop this already’ and the other side, I’m saying ‘This is feeling right. This is the way I should be feeling: Sadness for myself, tenderness towards myself, caring (Emotional Conflict Inside).

Overall, while she was experiencing sadness and crying, she “felt very soft, very sort of vulnerable” (Felt Very Vulnerable).

***Provide Self-Protection.*** Sarah reacted with fear to the experience of vulnerability in the context of sadness. She drew an analogy between her experience of epileptic seizures and sadness. They both involved a sense of being alone (“No one’s gonna help me with this”) and at the mercy of a powerful, “pre-verbal” force activated in her body that was both outside her control and potentially life threatening (Reactive Emotion-Fear). She described how the experience of reactive fear itself was also “preverbal” and that she feared she “might be scared to death” (Reactive Emotion- Fear). The need for protection was implicit in these descriptions of vulnerability and fear.

In addition to reactive fear, Sarah described “an ancient voice from my parents” of anger and criticism. The critical voice of reactive anger, “What’s wrong with you?” admonished her to strengthen the weakened sense of self and “Stand up. Have a backbone.” She commented about a point on the therapy tape where she described to the therapist how sadness and anger were “going around in a circle,” and she explained, “It was like the sadness and the anger were playing each other” (Reactive Emotion- Anger).

***Effect of Protection: Limited Emotional Experience.*** The effect of fear, which signaled the need for protection in her vulnerable state, and protection by angry admonishment was to impede the experience and expression of profound sadness as Sarah recalled and enacted childhood experience.

### **3. Profile of John: Pattern 1- Protection from Anger (78/#6/#13.EFT).**

The participant in the second profile is a man, John, in his sixth<sup>th</sup> session of EFT who protected himself from an experience of anger in the context of an emotionally vulnerable sense of self.

*Emotionally Vulnerable Sense of Self.* John described a longstanding fear of anger. “I’ve been afraid of this thing for a long time, as long as I can remember. The unpredictability of it,” he explained (Emotion Histories-Dangerous to Feel/Express Emotion). Twenty years earlier he had an aversive emotional experience where he “got into a state” of anger and punched a structure with a pipe in it and he broke a small bone in his hand. He also recalled a negative experience of anger in a previous therapy.

One experience I had a long time ago, this was with another therapist, the whole room went black. I couldn’t see anything except the face of the person that was sitting in front of me and that was a totally frightening experience. I mean, I couldn’t see the floor, I couldn’t see the ceiling, no walls nothing. And that’s how it [anger] came on me that time.

John reported that these past experiences coloured his experience of anger and a related sense of vulnerability in his current therapy session.

The therapist’s empathic reflection in a two-chair self-critical split served to bring on the feeling of anger at one point in the session. John explained, “I’m starting to feel angry at the other part. She’s reminding me that something caused the pain that I’m in and that’s what’s getting me angry...It happens gradually” (Feeling is Triggered- Therapist Behavior: Empathic reflection).

Suddenly, he was at the mercy of a private, visceral “thrust” of very strong feelings of anger located “in the solar plexus,” that he likened to a monster. He described how his experience of this anger monster in his body was very painful; “I don’t recall it ever being that painful... like a sharp knife (Felt Very Vulnerable-Awareness of Feeling in the Body; Emotion Metaphors).

John also recalled, “I remember here getting really mad and thinking ‘Well say something’.” However, as he later explained, he could not express the visceral sense of anger because he did not “know much about it” (Felt Very Vulnerable- Hazy Emotional Experience).

***Provide Self-Protection.*** John feared losing control of the “thrust” of intense and incoherent angry feelings that were potentially destructive and even life-threatening. He explained,

I really didn’t feel like yelling it. I think I was afraid of something happening...It was still filtered somehow, withheld somehow. I was afraid to let it go right over the top somehow...just not knowing what it would do or what it was like. It feels like a stick being poked through from the inside. When I went home last night [the movie] ‘Alien’ was on. That’s exactly what it reminds me of. This guy he’s got a thing growing inside of him and suddenly, destructively chews and gnaws its way out and kills him in the process (Reactive Emotion- Fear).

At some points he sought to control the feeling and expression of incoherent anger and at other times he tried to avoid or escape it. The excerpts below illustrate the combination of control and avoidance across a segment of the session where the therapist is directing him

to express anger and related needs in a two-chair self-critic split dialogue. John explained,

I suppose what's happening is I start doing something to alleviate it or distract myself from feeling it somehow (Avoid Emotional Vulnerability)...there comes a tense –the feeling that I want to break something, you know, I don't want to...so I kind of restrain myself. I feel like I'm being dragged or held back to a certain extent but not completely (Control Emotional Vulnerability)...I characterize it as a lot of tension just through my whole body and I can't relax. I'm on the edge of my seat and it's sort of like every muscle is tensed to keep the opposite one from moving. It's like a paralysis of exertion somehow. No mental images at all that I can remember... and I feel that through most of my body...this happening mostly in my arms and my legs and also in my stomach (Control Emotional Vulnerability)...I have trouble breathing and, like I really wanted to get out of there, out of the room (Avoid Emotional Vulnerability)...I become aware of wanting it to go away and I'm thinking about ways to try and make it go away (Avoid Emotional Vulnerability).

At a later point in the session, the therapist directs him to express resentment and “hate.” He recalled a shift in focus from what he was feeling in his body to what he was thinking.

My mind focuses on keeping that down, keeping it from getting out of hand and it takes away from this somehow. It's almost like it wants to move the focus away from her [points to torso] up to here [points to head] and I want to keep it there somehow (Avoid Emotional Vulnerability).

He also recalled how he started to worry, which served to move his attention away from angry feelings.

I start to worry about who was outside the door. I was worried about, I mean here I am in some building which I don't know and I'm expected to let all of this stuff out. I don't feel comfortable doing that so I started worrying about that. And the more I did that, the further I got away from this [points to torso] (Avoid Emotional Vulnerability).

***Effect of Protection: Limited Emotional Experience.*** The effect of protection from his internal experience of the anger monster was a diminished feeling of emotion. John described the sense that “all of it” was “not going to be allowed” in the session.

I got the feeling I'm getting a piece of it but not all of it. Like maybe 40% or 50% but not the 100%. I can't. I can't get the 100%. I know I can't. It's just not going to be allowed and I'm feeling this while this is going on here.

**4. *Profile of Bill: Pattern 2-Protection from Fear (04/#14.EFT).*** Bill participated in an IPR interview of a segment of his 14<sup>th</sup> session of EFT. In this segment, he told his therapist a story of a troubled time in his marriage when he was fearful that his marriage was “on the rocks.” In the IPR, Bill described how he interrupted his experience of fear that he felt while telling the story.

***Emotionally Vulnerable Sense of Self.*** Bill reported that he does not have memories of positive experiences or emotions in childhood. He also explained that he “never” talks to anyone about his emotional problems as it is his belief that “nobody can feel what I'm feeling...nobody really cares ...I won't let anybody in.” He described how

he has schooled himself not to react emotionally to losses, such as financial losses in his business, and he recognized “that’s exactly what I’m doing now” in the therapy session (Emotion Histories).

While telling his therapist the story of a troubled time in his marriage, when he could not find his ex-wife while searching for her on a mountain, Bill was privately aware that in doing so it initiated a parallel internal experience of emotion. He explained, “I picked up on all of the emotions of that day,” especially the feeling of fear (Feeling is Triggered).

As Bill watched the therapy tape he recalled his awareness of “many scared feelings in that whole conversation. That minute there.” A great feeling of fear was expressed in tears and he recalled “I was really hurting” (Awareness of Feeling in the Body- Intense feeling). He explained, “The tears were scared tears. I know I felt just for a couple of minutes there the cry that I had on that mountain (Felt Very Vulnerable- Expression of Emotion).”

***Provide Self-Protection.*** Bill recalled that he was “really struggling through this time” and he did not “want to continue the session.” He “tried to find somewhere I could go in my head” to get away from the feeling of fear. He explained that avoidance was a conscious act, “I just tried to go off track, not be in this scenario.” He recalled that a voice “in the back of my head” was “saying ‘give up. Forget about it.’” Overall, he described the experience of avoidance of fear as “the strangest feeling that I just shouldn’t continue it” (Avoidance/Control of Emotional Vulnerability- Desire/Intention to Avoid/Stop, Voice of Protector).

*Effect of Protection: Limited Emotional Experience.* For Bill, the effect of avoidance of fear was an overall sense of “numbness” in his body (Negative Effect- Depleted, Drained).

## Appendix C

CATEGORY	PSs per Participant													
	A	B	C	D	E	F	G	H	I	J	K	L	M	Total
<b>Emotionally Vulnerable Sense of Self (N=13)</b>														
<i>Emotion Histories</i>														
Dangerous to feel/express	3	0	2	3	3	3	0	1	0	0	0	1	0	16
Learned how to stay safe	4	0	4	1	4	3	0	0	1	0	0	1	0	18
“Hard” to feel/express	1	4	2	0	1	0	3	1	3	0	0	0	2	17
“No support”/validation for emotional self	2	0	0	0	0	0	0	1	1	1	2	2	0	9
<i>Feeling is “Triggered”</i>														
General Triggers	0	0	1	0	0	0	1	0	0	0	0	0	0	2
Client Memories	0	0	0	0	2	0	0	2	7	0	0	0	0	11
Client Imagery	1	0	0	0	0	2	0	1	0	0	0	0	1	5
Therapist Behavior														
Metaphor	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Empathic Reflection of Emotion	0	3	0	1	0	1	2	0	0	0	2	0	1	10
Direction	3	0	0	0	0	0	0	2	0	0	0	0	0	5
“Close” attention	1	0	0	0	6	0	1	0	0	0	0	0	0	8



CATEGORY	PSs per Participant													
	A	B	C	D	E	F	G	H	I	J	K	L	M	Total
<b>Hazy Emotional Experience</b>														
Hard to “Put Words to”/Express	3	8	3	5	5	1	11	3	0	0	0	0	2	41
Cloudy Feeling	0	3	3	0	5	0	0	4	0	0	0	0	0	15
Confusion	1	3	0	2	1	0	1	4	1	1	2	0	2	18
<b>Weakened</b>														
“Overwhelming” Emotion	1	5	0	0	6	1	3	4	0	0	5	1	2	28
Losing “Control”	0	0	3	0	0	0	3	1	0	0	4	0	0	11
“No Hope”/Helpless	3	0	0	0	0	0	0	0	2	0	0	0	0	5
“Without Defenses”	0	0	0	0	0	8	1	1	2	6	2	0	0	20
<b>Provide Self-Protection (N=13)</b>														
<b><i>Reactive Emotion</i></b>														
Fear/ “Afraid” of Emotion	12	9	5	6	6	2	7	3	1	0	1	0	0	52
Shame Stops Emotion	2	4	0	0	0	0	3	0	3	0	0	4	0	16
Anger “Covers” Sadness	1	0	0	0	0	0	1	3	0	0	0	1	0	6
Sadness Defuses Anger	0	0	0	3	0	0	8	0	0	0	0	0	0	11
Guilt “Shut Down” Anger	1	0	0	0	0	0	2	0	0	0	0	0	0	3
<b><i>Control Emotional Vulnerability</i></b>														
Intention: “Got to Stop”	2	0	1	1	4	1	0	1	1	1	3	2	0	17

CATEGORY	PSs per Participant													
	A	B	C	D	E	F	G	H	I	J	K	L	M	Total
<b>Physical Control</b>														
Hold “Back”/Contain	0	0	0	5	1	10	8	8	1	0	8	0	10	51
Breath Control	0	0	0	1	1	4	4	0	0	0	0	0	0	10
Muscles/Constriction	0	0	0	3	0	6	1	0	1	0	2	0	6	19
“Gulping Down”/“Choking”	0	0	0	1	0	0	0	5	0	0	2	0	1	9
Feeling of “Resistance”/Block	0	1	0	0	0	0	3	3	0	0	0	0	3	10
Posture	0	0	0	0	0	1	0	0	0	0	4	0	0	5
Sigh/Exhale	0	0	4	1	1	0	0	0	0	0	2	0	0	8
<b>Cognitive Control</b>														
Prohibitions/Beliefs	2	0	0	3	1	1	0	0	6	1	4	1	0	19
Critical Voice of “Protector”	2	0	0	0	0	0	2	6	2	1	1	4	0	18
“Intellectualize”	0	0	0	5	0	0	0	1	0	0	0	0	0	6
Imagery/Sensation	0	0	0	0	0	2	0	0	0	0	0	0	0	2
“Laugh”/“Joke”	1	0	0	0	0	0	0	1	0	0	0	0	0	2
Silence	0	0	0	1	0	0	0	0	2	0	1	2	0	6
Wall Off/Push Away	2	5	0	3	1	7	0	0	2	0	2	1	0	23
<b><i>Avoid Emotional Vulnerability</i></b>														
“Distract”/“Divert” Attention	0	0	2	2	0	4	0	0	0	0	0	2	0	11
Intention: “Get Away”	0	5	0	0	0	1	2	0	3	1	0	1	0	13

CATEGORY	PSs per Participant													
	A	B	C	D	E	F	G	H	I	J	K	L	M	Total
“Deflect”	0	5	0	0	0	0	0	0	0	1	0	0	0	6
Urge to Leave	2	1	0	1	1	1	0	0	0	0	0	0	0	6
“Masking”: Laugh/Smile/Joke	0	4	0	0	0	0	1	0	0	2	0	0	0	7
Held Back	0	3	0	2	0	2	0	3	0	0	0	0	0	10
Safe “Distance”	2	4	0	0	1	0	0	4	2	0	0	1	0	14
Tell a Story/Talk	0	0	0	0	1	0	0	1	0	0	0	0	0	2
Think/ “Worry”	0	0	5	1	0	0	0	0	1	0	2	0	0	9
Back Away/Push Away	0	0	2	0	2	0	0	1	0	1	0	1	0	7
“Shut Down”/ “Numb”	0	2	0	0	0	0	0	0	8	0	0	0	0	10
<b><i>Automatic Stop</i></b>														
Out of Awareness	0	0	0	5	0	0	2	0	0	2	0	0	0	9
“All of a Sudden”	1	0	0	0	0	0	1	0	0	0	0	0	0	2
<b>Effect of Protection: Limited Emotional Experience (n=13)</b>														
<b><i>Positive Effect: Less “Vulnerable”</i></b>														
“Relief” /Relax	0	0	4	0	0	4	1	0	0	0	0	0	0	9
“Protected”	0	0	0	0	0	2	0	3	1	0	0	0	0	6
“In Control”	0	0	1	1	1	0	0	2	0	1	0	0	0	6
“Mind Open”	0	0	0	0	0	0	0	0	0	1	0	0	0	1

CATEGORY	PSs per Participant													
	A	B	C	D	E	F	G	H	I	J	K	L	M	Total
<i>Negative Effect: “Depleted, Drained”</i>														
“Numb”	0	0	0	0	0	0	0	0	5	0	0	2	0	7
Shut Down/ “Tired”	0	0	0	2	1	0	0	1	2	0	0	0	0	6
Frustrated	0	0	0	1	0	0	1	0	0	0	0	0	0	2
“Empty”	1	0	0	0	0	0	1	0	0	0	1	0	0	3
“Depressed”/ Sad	0	0	0	1	0	0	0	0	1	0	1	0	1	4
“Confused”/Unsure Inside	1	3	0	0	0	0	1	1	1	0	0	0	0	7
“Bad” Feeling	1	0	1	0	0	0	1	0	0	0	0	0	0	3
Sense of Hopelessness	0	0	0	0	0	0	0	1	1	0	0	0	0	2
Physical tension, pain	0	0	0	1	0	0	0	0	0	0	1	0	1	3

Table 8. Taxonomy of Categories in Subjective Experience Model, Including Number of Property Statements (PSs) from Each Participant Contributing to Each Category