Responding to distressed clients: Therapist influence on client emotional processing

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Abstract

This study examined therapist responses to distressed clients as they occurred moment-by-moment within single sessions of psychotherapy. Researchers examined the videotaped sessions of a sample of 26 therapist-client dyads. Results indicated the following: (i) Hierarchical cluster analysis revealed two clusters of therapist responding, labeled Reflection-focused and Emotional Experience-focused. Clients treated by an Emotional Experience-focused therapist were more likely to experience good outcome; (ii) Good outcome was more likely to be preceded by more frequent therapist intervention shifts, and; (iii) Emotional variability did not mediate the relationship between depth of therapist experiential focus and outcome. However, further analyses revealed that the presence of productive emotions (as described by Pascual-Leone & Greenberg, 2007) did mediate the relationship between depth of therapist experiential focus and outcome. Clinical implications of the findings are discussed.
It may not be very original,
but this work is
dedicated to
Josefine Maria Theresia Singh
, my mother,
because she is.
Acknowledgements

Likely no one will be more surprised than me to see that I’ve made it to a second acknowledgements page, but I will not use this space to congratulate myself. I begin instead by offering my foremost thanks to my supervisor, Antonio Pascual-Leone, for his excellent supervision, naturally—but also for his straightforward humanity, the enviable enthusiasm and conscientiousness he brings to his work and, most of all, for his patience. I have perhaps not been the easiest of students to deal with over the past two years, and he has been kind enough not to say so.

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And finally, to Ruby Sharma:
It’s done now, and I feel like talking. Without you near there is less to say.
The meeting of two personalities is like the contact of two chemical substances; if there is any reaction, both are transformed.

Carl Jung, 1933, p. 57

By the way...it's hard to describe.

David Foster Wallace, 2006
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Responding to Distressed Clients: Therapist Influence on Client Emotional Processing

OVERVIEW

While there has been longstanding debate concerning its essential ingredients, one of the fundamental assumptions of most psychotherapy research is that what the therapist does makes a difference. The therapist’s role is to facilitate change, in accord with therapeutic goals and guided by his or her own theoretical orientation. However, research examining the therapeutic process of change—that is, how does change occur?—remains an emerging area of focus within the field of psychotherapy. Currently, psychotherapy research is most commonly conducted with the aim of examining grouped data (e.g., through the use of pre-post measures). However, as Hayes and Strauss (1998) have noted, this manner of research design often inadvertently obscures the dynamic and discontinuous nature of individual change patterns.

In an attempt to describe how moment-by-moment affective processes contribute to larger units of therapeutic change, Pascual-Leone and Greenberg (2007) examined observable moment-by-moment sequences in the emotional processing of clients experiencing global distress as they occurred within productive sessions of Emotion Focused Therapy (EFT). Global distress is defined as the experience of high expressive arousal and low meaningfulness in regards to some personally sensitive theme and/or life event. Individuals experiencing global distress believe themselves to be passive recipients of this state. Moreover, the object of distress is never well elaborated; it is either unknown, minimally elaborated, or is not addressed beyond a subjective sense of victimhood (Pascual-Leone, 2005). Global distress has been referred to as secondary emotion in EFT and is often referred to as defensive emotion or a broad sense of anxiety.
by psychodynamic therapists (e.g., Greenberg & Mitchell, 1983). The results of the Pascual-Leone and Greenberg (2007) study provided evidence to support the notion of individual client change as dynamic and discontinuous, as improvement in emotional processing was found to coincide with increased emotional variability.

Revisiting the sample of therapist-client dyads examined in the Pascual-Leone and Greenberg (2007) study, the present work shifts this focus on individual change patterns from the client to the therapist. Whereas the above study focused on the distressed clients, examining their emotional processing moment-by-moment to track the process of therapeutic change (i.e., the manner through which global distress is, or is not, resolved), the present study employs a similar methodology to follow therapist interventions as they occur moment-by-moment. The resulting data is thus understood to reveal the therapist’s in-session “response” to the distressed client.

The present study has three primary aims. The first objective is exploratory in nature: Can therapist responses to distressed clients be grouped into reliably distinct clusters? And, provided that more than one cluster of therapist responses is evidenced, do these clusters differentially relate to within-session outcome? Pascual-Leone and Greenberg (2007) were able to articulate the dynamic process of client distress resolution in fine detail, and provide evidence indicating that good within-session outcome is more likely to be preceded by the experiencing and expression of specific emotions. The current study seeks to determine whether therapists working within the same therapeutic modality employ therapeutic intervention techniques with different foci (i.e., “respond” differently) when confronted with a distressed client. If it is the case that more than one distinct grouping of therapist responses is found, analyses will be conducted to examine
whether certain therapeutic interventions are more likely to produce good within-session outcome than others.

While the first objective of the present study is concerned with the focus of therapist interventions, the second objective involves examination of the frequency with which therapists shift the focus of their interventions (e.g., a move from exploring a client’s behaviour to exploring the client’s emotions). As part of objective #1 of the present study, the foci of therapists’ moment-by-moment interventions will be measured. This data will be revisited in objective #2 in order to examine the frequency of therapist intervention shifts. Following the conceptualization of psychological growth posited by dynamic systems theory (Thelen & Smith, 1994), it is hypothesized that good within-session outcome is more likely to be preceded by more frequent intervention shifts.

The third objective of the current study draws directly on the findings of Pascual-Leone and Greenberg (2007) to posit the hypothesis that client emotional variability mediates the relationship between depth of therapist experiential focus and within-session outcome (as measured by depth of client experiencing). As part of the first objective of the present study, depth of therapist experiential focus will be assessed as a component of therapist responses. Once the data for this variable has been obtained, the data for the variables of client emotional variability and within-session outcome will be drawn from Pascual-Leone and Greenberg (2007), and incorporated into a mediation analysis in order to test the research hypothesis.
OBJECTIVE #1: GROUPING THERAPIST RESPONSES

The Therapist as a Neglected Variable

There has recently developed a growing recognition of the need to consider the role of the therapist in the field of psychotherapy research. Indeed, some researchers (Beutler, 1997; Garfield, 1997) have gone so far as to label the therapist a “neglected variable” in the field, noting that differences between therapists are commonly relegated to the status of error variance. Therapist characteristics are thus commonly ignored, excluded from the list of variables considered for systematic study. Moreover, the matter of individual differences among psychotherapists of the same orientation, and the role such variation plays in the facilitation of client emotion, has remained a rather neglected topic and area of research (Garfield, 1997).

Despite careful, systematic attempts to control for heterogeneous influences in clinical research studies, differences across individual therapists have long been acknowledged as a major contributor to the outcome variance of psychotherapeutic treatment (Blow, 2007). Moreover, it is evident that such variability persists in spite of efforts to homogenize treatment according to theoretical modality or therapy manuals for specific psychiatric disorders (defined in adherence with DSM-IV-TR criteria; Garfield, 1997). As Lambert (1989) suggests, given such findings, treatment outcomes of individual therapists could readily be reanalyzed in order to draw general conclusions about therapist (as opposed to treatment) interventions that were associated with productive and non-productive outcomes. However, while therapist variables have frequently been studied in order to better understand or predict the role of the therapist in the process and outcome of psychotherapeutic treatment, their results have generally not
been used to qualify conclusions about research findings (Elkin, 1999). Rather, in order to control for variability across therapists, researchers have often unwittingly relied on "homogeneity myths," such as the assumption of therapist uniformity (Kiesler, 1966).

In his classic article, Kiesler explains that homogeneity myths are dangerous oversimplifications of the psychotherapeutic process that hinder the researcher's ability to elucidate the therapeutic processes under investigation. The potential for research design to take precedence over faithful examination of the phenomena being investigated has long been cautioned against. Bannister and Fransella (1971) have sardonically observed that studies favoring methodological considerations over clinical significance are typically "born out of the literature and...buried in it" (p. 193). In the same vein, Lebow (2006) elaborates:

Psychotherapy researchers typically focus exclusively on different clinical interventions while ignoring the psychotherapists who make use of them. It's as if treatment methods were like pills, in no way affected by the person administering them. Too often researchers regard the skills, personality, and experience of the therapist as side issues, features to control to ensure that different treatment groups receive comparable interventions (pp. 131-132).

Goldfried and Wolfe (1998), in an examination of several reviews of the literature (Baucom, Shoham, Meuser, Daiuto, & Stickle, 1998; Compas, Haaga, Keefe, Leitenberg, & Williams, 1998; DeRubeis & Crits-Christoph, 1998; Kazdin & Weisz, 1998), note that the vast majority of psychotherapeutic literature involves comparisons of theoretically "pure" interventions. A serious limitation to such research is demonstrated in studies
Therapist Responding

which suggest that there are very few therapists who are actually administering theoretically pure interventions (e.g., Norcross & Goldfried, 1992; as cited in Goldfried & Wolfe, 1998). Rather, the majority of practicing therapists today report practicing therapy in an integrative, or “eclectic,” fashion (Beutler, 2008). Blow (2007) summarizes: “We need to study therapists. It may be better to talk about empirically supported therapists than models” (p. 312).

Examining Therapist Differences: Current Research Issues

Therapist variation within treatments has frequently been found to exceed the effects of different psychotherapeutic approaches (Beutler, 2004). However, determining the degree to which therapists differ in their effectiveness has proven to be a complex undertaking—and the findings are often not particularly clear (Hall, 2007). Several recent studies have investigated therapist effects in outpatient therapy (e.g., Elkin, Falconnier, Martinovich, & Mahoney, 2006; Kim, Wampold, & Bolt, 2006; Lutz, Leon, Martinovich, Lyons, & Stiles, 2007; Okiishi et al., 2006). These studies report contradictory conclusions; in one particularly interesting case, contrasting conclusions were found in two studies investigating the same data set (Elkin et al. 2006; Kim et al., 2006). Accordingly, several researchers stress the importance of therapist variability while others find that the empirical evidence indicating substantive therapist differences is lacking (e.g., Elkin et al., 2006).

There are several problematic issues common to studies of therapist variability: The number of participating therapists in the study is often small, patient samples tend to be homogeneous, and therapist manual training (a common research technique intended to enhance standardization of treatment) is likely to reduce variability in therapist
behavior (Dinger, Strack, Leichsenring, Wilmers, & Schauenburg, 2008). Accordingly, there have been calls for more naturalistic studies of therapist variability, in order to estimate the magnitude of therapist effects with greater precision (e.g., Wampold & Brown, 2005). In addition to their greater clinical validity, naturalistic studies of therapist variability have the potential advantage of examining a considerably greater number of therapists (e.g., Okiishi et al., 2006). To date, the empirical effect sizes reported for naturalistic studies have been significant, but moderate. Wampold and Brown (2005) found that approximately 5% of pre-outcome and post-outcome variance was due to therapist variability, while Lutz and his colleagues (2007) attributed 8% of the total variance and 17% of patient improvement to therapist variance. Reviewing the literature on therapist contribution to psychotherapy outcome, Diener, Hilsenroth, & Weinberger (2007) highlight the importance of observing actual therapist techniques or interventions, and conclude that it is essential that researchers define outcome in a multidimensional way in order to properly assess theoretically relevant effects.

Process Research: Investigating Therapist-Client Interactions

The emergence of psychotherapy process research, generally understood to be the study of interactions between client and therapist (Greenberg & Pinsof, 1986), has coincided with a conceptual shift in the field of clinical research. Historically, the areas of process and outcome research were viewed separately. However, it soon became clear that, in order for psychotherapy to develop as a science, it was just as crucial to articulate how psychotherapy worked as it was to note what worked (Bergin & Lambert, 1978). As Greenberg and Pinsof (1986) explain:
As outcome researchers were coming to realize that outcome research without process or therapy measures could never illuminate the basic mechanisms of psychotherapy, process researchers were realizing that process research that is not eventually linked to some kind of outcome is ultimately irrelevant (p. 6).

In bridging the process and outcome research traditions, Greenberg and Pinsof (1986) describe treatment “outcome” at various levels. They distinguish between in-session event outcomes (i.e., intermediate outcomes, or “small o’s”) and larger treatment outcome (i.e., a “big O”). Conceptualizing outcome in such a multi-leveled manner allows for consideration of final treatment outcome (i.e., good versus poor therapy; a big O), as well as, on a more detailed level of analysis, session outcomes or even within-session events (i.e., good versus poor sessions/events; little o’s). Moreover, little o’s can be considered in terms of their relation to big O’s. In this way, researchers can explore whether the processes evident in selected within-session events contributed to the larger treatment outcome.

Getting Specific: Examining Micro-Interventions

One of the chief difficulties confronted by researchers examining therapist variability has been disentangling “the effects due to the therapeutic approach from those due to the particular therapists who have carried out the approach” (Elkin, 1999, p. 11). The plurality of methods available to researchers attempting this feat is reflective of the complexity of the task; Couture and Sutherland (2006) suggest that even a slight change in what a therapist says to client, or a slight change in when he or she says it, can radically change the meaning of an interaction. Moreover, all therapy encounters are
essentially interactive: Both parties work toward generative, and ultimately curative, conversations. Within this framework, separating the therapist’s contributions to productive client change from the client’s efforts toward the same is an inherently problematic assignment (Couture & Sutherland, 2006). As such, the authors argue that researchers would do well to focus on “how specific therapeutic techniques or overall conceptual sequences...are actually done” within the context of psychotherapeutic discourse (Couture & Sutherland, 2006, p. 340).

A common tact used by researchers exploring questions of therapist contribution to change has been to focus their examinations on the effects of particular therapeutic techniques specific to therapists of a particular theoretical orientation. For example, such research has shown experiential therapists that Gestalt two-chair exercises (Greenberg & Clarke, 1979) and meaning symbolizations (Clarke, 1989) are associated with increased emotional experiencing. Similarly, psychodynamic therapists’ use of plan-compatible interpretations has been found to correlate with deepened experiencing (e.g., Silberschatz, Fretter, & Curtis, 1986; Weiss, 1988). Such findings can both highlight particularly efficacious techniques and reveal why they are effective. However, the use of such specialized techniques often requires substantial knowledge of theory and experience with the technique, factors which exclude a substantial number of therapists from making use of the knowledge gained. Moreover, reducing one’s subject of interest to a particular technique utilized by a specialized group of therapists (often working with particular populations) does not truly allow for the measurement of differences among individual therapists.
Wiser and Goldfried (1998) propose a conceptual shift intended to circumvent these limitations. Instead of focusing on techniques particular to a specific therapeutic modality, the authors suggest that researchers examine much briefer interventions which are common across psychotherapy orientations. For example, such transtheoretical intervention techniques might include therapist self-disclosure, a therapist asking an open question to her client, a therapist paraphrasing client speech, and so forth. Wiser and Goldfried (1998) suggest that examining such “smaller,” more specific techniques will result in data that is likely to be meaningful to a wider range of clinicians, as the behaviours being observed transcend the theoretical orientation of the therapist. This methodological shift is also intended to more directly allow for the examination of differences among individual therapists. As such “micro-interventions” are specific to neither therapist nor theoretical orientation, both the frequency and pattern of usage of these techniques can be attributed to the proclivities of the therapist.

Objective #1: Exploratory Aims

The first of the three primary aims in the current research involves an exploratory examination of the “micro-interventions” of a sample of therapists conducting EFT. The present research draws its sample from the participants described in Pascual-Leone and Greenberg (2007). Therapist interventions will be recorded over the course of a key emotion event within single sessions of therapy.

The therapist responses under investigation are thus understood to be circumscribed by their specific context (i.e., the distressed client). However, the context-specificity of this work is not viewed as a significant limitation to the generalizability of potential findings. Client expression of distress is an event of key importance in
psychotherapy, and neither excludes nor is specific to any particular psychotherapy treatment. Moreover, examining emotion events through the use of transtheoretical micro-interventions is expected to lead to results that are generalizable across, and applicable to, several psychotherapeutic modalities. That is, the specific orientation of the therapists under investigation (i.e., EFT) is a potential restriction on the variety of micro-interventions that will be recorded (as therapists of specific orientations tend to favor interventions with specific foci, and use others sparingly). It is not necessarily, however, a restriction on the generalizability of the results of this work.

Through comparison of the frequency and pattern of micro-interventions across therapists within these emotion events, the present research aims to identify and articulate reliably distinct therapist "responses" (as measured by the focus of therapeutic interventions and depth of therapist experiential focus) among the research sample. It is hypothesized that more than one reliably distinct cluster of therapist responses will be evidenced, despite the fact that all therapists in the sample are operating within the same theoretical modality. Articulation of these different clusters is intended to demonstrate the differential application of the same therapy across therapists, within the specific context of the events under investigation (i.e., confrontation with a client experiencing global distress). Further, the potential presence of a limited number of therapist response clusters would suggest that the therapist response clusters described are to some extent generalizable and not wholly idiosyncratic.

Each therapist response cluster will then further be examined in relation to therapy event outcomes, with the intent of examining whether response clusters are differentially related to productive therapy event-outcome. If applicable, individual
response clusters will be further examined, such that particular aspects of a given response cluster may be found to contribute most strongly to productive outcome.

OBJECTIVE #2: FREQUENCY OF INTERVENTION SHIFTS

The Nature of Therapeutic Change

Psychotherapeutic change has traditionally been viewed as a gradual, linear process. Conventional research designs, such as traditional pre-post measures, allow for only brief glimpses into the process of change. Similarly, traditional methods of data analysis are restricted in their ability to capture potential variability in the psychotherapeutic change process (Nowak & Vallacher, 1998). In the interest of obtaining generalizable results, researchers have tended to lump data along group averages, with the effect of deemphasizing variability along individual change patterns. Collins and Seyer (2000) note that relatively few studies have reported analyses of intra-individual variability, with researchers often viewing such variability as "noise," or a contributor to error variance.

Therapists generally promote a stable therapeutic environment in order to facilitate clients' readiness and resources for change. At the same time, they also typically introduce a variety of interventions designed to interrupt, challenge, or destabilize old patterns over the course of therapy (Hayes, Laurenceau, Feldman, Strauss, & Cardaciotto, 2007). Although therapeutic change can occur in a gradual, linear fashion, there is increasing evidence across disciplines that it can also occur in a discontinuous and nonlinear manner. Such non-linear change is often marked by sudden, dynamic shifts in therapist-client interactions. This destabilization often occurs within the context of emotional arousal which, when accompanied by increases in emotional processing and
meaning-making, appears to contribute to more productive therapeutic outcomes (Davies et al., 2006).

In order to study non-linear change, multiple observations must be recorded over time. Such examination is focused on individual change trajectories rather than mean change across groups. Kazdin (1982) presents this methodological shift as a return to traditional single-subject psychotherapy research design, which allows for greater understanding of those factors which facilitate and inhibit change. Moreover, studies which report results at the level of individual change are often most relevant to clinical practitioners (Krause, Howard, & Lutz, 1998), allowing unique insight into the psychotherapeutic process. Attending to individual shifts could direct researchers to those segments of therapy wherein the process factors which aid and inhibit productive client change are especially observable. This research strategy has been described as facilitating especially fruitful investigation (Rice & Greenberg, 1984; Greenberg, 1986). In this way, the study of non-linear change allows for a finer examination of change than is possible through traditional pre-post designs, potentially yielding predictors, moderators, mediators, and mechanisms of psychotherapeutic change processes (Hayes and Strauss, 1998). As such, investigations of non-linear therapeutic change can be viewed as a vital component of treatment development, providing clinicians and researchers alike the opportunity to better understand the “when,” “how,” and “why” of change (Paul, 1967; as cited in Hayes, Laurenceau et al., 2007).

Evidence of Non-linear Patterns of Change in Therapy

Empirical evidence demonstrating the presence of non-linear change in psychotherapy has been accumulating in recent years. Non-linear patterns of change have
been found present over the course of a wide variety of psychotherapeutic treatments. Investigating patterns of improvement in clients undergoing treatment for social anxiety, Heimberg and Becker (2002) describe three distinct patterns of productive change. One pattern is linear, a process referred to as "steady decline." The other two patterns, descriptively termed the "spike" and "habituation curve" follow curvilinear and discontinuous patterns.

The presence of such non-linear patterns of change suggests that client anxiety tends to increase before it decreases. Moreover, these findings support the idea that increased emotional arousal facilitates productive therapeutic change. This notion is emphasized by a number of theoretical orientations (Mahoney, 1991). Exposure-based therapy programs, for example, presume that the client's fear structure must be activated in concord with a sufficiently high level of affective arousal for productive change to occur (Foa, Huppert, & Cahill, 2006). Emotion-focused therapy also targets emotions directly, with the aim of increasing emotional arousal in order to facilitate therapeutic change (Greenberg, 2002).

While it should be noted that the investigation of non-linear change is increasingly occurring across disciplines, an examination of the psychotherapy literature reveals three dominant patterns of non-linear therapeutic change: rapid response, sudden gains, and depression spikes. These non-linear change patterns are briefly reviewed below.

**Rapid Response**

A sudden, substantial decrease in depression symptoms occurring early in the course of treatment has been found to be predictive of symptom improvement in
cognitive-behavioral therapies for depression. Such rapid response patterns are described as beginning with a substantial decrease in depression symptoms within the first four sessions of therapy, after which the level of change from session to session begins to decrease (Ilardi & Craighead, 1994). Similar early symptom decline patterns have been identified as predictive of improvement for clients experiencing alcohol abuse (Breslin, Sobell, Sobell, Buchan, & Cunningham, 1997), panic disorder (Penava, Otto, Maki, & Pollack, 1998), and bulimia (Grilo, Masheb, & Wilson, 2006).

In an examination of exposure-based cognitive therapy for depression, rapid response patterns were found predictive of improvement in depression (Hayes, Feldman et al., 2007). As part of treatment, participants were asked to write narratives every week over the course of therapy. Narratives written during the rapid response period were found to be characterized by more hope for rapid responders (Hayes, Feldman et al., 2007). This finding is consistent with Ilardi and Craighead's (1994) hypothesis that the presence of rapid response is positively correlated with increased hope.

**Sudden Gains**

Tang and DeRubeis (1999) report observing that certain clients appear to experience dramatic reductions in symptom intensity from one session to the next. This phenomenon, which they have termed “sudden gains,” consists of sudden, substantial symptom improvement. This improvement appears to have “long-lasting impact on therapy process and outcome” (p. 902).

Sudden gains appear to occur following “critical sessions,” or sessions wherein important therapeutic events occur such that the nature of the therapy appears to change significantly afterward (Elliott, 1984). Indeed, the presence of sudden gains following
critical sessions over the course of therapy appears to strongly impact therapy outcome. Tang and DeRubeis (1999) note that clients who experienced sudden gains were less depressed than other clients following treatment and tended to maintain their gains at follow-up. The sudden gains represented, on average, 51% of total pretreatment-to-posttreatment improvement. Moreover, approximately 40% of clients were observed to have experienced sudden gains (Tang & DeRubeis, 1999). In a separate study, clients who had experienced sudden gains were found to have better therapeutic outcomes than clients with more linear change patterns (Stiles et al., 2003). The sudden gains observed appeared to contribute significantly to this discrepancy.

Interest in the fact that psychotherapy progress is not gradual or smooth but instead marked by sharp discontinuities represents an important shift in the literature (Kopta, Howard, Lowry, & Beutler, 1994). Previous studies have demonstrated that the nature and intensity of many clients' psychological symptoms often varies sharply from day to day (e.g., Barkham, Stiles, & Shapiro, 1993). However, such instability has often been considered "noise," attributable to individual life events which serve to obscure the observation of gradual improvement. Although certain symptom fluctuations may well represent transient shifts, evidence of sudden gains indicates that some shifts appear to represent enduring improvements. To this end, Wilson (1999) provides the results of a literature review, suggesting that sudden gains are not restricted to depressed clients but occur also in the treatment of a number of other disorders, such as bulimia nervosa and alcohol abuse. To date, sudden gains have been associated with improved outcomes for clients undergoing supportive-expressive therapy (Tang, Luborsky, & Andrusyna, 2002),
systematic behavioral family therapy (Gaynor et al., 2003), and a variety of non-manualized psychotherapeutic treatment programs (Stiles et al., 2003).

**Depression Spikes**

A depression spike can be understood as the conceptual opposite of a sudden gain (Hayes, Laurenceau et al., 2007). Characterized by a large increase in depression followed by a significant decrease in symptoms, depression spikes have been found to predict increased improvement in depression at the end of treatment (Hayes, Feldman et al., 2007).

Depression spikes typically occur in the exposure phase of therapy. The exposure phase of treatment consists of therapist-facilitated activation of the depressive network, an increase in arousal (i.e., the depression spike), and subsequent introduction to corrective information (Foa et al., 2006). Hayes, Feldman et al. (2007) report that more cognitive/emotional processing occurs in the exposure phase of therapy when a depression spike is present than when such a spike is not present. Such increased processing is correlated with significant shifts in perspective and emotional response. In this way, depression spikes appear to facilitate productive client change, and positive therapy outcome. Higher rates of cognitive/emotional processing in the exposure phase of therapy have also been found to predict greater improvement in symptoms of personality disorder, depression, and anxiety (Hayes et al., in preparation).

Because the three patterns of non-linear change examined above (i.e., rapid response, sudden gains, and depression spikes) are discontinuous and nonlinear, they may not readily be apparent in traditional pre-post analyses of grouped data. The importance of research investigating such non-linear patterns of change is thus vital to our
understanding of the client change process, and of the factors that contribute to productive change.

Dynamic Systems Theory: A Theory of Non-Linear Change

Dynamic systems theory presents psychological growth as a lifelong process characterized by alternating periods of stability and instability. Stabilizing forces sustain the coherence or integrity of a system, while instability, or variability, allows the flexibility necessary for change. Thus, change is perceived as one’s movement through a series of states of stability and variability (Thelen & Smith, 1994). A system undergoing such change is experiencing a transition. Once a transition is complete, old forces compete with new patterns until the system regains stability (Thelen, 2005).

Dynamic systems theory posits that a dynamic system self-organizes into preferred patterns, which are termed attractor states. The stability of a given attractor state is a function of its history. Attractor states that have been maintained repeatedly over time tend to be more stable, may be achieved through a variety of conditions, and require more energy to destabilize (Tschacher, Schiepek, & Brunner, 1992). Attractor states with the greatest potential for change are less stable, and tend to have less history within the system. A therapist with a certain understanding of the history of a client’s system then, may be able to facilitate destabilization through exposure to new, powerful information designed to challenge and change the client’s existing patterns (Caspar, Rothenfluh & Segal, 1992). Alternatively, the therapist may instruct and encourage the client to repeatedly engage in novel behavior (Teasdale & Barnard, 1993).

Destabilization is therefore viewed as a necessary process which enables individual growth and change. Destabilization is a period of system-wide disorder which
may be marked by variability in several domains (Mahoney, 1991). Unless a system is
challenged, it will gravitate toward the attractor state. Schiepek, Fricke and Kaimer
(1992) note that minor change can be facilitated via adjustments in the attractor state or
enhancing the system's ability to shift between attractor states. However, new patterns
(i.e. new attractor states) can only emerge when old ones are destabilized. If a state of
destabilization is prompted when a client is ready, it can facilitate the emergence or
discovery of a more adaptive attractor state. However, if the client does not have the
resources to engage the period of disorder, the client may maintain the same attractor
state, or even regress to a less adaptive one (Mahoney, 1991).

The individual's psyche is thus viewed as a dynamic system, consisting of
interacting components that shift and evolve over time. Psychopathology is
conceptualized as a state of "dynamic equilibrium," wherein a maladaptive pattern (or
patterns) of functioning interferes with an individual's well-being (Mahoney, 1991). These patterns are often well-established within the individual, and can in fact become so
entrenched that they are considered "lifestyles" (Schiepek et al., 1992). However, such
functional (albeit maladaptive) patterns contribute to the structure of the individual's
daily living. These stabilizing, self-protective forces work to maintain the presenting
patterns, despite their inhibition of optimal functioning (Hayes & Strauss, 1998). The
therapist must attend to these forces, as they influence the nature of change because such
stabilizing forces must be overcome before productive client change is possible
(Mahoney, 1991).

Drawing on dynamic systems theory, several studies have demonstrated that one
important predictor of system transition is a type of discontinuity called critical
fluctuations (e.g., Bak & Chen, 1991; Kelso, 1997; Schiepek, Eckert, & Weihrauch, 2003). A case in point is the observation of sudden gains during critical sessions (Tang & DeRubeis, 1999). When challenges to a stable system are too great to assimilate, sudden, dramatic disturbance and increased variability in system behavior is often observed before the system reorganizes itself. During this period of critical fluctuation the system is both destabilized and open to new information, including the exploration of more adaptive patterns (Hayes, Laurenceau, et al., 2007). Following a critical fluctuation, the system oscillates between old and new patterns until it stabilizes once again, arriving at a new attractor state. Periods of critical fluctuation have been found helpful in identifying points of system transition. Kelso, Ding, & Schoner (1993) report that system transitions are preceded by critical fluctuations and followed by periods of increased stability. Indeed, psychotherapy researchers have already started to identify critical fluctuations in order to study system change and its causes (e.g., Vallacher, Read, & Nowak, 2002).

Objective #2: Aims

The second objective of the current work is to determine the nature of the relationship between the frequency with which therapists change the focus of their interventions (i.e., frequency of "intervention shifts") and event outcome. Following the notion that psychotherapeutic change can be conceptualized as non-linear movement through a series of states of stability and variability (as proposed by dynamic systems theory), this line of inquiry seeks to determine whether the frequency of therapist intervention shifts alone is predictive of event outcome. Borrowing the language of dynamic systems theory, a therapist intervention shift can be understood as a potential
destabilizing force, capable of contributing to the destabilization of a system, and ultimately facilitating transition in a maladaptive attractor state.

Frequency of intervention shifts will be measured by revisiting the data on the moment-by-moment focus of therapist interventions collected as part of objective #1 and determining how many times each therapist altered the focus of their interventions, relative to the length of the emotion event. In accordance with the dynamic systems theory framework, it is hypothesized that good within-session outcome is more likely to be preceded by more frequent intervention shifts.

OBJECTIVE #3: EMOTIONAL VARIABILITY AS A MEDIATOR

Continuing with an understanding of therapeutic change as a dynamic, non-linear process, the third objective of the present research draws specifically on research examining emotional processing as a process predictor of psychotherapy outcome.

Emotional Processing: A Process Predictor of Therapy Outcome

Examining clients' depth of experiencing in Emotion-Focused Therapy, researchers have found that clients tend to develop their capacity for emotional processing over the course of therapy. Examining changes in the depth of a client's experiencing, Goldman, Greenberg, and Pos (2005) reported that changes in the depth of a client's experiencing from early to late sessions was predictive of treatment outcome. Focusing on clients' good moments within a single session of Gestalt therapy, Stalikas and Fitzpatrick (1995) found that productive in-session change is related to the strength of client feeling and the presence of higher levels of experiencing.

Similar findings have led some to suggest that Emotion-Focused Therapy cultivates a client's emotional processing ability or "skill," and that client emotion may
be an important predictor of therapy outcome (Pos, Greenberg, Goldman, & Korman, 2003). To date, several studies have demonstrated that therapist facilitation of emotionally-charged chair-dialogues is predictive of good treatment outcome and better resolution of interpersonal difficulties (e.g., Paivio & Greenberg, 1995; Greenberg & Malcolm, 2002).

**Emotional Variability: A New Process Predictor of Therapy Outcome**

In a recent study, Pascual-Leone and Greenberg (2007) investigated the process through which emotional distress is changed within a session of Emotion-Focused Therapy by examining variability in clients’ emotional processing. Their aim was to investigate the client’s subjective experience of “feeling better.” They ask: Is “feeling better” simply a result of improvements in meaning construction and more positive experience? Or instead, in accord with dynamic systems theory, do successful clients develop their ability to shift toward healthier self-organizations?

The authors examined emotionally significant segments of individual therapy sessions (“emotional events”). Their results indicated that, among clients who were able to successfully process their emotional distress, therapeutic change appeared to move in a positive linear fashion. However, at the same time, these clients demonstrated increasing flexibility in their ability to shift between different states of affect and meaning. When viewed moment-by-moment, this emotional transformation presented as a “two-steps-forward, one-step-back” pattern. In this way, steady overall progression was found to coincide with an increasingly wide range of emotions.

In a closer examination of this pattern of emotional variability reveals its cyclical nature: periods of “feeling better” followed by periods of “feeling worse” (Pascual-
Leone, 2008). This up-and-down pattern was evidenced in both good and poor emotional processing events; multiple periods of feeling worse were not indicative of a poor in-session event. Rather, good events were distinguished by shortened periods of feeling worse. Successful emotional processing led to feeling better through the progressive shortening of periods during which a client was feeling worse. By contrast, in the poor emotional events, clients actually experienced longer and longer periods of feeling worse as the event progressed.

According to dynamic systems theory, repeated practice or exposure to new information facilitates the destabilization of an existing system, eventually leading to the construction of a new system, or a new way of being. The pattern of emotional flexibility found by Pascual-Leone and Greenberg (2007) can be understood as indicative of the dynamic nature of engaging a range of emotional self-organization.

While emotional awareness refers to being attentive to current experiences, emotional flexibility refers to one's ability to dynamically shift from one set of feelings and meanings, one self-organizing framework of action, to another. A single qualitative shift in emotional state has been called an “emotional transformation” (Greenberg & Pascual-Leone, 2006). An individual's facility in creating such transformations is called emotional flexibility (Pascual-Leone, 2008, p. 33; original italics).

Objective #3: Aims

One component of therapist responses to distressed clients measured as part of objective #1 of the present research is the relative depth of therapist experiential focus. In
objective #3 of the present research, this data will be reanalyzed as a component of the mediation model being tested. The third aim of the current research builds directly on the work of Pascual-Leone (2008), who reported that client emotional variability is related to event outcome (as measured by depth of client experiencing). This finding is particularly significant when considered in conjunction with previous studies that have reported a significant relationship between depth of therapist experiential focus and depth of client experiencing (e.g., Adams, 2001; Hitz, 1994). These studies provide support for two of the three relationships necessary to establish emotional variability as a mediator variable in the relationship between depth of therapist experiential focus and depth of client experiencing (measured in the present study in terms of event outcome). The current study is in a position to investigate whether the third relationship, between depth of therapist experiential focus and client emotional variability, is significant. If this relationship is found to be significant for the current data set, alongside the other two, previously established relationships, sufficient evidence to test the mediation model will exist.

To summarize, in order to determine whether a mediation effect is present, Baron and Kenny (1986) state that the following relationships must be demonstrated: (i) depth of therapist experiential focus is significantly related to event outcome; (ii) depth of therapist experiential focus is significantly related to client emotional variability; (iii) controlling for therapist depth of experiential focus, client emotional variability is significantly related to event outcome, and; (iv) when client emotional variability is present, the strength of the relationship between depth of therapist experiential focus and event outcome is reduced.
In statistical terms, it has thus far been established that depth of therapist experiential focus and depth of client experiencing (i.e., event outcome) are significantly related, such that a therapist engaged at high level of experiencing is both more likely to encounter a client engaged at a high level of experiencing, and more likely to facilitate good in-session, or event, outcome. It has also previously been established that clients who experience greater emotional variability (i.e., more—and more intense—emotional “highs and lows”) are more likely to experience good event outcome (or, higher levels of experiencing). The second aim of the present research is premised on the hypothesis that depth of therapist experiential focus is also significantly related to client emotional variability. Stated conceptually, the hypothesis posits that depth of therapist experiential focus and depth of client experiencing are related, at least in part, because a therapist engaged at high level of experiencing is significantly more likely to encounter a client experiencing greater emotional variability, which in turn will be more likely to facilitate deeper (i.e., higher levels) of experiencing in the client. It is hypothesized that when the presence of emotional variability is accounted for, the strength of the relationship between depth of therapist experiential focus and event outcome will be significantly weakened.

Summary of Hypotheses

In sum, the hypotheses that will be tested in the present study are as follows:

- Hypothesis, Objective #1 (Exploratory): More than one reliably distinct cluster of therapist responses will be evidenced.

- Hypothesis, Objective #2: Good event outcome is more likely to be preceded by more frequent therapist intervention shifts.
• Hypothesis, Objective #3: Emotional variability will mediate the relationship between depth of therapist experiential focus and event outcome.

METHOD

Participants

Sample

The sample in this study of single sessions consisted of 26 client-therapist dyads drawn from a data set previously collected and described in part by Pascual-Leone (2005). This archival sample was derived from several larger subject pools originally recruited for four clinical trials completed at the York University Psychotherapy Research Clinic between 1991 and 2002. In order to participate in the aforementioned clinical trials, participants had to be between the ages 18 to 65, not involved in pharmacotherapy or alternate psychotherapy treatments at that time, and (depending on the study) either suffered from major depression or had unresolved “emotional injuries” with a significant other that have persisted for two or more years.

All of the clinical trials from which the sample was drawn involved brief psychotherapy treatments (ranging from 12 to 20 sessions). Of the 26 sessions selected, 2 cases were originally drawn from the Unfinished Business Study (Paivio & Greenberg, 1995); 1 case was selected from the York I Depression Study (Greenberg & Watson, 1998); 9 cases were selected from the York II Depression Study (Goldman, Greenberg, & Angus, in press); and 14 cases were selected from the Emotional Injury Study (Greenberg & Malcolm, 2002). Thus, for a total of 10 cases the primary treatment target was depression while for the other 16 it was longstanding interpersonal difficulty. Still, there
was substantial overlap and coherence in the nature of presenting problems regardless of which study cases were drawn from.

**Clients**

The research sample of 26 clients included 23 females and 3 males between the ages of 27 and 59 (M = 41.4, SD = 10.4). 8 participants were single, 14 were married or common-law, and 4 were separated or divorced. The education level of the selected sample included 4 participants who had completed high school, 3 who had completed some college or university, 10 graduates of college or university, 3 with some post-graduate education, and 6 participants who had post-graduate or professional school educations. While data on ethnicity was not collected, the ethnic diversity of the participants evidenced in the videotaped data set appears to be fairly representative of the multiculturalism found in large, urban settings such as Toronto. Information regarding client socio-economic status was not systematically collected.

All participants in the study were evaluated on both DSM-III-R criteria and the Global Assessment of Functioning (GAF) Scale. Pre-treatment assessments indicate that the mean GAF score for the sample was 69.7 (SD = 10.9, Range = 53 to 90). This mean score is indicative of mild to moderate symptoms of impairments in psychological, social, and occupational functioning. More specifically, 14 participants (53.9%) suffered primarily from mood disorders: 13 were diagnosed as having a Major Depressive Episode, and 1 client was diagnosed with Bipolar Disorder. 6 clients (23.1%) suffered primarily from anxiety disorders: 5 were diagnosed as having an Anxiety Disorder not otherwise specified (with features of panic and generalized anxiety) and 1 client was
Therapist Responding 28

diagnosed with Social Phobia. There were 6 participants (23.1%) who did not receive any Axis I, DSM-III-R diagnosis at all.

Assessment of personality disorders indicated that 11 (42.3%) participants in this sample had Axis II disorders, according to clinical assessments based on the SCID. The personality disorders represented in the sample included: 4 avoidant, 1 negativistic, 1 obsessive-compulsive, 1 paranoid, and 2 personality disorders not otherwise specified. The other 15 remaining participants (57.7%) did not suffer from personality disorders. Five participants out of the total sample did not meet DSM-III-R criteria for either axis I or axis II disorders but did meet study-specific criteria for suffering from long-standing emotional injuries.

**Therapists**

In the sample of 26 cases, treatment was conducted by 18 therapists (17 females and 1 male). Seventeen therapists were advanced doctoral students of clinical psychology and 1 was a registered clinical psychologist. All therapists had a minimum of three years of clinical experience. Due to the heavy gender imbalance of the sample, results will necessarily be limited in terms of generalizability. Similarly, analyses of results by gender are not possible. Training for the clinical trials involved didactic instruction, viewing videotaped sessions of therapy, live demonstration, and in-vivo practice of the treatment with fellow trainees. Adherence was ensured through weekly video-supervision of therapy sessions. A registered psychologist supervised all clinical work.

**Treatment: Emotion Focused Therapy**

The psychotherapy in each of the four clinical trials differed slightly according to the nature of the original study. The therapeutic modalities included 25 clients in
Emotion-Focused Therapy (EFT) for depression (Greenberg, Rice, & Elliott, 1993) and one client in experiential client-centered therapy (Rogers, 1957, 1961). Both therapies can be described as representing different versions of EFT; comparison of the events selected across the different clinical trials reveals virtually no reliably identifiable difference in therapeutic orientation or techniques. Moreover, given that the research sample consists only of portions of a single session per client, the segments might or might not have captured obvious key distinctions between therapies, such as the two-chair interventions found in process-experiential therapy.

EFT explicitly aims at providing the "necessary and sufficient conditions" for therapeutic personality change described by Rogers (1957). Thus, participants in these treatments were met by both the empathic attitude and relationship conditions of client-centered therapy (Greenberg et al., 1993). Experiential and emotion focused therapies attempt to facilitate the activation, exploration, and understanding of emotion by providing an empathic working alliance. A good working relationship which allows the client to explore their emotions more deeply, with or without active intervention, is theorized to enable the client to develop his or her emotional repertoire. In turn, such development results in the improvement of depressive symptoms and allows the client to activate more adaptive emotional states in the future. The approach is put into practice by helping clients to attend to their immediate emotional experience in an accurate and undistorted manner. Through this process-directive approach aspects of a client's spontaneously emerging experience are activated in order to produce moment-by-moment changes. Interventions of this general orientation include encouraging the expression of previously unacknowledged wants or needs, and prompting individuals to
use a more deliberate (and less automatic) style of processing to reflect on the ongoing
flow of their emerging affect and meaning (Toukmanian, 1992).

Depending on the session, some of the sampled events contain aspects of two-
chair interventions, which is characteristic of EFT and not of a client-centered modality.
These interventions are semi-structured, imaginal tasks wherein clients are encouraged to
explicitly dialogue with themselves or a significant other (described as seated in the
opposing chair) who is not actually present. The emphasis these experiential approaches
place on momentary experiences serves two essential functions: First, it aims to teach
clients how to focus on their own experience. Second, it aims to help clients trust their
emotional experiences as the eventual sources of self-knowledge to inform choice and
action.

*Final Treatment Outcome*

The current research sample consists of within-session events, rather than entire
treatment sessions. As such, it is important to consider whether the selected cases were
derived from successful or unsuccessful therapeutic treatment. Final treatment outcome
can thus be considered a descriptive variable for the sample of 26 therapist-client dyads.
Relative to the original outcome studies from which they were drawn and according to
the measures used in the respective studies, 14 clients in the sample (54%) reported good
final treatment outcomes and 12 (46%) had had poor final treatment outcomes. These
proportions are not substantial deviations from chance (i.e., 50%), indicating that the
selected events comprising the current sample are not differentially representative of
overall outcomes.
Measures

Therapist Process Measures

Coding sheets for the CSTF and the EXP-T, as well as brief descriptions of each of the coding categories for both therapist process measures, can be found in Appendices A and C, respectively.

Coding System for Therapist Focus

The Coding System for Therapeutic Focus (CSTF; Goldfried, Newman, & Hayes, 1989) is a direct, comprehensive cross-theoretical coding system, with the significant time demands (e.g., extensive training; labor-intensive procedure) required by such comprehensive coding measures. The utility of the CSTF’s coding scheme has been demonstrated in several studies involving cross-therapy comparisons, detailed analyses of therapeutic events, and examinations of the relationship between process and outcome (e.g., Castonguay, Hayes, & Goldfried, 1996; Goldfried, Castonguay, Hayes, Drozd, & Shapiro, 1997; Goldfried, Raue, & Castonguay, 1998).

In an effort to retain the advantages offered by the CSTF while increasing its clinical utility (e.g., reducing the time and labor required by the measure), researchers developed a measure focused on the “Action” and “Insight” (i.e., constructing meaning) dimensions of the CSTF (producing the CSTF-“AI”). The CSTF-AI allows for coding of therapeutic interventions in a theoretically neutral language (Wolfe & Goldfried, 1988). Detailed analysis of therapeutic focus is enabled through the coding categories, which describe therapists’ focus among several categories, including: basic components of client's functioning, such as emotions or thoughts; links made by the therapist (e.g.,
highlighting a connection between client's behaviors and thinking—interpersonal links are coded in a separate category), and; the therapist's temporal focus.

Recently, Ellison and Greenberg (2007) presented a revised version of the this measure, the CSTF-AI-R, which featured the inclusion of new coding categories tailored to the techniques utilized by therapists conducting Emotion-Focused Therapy (EFT), and which are more generally applicable to client-centered therapeutic approaches. The additional categories include: (i) therapist focus on a client’s desire for fulfillment of a basic concern, need, or wish; (ii) physical sensation associated with an emotional response; (iii) action disposition or tendency associated with an emotional response; (iv) therapist focus on persons who are not the client, and; (v) an “unspecified” category for non-applicable verbal exchanges. These coding categories are presented alongside the CSTF-AI’s established categories.

The CSTF-AI’s categories are ordered along two dimensions. The first dimension, “Constructing Meaning,” includes therapist focus on the client’s emotions, self-appraisals, intentions or future-oriented volition, general thoughts, connections between various components of client’s functioning (intrapersonal links), and connections between various components of client’s functioning and those of another person (interpersonal links). The second dimension, “Facilitating Action,” includes focus on the client’s expectations, behaviours, and external situations. In addition, the coder determines the focus of the therapist’s frame of reference (either on the client; another person; or a joint reference, on both the client and another person) and time frame (past, present, or future).
Preliminary results from Ellison and Greenberg (2004) indicate that the CSTF-AI-R’s additional coding categories successfully enhanced an observer’s ability to conduct fine-grained analysis of therapist focus within the EFT and client-centered modalities. The unit of analysis for rating with this measure is a pre-determined standard length of time. For the current study, CSTF-AI-R coding was conducted in 30 second segments. See Appendix A for CSTF coding categories and sample CSTF coding sheet.

**Therapist Experiencing Scale**

The Therapist Experiencing Scale (EXP-T; Klein, Mathieu-Coughlan, & Kiesler, 1986) is a 7-point scale, each stage describing the therapist’s emotional and cognitive involvement in the client’s experiencing. The EXP-T is the therapist analogue of the more commonly known and utilized (Client) Experiencing Scale, described below. The EXP-T has two components: referent and manner. Referent refers to the component or level of the client’s experiential process that is emphasized by the therapist. Manner refers to the level of the therapist’s own experiential involvement in the therapist-client interaction. Due to a functional overlap between the two components of the EXP-T, in the present research, therapist referent alone was coded. However, descriptors of therapist manner were used to inform referent coding. (as done by Adams & Greenberg, 1996).

The gradual change from lower to higher stages of the EXP-T represents a progression from intellectual interest, to references to feeling or the client’s experiencing, to the development of a shared, common process. At the lowest EXP-T level (i.e. levels 1-2), the therapist is impersonal and detached; the client is not referred to. At level 3, limited, behavioural description of the client’s feelings is referenced by the therapist. This reactive style of therapist reflection is deepened in level 4, wherein the therapist’s
commentary is focused on the careful articulation of the client’s feelings and personal experiences. The therapist at this level is empathically involved, aiding the client through elaboration of the client’s feelings and by making associations in this context. At level 5, the therapist directly engages the client, focusing on problems or propositions about the client’s feelings or experiences. The therapist at this level commonly uses his or her own feelings to explore the client’s experiencing. At the highest levels (i.e. levels 6 and 7), this shared, common process becomes the focus for exploration and the emergence of new experiencing for both the client and the therapist.

Rather than coding each utterance, ratings using this measure were conducted by using an overall code for each two-minute segment. The procedure of relating larger units of therapist behaviour to client process, rather than using utterance-by-utterance ratings, is supported by the work of both Paivio, Holowaty, and Hall (2004) and Elliott et al. (1982). See Appendix A for EXP-T coding categories and sample EXP-T coding sheet.

Client Process Measures

Classification of Affective-Meaning States

The Classification of Affective-Meaning States (CAMS) is an instrument for the systematic observation of emotion and affective-meaning states, and was used to evaluate client emotional variability (Pascual-Leone, 2005). The measure is applicable to coding emotion events when participants are engaged, emotionally involved, and aroused. Thus, the CAMS assumes that participants are not explicitly avoiding or interrupting arousal or emotional experiencing. The codes themselves are intended to describe emotional experiences that are being “allowed” by the individual.
The CAMS is designed to track the changing “flow of emotions”: Which emotions are occurring and in what sequence. The measure was created in light of evidence suggesting that some emotional experiences may be more productive than others (e.g., Greenberg et al., 1993; Greenberg & Paivio, 1997; Sicoli & Greenberg, 2005). Each emotion state is evaluated according to three distinct facets: emotional tone; involvement, and; meaning. In combination, these criteria capture key affective-meaning (i.e., “emotion”) states.

In total, the CAMS contains 11 category codes for emotionally activated states for which there are both affective and meaning related criteria. The full CAMS criteria are can be found in Pascual-Leone (2005). Ratings of client emotional variability used in the present study are archival and have been reported in Pascual-Leone (2005); these ratings were incorporated into the current study’s analyses of client emotional variability.

*The Experiencing Scale*

The Experiencing Scale (Klein et al., 1986) is a 7-point scale that measures the degree to which clients orient to and symbolize their internal experience and use this felt experience as information to resolve their problems. Raters use content distinctions as well as expressive, grammatical, and paralinguistic features to classify events of therapy on a 7-point scale. Lower levels on the scale (i.e., 1-3) represent the degree to which a client orients toward and makes use of internal referents; while mid-level ratings (i.e., 4) represent the detailed exploration of those felt experiences. Higher levels on the scale (i.e., 5-7) capture processes that continue to be highly experiential but are less embedded in the actual feeling so as to allow reflecting on the presenting meaning of one’s immediate
experience. Thus, there is a shift in the nature of processes represented by the Experiencing Scale as one moves from lower to higher levels.

At level 5 the individual begins to formulate problems or propositions about feelings and personal experiences. This “questioning” is done in a style that is very exploratory, elaborative, or hypothetical. At level 6, clients make syntheses of readily accessible feelings and experiences to resolve personally significant issues. Often at this level of “answering” or “feeling more”, client’s feelings are vividly expressed and are reflected on in an integrative, conclusive or affirmative manner. Finally, at level 7 the content is full, with an easy presentation of experiencing and all elements are confidently integrated. This level of processing represents a “rising above” the presenting concerns and the style is often expansive, illuminating, confident, and buoyant.

This measure is most often used in the literature as a psychotherapy process measure of emotional processing. Even so, some authors have highlighted the natural separation between lower and higher levels of experiencing (see Pascual-Leone & Greenberg, 2006). In this sense, higher levels on the EXP-C are positive therapeutic achievements indicative of positive therapeutic effects (i.e. reflecting, questioning, synthesizing, resolving), also referred to as moments of “good within-session outcome”.

In order to use the EXP-C as a measure of within-session outcome, Pascual-Leone and Greenberg (2007) converted the 7-point EXP-C scale to a binary measure. Similarly, the level of analysis in the present study is neither the outcome of treatment as a whole, nor post-session outcome, but is rather the outcome of emotion “events” that have occurred within a given session. Thus, in the current study the 7-point EXP-C scale was reduced to a binary scale of lower (levels 1-4) vs. higher (levels 5-7). Higher EXP-C
ratings at or near the end of a given emotion event were used as indicators of good event outcome with respect to the immediately preceding client processes. Event outcomes in the present study are based on archival EXP-C coding that was conducted as part of Pascual-Leone and Greenberg (2007).

Procedures

Event Selection

The present research uses a predetermined sample in order to be consistent with prior research. As such, the within-session events were selected as part of the methodology of Pascual-Leone and Greenberg (2007), and are reported therein. Event selection was conducted in a series of convergent appraisals, with an emphasis on direct, reliable observation of the data (i.e., face validity, as agreed upon by the researchers). Event selection was conducted through the combined efforts of the therapist, two independent expert observers (i.e. "event selectors"), and the principal investigator.

The initial step in event selection involved identifying the affective-meaning state of Global Distress (as defined in the CAMS coding criteria). Global Distress, defined as a state of high expressive arousal (e.g., tears, emotional voice, etc.) combined with low specificity in meaning (such that the object of the client's distress is often unknown, or the client has no sense of direction), served as the initial marker of the selected events.

The sequence of convergent appraisals used to select events was as follows: First, therapist session notes for each client indicated those sessions that had particularly high emotional arousal and offered a brief description of the quality of emotion in-session. These served as a preliminary sorting of potential events and directed event selectors in their initial search. Second, a rater acting as an event selector coded two to three of the
most promising video recorded sessions for a given client (i.e. those reported by therapists as having the highest emotional arousal) for the presence of Global Distress. Third, the principal investigator verified the marker criteria of events proposed by raters. Finally, an independent team of “emotion raters” coded selected events beginning with Global Distress markers and continuing with as much of the session as needed.

The above procedure did not delimit the ending point of the events. The end-marker of each distress event was determined through CAMS rating using the CAMS “End Code” (i.e., a drop in arousal accompanied by a change in the topic of conversation). See Pascual-Leone (2005; Pascual-Leone & Greenberg, 2007) for further details.

**Client Process Measures: Emotion and Event-outcome**

Data on client emotion and event-outcome was collected as part of the study described in Pascual-Leone and Greenberg (2007).

**Emotional Variability**

The data for the variable of emotional variability were drawn from Pascual-Leone (2005), and the methodology for obtaining these data are described in full therein. Briefly, the emotional variability data resulted from the “flattening” of the Pascual-Leone and Greenberg (2007) model of emotional processing for each case. The resulting data represent a linear scale that reflects the degree to which each emotion state is generally indicative of processes toward resolution. Conducting a regression analysis of these data onto time revealed the “slope” of the client’s changing emotional variability, or their progress in emotional transformation over the course of the emotion event. Measures of
emotional variability for each client are used here to represent a process variable that reflects a key facet of client emotion.

*Therapist Process Measures*

Observer rating of the therapist process measures will be conducted by the author and two 4th year undergraduate psychology students who have completed an advanced counseling course which provided extensive general training on the process measures used in the present research. This exposure has been followed by a minimum of 20 hours of training focused specifically on differentiating the relevant affective-meaning states in psychotherapy sessions from video. As such, raters have substantial prior experience with the therapist process measures and relevant underlying theory. Training for each coding system will be done independently and each will consist of: study and discussion of relevant coding manuals and specific coding criteria, practice coding on selected video segments, preliminary coding to assess baseline reliability, and discussions of relevant theory. As the complexity of the coding process for the therapist process measures was less than the same for the client event-outcome measures, the training period for the therapist process coders was less extensive than the same for the client event-outcome coders.

The author acted as primary rater and coded video segments for all cases on both the CSTF-AI-R and the EXP-T. To establish reliability, all cases were re-coded on each measure by secondary raters. One undergraduate student acted as secondary rater on the CSTF-AI-R; the other acted as a secondary rater on the EXP-T. All raters coding therapist behaviours were blind to both the existing ratings of client behaviours and the existing ratings of the event outcomes. As such, the likelihood of the raters' personal
biases (based on knowledge of the client-event outcome measures) influencing their coding was substantially reduced.

**Therapist Process Measures: Establishing Reliability**

For the current study, three raters (including the author) were trained to code videotaped segments using the therapist process measures. The author and the second coder were trained on the CSTF, while the author and the third coder were trained on the EXP-T. Weekly meetings were conducted to train raters using the CSTF and EXP-T manuals and three randomly selected psychotherapy sessions not included as part of the study sample (meetings for each measure were held independent of each other). Those responses that were selected for training purposes were not coded in the present study. Within the training process, additions and revisions to the manual rules were made. After two months the raters established adequate inter-rater reliability (minimum $\kappa = 0.75$; Fleiss, 1981). Both the primary rater (author) the secondary raters coded the entire sample on the measure(s) in which they were trained, such that both measures were fully coded by two coders.

**Frequency of Intervention Shifts**

After the final CSTF coding data was established, the coded CSTF data sheets were reanalyzed by the author in order to determine the frequency with which therapists changed the focus of their interventions (i.e., as indicated by a move from one CSTF code to another). An “intervention shift” was thus defined as a CSTF code change between contiguous 30-second intervals. This process resulted in the creation of the variable “frequency of intervention shifts.”
Due to the naturalistic length of the emotion events, the resulting raw data (number of intervention shifts) was converted to proportional intervention shifts (i.e., number of intervention shifts divided by the number of 30-second segments comprising the emotion event).

RESULTS

Reliability and Validity

*Inter-rater Reliability*

The average inter-rater reliability for scores on the CSTF was 0.85 Kappa. The average inter-rater reliability for scores on the EXP-T was 0.84 Kappa. According to the literature on the statistics of measurement, levels of agreement above 0.75 Kappa are considered excellent agreement above chance (Fleiss, 1981). Therefore, data collected using each of these measures was found to be highly reliable.

*Revisions to CSTF Coding Category Definitions*

After reviewing the data for validity, two CSTF coding categories were found primarily to reflect more specific interventions/behaviours than their original operational definitions suggested. The “General Thought” category, originally defined as measuring therapist reference to unspecified thinking, was coded to indicate therapist reflection of client speech 91.3% of the time (199/218 total observations). Similarly, the “Unspecified” category, originally defined as therapist focus on client’s functioning not specified by any other CSTF component, was found to reflect uninterrupted client speech (i.e., no verbal contributions from the therapist during a 30-second segment) 95.7% of the time (268/280 total observations).
In order to enhance the validity of the current findings, the operational definitions of these two categories were amended after coding was completed to more closely reflect what coders observed for the vast majority of occurrences. See Appendix B for the revised operational definitions of the above two CSTF coding categories; see Appendix A for all original CSTF coding category definitions.

Objective #1 Findings: Therapist Response Clusters

Because the emotion events in this study were of naturalistic (i.e., not uniform) duration, it was necessary to transform the raw data in order to avoid having results confounded by the variable session lengths. As such, the CSTF coding category data for each emotion event was converted into proportional frequencies (i.e., the number of occurrences of the coding category divided by the number of 30-second segments comprising the emotion event). Similarly, raw EXP-T ratings (each rating representing the therapist’s modal depth of experiential focus for a given two-minute segment) were converted into a single mean EXP-T score for each emotion event. Thus, these EXP-T averages represent a therapist’s average modal level of experiential focus.

Hierarchical cluster analysis of the proportional frequencies of the fourteen CSTF coding categories and the mean EXP-T ratings produced an initial dendogram (using Squared Euclidean Distances, Ward’s method). Visual inspection of the dendogram resulted in the identification of three outliers. Following more detailed inquiry it was evidenced that two of these outliers were exceptional in terms of duration: they were the two shortest emotion events in the sample (5 and 6 minutes in length), and the only events less than 10 minutes in length. Moreover, the third outlying case was the only emotion event in which less than half of the observations recorded indicated therapist
interventions focused on the client; the majority of observations instead indicated therapist focus on persons other than the client, and uninterrupted client speech (i.e., the “Other” and “Uninterrupted Client Speech” CSTF coding categories, respectively). Thus, all three outlying cases were similar in their having low frequency of therapist focus on the client, relative to the sample. These unusual characteristics were the rationale for removing outliers from the sample for the purpose of cluster analysis.

With the above three outliers removed (N = 23), hierarchical cluster analysis produced the dendogram presented in Figure 1. Comparison of the cluster formations in this dendogram and the initial (N = 26) dendogram revealed minimal differentiation. Examination of the dendogram presented in Figure 1 clearly indicated the presence of two distinct clusters of therapist response to distressed clients (Cluster 1, n = 10; Cluster 2, n = 13). T-tests were used to identify which categories of therapist behavior were distinctively associated with each cluster. As indicated in Table 1, and summarized below, these clusters were differentiable along both CSTF coding categories and mean EXP-T ratings.

Due to the exploratory nature of the following analyses, no adjustments were made to control for type I error inflation. Instead, Cohen’s $d$ values were calculated as a measure of effect size. As indicated in Table 1, almost all of the data reported below as significant or as noteworthy trends were found to have large effect sizes ($d > 0.8$; Cohen, 1988). Only the trend evidenced regarding the “physiological sensation” variable was found not to have a large effect size ($d = 0.69$, a moderate-high value). These data are consistent with the t-test findings described below.
Final Two-Cluster Solution

Cluster 1: Reflection-focused Therapists

Therapists in Cluster 1 were significantly more likely than therapists in cluster 2 to focus on verbally reflecting client responses ($t(21) = -2.15, p < .05$). These therapists also permitted significantly lengthier uninterrupted client discourse ($t(17) = -3.37, p < .05$). Moreover, cluster 1 therapists demonstrated a trend which suggests they were focused more on the physiological sensations associated with their client’s feelings, although this finding was not significant at the .05 level ($t(21) = -1.75, p < .1$). For theoretical reasons this trend is worth noting because it reflects a common EFT technique, whereby a therapist focuses on a particular bodily sensation mentioned by a client, and encourages the client to focus on the sensation and elaborate on its associated feelings (e.g., in response to a client mentioning that their “stomach feels tight,” the therapist might direct the client to focus on their stomach, and describe how the tightness feels).

For these reasons, therapists in cluster 1 were labeled “Reflection-focused”. In sum, relative to therapists in Cluster 2, these client Reflection-focused therapists allowed clients to speak for longer periods of time, and were more likely to follow client discourse with reflective statements such as: “So, it sounds as though you’re saying that...” These therapists also may have tended to focus on client physiological sensations, encouraging clients to more fully articulate their bodily felt sensations.

Cluster 2: Emotional Experience-focused Therapists

Therapists in Cluster 2 were significantly more likely than therapists in cluster 1 to focus on client emotion ($t(20) = 2.11, p < .05$) and client needs ($t(21) = 6.81, p < .001$).
In addition, a trend was evidenced whereby the mean depth of therapist experiential focus in Cluster 2 tended to be higher than therapists in Cluster 1, (t(19) = 2.02, p < .1).

For these reason therapists in cluster 2 were labeled “Emotional Experience-focused”. In sum, relative to therapists in Cluster 1, Emotional Experience-focused therapists focused more on directing their clients to further articulate their emotions, and particularly their needs. These therapists were more verbally active during emotion events, and asked more questions like “How does that make you feel?” and “So, what do you need/want?” These therapists’ interventions also may have tended to reflect deeper experiential focus.

**Relating Therapist Response Clusters to Event Outcome**

A chi-square test was conducted in order to determine whether the two observed clusters were differentially related to event-outcome. Due to the relatively small size of the sample, examining clusters by outcome in this way (i.e., good versus poor event outcome) resulted in one cell violating the minimum expected cell count (Cluster 1 events with good outcome: n = 1). However, several studies (e.g., Campbell, 2007) have indicated that such a violation need not be considered problematic, nor should it lead to the conclusion that the results of the chi-square test are invalid. Camilli and Hopkins (1978, p. 166) summarize the point, noting that:

...both the chi-square test of homogeneity and the chi-square test of independence for 2 x 2 contingency tables give accurate Type I error probability statements even when the expected frequencies in one or two cells are as low as 1 or 2 when N is 20 or more. The conclusion applies when marginal frequencies are equal or unequal.
Sub-dividing both clusters according to event outcome revealed that Cluster 1 contains 1 event that resulted in good event outcome and 9 events with poor event outcomes. Also, Cluster 2 was found to consist of 9 events that resulted in good event outcomes and 4 events with poor event outcomes. As Figure 2 illustrates, results of the chi-square analysis indicate that Emotional Experience-focused (Cluster 2) therapists were significantly more likely to facilitate good event outcome than were Reflection-focused therapists (Cluster 1) \( (\chi^2(1, N = 23) = 8.07, p < .01) \).

**Descriptive Analysis: Exploratory Sub-clusters**

Returning to the dendogram presented in Figure 1, visual inspection reveals that the set of emotion events under investigation appear to group distinctively into two clusters, which serve as the final cluster solution in the present research. However, the emotion events also appear to group distinctively into four clusters. Analyses on these four clusters are limited in an important way: Due to the limited size of the present sample, these four groups cannot be differentiated statistically in terms of event outcome. However, while the four sub-clusters cannot be differentiated as a function of event outcome, the characteristics of the clusters themselves can still be examined in a descriptive manner. Such inspection of the characteristics of the four sub-clusters with respect to one another is likely to provide further insight into the manner in which the Reflection-focused therapists and the Emotional Experience-focused therapists differ.

The results of an exploratory, descriptive analysis of the four sub-clusters are presented here, in an attempt to aid deeper understanding of the final two-cluster solution. A one-way ANOVA was conducted to determine the distinctive characteristics of each
sub-cluster (i.e., among the CSTF coding categories and mean EXP-T scores). Following the recommendations of Dallal (2001), Fisher’s LSD was selected as a post-hoc test.

Results indicated that the sub-clusters differed significantly as a function of the CSTF coding categories of need ($F(3,19) = 13.57, MSE = 20.37, p < .001$), physiological sensation ($F(3,19) = 16.12, MSE = 14.03, p < .001$), general thought ($F(3, 19) = 18.55, MSE = 14.17, p < .001$), uninterrupted client speech ($F(3,19) = 15.72, MSE = 35.69, p < .001$), and mean level of therapist experiencing ($F(3,19) = 3.78, MSE = 0.14, p < .05$) (see Table 2). Post-hoc Fischer’s LSD test revealed the directionality of the difference between sub-clusters at the .05 level of significance. Significant findings obtained from these multiple comparison analyses are summarized below. (See Table 3 for an illustrative summary of the four sub-clusters.)

Sub-clusters of Cluster 1: Two groups of Reflection-focused therapists

Cluster 1a: Non-directive exploration ($n = 6$). Therapists in Cluster 1a appeared to be characterized primarily by their permitting significantly lengthier uninterrupted client speech, relative to therapists in the three other sub-clusters. When compared to the other sub-clusters, therapist interventions in this cluster were also coded using significantly lower levels of the therapist experiencing scale, indicating that therapist interventions within this cluster maintained a more general and external focus. In comparison to therapists in Clusters 2a and 2b, client needs were also emphasized significantly less by these therapists.

In sum, therapists in Cluster 1a appeared relatively passive, choosing to allow their clients to verbally work through their distress. In addition to permitting lengthier
uninterrupted client speech, therapist interventions tended to be less frequent and reflected relatively lower levels of depth of therapist experiential focus.

*Cluster 1b: Physiological experience-focused (n = 4).* Relative to therapists in the three other sub-clusters, therapists in Cluster 1b were characterized primarily by their tendency to focus significantly more on the physiological sensations associated with their clients' feelings. Interestingly, when compared with therapists in Cluster 1a, therapists in this cluster were significantly less likely to permit lengthy, uninterrupted client speech. In comparison to therapists in Clusters 2a and 2b, client needs were also emphasized significantly less by therapists in this cluster.

In sum, therapists in Cluster 1b focused primarily on their clients' physiological experience and associated feelings. One result of this focus appeared to be that these therapists were relatively more active in session, in comparison to therapists in Cluster 1a.

*Sub-clusters of Cluster 2: Two groups of Emotional Experience-focused therapists*

*Cluster 2a: Active Need Exploration (n = 7).* Therapists in this cluster were characterized primarily by a significantly greater focus on the distressed client's needs, relative to therapists in Clusters 1a and 1b. In addition, when compared with therapists in Clusters 1a and 2b, these therapists were found to permit significantly less lengthy, uninterrupted client speech.

In sum, Cluster 2a therapists focused primarily on client needs. These therapists were relatively active; their sessions were not characterized by lengthy, uninterrupted client speech. Rather, client responses were aided and elaborated upon by the therapist.
Cluster 2b: Passive Need Exploration (n = 6). Therapists in this cluster were characterized primarily by a significantly greater focus on the distressed client’s needs, relative to therapists in Clusters 1a and 1b. In addition, though these therapists tended to permit significantly less lengthy, uninterrupted client speech than therapists in Cluster 1a, they allowed significantly more of the same than therapists in Cluster 2a. When compared to all three clusters, therapists in this cluster focused significantly less on verbally reflecting clients’ statements.

In sum, therapists in this cluster focused on the distressed client’s needs. However, compared to Cluster 2a therapists, these therapists were relatively passive, and appeared to choose not to aid clients through verbal reflection of client statements, but instead allowed clients more time to verbally express what their needs were.

Objective #2 Findings: Frequency of Intervention Shifts

To determine whether good outcomes were preceded by more frequent therapist intervention shifts, a t-test was conducted. As data screening did not reveal any outliers, all cases were included in these analyses (N = 26). Results indicated that good event outcome was more likely to be preceded by more frequent intervention shifts ($t(24) = 2.65, p < .05$). This finding confirmed the research hypothesis of objective #2.

To examine this finding in greater detail, the sample was split into four groups. Group membership was determined according to magnitude of intervention shifts, such that the first group consisted of therapists who shifted the focus of their interventions most infrequently, the second group consisted of those remaining therapists who shifted the focus of their interventions most infrequently, and so forth. Thus, Group 1 consisted of those therapists who shifted the focus of their interventions the least, while Group 4
consisted of those who shifted the focus of their interventions the most. Moreover, this produced groups of near-equal size (Group 1: lowest frequency of intervention shifts, n = 6; Group 2: low-moderate shifts, n = 7; Group 3: high-moderate shifts, n = 6; Group 4: highest shifts, n = 7).

To examine the relationship of these four groups to event outcome, a one-way ANOVA was conducted. (See Figure 3 for group-by-group differences according to event outcome.) Results revealed that, for Group 4 (i.e., highest frequency shifting), no significant differences were evident between those therapist-client dyads who experienced poor outcomes and those who experienced good outcomes ($F(1,5) = 0.11$, $MSE = 24.55$, ns). In addition, all of the Group 1 (i.e., lowest frequency shifting) therapists had experienced poor outcomes. However, within both Groups 2 and 3, good event outcomes were significantly more likely to be preceded by more frequent intervention shifts ($F(1,5) = 6.73$, $MSE = 5.75$, $p < .05$; $F(1,4) = 7.12$, $MSE = 2.83$, $p = .056$, respectively). Figure 4 provides an illustrative summary of these analyses, and appears to indicate the presence of a curvilinear relationship between frequency of intervention shifts and event outcome.

Objective #3 Findings: Emotional Variability as a Mediator

The following analyses were conducted in accord with the recommendations outlined by Preacher and Hayes (2004), and with the use of the SPSS macro discussed in the same. Initial data screening, following the guidelines outlined by Field (2005) and the recommendations of Tabachnik and Fidell (2000), revealed no outlying variables. As such, all emotion events were included in the following analyses ($N = 26$). Due to the
results obtained through testing of the research hypothesis, two separate mediation models were examined. They are indicated below as Mediation Models #1 and #2.

**Mediation Model #1: Emotional Variability**

Baron and Kenny (1986) recommend examining the intercorrelations among variables in mediation models to determine if all variables are significantly related. Significant correlations among all model variables are necessary to proceed with mediation analyses. A significant relationship was found to exist between depth of therapist experiential focus and event outcome (i.e., client experiencing) \( B = .59(.24), p < .05 \). However, results indicated only a trend in the relationship between depth of therapist experiential focus and emotional variability \( B = 9.87(5.65), p = .1 \), and a nonsignificant relationship between emotional variability and event outcome \( B = .01(.01), \text{ns} \). These findings run contrary to the research hypothesis, and provide insufficient justification for testing the proposed mediation model.

**Mediation Model #2: Presence of Productive Emotion**

Given that the above findings disconfirmed the research hypothesis, further exploratory analyses were conducted to determine whether or not the relationship between depth of therapist experiential focus and event outcome is mediated by client emotion.

In the model of emotional processing developed by Pascual-Leone and Greenberg (2007), emotional variability is considered along the course of different groupings of observable emotion (i.e., the components of the emotional processing model). These model components can be viewed as comprising two groups: productive components, which include assertive anger, self-soothing, and grief/hurt, and unproductive
components, which include global distress, rejecting anger, and fear/shame. This distinction corresponds with EFT theory, which posits that the experiencing and expression of productive (i.e., primary adaptive) emotion is an essential component of psychotherapeutic change (Greenberg, 2002). As such, an analysis was conducted which sought to determine whether the presence of productive client emotions (i.e., assertive anger, hurt/grief, and self-soothing) plays a mediating role in the relationship between depth of therapist experiential focus and event outcome.

Due to the naturalistic length of the emotion events, data on productive emotion were converted to proportional presence (i.e., the number of occurrences of productive emotions divided by the total number of occurrences of productive and unproductive emotions). The resulting variable, proportional presence of productive client emotion, provides a clear indicator of the extent to which each client experienced and expressed productive emotion, relative to the total length of the emotion event.

Following the recommendations of Baron and Kenny (1986), the intercorrelations among all variables in the mediation model were examined (see Table 4 for pearson r correlations between variables). Results indicated that significant relationships existed between depth of therapist experiential focus and event outcome (i.e., client experiencing), depth of therapist experiential focus and proportion of productive emotions, and proportion of productive emotions and event outcome. Testing the direct effect, or the size of the correlation between the independent variable and the dependant variable with the mediating variable included in the regression, revealed a substantial reduction in magnitude of the original relationship between depth of therapist
experiential focus and event outcome (see Table 5 for results of the described mediation analyses).

The next step in establishing mediation required testing the indirect effect, or the amount of the original correlation between the independent variable and the dependant variable that now goes through the mediating variable to the dependant variable. The Sobel test revealed a fairly substantial indirect effect; 86% of the original correlation between depth of therapist experiential focus and event outcome was mediated by the presence of productive emotions.

Because the size of the present sample was relatively small, a bootstrap analysis was conducted as part of the previous analyses to serve as an additional validity check (Preacher & Hayes, 2004). Bootstrapping facilitates assessment of the reliability of a dataset through the creation of pseudoreplicate datasets the same size as the original. The frequency with which a given finding is evidenced across resamples is recorded as the bootstrap proportion. The results of the bootstrapping analysis (number of bootstrap resamples = 10000) indicated, with 99% confidence, that the indirect effect reported was reliably different from 0.

DISCUSSION

The results of objective 1 of the present research demonstrated that based on their responses to distressed clients' therapists can be grouped into reliably distinct clusters, and that these clusters are differentiable as a function of good versus poor event outcome. Together, these findings lend support to the notion that therapist variation within the same therapeutic modality can contribute differentially to outcome. Moreover, these results highlight the utility of examining psychotherapeutic change processes in a way
that enables an understanding of such processes as a sequence of interaction patterns between therapist and client that extend over time (Diener et al., 2007; Jones, Pare, & Pulos, 1992).

Objective 2 of the present research examined the relationship between frequency of therapist intervention shifts and event outcome. Following the conceptual framework outlined in dynamic systems theory, it was hypothesized that good outcome would be more likely to be preceded by more frequent intervention shifts. This hypothesis was confirmed, providing support to the notion of psychotherapeutic change as a dynamic, non-linear process.

Objective 3 of the present research examined client emotion as a potential mediating variable in the relationship between depth of therapist experiential focus and event outcome. While client emotional variability was not found to mediate this relationship (as was originally hypothesized), further analyses revealed that the presence of "productive" (i.e., primary adaptive) client emotions was a significant mediator. The results of these three objectives provide insight into the process through which client distress is resolved.

Understanding Therapist Responses to Client Distress

*Grouping Variability: The Similar Ways in which Therapists Differ*

The evidence supporting the present study's exploratory hypothesis (i.e., that more than one reliably distinct cluster of therapist responses would be evidenced) is important for several reasons. First, it indicates that, when confronted with a distressed client, therapists operating within the same therapeutic modality (i.e., EFT) respond in distinctly different manners, such that the foci of their interventions differ significantly.
Second, the final two-cluster solution indicates that, nonetheless, there is a significant degree of similarity in responses across therapists. In this way, the application of cluster analysis to the clinical setting highlights a gap in the existing literature on therapist contribution to change. As psychotherapy research has increasingly concerned itself with the development of treatment manuals intended to specify treatment technique, so too have researchers increasingly engaged themselves in the study of therapist fidelity to prescribed interventions (Chatoor & Krupnick, 2001). However, while such measures of therapist adherence have become increasingly commonplace, high levels of therapist adherence to treatment have not consistently been associated with improved outcome (Barber et al., 2008; Hall, 2007). While several explanations for such mixed findings have been put forth (e.g., Barber et al., 2006), these theories focus wholly on the overall relationship between magnitude of therapist adherence and outcome (e.g., Does high adherence indicate therapist skillfulness or excessive rigidity?).

Conversely, the present research is indicative of the fruitfulness of exploring how therapist interventions differ. As such, this study serves as an inquiry into individual differences rather than the usual group averages approach, which is often the level of study for adherence studies (Hall, 2007). The final two-cluster solution provides strong evidence that therapist responses were found to group into two reliably distinct clusters. Thus, the results of the current study are a step toward an increased level of specificity, demonstrating that therapist differences can be understood not only as individual deviations from a standardized treatment, but also as patterns of response that can be grouped across therapists.
A third reason the two-cluster solution is illuminating is that the two clusters reveal how the therapists’ responses differ. That is, statistical comparison of the coding categories between clusters enables understanding of what makes each cluster distinct. Further, each cluster was found to relate differentially to event outcome. This finding is particularly important albeit potentially misleading. The first objective of the present research was conducted primarily with descriptive aims—to enhance understanding of therapist responses to client distress through detailed elaboration of those responses. However, the nature of the differential relationships between the clusters and event outcome may be used as the basis for prescriptive claims (i.e., the notion that one response cluster is “better” than the other). However, though the results indicate that the clients of Emotional Experience-focused therapists were more likely to experience good outcome than were the clients of Reflection-focused therapists, it is not correct to conclude that the one orientation toward dealing with distressed clients is categorically superior to the other. Rather, comparison of the two clusters in light of their relationship to event outcome highlights those specific therapist interventions which appear to best facilitate the working through of client distress in EFT (e.g., focus on client needs).

*The Importance of Client Needs in Resolving Distress*

The most striking difference between the Emotional Experience-focused therapists and the Reflection-focused therapists is therapist focus on client needs, or wants. Emotional Experience-focused therapists focus on client needs significantly more than Reflection-focused therapists.

The importance of focusing on client needs is consistent with the theory and practice of EFT. As noted by Pascual-Leone and Greenberg (2007), the significance of
expressing needs—a wish for attachment, personal agency, or survival as the "gateway" to deeper emotional experiencing—has been detailed extensively (Greenberg, 2002; Greenberg & Paivio, 1997; Greenberg et al., 1993). In a recent study (which the current work extends), Pascual-Leone (2005) reported that the heartfelt expression of a need was predictive of good event outcome. Significant emotional transformations in couples' therapy, such as forgiveness and letting go, have also been found to be preceded by the expression of core personal or interpersonal needs. These same transformations were found to occur significantly less often or not at all in unresolved cases (Greenberg & Malcolm, 2002). Similarly, relational psychodynamic therapies have reported that productive emotional processing can occur though the expression of interpersonal needs or wishes within the context of emotionally charged psychotherapy sessions (Safran & Muran, 2000; Fosha, 2000).

By their very nature, several approaches to psychotherapy explicitly value a client's articulation of their personal needs. EFT therapists, in particular, are trained to actively support clients in their efforts to acknowledge and experience their needs more fully. This process is understood to be one of the main targets and catalyst of productive psychotherapeutic change (Greenberg & Pascual-Leone, 2006). Discussing the specific context of client distress, Greenberg (2002) writes that therapists can help clients work through their maladaptive states by directly asking the client what they need. Identification of client needs and wants in this context is a means toward self efficacy; knowing what one needs in a situation is thought to enable feelings of control over the situation. The therapist's validation of the need becomes an important element in strengthening it, and further enables the client's ability to shift out of their negative state.
Therapist Directiveness Varies within Both Clusters

Despite the evidence indicating that asking clients what their needs or wants are is significantly associated with good outcome, it does not appear to be the case that high therapist directiveness is necessarily associated with good outcome. Rather, comparison of the four sub-clusters reveals that Emotional Experience-focused and Reflection-focused therapists vary significantly in both their directiveness and levels of activity. Therapist directiveness is defined as the extent to which therapist interventions focus on specific components of client affect (Karno & Longabaugh, 2005), while therapist activity is understood as the frequency of therapist interventions observed (Ackerman & Hilsenroth, 2003).

Among the Reflection-focused cluster, therapist directiveness varied widely. Despite the finding that both sub-clusters of Reflection-focused therapists were significantly less likely to experience good event outcome, those therapists described as responding in a Physiological Experience-focused manner were engaged in actively encouraging and directing client expression of specific affect. In contrast, therapists described as engaging in Non-directive Exploration were more passive in this regard, allowing clients to verbally work through their distress, contributing interventions characterized by significantly lower levels of therapist experiencing (i.e., limited, behavioural descriptions of client commentary). Similarly, significant variation was found to exist among the two sub-clusters of Emotional Experience-focused therapists. While both sub-clusters centered their interventions on explorations of client need, the manner of these explorations differed significantly in terms of directiveness between sub-
clusters (as indicated by their descriptive labels, “Active Need Exploration” and “Passive Need Exploration”).

Taken together, these findings highlight the different levels of therapist directiveness and activity are present in both clusters of therapists. This variability suggests that it is not simply the level of therapist activity or degree of therapist directiveness that facilitates alleviation of client distress.

**Infrequent Intervention Shifts are Associated with Poor Event Outcome**

Dynamic systems theory posits that productive therapeutic change entails movement through a series of states of stability and variability (Hayes, Laurenceau, et al., 2007). The absence of such variation is thought to contribute to maladaptive states. Similarly, interpersonal and psychodynamic theories propose that compared with those lower in rigidity, individuals higher in rigidity are less flexible in their ways of thinking, feeling, and behaving across relationships, and are less able to adapt to interpersonal demands. As a result, such individuals experience poorer quality relationships and greater symptomology (Benjamin, 2002; Bucci, 2000). Within the psychotherapeutic setting, the belief that rigidity across relationships is related to greater symptoms and poorer functioning commonly informs the practice of many psychodynamic and interpersonal therapists (McCarthy, Gibbons, & Barber, 2008).

Consistent with these notions, the findings of this study indicate that good event outcomes were significantly more likely to be preceded by more frequent intervention shifts. Moreover, the group of therapists who were found to shift the focus of their interventions least frequently experienced poor event outcomes. These findings support the view that excessive therapist rigidity in the use of interventions contributes to client
frustration, increasingly hostile exchanges, and is likely to facilitate poor outcome (Samstag, Muran, & Safran, 2003).

In addition, the results of the present work suggest that frequency of therapist intervention shifts and event outcome may be related in a curvilinear fashion. While the current study's sample size is not large enough to demonstrate such a relationship empirically, this tentative finding corresponds with the views expressed by a number of researchers who have cautioned against the dangers of shifting the focus of therapeutic interventions too frequently. Reflecting on the “necessary and sufficient conditions” of psychotherapeutic change, Rogers (1957) noted that is essential that clients be allowed the opportunity to absorb the changes they experience during the therapeutic session; emotional processing takes time. Similarly, the notion of “resonating,” or allowing time for freshly-sensed affective experience to settle within oneself, is also crucial to the philosophy of Gendlin’s (1996) focusing-oriented psychotherapeutic approach. Thus, while infrequent intervention shifts have been found to be less likely to precede good event outcome (potentially due to rigidity on the part of the therapist), so too might excessive intervention shifting be found to result in unproductive “rushing” of the client.

Understanding the Distressed Client’s Response to the Therapist

“Not all Emotions are Created Equal”

Consistent with the findings reported by Pascual-Leone (2008), client emotional variability was found to be significantly related to event outcome. However, contrary to the research hypothesis, depth of therapist experiential focus was not found to be significantly associated with client emotional variability. Methodologically speaking, it is possible that the lack of association between depth of therapist experiential focus and
client emotional variability may be due to the limited size of the present study's sample. Conceptually, one can also speculate upon an alternative explanation for the non-significant relationship, namely, the variable intent of therapist interventions.

EFT theorists, alongside other psychotherapy researchers, have argued that therapeutic emotional experiences are brought about through the combination of affective arousal and meaning-making (e.g., Greenberg, 2002; Kennedy-Moore & Watson, 1999; Missirlian, Toukmanian, Warwar, & Greenberg, 2005). As such, EFT therapists are concerned both with the elicitation of emotional arousal and expression in the client, as well as facilitating client understanding of such affective responses. Though enabling clients to shift between varying levels of perceptual processing is an overarching goal of successful psychotherapy (Toukmanian, 1996), it is not necessarily the case that this is the goal of all therapist interventions that reflect deep therapist experiential focus. Rather, deep therapist experiential focus may, for example, embody the therapist's attempt at temporarily reducing client emotional variability. For example, directing the client to "slow down" and focus on a particular affective experience may serve to bring about the emergence of new experiencing for the client.

In the second mediation analysis, which focused on productive client affective-meaning experiences (as identified by Pascual-Leone & Greenberg, 2007), the results demonstrate that the presence of productive emotions in clients (i.e., assertive anger, hurt/grief, and self-soothing) mediated the relationship between depth of therapist experiential focus and clients' event outcomes. This finding provides complimentary evidence for Pascual-Leone and Greenberg's (2007) model of emotional processing, and provides new insight into the role of the therapist in the process of productive client
emotions contribute to good event outcome. More broadly, in addition to being consistent with EFT theory, this finding also supports psychodynamic accounts of how the experiential process progressively unfolds in therapy (e.g., Fosha, 2000).

Global Distress as Critical Incident: A Note on Generalizability

For psychotherapy process researchers, clarifying the paradigm in which emotional processing occurs and the parameters of the problem under investigation is the first challenge to be faced. The fundamental assumption underlying these endeavors is the belief that, “in highly specified in-therapy contexts, behavior and experience are lawfully explainable, and valid, specific models or micro-theory can be developed to help explain therapeutic change processes” (Greenberg, 1991, p. 7). In this view, the development of context-specific models is not a limitation, but rather an aid toward understanding psychotherapeutic process. In addition, it may be argued that the study of “highly specified in-therapy contexts” is instructive in and of itself, and need not be conducted with a view toward overall change processes. The goal of such a study may well be simply to determine what manner of treatment is most effective within the context of client’s emotional distress.

In regard to the context investigated here (i.e., clients experiencing global distress), it should be noted that, irrespective of intervention style, the deliberate immersion into “feeling bad” is a task that leaves clients with a great sense of ambivalence and apprehension (Pascual-Leone, 2005); these responses are sometimes referred to as “treatment resistance” (Davenloo, 1990). Moreover, such key moments in therapy have also been referred to as “critical incidents” (Lewis, 2008).
The critical incident under investigation in the present study occurs across all therapeutic approaches, and tends to be especially difficult for therapists to cope with. Therapists who are not explicitly trained in engaging emotional arousal have been found to display anxiety, and will often abandon the task. Rhodes (1991; Greenberg & Rhodes, 1991) reports that, immediately following clients' emotional arousal and expression of sadness, therapists who are not trained in person centered approaches are much more likely to respond in invalidating ways. Such absence of validation appears to result in subsequent client expression of fear or shame about their tears. In short, the present study of within-session events was designed as a study of critical incidents, easily relatable to therapists of all orientations.

Summary and Clinical Implications

Previous research has demonstrated the process through which client distress is resolved and which processes appear to best facilitate resolution (e.g., Pascual-Leone & Greenberg, 2007). The present study has described two distinct therapist responses to client distress, and has indicated which therapist intervention patterns seem most effective in eliciting productive client distress resolution processes. While a variety of theoretical orientations and training approaches exist to inform therapists faced with a client experiencing global distress, few studies have utilized a bottom-up methodology to examine what effective therapists actually do within psychotherapy sessions. Given the emerging importance of therapist factors as a key variable in the psychotherapeutic process (Diener et al., 2007), the results of the present study provide a timely contribution to the field of psychotherapy research. This examination of interactions between therapist patterns of intervention and client emotional processing has resulted in empirical
evidence indicative of both what effective therapists are doing (and not doing) to resolve client distress, and what types of interventions are predictive of good client outcomes.

The present work provides therapists with a new layer of insight into the process of resolving client distress: An analysis of the effectiveness of therapist intervention patterns. The results of this study describe two groups of therapist responses to distressed clients, or patterns of interventions focused on specific components of the distressed client. From these two clusters of therapist responses, the importance of administering interventions with certain foci, such as client needs, were highlighted. Also, certain other components of therapist behavior were found not to be significantly related to the resolution of client distress (i.e., therapist directiveness/activity).

The present results also have implications for therapists seeking a greater understanding of psychotherapeutic change. Supporting the notion that such change occurs through a dynamic, non-linear process, good event outcome was found to be more common among cases in which therapists simply shifted the focus of their interventions more frequently. Support was also found for Pascual-Leone and Greenberg's (2007) suggestion that “not all emotions are created equal”: The presence of productive client emotions was found to mediate the relationship between depth of therapist experiential focus and event outcome. This finding suggests therapists seeking to engage their clients at high levels of experiencing facilitate good event outcome through the facilitation and encouragement of specific, productive affective experiences in their clients.

Limitations

The findings of the present research on therapist facilitation of client emotional processing are consistent with theory and evidence from different psychotherapeutic
approaches and populations. Nonetheless, these results cannot be generalized to the population at large or to other therapeutic contexts. As this study was a secondary analysis of data from a previously published dataset, future replication with an independent sample is important. The relatively small sample size of the present study also limited the statistical power of the analyses and generalizability of the results; future research would do well to examine a greater number of cases. With regard to the population from which the sample was derived, the client sample for this research was limited to individuals suffering primarily from depression and/or long-standing interpersonal grievances and was screened for suitability to brief treatment. As such, the results of the present study may not apply to individuals suffering from other psychological disorders or those requiring extended forms of treatment (e.g., long-term psychotherapy).

Future Directions

Through examination of therapist interventions, the results of the current research have provided insight into the processes through which therapists facilitate the resolution of client distress. Future research would do well to further explore the nature of the interactions between therapist and client. For example, the present research has indicated the importance of therapist focus on client needs. However, the nature of this interaction has not been determined. Therapist focus on client need may precipitate productive emotion in a client (a causal relationship); alternatively, such focus may arise in response to an emerging client need (a co-occurring process). In the same vein, further studies may explore specific patterns of therapist-client interaction as they relate to common factors of
psychotherapy, such as the therapeutic alliance. Do productive patterns of therapist intervention precede a good therapeutic alliance or are they a consequence of the same?

One of the earliest decisions made in the present study was to examine therapist interventions at the event level. Thus, relation to outcome has been discussed exclusively in terms of outcome at the end of the emotion event. As such, another question that should be explored is the nature of therapist-client interaction at a different outcome level (e.g., examination of the relationship between therapist intervention patterns and final treatment outcome). In addition, the current sample consists exclusively of therapists practicing EFT. It is necessary to determine whether similar patterns can be evidenced in therapists working other different therapeutic modalities.

Finally, it will be important to explore the productive emotions identified in the present work as mediating the relationship between depth of therapist experiential focus and event outcome. Further articulation of the manner in which assertive anger, hurt/grief, and self-soothing facilitate productive emotional processing is essential. As the present work demonstrates, examination of the ways in which responses differ can provide insight into the process of therapeutic change.
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Table 1

Comparison of Therapist Response Clusters on Component Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>t</th>
<th>df</th>
<th>p</th>
<th>d</th>
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<tbody>
<tr>
<td>Emotion</td>
<td>2.11</td>
<td>20</td>
<td>.048**</td>
<td>0.88</td>
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<tr>
<td>Need/Wish</td>
<td>6.81</td>
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<td>.000***</td>
<td>2.80</td>
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<tr>
<td>Physiological Sensation</td>
<td>-1.75</td>
<td>21</td>
<td>.095*</td>
<td>0.69</td>
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<tr>
<td>Action Tendency</td>
<td>0.20</td>
<td>20</td>
<td>.843</td>
<td>0.08</td>
</tr>
<tr>
<td>General Thought</td>
<td>-2.15</td>
<td>21</td>
<td>.044**</td>
<td>0.93</td>
</tr>
<tr>
<td>Self-evaluation</td>
<td>-0.66</td>
<td>21</td>
<td>.514</td>
<td>0.27</td>
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<tr>
<td>Expectation</td>
<td>1.28</td>
<td>21</td>
<td>.215</td>
<td>0.56</td>
</tr>
<tr>
<td>Intention</td>
<td>1.00</td>
<td>12</td>
<td>.337</td>
<td>0.35</td>
</tr>
<tr>
<td>Behaviour</td>
<td>-0.59</td>
<td>16</td>
<td>.565</td>
<td>0.25</td>
</tr>
<tr>
<td>Situation</td>
<td>0.07</td>
<td>21</td>
<td>.945</td>
<td>0.03</td>
</tr>
<tr>
<td>Other</td>
<td>1.43</td>
<td>19</td>
<td>.170</td>
<td>0.58</td>
</tr>
<tr>
<td>Intrapersonal link</td>
<td>0.83</td>
<td>20</td>
<td>.419</td>
<td>0.34</td>
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<tr>
<td>Interpersonal link</td>
<td>-0.09</td>
<td>19</td>
<td>.929</td>
<td>0.04</td>
</tr>
<tr>
<td>Uninterrupted Client Speech</td>
<td>-3.37</td>
<td>17</td>
<td>.004**</td>
<td>1.44</td>
</tr>
<tr>
<td>Mean EXP-T</td>
<td>2.02</td>
<td>19</td>
<td>.058*</td>
<td>0.86</td>
</tr>
</tbody>
</table>

Note. Comparing Cluster 1 (n = 10) and Cluster 2 (n = 13). Variations in df across t-tests occurred when variance equivalence was not assumed, as indicated by Levine’s test for equality of variances.

*p < .1. ** p < .05. ***p < .001.
### Table 2

*Relating Exploratory 4-Cluster Solution Component Variables to Event Outcome*

<table>
<thead>
<tr>
<th>Variable</th>
<th>MSE</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotion</td>
<td>60.185</td>
<td>2.225</td>
<td>.118</td>
</tr>
<tr>
<td>Need/Wish</td>
<td>20.365</td>
<td>13.565</td>
<td>.000***</td>
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<tr>
<td>Physiological Sensation</td>
<td>14.030</td>
<td>16.115</td>
<td>.000***</td>
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<tr>
<td>Action Tendency</td>
<td>9.949</td>
<td>.065</td>
<td>.978</td>
</tr>
<tr>
<td>General Thought</td>
<td>14.169</td>
<td>18.550</td>
<td>.000***</td>
</tr>
<tr>
<td>Self-evaluation</td>
<td>12.665</td>
<td>.784</td>
<td>.517</td>
</tr>
<tr>
<td>Expectation</td>
<td>2.030</td>
<td>.534</td>
<td>.664</td>
</tr>
<tr>
<td>Intention</td>
<td>.175</td>
<td>.936</td>
<td>.443</td>
</tr>
<tr>
<td>Behaviour</td>
<td>2.135</td>
<td>.820</td>
<td>.499</td>
</tr>
<tr>
<td>Situation</td>
<td>5.056</td>
<td>.368</td>
<td>.777</td>
</tr>
<tr>
<td>Other</td>
<td>17.714</td>
<td>1.097</td>
<td>.375</td>
</tr>
<tr>
<td>Intrapersonal link</td>
<td>31.387</td>
<td>.500</td>
<td>.686</td>
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<tr>
<td>Interpersonal link</td>
<td>2.887</td>
<td>1.568</td>
<td>.230</td>
</tr>
<tr>
<td>Uninterrupted Client Speech</td>
<td>35.689</td>
<td>15.724</td>
<td>.000***</td>
</tr>
<tr>
<td>Mean EXP-T</td>
<td>.144</td>
<td>3.779</td>
<td>.028**</td>
</tr>
</tbody>
</table>

*Note. df = 3(19) for all of the above.*

*p < .1. ** p < .05. ***p < .001.*
### Table 3
**Summary of Significant Differences between Exploratory Sub-Clusters**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Cluster 1a</th>
<th>Cluster 1b</th>
<th>Cluster 2a</th>
<th>Cluster 2b</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-directive exploration</td>
<td>(N = 6)</td>
<td>(N = 4)</td>
<td>(N = 7)</td>
<td>(N = 6)</td>
</tr>
<tr>
<td>Physiological experience focused</td>
<td>1 good, 6 poor</td>
<td>0 good, 3 poor</td>
<td>5 good, 2 poor</td>
<td>4 good, 2 poor</td>
</tr>
<tr>
<td>Need/Wish</td>
<td>Low</td>
<td>Low</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Physiological Sensation</td>
<td>High</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Thought</td>
<td></td>
<td></td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Uninterrupted Client Speech</td>
<td>High High</td>
<td>Low</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Mean EXP-T</td>
<td>Low</td>
<td></td>
<td>High</td>
<td></td>
</tr>
</tbody>
</table>

Low = significantly lower than all cells not also labeled “Low”

*unlabeled* = significantly higher than all cells labeled “Low”

High = significantly higher than all *unlabeled* cells

High High = significantly higher than all “High” cells
Table 4

*Pearson's Correlation Coefficients between Variables included in Mediation Model #2*

<table>
<thead>
<tr>
<th></th>
<th>Event Outcome</th>
<th>Proportional Presence of Productive Emotion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist Experiencing</td>
<td>.412**</td>
<td>.446**</td>
</tr>
<tr>
<td>Event Outcome</td>
<td></td>
<td>.827***</td>
</tr>
</tbody>
</table>

*Note. N = 26 for all of the above.*

*p < .1. ** p < .05. ***p < .001.*
Table 5

*Testing Proportional Presence of Productive Emotion as a Mediator between Therapist Experiencing and Event Outcome*

<table>
<thead>
<tr>
<th></th>
<th>Unstandardized Coefficient B</th>
<th>Sobel</th>
<th>Standard Error</th>
<th>t</th>
<th>z</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV to DV</td>
<td>.42**</td>
<td></td>
<td>.19</td>
<td>2.22</td>
<td></td>
</tr>
<tr>
<td>IV to MV</td>
<td>.20**</td>
<td></td>
<td>.08</td>
<td>2.44</td>
<td></td>
</tr>
<tr>
<td>MV to DV</td>
<td>1.86***</td>
<td></td>
<td>.30</td>
<td>6.15</td>
<td></td>
</tr>
<tr>
<td>Direct Effect</td>
<td>.06</td>
<td></td>
<td>.13</td>
<td>.42</td>
<td></td>
</tr>
<tr>
<td>Indirect Effect</td>
<td>.37**</td>
<td></td>
<td>.16</td>
<td>2.24</td>
<td></td>
</tr>
</tbody>
</table>

IV to DV = Therapist Experiencing predicts Event Outcome

IV to MV = Therapist Experiencing predicts PPR

MV to DV = PPR predicts Event Outcome

Direct Effect = Therapist Experiencing predicts Event Outcome, when PPR included in Model

Indirect Effect = Amount of original correlation between Therapist Experiencing and Event Outcome that is mediated by PPR

*Note. PPR = Proportional Presence of Productive Emotion. N = 26 for all of the above.*

*p < .1. ** p < .05. ***p < .001.
Hierarchical Cluster Analysis on the Foci of Therapist Interventions

N=23 cases

Rescaled Distance Cluster Combine

by group

0 5 10 15 20 25

by outcome

+---------------+---------------+---------------+---------------+---------------+---------------+---------------+

1 Good and 5 Poor Event Outcome

Cluster 1a, n = 6

Cluster 1b, n = 4

Cluster 2b, n = 6

Cluster 2a, n = 7

Reflection-focused, n = 10

Emotional Experience-focused, n = 13

Dendogram cut at 2 clusters

Dendogram cut at 4 clusters

Note. Squared Euclidean Distances between cases were measured. Ward’s method served as the clustering method.

Cluster 1a = Non-directive exploration
Cluster 1b = Physiological experience-focused
Cluster 2a = Active Need Exploration
Cluster 2b = Passive Need Exploration
Figure 2

Relating the Therapist Response Clusters to Event Outcome

![Bar graph showing the comparison between Cluster 1 and Cluster 2 for poor and good event outcomes. The graph indicates that Cluster 1 has a higher number of cases for poor event outcomes compared to Cluster 2 for both outcomes.]
Figure 3

*Comparing Event Outcome in Relation to Relative Frequency of Intervention Shifts*

*Note.* For all four graphs, Y-axis reflects proportional frequency of intervention shifts.

Group 1: lowest frequency of intervention shifts, (n = 6)

Group 2: low-moderate frequency of intervention shifts, (n = 7)

Group 3: high-moderate frequency of intervention shifts (n = 6)

Group 4: highest frequency of intervention shifts (n = 7)
Within-Group Mean Differences in Proportional Frequency of Intervention Shifts between Good and Poor Event Outcome (G - P)

Note. Group 1 cases all had poor event outcomes. For all other groups, the mean number of intervention shifts for good event outcome cases was greater than the mean number of intervention shifts for poor event outcome cases.

Group 1: lowest frequency of intervention shifts, (n = 6)
Group 2: low-moderate frequency of intervention shifts, (n = 7)
Group 3: high-moderate frequency of intervention shifts (n = 6)
Group 4: highest frequency of intervention shifts (n = 7)
### CSTF-AI-R Initial Coding Categories

(cited from Ellison & Greenberg, 2004)

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotion</td>
<td>Focus on client’s feelings</td>
<td>“You felt angry at me.”</td>
</tr>
<tr>
<td>Need/Wish</td>
<td>Focus on client’s desire for fulfillment of a basic concern, need, or wish.</td>
<td>“You really wish that you could be closer to him.”</td>
</tr>
<tr>
<td>Physiological</td>
<td>Focus on physical sensation associated with an emotional response (NOT things like nausea, tired, etc.)</td>
<td>“You felt this churning in your stomach when he told you he was leaving.” “There was this pressure on your chest, like you were going to suffocate from fear.”</td>
</tr>
<tr>
<td>Sensation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action Tendency</td>
<td>Focus on client’s action disposition or tendency associated with an emotional response</td>
<td>“You felt like lashing out at him.”</td>
</tr>
<tr>
<td>General Thought</td>
<td>Reference to unspecified thinking</td>
<td>“You think the relationship is over.”</td>
</tr>
<tr>
<td>Self-evaluation</td>
<td>Focus on self-appraisal, involving an evaluation of self</td>
<td>“You’re telling yourself that you’re a loser.”</td>
</tr>
<tr>
<td>Expectation</td>
<td>Focus on client’s anticipation about the future</td>
<td>“You’re waiting for something to go wrong.”</td>
</tr>
<tr>
<td>Intention</td>
<td>Focus on client’s future-oriented volition (future-orientation associated with plans or goals)</td>
<td>“You’re determined to make that happen.”</td>
</tr>
<tr>
<td>Behaviour</td>
<td>Reference to performance or specific action</td>
<td>“You were pacing around.”</td>
</tr>
<tr>
<td>Situation</td>
<td>Focus on circumstances external to the client</td>
<td>“When you got the promotion, you began to doubt your abilities.”</td>
</tr>
<tr>
<td>Other</td>
<td>Focus on other person and/or people (who are not the client)</td>
<td>“He went to the party. He said he felt very angry afterward.”</td>
</tr>
<tr>
<td>Intrapersonal link</td>
<td>Connections between various components of client’s functioning</td>
<td>“You often wanted to do it, but you never did.”</td>
</tr>
<tr>
<td>Interpersonal link</td>
<td>Connections between various components of client’s functioning and those of another person.</td>
<td>“She left you because of your gambling.”</td>
</tr>
<tr>
<td>Unspecified</td>
<td>Focus on client’s functioning where no specific component has been identified</td>
<td>“What happens when you walk through the hall?”</td>
</tr>
</tbody>
</table>
Example CSTF Coding Sheet

<table>
<thead>
<tr>
<th>Time</th>
<th>Min</th>
<th>E</th>
<th>NEED</th>
<th>PHYSIO</th>
<th>AT</th>
<th>GT</th>
<th>SE</th>
<th>EXP</th>
<th>INT</th>
<th>B</th>
<th>SIT</th>
<th>OTHER</th>
<th>INTRA</th>
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<tbody>
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### Appendix B

Revisions to Two CSTF-AI-R Coding Category Definitions

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
<th>Example</th>
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<td><strong>1. General Thought</strong></td>
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<td><strong>ORIGINAL</strong></td>
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<tr>
<td>General Thought</td>
<td>Reference to unspecified thinking</td>
<td>“You <em>think</em> the relationship is over.”</td>
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<tr>
<td>General Thought</td>
<td>Reflection of previous client speech</td>
<td>C: “I’m not sure, but I think me and him are through.”</td>
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<td>T: “So you think the relationship is over.”</td>
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<td>- (must not already be captured by another CSTF coding category, e.g., emotion)</td>
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<td><strong>2. Unspecified</strong></td>
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<td><strong>ORIGINAL</strong></td>
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<tr>
<td>Unspecified</td>
<td>Focus on client’s functioning where no specific component has been identified</td>
<td>“<em>What happens</em> when you walk through the hall?”</td>
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<td><strong>REVISED</strong></td>
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<tr>
<td>Uninterrupted Client Speech</td>
<td>30-second segment in which the therapist does not speak</td>
<td>- client speaks throughout</td>
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<td>- (i.e., no utterances &gt; 3 words in length)</td>
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## Appendix C

**EXP-T Coding Categories**

(cited from Klein et al., 1986)

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>DESCRIPTION</th>
<th>EXAMPLE</th>
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| 1     | Events external to, or not about, the client | - therapist talks about something unrelated to the client  
“I was on vacation last week” |
| 2     | Events including the client w/ behavioural or intellectual elaboration of client’s thoughts, but not emotions | “You thought that was unfair” |
| 3     | Client’s rxn to external events w/ some reference to feelings but, these are limited to behavioural or descriptive comments | “…and then you went out drinking”  
- feelings mentioned but not described or elaborated  
“you were angry” |
| 4     | Reflection/Exploration  
Client’s feelings and personal experiences  
- including immediate emotions, past emotions, and immediate experiencing | “What’s that like?”  
“What are you feeling now?”  
“…you’re feeling very hopeless” |
| 5     | Elaboration  
T invites the C to explore and expand feelings by stating a problem/need or proposition about them  
-incl. bridging associations (e.g., “it sounds as if you get angry when you feel put upon”) | “Why are you so depressed?”  
“It sounds like you’re struggling w/ that”  
“You feel that you shouldn’t be loved b/c of what you have done, yet you have a need to feel loved”  
“Is it just anger that you feel, or is there more?” |
| 6     | Newly Emerging  
T focuses on C’s directly sensed, emergent, newly recognized, or more fully recognized feelings  
- must be new; idiosyncratic (client); can be a tentative statement | - therapist walks client through experiencing exercise to guide newly emerging feelings (e.g. felt sense)  
“It sound as if you’re angry, but I wonder if there’s some sadness in what you just said” |
| 7     | Integration  
T focuses on the C’s ability to move from one inner referent to another  
- client’s ability to link, build upon, and integrate new realizations with others is noted and shared by T | “Does this link to other parts?”  
“What’s the whole picture like now?”  
“Now that you have a good understanding, is there anything else you’d like to say about it?” |
Example EXP-T Coding Sheet

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Vita Auctoris

Terence Singh was born in 1983 in Edmonton, Alberta. He obtained his high school diploma from Archbishop MacDonald High School and graduated from the University of Alberta (Edmonton, AB) with a B.A. (Honors) in Psychology (First-Class Distinction) in 2001. He is currently a candidate for a M.A. degree in Psychology (Adult Clinical) at the University of Windsor. He intends to pursue a PhD in the same.