CHANGE IN THEMATIC DEPTH OF EXPERIENCING AND OUTCOME IN EXPERIENTIAL PSYCHOTHERAPY

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ABSTRACT

The relationship between theme-related depth of experiencing (EXP) and outcome was explored in two types of brief Experiential therapy with depressed clients. The study sought to investigate whether a) overall average depth of EXP predicts outcome, b) change in depth of EXP predicts outcome, and c) these factors are separate predictors that are distinct from the therapeutic alliance. The sample consisted of 35 clients, 17 Client-centered and 18 Process-experiential, each of whom received 16-20 weeks of therapy. Based on therapist post-treatment interview reports, a method was developed for ascertaining the major core themes that evolved over the course of therapy. Themes tended to be confirmed by client post-session report. Observation revealed that themes were either interpersonallly and intrapersonally based. Depth of experiencing was measured at four different points over the course of therapy: one early session, and in three different, highly theme-related sessions sampled from the last half of therapy. The therapeutic alliance was measured by the Working Alliance Inventory (WAI) and was measured after the fourth session, and over the last half of therapy. Change in therapy was measured by four outcome indices: the Beck Depression Inventory (BDI), the Symptom Checklist 90-R (SCL-90R), the Rosenberg Self-esteem (RSE), the Inventory for Interpersonal Problems (IIP). Correlational analyses indicated that overall average EXP was positively correlated with changes in depressive symptoms (as measured by the BDI

and the SCL-90R), and increases in self-esteem (as measured by the RSE). EXP did not correlate significantly with changes on the IIP. Hierarchical regression analyses revealed that EXP in the last half of therapy was a significant predictor of a reduction in symptom distress (as measured by the SCL-90R and the BDI) and increases in self-esteem even when a) early EXP, b) the alliance after session 4, and c) the alliance in the last half of therapy are taken into account. Findings suggest that, over the course of short-term Experiential therapy for depression, depth of experiencing increases in the context of a focus on problem-oriented themes, and that this change is related to an overall reduction in symptoms and improvement in self-esteem. In addition, hierarchical analyses suggest that the process of achieving progressively deeper levels of experiencing in the context of a focus on thematic problems predicts outcome separately from the alliance.

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Introduction

The question of how people change in psychotherapy represents a major challenge in the field of psychotherapy research; the question has inspired continual investigation into the actual in-therapy processes that lead to improvement at the end of therapy. To date, there are relatively few studies that provide empirical evidence to substantiate the vast number of theoretically-held beliefs about the specific change processes in therapy that lead to a positive therapeutic outcome. The pattern of experiencing across therapy, or in other words, change in how clients make sense of their worlds, is thought to be an important area deserving of further investigation.

Experiencing has long been seen as an important medium through which we come to know, apprehend, order and categorize our world. In this past century, philosophers, particularly phenomenologists such as Husserl and Merleau-Ponty, have been concerned with understanding and defining the nature of experiencing and its role in shaping our conception of reality. More recently, within the field of humanistic psychology, psychotherapy researchers (Gendlin, 1962; Gendlin & Zimring, 1955; Rogers, 1959; Walker, Rablen, & Rogers, 1960) have identified bodily felt experiencing as an essential characteristic of consciousness that consistently is referred to in therapy, is the basis for meaning creation, and is a medium through which change occurs.

The experiencing scale (EXP) (Klein, Mathieu, Gendlin & Kiesler, 1969) was originally designed to describe and measure the phenomena of client experiencing during the therapy hour. Both Rogers and Gendlin contributed to the creation of the experiencing

scale in independent ways. Client-centered theory, with Rogers as its creator, "discovered" the importance of experiencing through material gathered via direct observation of therapy hours. As early as 1950, Rogers labelled experiencing as the client's sense of exploring his or her perceptual field (Rogers, 1950). Gendlin became interested in the construct of experiencing from the perspective of phenomenological philosophy. Gendlin and his colleagues first articulated the importance of the experiencing process in psychotherapy in a seminal paper (Gendlin & Zimring, 1994). Gendlin describes experiencing as the "concrete...ongoing functioning (in us) of what is usually called experience; it is the basic felt datum of our inwardly directed attention" (Gendlin, 1962, p. 18). Experiencing in therapy was thought to consist of clients' capacity to focus on and express the feeiing, attitudinal, and meaning aspects of their experience; to integrate these affective and rational aspects of themselves, and to use this differentiated composite as a referent to help structure present and subsequent experience (Klein et al., 1986, p.25). This was thought to describe the ideal in-therapy set of client behaviours described by the Experiencing scale. Thus, movement and progression through the sequence of stages of the scale was desired of a psychotherapy client (Rogers, 1958, 1959b; Rogers, Gendlin, Kiesler & Truax, 1967; Walker, Rablen, & Rogers, 1960).

The underlying hypothesis that guided the original construction of the Experiencing scale arose from Rogers' process conception that successful therapy consisted of a gradual and cumulative process of moving from rigid to fluid expression

that fostered increased awareness. This was associated with what Rogers called optimal personality functioning, or "the fully functioning person" (Rogers, 1959a). The Experiencing scale was thought to describe this progression from fixed to open processing and was associated with optimal personality change. Successful therapy was thus considered to be a process of a client becoming aware of feelings, and of these feelings constantly changing as the person is fully engaged in the process of living. This leads to optimal personality change which is synonymous with constant high experiencing.

Rogers' hypothesis therefore, in many ways, directed the research designs used in the early process-outcome studies of the Experiencing scale. Researchers were interested in two related questions. First, is average depth of experiencing in therapy related to positive outcome? Second, is a progressive linear increase in experiencing over the course of therapy associated with success? To answer these questions, experiencing levels were randomly sampled across each therapy session and both overall average experiencing and the patterns of experiencing over the course of therapy were correlated with outcome variables. Researchers hypothesised that deeper experiencing would be associated with positive outcome. Early studies did in fact indicate that overall, deeper experiencing was related to positive outcome in psychotherapy. What was not established, however, was a clear linear trend in experiencing over the course of therapy toward constructive personality change (Gendlin & Berlin, 1961; Gendlin, Jenney, & Shlien, 1960; Tomlinson, 1962, 1967; van der Veen, 1965; Rogers, Gendlin, Kiesler &

Truax, 1967; Kiesler, 1971). Thus, while experiencing was seen as an important change variable, Rogers' hypothesis of a cumulative increase in EXP was not borne out in the data, or at least not demonstrated in the early studies.

During the 1960's and early 1970's a wealth of research studies were conducted that related client experiencing within and across therapy sessions, as well as the occurrence of particular patterns in experiencing to successful psychotherapeutic outcome (Kiesler, 1971; Gendlin, Beebe, Cassens, Klein & Oberlander, 1968; Tomlinson et al, 1962; Rogers et al, 1967; Tomlinson, 1967). The failure to find a clear pattern of increased depth of experiencing across therapy may in fact be part of the reason that research on the relationship between depth of experiencing and outcome in psychotherapy has virtually disappeared since the early seventies.

This study proposes an alternative to Rogers original hypothesis. It does not assume that therapy is a process of moving from rigid to fluid functioning, nor that depth of experiencing increases linearly over therapy regardless of context. Rather, a major hypothesis of this study is that increased depth of experiencing occurs in relation to key thematic client problems that emerge during therapy, and it is theme-related EXP which is associated with successful outcome. An underlying assumption of this hypothesis is that clients enter therapy because the ways in which they are currently dealing with life issues is problematic. Moreover, their style and manner of processing experience in relation to these emotional problems has proven ineffective and led to painful consequences. Psychotherapy is thus construed as a process of working through thematic

emotional problems and life issues, at a deeper level of experiencing, in order to gain increased awareness. In turn, this ultimately allows for increased access to affective self-information that informs wider choice and gives clients alternative coping strategies for dealing with problems. Through theme-engagement in therapy, clients develop new attitudes, ways of being, and alternative affective processing styles. It is, however, unlikely that people change in psychotherapy in such a way that they are *constantly* processing at higher levels of experiencing, or in Rogers' terms that they have optimal personality change. Thus, therapy, especially brief treatment, is seen as leading to the resolution of emotional problems related to current living environments, rather than as seen as promoting deep character change.

If the alternative hypothesis that increased, theme-related experiencing over the course of therapy is associated with successful outcome is in fact true, it follows then that employing a method of randomly selecting segments from each session across therapy will **not** reveal a pattern of increased depth of experiencing in relation to positive outcome. In fact, random selection across therapy might serve to obscure any differences between successful and unsuccessful outcome. Instead, this method might reveal of pattern of inconsistent or jagged experiencing levels. One random segment may contain material in which a client is experiencing very deeply in relation to a meaningful thematic topic, while another segment may reveal the same client talking very superficially about her pet. To validly test the hypothesis that experiencing throughout therapy gets deeper in relation to meaningful material, a method of measuring experiencing in relation to core

thematic issues must be developed.

Thus the rationale for the method developed in the current study is that rather than randomly extract segments, it will be more meaningful to first identify therapy segments that contain material that has emerged as "thematic" for clients. By extracting thematic sequences and measuring EXP in relation to them, we believe that a more accurate picture of the relationship between experiencing and outcome will be revealed.

This study will re-examine and explore the role of the experiencing construct as a key element in successful therapeutic process. It will explore the overall relationship between theme-related EXP and psychotherapy outcome, in addition to looking at the pattern of experiencing over the course of therapy in relation to post-therapy outcome in a population of clinically depressed clients. A method will be developed for delineating core thematic portions of therapeutic dialogue, for the purpose of exploring a meaningful relationship between EXP and therapeutic outcome. Segments will be extracted from across the last half of therapy wherein clients are discussing and exploring thematic material related to their depression. EXP in relation to this material will then be related to therapeutic outcome. This study will also look at the relationship between change in theme-related experiencing across therapy and outcome. Segments will also be extracted from an early session in therapy. The relative strength that early session and late session theme-related EXP has in predicting outcome will be explored. Finally, given that the strength of the alliance early in therapy has been shown to be a strong predictor of outcome (Luborsky, 1990; Horvath, 1994), this study will assess the relationship between

the therapeutic alliance and EXP and outcome. The investigation will ascertain the relative contributions of EXP, and the alliance for therapeutic change in an effort to identify the most powerful influence on outcome.

Literature Review

Current recognition for the importance of 'experiencing'

In recent years, theorists from a wide range of disciplines have recognized the important role of bodily-based experiencing in understanding how we organize and come make sense of our world. In a ground-breaking book, Lakoff (1987), emerging from a Cognitive science perspective, puts forward a theory that contests a traditionally held objectivist position that reason is abstract and disembodied.

According to an objectivist position, rational thought consists of the manipulation of abstract symbols which are given meaning via conventional correspondences with things in the external world. That is, symbols get their meaning via an objectively construed system that is independent of the understanding of the organism. In this view, the mind is an abstract machine, manipulating symbols in the way a computer does. Symbols that correspond to the external world are internal representations of external reality. In this sense the mind is a mirror of nature. Abstract symbols may stand in correspondence to things in the world independent of the particular properties of the organism. Thus, thought is atomistic; it can be broken down into simple "building blocks" which are formed into complexes and manipulated by rule and logic. Thought is also logical; it can be modelled accurately by mathematical logic.

Lakoff puts forward an opposing position, supported by evidence from different disciplines, including anthropology, linguistics and psychology. He argues that the conceptual categories we use to make sense of our world, and human reason in general

are not "objective." He argues that the category system through which we conceptualize the world is *embodied*. That is, the structures used to put together our conceptual system grow out of bodily experience and make sense in terms of it. The core of our conceptual system is directly grounded in perception, body movement, and experience of a physical and social character. In addition, those categories are *imaginative*. They are directly grounded in our experience which employs metaphor and mental imagery that goes beyond literal mirroring, or representation of external reality. He also argues that thought has gestalt properties and is thus not atomistic; concepts have an overall structure that goes beyond merely putting together conceptual "building blocks" by general rules. Finally, he argues that thought has an ecological structure. The efficiency of our cognitive processing depends completely on the overall structure of the conceptual system and on what the concepts mean. Thought is thus more than just the mechanical manipulation of abstract symbols. Citing many examples, Lakoff goes on to make a convincing case for human reason and category conceptualization having an "experiential" basis in the body. It follows then that in order to more fully understand how a particular person comes to know his/her world, we must explore bodily-based experiencing.

Within the field of psychotherapy research, Bohart (1993) has argued that "experiencing", broadly defined, is a common dimension of change that exists across a variety of psychotherapies. For cognitive-behavioral theorists, (eg. Arkowitz & Hannah, 1989; Goldfried, 1979, 1980) experiencing refers primarily to the provision of new experiences, such as encouraging clients to enter new situations and to encounter new

feedback. For experiential theorists (Gendlin, 1991; Mahrer, 1989; Greenberg, Rice & Elliott, 1993) experiencing refers to an inner bodily-felt process. Despite the differences in use of term, Bohart argues that experiencing is a key element that changes through the therapeutic process. It is a dimension he sees as important but in need of further definition (Bohart, 1993; Bohart & Wugalter, 1991).

Bohart defines experiencing as the process by which we recognize our place in the world. It is the immediate whole-bodied apprehension of the complex pattern of interaction that constitutes our living in situations. It involves "ordinary" thinking and feeling, but at the same time is also nonconceptual and nonverbal. At a phenomenal level, he defines experiencing along three dimensions: immediate, bodily, and contextual.

Experiencing is immediate in the sense that it involves a process of direct perception and recognition more than thinking and conceptualizing. While inference, interpretation, and reasoning may become involved in experiencing, there is definitely an element of knowing that is nonconscious and automatic.

Drawing from work by Lakoff (1987) and Varela, Thompson, & Rosch (1991), Bohart points out that experiencing is embodied cognition. It involves perceptual-sensory acts, and visceral aspects. Experiencing involves inner-sensing that is visceral and bodily. When something is understood or comprehended experientially, it is usually a bodily felt recognition that may or may not be accompanied by an explicit intellectual process. Experiencing involves the apprehension of an integrated gestalt of a set of inner referents.

Experiencing is always felt holistically and within a particular context. The holistic nature of experience is best articulated by Gendlin (1991):

> Your situation is not just what the fives senses give you. Consider: Does your sense of a situation consist of bits of color, sound, and smell, arranged by your thoughts? No, a situation doesn't consist of sense bits. Nor does it consist of separate bits of any sort. You can think of a few special factors, but you cannot think all of the parts of a situation separately. But you speak and act from a sense of the whole situation (p.257)

The holistic nature of experiencing is related to its contextual nature. For example, the experience of "I am damaged goods" is contextual, and embedded in one or more situations of occurrence. The meaning is given in terms of contextual links. Thus, the meaning of being damaged may be located within a complex sequence of interactions from a history of relationships beginning with parental figures and including a series of intimate relationships. One's historical and cultural backgrounds are also integrated as parts of the context of an experience. The context constitutes the "real" specific, experienced meaning of the abstract phrase "I feel like damaged goods."

Current theorists such as Bohart and Lakoff give weight to the importance of the experiencing construct in the context of furthering our understanding of how we make sense of our world. Bohart revived the notion that experiencing is a dimension of psychotherapy worthy of further exploration. Rogers and Gendlin, the original creators of the Experiencing Scale, also recognized the importance of experiencing as a change process in psychotherapy. In order to understand more fully the construct that is being measured by the Experiencing scale, it is necessary to explore the history of the creation

of the Experiencing Scale (EXP).

Gendlin and Rogers: Divergent paths converging in the Experiencing Scale

During the 1950's both Gendlin and Rogers were involved in the articulation, definition, and operationalization of experiencing, attempting to describe how it changed through psychotherapy. Taking separate paths initially, they arrived at a concept of process that each saw as central to authentic and in-depth self-understanding. Gendlin's effort was more theoretically-driven while Rogers was more empirical. The following sections will explore the different paths each took to arrive at the same conclusion.

Gendlin's path: Definition and elaboration of the experiencing construct

Gendlin initially approached the construct of experiencing initially from the perspective of the phenomenological philosophers. It was primarily through the writings of Husserl and Merleau-Ponty that Gendlin moved in the direction of psychotherapy as a possible source of in vivo phenomenological processes (Gendlin, 1955). In his early work, Gendlin translated difficult abstract philosophical concepts into applied psychotherapeutic terms. Those aspects of the work of each of the philosophers who particularly inspired Gendlin to apply the concept to psychotherapy will be explored.

The influence of Husserl

For Husserl, the main objective of philosophy was to seek absolute and pure knowledge (Husserl 1910-1911/1965, p.72). He believed that philosophy should be concerned with "essence" and its goal should be the clear comprehension of the essential nature of reality. By definition, an essence must be a fact or entity that is universal,

eternally unchanging over time, and absolute. Conversely, an essence is not relative to a given culture or historical age, is not restricted to personal opinion and is not dependent on logical arguments (Jenney, 1986).

For Husserl, consciousness makes possible the appreciation of all the other forms of being that compose reality (DeBoer, 1978). It is our "preunderstandings" of the world that he sought to clarify. He recognized that the quintessential property of consciousness is *intentionality.* Husserl once said: "The title of the problem which in its scope covers phenomenology in its entirety is intentionality" (Husserl, 1913/1931, p.373). Husserl attempted to demonstrate that every act of consciousness is necessarily "intentional" which is to say, it is always directed toward, or pointing toward some "object." Consciousness is always consciousness of something. It always intends or is about something. In the same way that consciousness can intend a physical object, consciousness can serve as an "object" itself. Knowing something or accounting for reality, involves not just that which is knowable and attracts inquiry, but also the act of knowing itself, the knower's knowing. Husserl called this the "paradox of human subjectivity," referring to the fact that human consciousness is both in the world and before the world (Jenney, 1986).

Husserl thus asserts that consciousness occupies a space separate from symbol, image, or perception. In fact, consciousness is the "primordial region" which makes possible the appreciation of all the other forms of being that comprise reality. He distinguishes between meaningful and meaningless objects, saying that the experience of

meaning and the function of it is in "acts" and the interrelation of "acts." He points out that the difference between meaningful and meaningless signs is not a property of a physical object but rather how it is experienced by someone. Meaning is created through a person's intention or action. Meaning depends on a distinct act and is shown by the difference in our experience of meaningful and meaningless symbols.

Based on his assertion of the basic "intentional" character of consciousness and its foundational position as the "point of access" to knowledge of the world, Husserl developed a specific method for the purposes of understanding the essential acts of consciousness. He called this the "phenomenological reduction" (Jenney, 1986). The specific procedure will not be explained here as it is beyond the scope of this work. Gendlin, who was influenced by the work of Husserl (Gendlin, 1962) in many ways, developed an in vivo technique for studying that to which Husserl was referring. This method is called focusing (Gendlin, 1981) and it involves a focus on inwardly felt experiencing.

Gendlin's work has revealed that any given instant of conscious awareness is characterized by a global, bodily felt experiential sense and that this bodily felt experiencing constitutes the originating ground for all our explicit words, ideas, thoughts, perceptions (Jenney, 1986). This bodily-felt experiential sense is not the same as our immediate experiencing of the world. Rather, our words, concepts, and ideas are considered *mediate* formulations arising from our *immediate* bodily felt experiencing of the world. Thus, the objects of consciousness are incredibly diverse and constantly

changing depending on circumstances of time, place, situation, and environment. When consciousness itself is attended to, however, we can observe that essential quality of consciousness called ongoing bodily felt experiencing. This is an example of which Husserl referred to as essence.

Gendlin has termed this phenomenon *direct reference.* During therapy (or anytime a person wishes to tap into it) it has been observed that a person can become distinctly aware of an important inner feeling experience, that s/he will not necessarily have words to symbolize. People can often *feel* (it) but not know what "it" is. Thus, a client can focus on experiential felt-datum without actually articulating that datum into words. The feeling is often, at first vague conceptually, but s/he can clearly attend to it, point to its tonal qualities and feel it change in response to various therapeutic interactions or events. This meaningful inwardly felt datum or "direct reference," and the way in which a client goes about exploring and articulating it in therapy is called Experiencing and it is what is being measured by the experiencing scale.

The influence of Merleau-Ponty

Merleau-Ponty employs a linguistic perspective to make a case for experiencing as process that is distinct from thinking and perception. Language is not just arbitrary symbols. It represents a way of being in and "signing" in the world. Through felt meaning, we use linguistic expression as a direct way of articulating experience in the world. He argues that "emotional essence" constitutes our experience of the meanings of words, rather than images or pure thoughts. There is no such thing as an object or an

essence that presents itself to our consciousness directly, but rather through language, we are given a route, an experience which gradually clarifies itself and, "rectifies itself and proceeds by dialogue with itself and with others."(Merleau-Ponty, 1964, p.21).

Merleau-Ponty asserts that through language we are constantly clarifying our ideas. They are not fixed or set. Rather, over time, our expression of ideas and their meanings change as we continually interact with the world. While we may repeatedly use the same formulas to express thoughts, over time they will change their meaning slightly as we gather experience.

> Do I not know that in six months, in a year, even if I use more or less the same formulas to express my thoughts, they will have changed their meaning slightly? Do I not know that there is a life of ideas, as there is a meaning of everything I experience, and that every one of my most convincing thoughts will need additions and then will be not destroyed but at least integrated into a new unity (Merleau-Ponty, 1964, p.23).

Gendlin (1962) notes that Merleau-Ponty's analysis of language, by discriminating felt meaning as that which is revealed in acts or expression, enables us to realize the function of language in expressing and articulating experience. "Emotional essence" which reveals the meanings of words and ideas, is a property of the body, analogous to gestures and one's sense of one's physical surroundings.

Thus, Merleau-Ponty was pointing to the important function of language in expressing our own experience. Language is the vehicle through which an individual's emotional essence or ongoing experience is expressed.

Gendlin's early articulation of the experiencing process in psychotherapy

Thus, Gendlin was responsible for translating some of Phenomenology's complex and abstract concepts of experiencing into concrete psychotherapeutic terms, thereby giving philosophical weight to experiencing in psychotherapy. He went on to further define the experiencing process in psychotherapy. Gendlin & Zimring (1994) sought to identify the characteristics of experiencing in aid of devising a scale that would allow the counsellor to estimate the level of the client's immediate experiencing. In many ways, this was a compilation of their ongoing thoughts on the subject of experiencing in psychotherapy. They characterize the dimensions of experiencing in terms of experiencing in general, experiencing of self and experiencing of other. The dimensions of experiencing in general could range from full-bodied to a bare outline (thin), immediate to postponed, intense to diminutive, fluid to stuck, capable of differentiation to frozen, and having the potential to be integrated or not. In terms of how a person experiences the self, s/he can fluidly move through feelings or operate from a self-concept. The person can view the self as medial (situated in the middle of one's experience) or as an object. In terms of how a person experiences others, they distinguish between structure-bound experiencing and process-experiencing. Structure-bound experiencing involves reacting to the current situation by finding it to be like a past experience, and then reacting to that past. Process-experiencing involves interpreting the situation anew and feeling it freshly.

Gendlin and Zimring (1994) imply that health is equated with the ability to finish

past experiences, and allow them to fade into the background. Past experiences in turn serve as a "seamless" mass through which one perceives, interprets and makes sense of new experience. Pathology is associated with restricted or inhibited, "structure-bound" experiences that are frozen and repetitive. On certain cues, there arises from past experience a whole construct or "unit" of experience that has not been differentiated internally. Thus, the inability to experience the "fullness of now" is owed not just to a mere lack of percepts, but to a tied-down nature of experiencing. It is a lag that represents a person being stuck with "what one was but couldn't fully be." Stunted growth is the result of inhibitions of experience which are inherent on old structures and are still operative on the person currently. Therapeutic change is therefore aimed at exploring these restrictions and allowing for "new experience". The repetitious, bare and frozen must somehow be opened up, so the past in its original fullness can be had now. Through exploration with a therapist, new situations are created that are called "now-processes". This effects change in the nature of experiencing generally, in the nature of the self as an experiencing agent, and in how others are experienced. Thus, successful therapy is seen as a process of moving from being structure-bound, and self-concept-ruled to becoming an ongoing set of self-descriptions and self-experiences. The person moves from experiencing the self as a structure to being an ongoing process. The self moves from object to "medial" subject; a self predominantly in action.

Gendlin's articulation of the experiencing construct

A survey of Gendlin's writings reveals his eloquent articulation of the nature of

experiencing. He describes it as our preverbal, preconceptual, bodily felt sense of being in the interaction with the environment. This includes an experience of a continuous stream of sensations, impressions, somatic events, feelings, reflexive awareness, and cognitive meanings that make up one's phenomenological field. It's a gut-level, felt-sense of felt meaning. It is not a reenactment of events, but includes their personally felt significance in the moment. It is not a set of concepts or logical operations; rather it is the inner experiential referent used to anchor concepts. It is not simply the experience of affect, self-consciousness, or self-management. Experiencing includes the broader band of implicit meanings that structure sensations and feelings and articulate one's sense of continuity by supplying the personal colouring of events and the personal significance of one's reaction to them. As the basic referent of inwardly focused attention, experiencing can exist or be symbolized in different modes. Although it is essentially complex, changeable, and even irreducible, it can be structured indefinitely, carried forward, used as the basis for action, and provide feedback to produce an experiential effect or shift. Experiencing provides continuity and direction from the past through the present to future and gives rise to a quality of wholeness and authenticity (Gendlin, 1962; 1964; 1967; 1969; 1974).

Rogers' path: The Process scale

Rogers discovered experiencing through the material gathered via direct observations of therapy hours (Rogers and Dymond, 1954). By 1959 Rogers had developed a new concept called "optimal personality functioning," which described the

"fully functioning person" (Rogers, 1959a). This was an end product of what Rogers had come to see as the "process" of therapy, whereby the goal of therapy would be for the person to be able to "open to his or her feelings, feelings that may constantly change as the person is fully engaged in the process of living." Thus, the client centered process of therapy focussed on the means by which the person moved from a closed to an open stance and thence to awareness. Rogers and his colleagues originally defined seven strands or components of therapy, necessary for the facilitation of this movement. The final two strands were concerned specifically with the quality of the person's awareness, acceptance of inner feelings and the extent to which those inner feelings were used for further thought, self-exploration, and action (Rogers, 1958; Walker, et al, 1960). The sixth strand was referred to as "relationship to feelings and personal meanings," and the seventh is termed "manner of experiencing."

The seventh experiencing strand was clearly influenced by Gendlin's theoretical and empirical efforts. Gendlin had also defined experiencing as the basic felt referent of awareness that can progress from feeling elusive to experiencing a clear referent. Thus defined, experiencing was dynamic and not static. This fitted into Rogers "non-pathological" concept of personality change so that pathology is anchored at the lower end of the experiencing dimension, and personality change and growth emerge at the higher end.

After the scale was developed, a number of studies were conducted to relate levels of therapist conditions to process (van der Veen, 1967; Rogers, et al., 1967; Tomlinson,

1962; Kiesler, Mathieu, & Klein, 1964, 1967) as well as to relate levels of process to outcome. Studies generally showed that process scale ratings were significantly higher in more successful outcome cases than in less successful cases (Rogers, 1958; Rogers, 1959b; Walker et al, 1960; Gendlin & Tomlinson, 1962; Tomlinson & Hart, 1962). Of all seven strands, the experiencing strand was the most tangible and concrete. It thus became the critical vehicle by which the movement from rigidity to fluidity was verbally manifested in the therapy interactions. Because of high intercorrelations between strands of the process scale, all the strands were eventually subsumed under the heading of the experiencing scale that was ultimately developed by Klein et al (1986).

The Emergence of the Experiencing Scale

Although coming from different perspectives, Gendlin and Rogers had thus collaboratively developed the experiencing construct, a critical element in the client-centered model for both the practice of psychotherapy, and the measurement of personality change. The Experiencing scale (EXP) was thus published in its current form in 1969 (Klein, Mathieu, Gendlin & Kiesler, 1969). It was designed to describe the ideal in-therapy behaviour of the psychotherapy client. Drawing on a research sample from a major study of Client-Centered therapy with schizophrenics undertaken at the University of Wisconsin (Rogers, Gendlin, Kiesler & Truax, 1967), a number of different researchers sought to establish that EXP was an important change variable in psychotherapy. Studies established that experiencing scale ratings were significantly higher in more successful cases than in less successful cases (Kiesler, Mathieu & Klein,

1967; Gendlin & Tomlinson, 1967).

The Experiencing Scale

Following are general descriptions of each of the seven scale stages of the final version of the Experiencing Scale (Klein et al, 1969; Klein et al., 1986). The experiencing scale is rated on clients' statements (therapist statement is not rated). While context is sometimes important in order to make a rating, prototypical examples are provided for each stage below.

Stage 1

The chief characteristic of this stage is that the content or manner of expression is impersonal. In some cases the content is intrinsically impersonal, being a very abstract, general, superficial, or journalistic account of events or ideas with no personal referent established. In other cases, despite the personal nature of the content, the speaker's involvement is impersonal, so that he or she reveals nothing important about the self and the remarks could as well be about a stranger or an object. As a result feelings are avoided and personal involvement is absent from communication (Klein et al., 1986). **Ex:** "I read a book that said..." or "I went to the store...."

Stage 2

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

not refer to or define the speaker's feelings. Thus the personal perspective emerges somewhat to indicate an intellectual interest or general, but superficial, involvement (Klein et al, 1986). **Ex:** "I wish I could be a stronger person," or "No one cares about the environment anymore. That really bothers me."

Stage 3

The content is a narrative or a description of the speaker in external or behavioral terms with added comments on feelings or private experiences. These remarks are limited to the events or situations described, giving the narrative a personal touch without describing the speaker more generally. Self-descriptions restricted to specific situations or roles are also part of Stage 3. Thus feelings and personal reaction come into clear but limited perspective. They are "owned" but bypassed or rooted in external circumstances (Klein et al., 1986). **Ex:** "I was aware of wanting to defend myself," or "It reminded me of being scolded as a child."

Stage 4

At Stage 4 the quality of involvement or "set" shifts to the speaker's attention the subjective felt flow of experience as referent, rather than to events or abstractions. The content is a clear presentation of the speaker's feelings, giving a personal, internal perspective or account of feelings about the self. Feelings or the experience of events, rather than the events themselves, are the subject of the discourse, requiring the speaker to attempt to hold on to inner referents. By attending to and presenting this experiencing, the speaker communicates what it is like to be him or her. These interior views are

presented, listed, or described, but are not the focus for purposeful self-examination or elaboration (Klein et al, 1986). Ex: "I feel like a nothing, as though no one even cares about me," or "When he turned up his nose at me, I shrivelled inside."

Stage 5

The content is a purposeful elaboration or exploration of the speaker's feelings and experiencing. There are two necessary components: First, the speaker must pose or define a problem, proposition or question about the self explicitly in terms of feelings. The problem or proposition may involve the origin, sequence, or implications of feelings or relate feelings to other private processes. Second, the speaker must explore or work with the problem in a personal way. The exploration or elaboration must be clearly related to the initial proposition and must contain inner references that have the potential to expand the speaker's awareness of experiencing. These may also be evidence of and/or references to the process of groping or exploration itself (Klein et al., 1986). **Ex:** "When the teacher is disapproving of what I am saying, I find myself hating her and wanting to just close down. I wonder if I get angry when I am feeling inadequate?"

Stage 6

At Stage 6 the way the person senses the inner referent is different. At this stage, the client synthesizes feelings and meanings to produce a felt-shift and resolve current problems. There is a *felt sense* of the there-and-yet-to-be-fully-discovered, that is, of an unclear inner referent that has a life of its own. This felt sense is more than recognizable feelings such as anger, joy, fear, sadness, or "that feeling of helplessness." If familiar or

known feelings are present, there is also a sense of "more" that comes along with the identified feelings (Klein et al., 1986). **Ex:** "It used to be that when he would just walk out, I would feel devastated, as if my whole world was caving in. Now, it is different. I still feel hurt, but I somehow know that I will be ok."

Stage 7

The content reveals the speaker's steady and expanding awareness of immediately present feelings and internal processes. He or she clearly demonstrates the ability to move from one inner referent to another, linking and integrating each immediately felt nuance as it occurs in the present experiential moment, so that each new sensing functions as a springboard for further exploration and elaboration. The speaker may start with an internally anchored problem, explore it, and reach an internally anchored conclusion that s/he then applies to a number of other problems (Klein et al. 1986). **Ex:** (often spread over a number of consecutive client statements): "I am no longer going to be a slave in this marriage. I am a good person and I deserve to be treated better. I wonder why I have put up with this for as long as I have. I think it was a pattern that I learned from my mother. I used to think this was the way marriage had to be, but now I know it is not, and I am not going to put up with it anymore. I am going to break the pattern. I don't want it to be passed on to my children either."

Directions in Psychotherapy Process-Outcome Research

This past decade has seen a continued interest in and recognition of the value of studying the relationship between the process and outcome of psychotherapy (Greenberg,

1986; Orlinsky, Grawe & Parks, 1994). In the last forty years, a number of developments have led researchers to ask more specific questions about the relationship between in-therapy processes and outcome. The following section will detail the developments in the field of psychotherapy research that preceded current trends in the field of psychotherapy research.

Carl Rogers (1951) and his colleagues (Rogers & Dymond, 1954; Barrett-Leonard, 1962) were the first researchers to study tapes of psychotherapy in an attempt to understand therapeutic processes. In many ways, early process-outcome studies were superceded by research studies with "bigger agendas." Psychotherapy research conducted prior to the past decade was predominantly concerned with a) establishing treatment efficacy, and b) comparative outcome studies.

Much of the psychotherapy research conducted between 1950 and 1980 was in response to a statement put forward by Eysenck's (1952) assertion that two-thirds of the people who entered therapy could expect to improve over a two year period, a recovery rate purportedly equivalent to that of individuals who received no form of treatment. This stimulated a flurry of research activity attempting to establish the efficacy of psychotherapy.

A number of studies conducted in the ensuing years punched holes in Eysenck's assertion and established the efficacy of psychotherapy. In a reanalysis of Eysenck's data, Bergin and Lambert (1978) observe that his conclusions were based on studies in which some clients improved while others got worse. When changes across clients were

averaged, the positive and negative results cancelled each other out leading to Eysenck's conclusion that psychotherapy was ineffective. Bergin & Lambert are quick to point out that the more accurate conclusion was that psychotherapy is effective for some people. A few large-scale meta-analyses and numerous outcome studies finally enabled researchers to confidently assert that psychotherapy is effective beyond spontaneous rates of remission (Howard, Kopta, Krause & Orlinsky, 1986; Lambert, Shapiro & Bergin, 1986; Smith, Glass & Miller, 1980).

In many ways, Bergin & Lambert's (1978) reanalysis of Eysenck's data also lead to a recognition of the complexities of evaluating the effectiveness of psychotherapy. Kiesler (1971) observed that it is erroneous to view clients as a homogenous group and then to analyze psychotherapies in global terms as if therapy is an experimentally-fixed treatment. From this point on, researchers began to attend to the comparison of the effects of different approaches to therapy. Overall, this effort did not yield promising results. A number of major reviews summarizing the results of comparative outcome studies have yielded findings of general equivalence across theoretical orientations (Lambert et al., 1986; Smith et al., 1980).

Disappointment with these finding has lead psychotherapy researchers to acknowledge the limitations of global questions regarding treatment efficacy. Many researchers feel that such broad questions fail to capture the complexities inherent in clinical situations that ultimately give us more insight into the workings of therapy (eg. Bergin & Lambert, 1978; Kiesler, 1971). Greenberg & Pinsof (1986) provide a sound

rationale for the need to understand the specific factors that are associated with positive outcome:

> To say that something worked (or failed) without being able to specify what it was that worked undermines the replicability criterion of scientific research. A treatment of intervention that is allegedly effective cannot be reproduced if its essential characteristics cannot be determined and evaluated. To know that psychoanalytic treatment helped more patients....than client-centered therapy is of minimal value if the researcher cannot specify what actually occurred in the respective therapies (p.5).

At the same time that those researching treatment efficacy were coming to understand the limitations of their approach, researchers investigating psychotherapy process were beginning to question their goals (Greenberg & Pinsof, 1986; Greenberg, 1986). A central criticism of early work on psychotherapy process was its failure to link process findings with outcome results (Hill & Corbett, 1993). Emerging from different places, representatives from both process and outcome research paradigms converged upon a central position. It was thought that a more meaningful approach to research involved the specific in-therapy change processes that relate to psychotherapy outcome (Greenberg & Pinsof, 1986). Such an approach enables a more comprehensive understanding of psychotherapy.

Early psychotherapy process-outcome study research did not yield the results that had been hoped for. Orlinsky and Howard (1978) conducted an extensive review of process-outcome research and found few studies that strongly associated in-session process variables with outcome variables. Greenberg & Pinsof (1986) clarify the two basic problems that accounted for the disappointing early findings. First, early approaches

employed a method of measuring a single point in therapy and relating this to change at outcome. This was seen as too simplistic and oblivious of the myriad of alternative variables that likely influence outcome. The second problem was that many of the methods relied upon an averaging of process variables without regard for context. This design was undesirable as it tended to obscure information about the processes of change that were associated with outcome. Greenberg and Pinsof (1986) succinctly summarize the problem:

> The assumption is that all behaviours are equivalent regardless of context, timing, appropriateness, and quality. Clearly the timing, context and sequence of interpretations or confrontations are of much greater significance than is their frequency (p.7).

Early process-outcome studies were also flawed by the same misconceptions that befell the early outcome research, that Kiesler (1971) referred to by "homogeneity myths" (Garfield, 1990; Greenberg & Pinsof, 1986; Marmar, 1990). Kiesler argued that to study process variables without a consideration of the clinical context reflected a myth that all psychotherapy processes are alike. To disregard such important factors as patient characteristics, the therapeutic relationship and the particular phase in therapy, oversimplifies a complex situation (Greenberg, 1986; Greenberg & Pinsof, 1986; Kiesler, 1973; Lambert & Hill, 1994; Rice & Greenberg, 1984).

Recent research initiatives have suggested methodological analyses that are more differentiated and designed to elucidate more clearly the link between psychotherapy process and outcome. A movement evolved in the mid-eighties that was directed toward

greater methodological refinement and specification. Leading proponents of this approach (Greenberg, 1986; Elliot, 1984; Rice & Greenberg, 1984; Stiles, 1988) recommend that analyses of psychotherapy processes be sensitive to issues of timing, context, and quality.

Research studies linking EXP with therapeutic outcome

Since the publication of the Experiencing Scale (EXP), a number of research studies have examined the relationship between EXP and outcome. For the most part, these have not examined the context and quality of the Experiencing process itself. They have been correlational studies looking at the relationship between either average EXP and/or random points in therapy and outcome. Measures of outcome range from patient and therapist success reports to personality and Q-sort outcome measures.

Studies that have attempted to measure the relationship between EXP levels measured at different points in therapy and outcome have yielded inconsistent results. For example, studies linking early EXP and outcome at the cessation of therapy have yielded mixed results. Some have found a positive significant relationship while others have found a positive but nonsignificant relationship (Brodley, 1988). The question of whether early session EXP predicts final outcome does not bear directly on whether EXP predicts outcome at the termination. It seems possible that early session EXP may indicate a *propensity* toward greater depth of EXP later in therapy. It is important to note however, that even if EXP early in therapy is a good prognosticator of successful outcome, this does not rule out the possibility that therapy can facilitate EXP in those people who are not so predisposed. In fact, Klein et al. (1986) surveyed nine studies in which patients

were given direct training in self-expression, focussing or other therapy-role behaviours. They conclude that studies confirm that experiencing skills can be taught, even to severely disturbed patients. The more directly the teaching is targeted to the experiential process itself, the more effective training is likely to be. Thus, research may help to determine which types of clients come with a propensity for high EXP and which clients need "further work" to directly help them attain increased depth of experiencing.

When EXP is considered at the therapy midpoint, there have been mixed results as well. Bommert and Dahloff (1978) found a clear relationship of EXP to outcome in their middle-session segments: More successful patients were significantly higher on the scale than less successful patients. Richert (1976), perhaps counter-intuitively, found ratings of EXP in eight middle sessions to be unrelated to cognitive change measures and to be negatively related to self-satisfaction at the end of therapy. Custers (1973) found no association for EXP and either MMPI or Butler-Haigh Q-sort outcomes with two segments sampled from the middle of therapy.

More consistently positive results have emerged when EXP late in therapy is related to outcome. Fishman (1971) found late EXP associated with his measure of patient success, and Jennen, Lietaer, & Rombauts (1978) found late EXP correlated with outcome scores on the Inner Support Subscale of the Personal Orientation Inventory.

Studies that have conducted more detailed process analysis of EXP and session outcome have yielded positive results. For example, Greenberg and Rice (1981) have demonstrated that EXP is significantly related to changes in a two-chair dialogue (a task

undertaken in Process-Experiential therapy, see Greenberg et al., 1993). According to the study design, therapists responded to a marker of a conflict statement with a predetermined random schedule of accurate empathy responses or "two-chair" operations (Greenberg et al., 1993). Higher levels of EXP, and specifically more peak EXP ratings at Stage 5 and above, were found after the two-chair operations than after empathic responding, suggesting that EXP consistently increased across a session in which a conflict was resolved. Greenberg (1983) then compared 14 instances of two-chair conflict resolution with 14 instances of non-resolution, and found that EXP was significantly higher for the resolution group.

More recently, Warwar & Greenberg (1997) conducted a study in which one high and one low EXP session from the same client within the same brief treatment, were compared. Results indicated that higher EXP sessions had significantly better session outcome (as evaluated by the client at the end of the session.) Thus studies that have investigated the relationship between EXP at various points in therapy and final outcome have demonstrated equivocal results. Studies linking EXP and session outcome have yielded more positive results. None of these studies have investigated the pattern of EXP in the context of particular or meaningful therapeutic dialogue.

Change in EXP and Outcome

A few attempts have been made to study the relationship between EXP change scores and outcome. Fishman (1971) found a significant correlation between EXP change and patient success. Custers (1973) found EXP change over all of therapy and from mid-

to-end of therapy to be correlated with both MMPI and Q-sort success measures.

Researchers have also attempted to determine the course of change in EXP over therapy or the pattern of EXP that is related to positive to outcome. Based on Rogers' original formulation of the process of therapy being a process of moving from fixed to rigid functioning that was related to optimal personality functioning, a number of studies after the Experiencing scale's publication, investigating this hypothesis. This relationship was investigated using data gathered from the Wisconsin project studying Client-centered therapy with schizophrenics (Rogers et al., 1967). Experiencing was sampled over the course of 30 sessions, and successful and unsuccessful cases were compared. While researchers found that in more successful cases there was a more positive trend in EXP than in less successful cases, they did not find that more successful cases showed a positive linear trend in EXP that distinguished them from less successful cases (Rogers et al., 1967; Kiesler et al., 1967). This analysis was based on an average of all interviews within successive thirds of the total therapy course. By looking at the trend in experiencing across five interview blocks, they found that the process could be described more accurately. For the more positive cases, the trend took the form of a U-shaped curve in which EXP dropped down until the fifteenth session only to progressively rise until the 30th session. This same slope of curve described the less successful cases, however, they found more backsliding, so that experiencing plummeted more deeply in early sessions, and while it did improve in the second half of therapy, it did not recover to the same level as that of the more successful cases (Rogers et al, 1967; Kiesler et al.,

1967).

Kiesler (1971) further investigated the relationship between EXP level, trend of experiencing level, and final outcome in psychotherapy. He compared the same schizophrenic population to a psychoneurotic population. The outcome measure used to dichotomize more and less successful psychoneurotic cases, was the Hunt-Kogan movement scale, a global scale for judgment of improvement in adjustment as seen by the therapist at the end of therapy. Therapeutic improvement in the schizophrenic population was determined by more objective measures such as MMPI Sc scale change scores, and a clinical assessment. More and less successful cases were compared in both groups. Four minute segments were randomly extracted from the second half of each of thirty sessions of psychotherapy. Experiencing scores were averaged across five interview blocks over both 20 and 30 sessions, and compared using an analysis of variance. The study replicated the finding that more successful cases had deeper levels of experiencing than less successful cases at all measured points in therapy. This was true in both populations, although, at all the measured points in therapy, levels of experiencing were significantly higher in the psychoneurotic cases than in the schizophrenic ones. Kiesler also found that more versus less successful cases could not be distinguished by slope or shape of experiencing ratings across sessions. The curve that he found to describe experiencing over the course of therapy for both more and less successful groups, drops after the beginning of therapy, until the tenth session, at which point it begins to rise again until the final phase of therapy, at which point it either drops again slightly or remains level.

Kiesler thus concluded that studies that use few data points may elicit dramatic results, but that these results are not likely to be widely generalizable or replicable when aggregate data from larger blocks of segments are considered. He also recommend that a more accurate picture of the trend in EXP might be found measuring EXP in relation to isolated themes.

These studies seem to challenge Rogers' original hypothesis that change in experiencing over therapy takes a positive linear course. There may be a number of reasons for the failure to find a positive linear trend in Experiencing. First, the Wisconsin data is based on a sample of schizophrenics; it may be that this hypothesis holds true in a less severely distressed population. While Kiesler's (1971) study includes a psychoneurotic population, the outcome data is based on therapist report, a highly subjective indicator. In all the samples studied, experiencing level is sampled from the first 20 or 30 sessions, not the entire therapy sequence. Thus, overall, for 47% of the cases, at least 25% of the total therapy interaction was not sampled. More importantly, in all samples studied, experiencing level was represented only by four-minute samples randomly chosen from the second half of each therapy session. Thus, to date, studies that have attempted to establish a pattern of EXP have found that a linear increase is not associated with positive outcome. Rather what has been observed is a curvilinear relationship between the pattern of EXP and outcome (Kiesler, 1971; Rogers et al., 1967; Klein et al., 1986). Random sampling may not, however, reveal an accurate picture of the relationship between EXP and outcome. The experienced psychotherapist can imagine

that "dipping" randomly into a session may reveal a client talking about something of significance or not. Clients do not constantly talk about meaningful issues. Rather, the process more likely waxes and wanes whereby a client moves from emotionally loaded and meaningful material, takes a step back, regroups and moves onto other important issues in his/her life.

In summary, research studies measuring the relationship between EXP and outcome have yielded the following results: a) Generally, there is a positive relationship between average EXP and outcome; b) there is a positive relationship between high EXP and positive session outcome; c) a few studies have found positive correlations between EXP change scores and outcome; d) a linear increase in EXP over the course of therapy was not established and e) researchers have had little success in identifying a pattern of EXP over the course of therapy that is associated with positive outcome. As mentioned earlier, there have been no studies that have examined the pattern of EXP over the course of therapy in the context of core thematic client issues nor have any occurred with depressed clients.

Experiencing and Personality

A controversial question surrounding the research on the EXP is whether the capacity for EXP is a personality trait that indicates positive prognosis for therapy, or whether it is a way of processing that is somehow facilitated or "turned on" by the therapeutic process. Early research suggested that EXP is to some degree a measure of health as well as an index of productive therapeutic involvement (Kiesler, Klein, &

Mathieu, 1965; Kiesler, 1971; Rogers et al., 1967). In addition, EXP was shown to be related to verbal and expressive capacities that have been associated with good motivation, prognosis for therapy (Rogers et al, 1967), and introspective style (Gendlin et al., 1968).

Such findings might lead researchers to query whether EXP is a personality variable that is characteristic of some clients and not others. Many researchers have examined the relationship between experiencing and various traits. In a thorough review of the literature, Klein, Mathieu-Coughlan, and Kiesler (1986) conclude that relationships of EXP to health, personality, and cognitive style have not been entirely consistent.

Turning to relationships between EXP and indices of psychological health and distress, research has suggested to some extent that "healthier" people tend to have higher EXP levels (Kiesler et al., 1965; Kiesler, 1971). A major qualification of these findings is the tendency for EXP to be somewhat elevated in conjunction with psychological distress and/or help seeking. Thus neurotic patients have higher EXP levels than schizophrenics, while non help-seeking "normal" people have low levels. Some analyses of EXP theory suggest that EXP relationships with either pathology or distress may be complex and curvilinear (Joyce, 1980). A survey of recent research led Klein et al., (1986) to report the following trends: In help-seekers as opposed to non-help-seekers EXP was not found to be more prevalent in one population or another, but more uniformly associated with neuroticism as a general factor than with any specific neurotic subtype, such as anxiety, depression, or hostility. EXP was not associated with any other category of affective

distress, such as character disorder or psychosis. Additional evidence suggests that EXP is related to introspectiveness, obsessiveness, and self-consciousness in both help-seeking and non help-seeking samples (Klein et al., 1986).

In terms of the question of the relationship between EXP and cognitive ability, research has been more unequivocal. Fontana, Dowds, & Eisenstadt (1980) reported first-session EXP to be significantly associated with verbal IQ and socio-economic status in a sample of 30 psychiatric outpatients with mixed diagnoses. Klein et al., (1986) conclude in their survey of the research that EXP has been positively associated with measures of cognitive style. That is, conceptual complexity and psychological differentiation, as well as indicators of reflectiveness, strong expressive capacity, or attraction to psychotherapy appear to be linked with EXP.

Overall, while findings have been inconsistent, studies have shown some relationship between EXP and particular client factors or capacities. This does not, however, provide evidence for EXP being a particular particular personality type that determines prognosis for therapy. Whether or not EXP is a personality trait, one might argue that those particular client factors that are associated with positive prognosis could give some people "an edge" over others. To determine whether or not EXP uniquely contributes to outcome, studies are necessary that control for cognitive/personality correlates and still show an effect for EXP.

Experiencing, the therapeutic alliance and outcome

Another variable that must be distinguished from EXP in terms of its relative

strength in predicting therapy outcome is the therapeutic alliance. Some researchers (.ie Brodley, 1988) have conjectured that the strength of a positive relationship between EXP and outcome is simply a function of the alliance. In other words, the claim is that EXP is just measuring the effect of the alliance. In a meta-analysis of 17 studies conducted between 1956 and 1982 that connected EXP with outcome, Brodley (1988) found a number of methodological flaws in their research designs. In many cases, early EXP was confounded with alliance factors. It is possible that positive results could have been attributed to the alliance; these two variables were not examined separately. For this reason, this study will examine the relationship between the therapeutic alliance as measured by the Working Alliance Inventory (WAI), EXP and therapeutic outcome.

The Working Alliance Inventory (WAI)

Description

The Working Alliance Inventory (Horvath, 1981, 1982; Adler, 1988; Horvath, 1981; Moseley, 1983; Plotnicov, 1990) is based on Bordin's (1979) original conceptualization of the working alliance as the active relational element in all change-inducing relationships. His formulation emphasizes the role of the client's positive collaboration with the therapist against the common foe of the client's pain and self-defeating behaviour. According to this model, the alliance has three constituent elements: Task, Bond, and Goal. Task refers to the in-therapy activities that form the substance of the therapeutic process. In a well-functioning relationship, client must perceive these tasks as relevant and effective in collaboration with the therapist; and each must accept

the responsibility to perform these acts. *Goal* refers to the therapist and client mutually endorsing and valuing the aims that are the target of the intervention. *Bond* embraces the complex network of positive personal attachments between client and therapist including issues such as mutual, trust, acceptance, and confidence. This conceptualization provides an important bridge between the "relationship" and "technique" aspects of therapy. Goals frame the client's wishes and tasks represent means to achieve ends.

The relationship is not seen as an independent process but rather the development of it is seen as directly linked to the therapeutic agenda. The act of negotiating and defining the agenda is central to the development of the positive alliance and to the therapeutic change process. People's real lives and processes are represented or take place through the alliance, and in this way the alliance is seen as curative. In addition, the alliance consists of dimensions that are specific to the therapeutic enterprise, such as the commitment to therapeutically sound and realistic goals and active endorsement of a set of procedures or tasks that will enable the client to reach those objectives.

Research

Part of the reason that researchers have made such strong claims about the possible confounding of the effects of alliance and EXP on outcome is the general finding in the psychotherapy research literature of a strong relationship between the therapeutic alliance and outcome (Horvath & Symonds, 1991; Luborsky, 1990). In a meta-analysis, Horvath (1994) reviewed eight studies that related Bordin's model of the alliance (the WAI) with outcome. Results showed an average effect size (expressed as a correlation

coefficient) of .33 for the client-based measures. This suggests a robust link between the client's estimate of the working alliance and the outcome of therapy. Further, alliance measures taken early in therapy tend to be the best prognosticators of final outcome (Horvath & Greenberg, 1994; Watson & Greenberg, 1994; Luborsky, 1990).

Process-Outcome Studies with Depressed Clients

Virtually no research has investigated the specific process factors in therapy that account for positive treatment outcome with depressed clients. A number of approaches to the treatment of depression have identified specific factors involved in the production and maintenance of depression and have designed specific interventions to target these factors. Cognitive therapy of depression targets depressive cognitions (Beck, Rush, Shaw & Emery, 1979) while Interpersonal therapy targets current interpersonal problems (Klerman, Weissman, Rounsaville & Chevron, 1984). These treatments have been shown to be somewhat effective in treating depression but no treatment has been found to be consistently superior. This has raised the issue of whether general factors such as the alliance (Horvath & Greenberg, 1994), positive expectancies, a helping relationship, and affective arousal (Frank & Frank, 1991) may account for the major treatment effects (Arkowitz, 1994). This view is strengthened by the fact that in the Collaborative study of depression (Elkin, Shea, Imber, Stotsky, Collings and Glass et al., 1989), the less severely depressed patients did relatively well in a placebo plus clinical management condition. In this condition, clients were seen once weekly by a psychiatrist or clinician for 20 minutes. Discussion superficially focussed upon their treatment and symptoms.

Two components of the treatment of depression that have been rarely studied are the effects of an empathic relationship and a focus on emotional processes in depression. Of course, one means of measuring emotional process is by studying the process of EXP throughout therapy. A study investigating cognitive therapy for depression by Castonguay, Goldfried, Wiser, Raue and Hayes (1995) revealed that two factors, the therapeutic alliance and EXP predicted client's improvement. This is the only study that the author knows of that investigates both the alliance, EXP and outcome in therapy for depression. Clearly, these are processes in need of further study. These factors form the core of experiential approaches to psychotherapy (Rogers, 1952; Perls, Hefferline & Goodman, 1951; Greenberg, Rice & Elliot, 1993). The proposed study is designed to explore the specific emotional processes involved in the treatment of depression. By exploring these emotional processes within the context of meaningful thematic client material, the study will further explore how in-therapy experiential processing relates to change in depression. First, a method for extracting meaningful thematic sequences needs to be developed.

Therapy themes: Theory, methodology, and research

In reviewing the psychotherapeutic theme literature, it becomes clear that what is meant by a "theme", and the methods that are used to extract "themes" from therapeutic dialogue, varies depending on different theoretical perspectives, therapeutic modalities, and research objectives.

Psychotherapy researchers have recognized that what has alternately been called

narratives, themes, or schemas characterize an important thread that weaves and is carried forward through the therapeutic process (Schafer, 1980; Spence, 1982; White & Epston, 1990). For example, Polkinghorne (1988) has defined narrative as the thematic story-line which weaves together the many different stories or narratives into a cohesive, coherent whole. Strupp and Binder (1984) suggest that when clients tell stories to their therapists, experiences and actions become sequentially organized into more or less stable patterns of situational feeling, perceiving, wishing, anticipating, construing and acting. White and Epston (1990) see narrative as an overall perspective on one's life in which discrete events are placed in a temporal sequence and are meaningfully organized along a set of intrapersonal and interpersonal themes. According to this author, psychotherapy is an interactive, co-constructive process in which clients and therapists both contribute to the description and elaboration of stories and narratives.

Other researchers have undertaken to develop methods for extracting narrative sequences from personal data or transcripts of psychotherapy. For example, Alexander (1988) has developed a method of analysis that can be used to analyse many forms of personal data including assessment of personality, personality variables, and psychotherapy. It is primarily directed toward extracting recurring dynamic sequences. He describes two major strategies. The first one called "letting the data set reveal itself" involves sifting through the data using a set of rules that are designed to identify salient features in the material. The second strategy involves "asking the data a question," which is answered in terms of the subject's personal view of the world in relation to particular

subjects of interest, such as work, or love. The data are reduced by attending to aspects of the data that are being explored and isolating only the relevant content from its total context.

Angus, Hardtke, & Levitt (1992) have developed a system for measuring different aspects of the narrative process. They argue that three narrative process modes, (descriptions or actual/imagined events, the articulation of subjective experiences and personal feelings, and the reflexive analysis and interpretation of actions and experiences) all contribute to the client's generation of a more coherent, differentiated account of self or macro-narrative. The Narrative Process Coding System (NPCS) allows raters to reliably subdivide transcripts into topic segments according to thematic content shifts and relational focus, and then characterize these segments in terms of one of the three narrative process modes.

In an intensive case analysis of 2 depressed clients (from the data set upon which the current study is based), Hardtke & Angus (1995) explored the use of the relational focus in topic segments as a method of theme identification. One client received Process-experiential and the other received Client-centered treatment. For each client, topic segments from across the entire therapy were categorized as either self-focussed or self-other focussed, and measured on EXP. T-tests revealed no differences between the two clients on both modal and peak EXP when the topic segments were rated as self-focussed. Modal and peak EXP was significantly higher in the Process-experiential case, however, when the topic segments were rated as focussed on the self in relation to the other.

More recently, Korman & Angus (in revision) have developed a method of identifying themes by following the progression of metaphors through the course of psychotherapy cases. All metaphor phrases from across therapy were inductively sorted into categories and then the categories were clustered into themes. Metaphor themes were intensively analyzed to examine whether themes change as therapy progresses. The research suggests that, in two cases of therapy, metaphor themes evolve and change as therapy progresses, and that metaphors reflect a resolution of certain problematic issues toward the end of therapy. Findings also indicate that metaphors follow a nonlinear transformation suggesting that clients have difficulty in concretizing changes in metaphors and/or that change in therapy occurs in a nonsequential manner.

Stiles, Morrison, Haw, Harper, Shapiro, and Firth-Cozens (1991) developed a method for tracing particular client problematic experiences through the course of therapy. Their assimilation model outlines six predictable stages through which the client assimilates a particular problematic or threatening experience into a schema that is developed during the therapist-client interaction. Research has shown that raters can reliably identify the sequence through which a client works through a particular problematic experience throughout the therapeutic interaction.

Horowitz and his colleagues (Horowitz, Marmar, Weiss, DeWitt, & Rosenbaum, 1984; Horowitz, 1993) have developed a method for identifying clients' schemas of self and other as represented by clients working through grief reactions. A "schematic discrepancy model" is formed by converging evidence from three different sources upon a

"schematic discrepancy hypothesis." Evidence is drawn from both quantitative and qualitative sources that include quantitatively obtained measures of self representations based on ratings provided by the subject, transcript excerpts from psychotherapy, and a case formulation based the "configurational analysis method" developed by Horowitz (1987). This method identifies important, idiographic relationship themes. Descriptors describing self and other are compiled from client statements, self-descriptors, and therapist process notes. Through a cluster analysis, schemas are operationally organized into configurations of patient's wishes, fears, and defences. Potentially, changes in schemas could be tracked across therapy.

More recently, Milbrath, Bauknight, Horowitz, Amaro, & Sughara (1995) have developed a method for identifying content and sequences of topics for the purpose of tracking the sequence of changes in the structure of discourse that they see as representative of shifts in mental organization or changes in self-schemas (Horowitz, Cooper, Fridhandler, Perry, Bond, Vaillant, 1992). They specifically developed a procedure for identifying topic units, by first segmenting transcripts into thematic units, and then interpreting their psychological meaning. Descriptive units are then grouped into broader content headings. Headings are then contrasted and reduced to a smaller set of topic content categories by an iteration process of continual comparison and reapplication to the text. Eventually, a set number of topic content categories emerge. Reliability for content categories has been established.

Milbrath et al. (1993) were then interested in tracking changes in the prevalence

of topic content categories as well as changes in the sequence of content categories in a single-case study. They found that changes in the sequence of discourse occurred in a case that involved the resolution of mourning. These changes were seen as representative of changes in mental structure in the sense that habitually organized schemas of mental contents became more flexible, better integrated, and more consistent with the client's overall self-schema.

Richards and Lonborg (1996) have developed a Counseling Topic Classification System (CTSC; Lonborg, Richards, & Owen, 1994; Richards & Lonborg, 1991) for studying the thematic content of psychotherapy sessions. The CTCS provides researchers with a standardized method of classifying the nature of 55 topics and eight emotional dimensions as they occur from moment to moment in therapy. This is a broad-gauged measure that is designed for application in diverse therapeutic orientations. Some topics exist on their own such as "Living conditions" whereas others are divided into sub-categories that make up a broader category. For example, the sub-categories of "parents" and "siblings" fall under the wider category of "Relationships." Reliability of their category system has been established. Research on two cases has indicated that the therapist's theoretical orientation tends to be related to the nature of the topics that become the focus of therapy. They demonstrate that the CTSC can be used to identify important change events in therapy, and as a contextual variable that can enhance the meaningfulness and clinical relevance of research. They relate topic shifts to therapist's level of intention (Hill & O'Grady, 1985) and client experiencing (Klein et al, 1969).

They do not track *change* in experiencing in relation to topic shifts, however.

Researchers have developed complex methods of data analysis that reveal important narrative or schematic threads that run through psychotherapy sessions. Identification of such sequences allows further analysis into the process by which clients come to form perceptions of self and other, differentiate new meaning, gain insight and awareness, and form more coherent, personally meaningful structures. They are designed to carefully isolate content that will reveal particular client processes .ie personality variables, assimilation of problematic experiences, narrative processes, or relationship schemas. Despite the interesting research findings that have been generated from these methods, none of them directly met the needs of the current research. For example, one method described above is designed to reveal the subtle nuances of change processes across therapy through intensive analysis with one or two cases.

What was required for the current study however, was a global method for isolating client themes across many therapies. Furthermore, the more broad-based methods described above appeared to generate strictly content-based categories that are identified a priori and deductively pulled out from the therapeutic dialogue. In this study, the investigator was interested in a method for identifying themes that were co-constructed by client and therapist, and emerged throughout the therapeutic dialogue. The method that was devised was seen as a viable one for isolating emergent meaningful content themes throughout therapy to which changes in EXP could be related.

Theme research supporting reliability of current theme identification method

In the actual development of a method for extracting global themes in the current study, the investigator drew upon two different sources that seem to support its validity. Research by Hatcher, Huebner & Zakin (1988) supports the assumption that in order to be accurate, themes should be ascertained at the end of therapy. They have investigated the notion of a "therapeutic focus". The term is borrowed from Strupp and Binder (1984) and has been defined as "the heuristic guide to inquiry that addresses how the interpersonal story is told." Hatcher et al. (1988) find that different therapists will establish different foci depending on their therapeutic modality. For example, some therapeutic techniques such as those of Malan, and Sifneos require the establishment of a nuclear conflict at the beginning of therapy and stray very little from the initially determined focus. Other therapists advocate a mutual establishment of a focus by the therapist and client. In fact, LaFerriere and Calsyn (1978) have shown that a patient is more motivated and treatment is more successful when goals are mutually established. In general, Hatcher et al. (1988) claim that the longer the therapy progresses, the more likely the focus will undergo revision. In their study, they track the evolution of the therapeutic focus from the initial consultation through to the termination of therapy and find that the therapeutic focus from the presenting complaint is not the same as the consultation focus, nor is it the same as the termination focus (Hatcher et al, 1988). Their findings suggest that the therapeutic themes, or the focus of the therapy, can best be ascertained at the end of therapy.

The approach of establishing themes retrospectively is more compatible with an

experiential approach to therapy, wherein the mutual establishment of the therapeutic focus is formed as the therapy progresses. It is co-constructed by both therapist and client and is continually evolving throughout the therapy. Therefore, in studying either Client-centered or Process-experiential therapy, it would make more sense to establish therapeutic themes that emerged through the progression of therapy.

Howard, Maerlender, Myers, and Curtin (1992) have conducted research that supports the reliable extraction of themes from narrative sequences by either therapists or outside observers. Their study explores the possibility of extracting what they call "life themes" from autobiographies. In their research study, they asked participants to write a detailed story of their life, highlighting significant events and themes. They sought to assess participants', judges and significant other's ability to recognize the subject's life themes on the basis of firsthand knowledge of the person only (significant other), the autobiography only (the judges) or both (the participant). Participants were perfectly able (with 100% accuracy) to discriminate their own life theme from the life themes of other participants. After only reading the autobiography, raters could identify the proper life theme from foil summaries with 95% accuracy.

Thus, research supports the reliability of two aspects of the theme identification method developed in this study. First, researchers have shown that themes can be ascertained after therapy has finished; second, a person's life themes can be reliably identified by either a significant other or an outside observer, lending support to the notion that a therapist can reliably identify the therapeutic themes of his/her client. Thus,

in the current study, the investigators developed a theme identification method whereby therapists were interviewed at the end of therapy and asked to identify the client's major core themes that developed over the course of therapy. Themes were validated by client session reports obtained over the course of therapy. A more detailed description of the method appears in the following chapter. EXP in the last half of therapy was measured in the context of thematic material.

Hypotheses

The study set out to measure the relationship between a) core theme-related depth of experiencing in therapy and treatment outcome and, b) early session depth of experiencing, c) the therapeutic alliance early in therapy and d) treatment outcome, e) change in core theme-related depth of experiencing from beginning to the last half of therapy and treatment outcome, and f) change in core theme-related depth of experiencing, the alliance in the last half of therapy and treatment outcome. Treatment gains were measured by changes on the following measures: reduced symptom distress, measured by the Global Severity Index (GSI) of the Symptom Checklist 90-R (SCL-90-R; Derogatis, 1983); reduced interpersonal distress, measured by the Inventory of Interpersonal Problems (IIP) (Horowitz, Rosenberg, Baer, Ureno, & Villasneno, 1988); reduced depressive symptoms, measured by the Beck Depression Inventory (BDI) (Beck et al., 1961), and increased self-esteem, measured by the Rosenberg Self-Esteem (RSE) (Rosenberg, 1965).

Depth of experiencing was measured by the Experiencing Scale (EXP) (Klein,

Mathieu, Coughlin, & Kiesler, 1969).

The specific hypotheses for the study were that:

1) Theme-related EXP over the last half of therapy will be positively correlated with treatment gains.

2) EXP early in therapy will be predictive of outcome.

3) An increase in core theme-related EXP from early to the last half of therapy will be predictive of treatment improvement as assessed at post-treatment.

4) The alliance early in therapy will be predicitive of outcome

5) Theme-related EXP in the last half of therapy will add significant predictability to treatment gains over and above the therapeutic alliance early in therapy.

6) Theme-related EXP in the last half of therapy will add significant predictability to treatment gains over and above the therapeutic alliance in the last half of therapy.

Method

The goal of this study was to investigate whether depth of experiencing as well as change over treatment in experiencing on core themes is related to therapeutic outcome. The procedure that was used to investigate these questions will be outlined below.

Context for data collection

The data set for this study came from the York University Psychotherapy Depression Project funded by the National Institute of Mental Health. The study ran from 1992 to 1995. The principal research study which served as the foundation for the project involved a comparison of two forms of therapy: Client-centered and Process-Experiential therapy. The procedures and guidelines used to generate the main psychotherapy data base were determined by this outcome study.

Subject recruitment

Participants in the study were recruited from the general public through advertisement on a local radio station, and through posters distributed across York University campus and throughout the community. Advertisement was directed towards individuals who were currently experiencing depression. Participants were self-referred to the programme. Prospective clients were initially screened over the telephone, and then, if deemed suitable, assessed for admission into the study. Individuals who were suicidal, on medication, or had a psychiatric history were excluded from the study. Subjects who were interested in continuing, and met the requirements of the telephone screening, participated in the assessment for admission to the programme. This involved two clinical

diagnostic interviews. In the first interview, a brief history of the individual's problems was obtained, and clients were assessed for the presence of a current major depression. Criteria for continuing included the presence of a current major depression as assessed by the Structured Clinical Interview for DSM-III-R (SCID, Form I)(Spitzer, Williams, & Gibbon, & First, 1989), a score on the SCL 90R Depression Scale above the 30th percentile of the norms for psychiatric patients, and a Beck Depression Inventory score above 16. If clients met these criteria, they were given a second diagnostic interview which included an assessment of DSM-III-R Axis I disorders (SCID, Form I), and DSM-III-R, Axis II personality disorders determined by the SCID, Form II (Spitzer, Williams, & Gibbon, 1987). Clients who did not meet criteria for the study were given referrals to appropriate therapeutic sources or agencies. The specific inclusion and exclusion criteria for the depression project are outlined below.

Inclusion and Exclusion Criteria

Criteria for inclusion into the study was a DSM-III-R classification of a Major Depressive Disorder (MDD), informed consent (see Consent form, Appendix II), and a Global adjustment score (GAS) greater than 50. The average GAS score of all clients who participated in overall study was 61.97 (s.d.= 4.77). Criteria for exclusion included a classification on the SCID of another axis I disorder other than major depressive disorder (besides Generalized Anxiety Disorder which is subsumed by MDD), or an axis II classification of borderline, antisocial or schizoid, or schizotypal disorders. Clients were also excluded if they were assessed as being a high suicidal risk on such standard criteria

as presence of a current plan, past attempts and current lack of support. Clients were also excluded if they were currently in psychotherapy or on medication for depression. Finally, clients who reported having three or more depressive episodes throughout their life were not included. Clients were randomly assigned to either a process-experiential, or a client-centered condition, so that there were 17 in each group. All participants received 15-20 sessions of psychotherapy.

Additional Selection Criteria for this study

In total, 34 clients were included in the final outcome study for the NIMH Depression Project. From that sample, thirty-three cases were selected for this study. One case was dropped because of missing data. In addition, two cases were added that were completed after the data had been collected for the wider depression study. Thus, the current sample is comprised of 35 clients, 18 Process-experiential and 17 Client-centered cases. The average number of sessions within the 35 cases in the sample was 17.74 (s.d.=1.95). Clients consented to audio and videotaping of sessions. For every session, clients were required to complete pre-session and post-session measures.

Client Characteristics

The age range for clients in the sample under study was between 28 and 63, with an average age of 40.74 (s.d). Of the 35 clients in the sample, 10 were male and 25 were female. Client's educational background ranged from a high school diploma to post-graduate and professional degrees. Twenty-two of the clients in the sample were married, 5 were separated or divorced, and 8 were single. All clients in the sample agreed to

participate in the research.

Treatment Method

Clients who partook in the wider Depression project from which the current sample under study was drawn, were assigned to either a Client-Centered or a Process-Experiential treatment condition. These two therapeutic approaches will be briefly described.

Both approaches have their historical roots in the humanistic and experiential approaches. Client-centered therapy was developed primarily by Carl Rogers (Rogers 1961, 1957). Client-centered therapy consists of the provision of the three crucial attitudes (Rogers, 1957) of empathy, congruence, and unconditional positive regard, which are seen as necessary conditions for safe exploration to occur. Within this relational condition, Client-centered response modes are adopted, such as various forms of empathic responses (Rice, 1974; Goldman & Greenberg, 1991; Greenberg et al., 1993). Process-experiential therapy consists of the provision of the same therapeutic attitudes and response modes, with the addition of other experiential therapist response modes and particular therapeutic tasks. Tasks are designed to facilitate the working through of dysfunctional cognitive-affective processing that is seen as inhibiting healthy functioning. I will briefly explicate the philosophical and theoretical underpinnings upon which each of these approaches are based, and then describe their respective therapeutic techniques and interventions.

Theoretical assumptions of both treatment approaches

Central to the approach of all humanistic and experiential techniques, is the belief that the organism possesses an innate emotion based system that provides an adaptive tendency toward growth and mastery. It is this growth tendency that therapy constantly fosters and nurtures. The therapist therefore views clients as experts on their own experience as they have privileged access to their unique experiences. Client processes of discovery and choice are therefore emphasized over the taking of an interpretive or advisory focus (Rice & Greenberg, 1992; May & Yalom, 1989).

Client-centered and Experiential therapists focus strongly on clients' present and ongoing emotional momentary experiencing as it is believed that attention to current needs and goals embedded in emotion leads to more adaptive functioning. Clients are consistently encouraged to identify and symbolize internal experience and bodily felt referents. This emphasis on current experience serves the function of a) teaching clients how to focus on such experience, and b) to trust such experience, as it will ultimately provide the self-knowledge that informs conscious choice and reasoned action.

Both of these approaches advocate an attention to <u>how</u> clients are currently creating emotional meaning. Therapists help clients clarify tacit meanings and carry these forward into new meanings through linguistic symbolization. The manner in which clients create emotional meaning is guided by underlying complex structures referred to as emotion schemes (Greenberg & Safran, 1987; Greenberg et al, 1993). Process-experiential therapy differs from Client-centered therapy in its focus on particular guided

interventions that are undertaken specifically in relation to particular types of emotional processing difficulties.

Emotion schemes

Emotion schemes consist of a complex integration of appraisals, affects, needs, cognitions and action tendencies that have developed from innate tendencies and responses to past experiences. In these past experiences, emotional reactions were encoded internally, both autonomically, in terms of sensori-motor responses such as increased heart rate and a shrinking away in fear; semantically, in terms of such subjective meanings as "the image of my mother turning away from me"; as well as conceptually in terms of such beliefs as "I am worthless." Together, these form an integrated scheme of self-experience in the world, in this instance, an experience of low self-confidence (Greenberg & Safran, 1987).

In early formative years, syntheses of many schemes based on biologically adaptive primary emotions develop and continue to be currently adaptive. Some however, that may have been adaptive in the person's early environment are now currently maladaptive (Greenberg & Safran, 1987; Greenberg & Korman, 1993) and are a source of emotional pain. Maladaptive schemas and the avoidance of pain associated with them is a primary source of dysfunction (Greenberg & Paivio, in press). Because of fears of annihilation in trauma, pain is often avoided, and when certain schemes that contain painful and traumatic memories are activated, the emotional material is often overwhelming and again avoided or the whole experience becomes dissociated. Such

unresolved trauma results in a variety of emotional problems. Thus, much pathology comes from disowned emotional experience.

Core maladaptive emotion schemes are seen as the underlying determinants that produce the dysfunctional bad feelings and meanings that people bring to therapy. Three major classes of determinants of emotional disturbances or barriers to healthy affect regulation have been delineated (Greenberg et al, 1993; Greenberg & Paivio, in press): 1) Difficulties in symbolizing feelings results in confusion, self-alienation or general malaise. 2) The activation of maladaptive affective-cognitive emotion schemes produces bad feelings and dysfunctional meanings such as feeling worthless, hopeless or insecure. These prevent adaptive responding, influencing thought and action in maladaptive ways. 3) The inability to integrate certain emotion schemes results in splits between two opposing aspects of self, for example, wishes and fears, or disowning for example of anger and dissociation from traumatic experience and memory. The overall goals of therapy then, are to go beyond surface bad feelings, to access their determinants and to restructure core maladaptive emotion schemes and/or integrate disowned emotional experience. Client-centered and Process-experiential therapists take somewhat different approaches to working with emotion schemes. The primary difference is that Process-experiential therapists implement specific interventions in relation to particular client markers that are directed towards the working through of various types of emotional processing difficulties (or dysfunctional emotion schemes). The basic techniques and interventions of the two approaches will be described below. Both approaches adopt the

Client-centered relational conditions and therapeutic response modes. Process-experiential therapy also incorporates affective-cognitive tasks.

Client-centered relational conditions

Both approaches adopt the Client-Centered relational attitudes. Rogers (1957, 1959) initially proposed that the relationship was the major change ingredient for successful therapy. He described three crucial therapist attitudes which continue to form the basis of the process-experiential approach. These attitudes are seen as necessary, and sometimes sufficient, although not necessarily most efficient, from the process-experiential perspective (Greenberg, Rice, & Elliott, 1993).

> First, the therapist needs to be empathic, that is, to perceive the internal frame of reference of another with accuracy, and with the emotional components and meanings which pertain thereto, as if one were the other person but without ever losing the `as if' condition (1959, p. 210).

Second, the therapist needs to feel an unconditional positive regard for the client. This means that therapist has no conditions of acceptance, or feelings of "if you were only...." The therapist must "prize" the client. This means that no self-experience can be discriminated as more or less worthy of positive regard than any other. Finally, the therapist needs to be genuine or congruent within the therapist-client relationship. This involves the therapist's commitment to an ongoing accurate symbolization of her/his experience, or "being oneself" as much as possible at any given moment.

These therapeutic attitudes are necessary to secure a stable bond with the client. A secure bond is one of three components of the therapeutic alliance which is seen as key to

successful process-experiential therapy. At all times, the therapist monitors the therapeutic alliance (Bordin, 1994) ensuring the existence of a stable bond, as well as mutually agreed upon goals and perceived relevance of tasks. It may be necessary for the client and therapist to explicitly establish the goals and tasks of therapy at the beginning of therapy, or the process may occur more implicitly. In either case, the therapist is continually aware of the status of the alliance, and will explicitly address it if s/he senses a breakdown. A stable alliance results in increased client participation, awareness, and disclosure. Furthermore, the establishment of problem definitions and continual focus on relevant and thematic issues is tantamount to the agreement on treatment goals in the formation of the initial alliance (Bordin, 1994). The manual for the Client-centered approach fleshes out more the specific application of the Client-centered relational conditions to the treatment of depression.

Therapeutic response modes

Both Client-centered and Process-experiential therapists implement various response modes throughout treatment that are detailed in a manualized format in the book, *Facilitating Emotional Change,* (Greenberg, Rice, & Elliot, 1993). The interested reader is referred to part II. This manual specifies the four major classes of response intentions, all of which are used in Process-Experiential therapy *(Empathic Understanding, Empathic Exploration, Process Directives,* and *Experiential Presence,* as well as three subsidiary classes: *Experiential Teaching, Process Observation* and *Revealing Self*), and two of which are used in Client-centered therapy (*Empathic*

Understanding and *Empathic Exploration).*

Affective-cognitive markers and tasks

Process-experiential therapists implement various affective-cognitive markers and tasks in relation to particular markers of emotional processing difficulties that emerge through the discourse of a given therapy session. They are designed specifically to focus on underlying emotion schemes that are seen as determinant of dysfunction. The steps of each task are detailed in the book, *Facilitating Emotional Change,* part III, (Greenberg et al., 1993). Each of the therapeutic tasks is designed to help resolve a particular type of processing difficulty. Verbal performance markers signify particular types of affective problems that are currently amenable to particular interventions. The therapist therefore notices when a marker emerges and intervenes in a specific manner to facilitate resolution of that type of processing problem. The markers and the affective tasks that have been identified and studied are as follows: 1) problematic reactions, expressed through puzzlement about emotional or behavioral responses to particular situations indicate a readiness to explore by systematic evocative unfolding. 2) conflict splits, in which one aspect of the self is critical or coercive towards another indicate readiness for a two-chair dialogue. 3) self-interruptive splits, in which one part of the self interrupts or constricts emotional experience and expression indicate readiness for a two-chair enactment. 4) an unclear felt sense, in which the person is on the surface of, or feeling confused and unable to get a clear sense of his/her experience indicates a readiness for focusing. 5) unfinished business, involving the statement of a lingering unresolved feeling toward a significant

other indicates an opportunity for empty chair dialogue, and 6) vulnerability, in which the person feels deeply ashamed, or insecure about some aspect of his/her experience, indicates a need for empathic affirmation.

Therapists and Training

Psychotherapists who administered the treatment had trained in both Process-experiential or Client-centered therapy. Specific training in each approach involved two-hour training sessions once per week for a period of one year. Training therapists received both didactic and practical education. Trainees learned the principles and techniques of the approach as well as practiced therapy with each other. Each therapist also practiced with at least one pilot client. Therapy was conducted by 10 therapists who each saw one to three clients in each treatment. Therapists were either doctoral students in clinical psychology or professional psychologists and psychiatrists. Therapist's years of experience ranged from 3-10 with an average of 5 years of experience. Three of the therapists were male and seven were female. All Process-experiential therapy was supervised by Dr. Leslie Greenberg and the Client-centered therapy was supervised by Dr. Shake Toukmanian and Dr. Greenberg.

Therapist adherence to treatment

For both the Client-centered and Process-experiential approach, adherence was checked by means of the Truax Accurate Empathy Scale. Therapists were checked at four random points across each therapy. All therapies were deemed to adhere to Client-centered empathic techniques (average scores above 7 on the Truax scale). For the

Process-experiential approach, adherence measures were found to be reliable (Pearson r, between 2 raters, ranging between .78 and .84).

Measures

Outcome Measures

The battery of outcome measures used to assess change in treatment are described below.

Rosenberg Self-Esteem Scale (RSE)

The RSE (Rosenberg, 1965) is a 10-item self-report inventory of respondents' attitudes about themselves, designed to measure self-esteem. Respondents are asked to rate on a 5 point scale from 0 (never) to 5 (almost always) how frequently certain attitudes about themselves are held to be true (eg. "I feel that I have a number of good qualities.") The scale includes six positively worded items and four negatively worded items. Rosenberg reports a test-retest reliability coefficient of .82.

The Inventory of Interpersonal Problems (IIP)

The IIP (Horowitz et al., 1988) is designed to measure the severity of distress in interpersonal functioning. The IIP is comprised of 127 items describing different interpersonal situations, of which 48 describe "things I do too much" and 78 describe "things I find hard to do." On a 5 point questionnaire, respondents are asked to rate the degree to which each situation is experienced as being problematic. Scores are derived from either an overall level of interpersonal dysfunction, as well as from each of the following six inventory subscales: assertive, sociable, intimate, submissive, responsible,

and controlling. Test-retest reliability of overall interpersonal dysfunction has been reported at .98, while alpha values across subscales are reported to range from .89 to .94 (Horowitz et al, 1988).

In terms of validity, the IIP has been found to be highly sensitive to clinical change and agrees well with other measures of clinical improvement including the SCL-90R (Horowitz et al., 1988). The average self-ratings across inventory items were used in the outcome analyses.

Beck Depression Inventory (BDI)

The BDI (Beck et al, 1961) is a 21-item self-report inventory designed to measure depression. The inventory includes items related to different aspects of depression including affect (i.e., "I am so sad or unhappy that it is very painful"), behaviour (i.e., "I can sleep as well as usual" (reverse-coded)), and attitudes about the self (i.e., "I feel that I have many bad faults.") For each item, respondents are asked to select one of four alternatives that best characterizes them at present. The responses are totalled, with larger scores reflecting greater degrees of depression. Tests of the BDI's internal reliability have yielded estimates ranging from .82 to .93 (Beck et al, 1961; Bosscher, Koning, & Van-Meurs, 1986; Gould, 1982). The BDI has also been shown to possess good construct validity (Beck, Steer, & Garbin, 1988), convergent validity (Gould, 1982), and divergent validity (Beck et al., 1961).

The Symptom Checklist 90-R (SCL-90R)

The Symptom Checklist-90-Revised is a self-report inventory that contains a list

of 90 clinical items to which the respondent is asked to rate, on a scale ranging from 0 (not at all) to 4 (extremely), the degree of symptom distress in the past seven days. The 90 inventory items can be clustered along 9 subscales providing scores to reflect specific areas of symptom distress. Subscale areas include 1) somatization, 2) obsessive-compulsiveness, 3) interpersonal sensitivity, 4) depression, 5) anxiety, 6) hostility, 7) phobic anxiety, 8) paranoid ideation, 9) psychoticism. The scale can also be summarized by three global indices of pathology: 1) Global Severity Index (GSI), 2) Positive Symptom Distress Index, and 3) Positive Symptom Total.

The inventory has strong psychometric properties. High internal consistency between its subscales has been demonstrated ranging from .77 for psychoticism to .90 for depression (n=219) and test-retest reliabilities of between .80 and .90 (n=94, one week delay) on the overall distress index (the GSI score) (Derogatis, 1983). The SCL-90-R has also been shown to have a high degree of convergence with other measures of psychopathology and be sensitive to detecting changes in a range of disorders (Derogatis, 1983). In this study, the only scale used was the GSI, a reflection of one's overall level of symptom distress.

Process Measures

Two process measures were used in this study to examine the relative contribution that depth of experiencing had on changes in outcome variables.

The Experiencing Scale (EXP)

The Experiencing Scale (EXP) is a process measure (Klein et al., 1969) which

evaluates the depth and quality with which client's explore inner referents. It is a 7-point ordinal scale that ranges from 1) where material is impersonal and superficial, to 2) where material is personal but involvement is detached, to 3) where material is narrative and descriptive, through to 4) where clients shift to an internally elaborated focus, 5) where clients self-reflexively pose a problem to the self and elaborate it from an internal perspective to 6) where client's synthesize newly realized feelings and experiences to produce personally meaningful structures and resolve issues, to 7) where there is a constant shifting and exploration of inner referents to lead to insights that produce change. The inter-rater reliability tests performed on the Experiencing Scale have ranged from .76 to .91 (Klein et al., 1969). A study of different segment lengths that were rated on the Experiencing Scale revealed that inter-rater and rate-rerate reliabilities were not affected by segment length (Kiesler, Mathieu, & Klein, 1964), with rate-rerate correlations showing a median value of .80. For a description of how the scale was specifically modified to rate transcripts in which specific Process-experiential interventions were undertaken (two-chair and empty-chair dialogues), please see Appendix I.

The Working Alliance Inventory (WAI)

The Working Alliance Inventory (WAI) (Horvath & Greenberg, 1989; Tracey & Kokotivic, 1989) was administered after each session. The long form of the WAI consists of 36 items is based on Bordin's (1979) tri-partite conceptualization of the client-therapist relationship which is comprised of goals, tasks, and bonds. Twelve items each of the

original inventory tap agreement between therapist and client on goals, the degree of concordance on tasks, and the strength of the bond. The short-form is derived from the long-form of the WAI and consists of 12 items, 4 from each subscale. Both forms were used in this study. In all therapies, the long-form was administered at sessions 4, 8, 12, 16, and 20 (if appropriate). The short form was administered after all other sessions. Alphas of all the scales (based on the long-form) range from .87 to .93 (Horvath & Greenberg, 1989). The reliability estimates of the subscales have demonstrated fairly high alpha coefficients: task subscale ranges from .82 to.88, goal subscale ranges from .82 to .87, and the bond's subscale reliability estimate was .85. Reliability data for the short form has revealed a test-retest index of .83 (Horvath, 1994). For both the short and the long form, the overall average of the three subscales was the score that was used in the analyses for this study.

Procedures

Instrumentation

The treatment outcome measures were administered at pre-therapy, mid-therapy, and post-therapy. Only the pre- and post-therapy assessments are used in this study. This battery of questionnaires took approximately 1.5 hours to complete. Sessional measures were administered to clients before and after each session. They took approximately 5 minutes before the session and 10-15 minutes after the session to complete. The only post-session measure reported in this study was the Working Alliance Inventory.

Theme Identification

The goal of the study was to measure depth of experiencing in relation to material that was thematic, meaningful and important to clients throughout therapy. In other words, themes in this study are issues in therapy that represent problems in clients' lives that continue to resurface, about which they feel unresolved or which cause them to suffer. Subsequently, a method was developed for choosing the most highly thematic sessions. Ultimately, rating segments could be chosen from thematic sessions, rated on depth of experiencing and related to outcome. Thus, a global method of theme identification was developed for this study in the following manner: At the end of treatment, therapists were asked to verbally identify (in an interview) what they saw as the three major themes that had been mutually established, and had evolved throughout the therapy. Therapists were asked to articulate themes in descriptive language that reflected their view of the client's perspective on their core issues. They were not asked to describe underlying motivations or dynamics. When all the themes were culled and collated, the investigator found that a) therapist's descriptions contained at least three individual major themes for each client, and b) the therapist-reported themes tended to overlap and cohere with what clients reported to be the major focus of therapeutic work and/or helpful aspects of their sessions, or, c) an issue that "shifted", according to clients' post-session reports. As a result, client statements from post-session reports were specifically incorporated as theme descriptors if the material helped to linguistically elaborate their themes. In addition, the investigator found that of these three themes all

fell into one of two categories: clients' "view of themselves," or clients' "view of themselves in relation to the other." In addition, at least one theme from each client fell into each category. Themes were subsequently organized into these two categories. Thus, each client had three individual themes which could be classified as intrapersonal or interpersonal. Where possible themes were described in the client's own words (for examples of themes, see Appendix III).

Inter-rater reliability

A procedure was used to check whether the theme-identification procedure was valid. The procedure was designed to check whether the identified themes could be recognized by a rater as being descriptive of the same client. This procedure was performed using six clients from the sample and their corresponding theme sets. For each of the six clients, a rater was given transcripts of three highly "on-theme" sessions, as identified by the theme identification method described above. That is, in each of these sessions, clients were talking about issues that were described by these themes. The rater was also given four sets of themes. One set of themes was the actual themes that had been designated for that client, while the other three sets were foil themes. The foil set of themes were randomly chosen from amongst the entire pool of theme sets for the sample, and matched the "actual" theme sets on gender. The rater was asked to identify which of the four sets of themes described the three "on-theme" sessions. A rater was be able to distinguish the correct themes from the foil themes with 100% accuracy. This is significant even with a small N of 6.

Theme-related session identification

Once themes had been identified for each client, a procedure was developed for choosing the three most theme-related sessions from the last half of therapy. For each client, a rater was asked to carefully read the client's theme sets and then listen to the second half of the therapy, excluding the final wrap-up session. In order to obtain a range of sessions, raters were asked to identify the most theme-related session from within each third of the last half of therapy. Each third consisted of 2-4 session blocks.

To obtain these three sessions, raters engaged in a two-step rating procedure. The raters first judged the degree to which each session in the last half of therapy was "on-theme". They then determined which session from each of the 2-4 session blocks was most "on-theme." Raters were given a set of instructions that explained how to complete this procedure (see instructions, Appendix II). The steps of the procedure will be described below.

As raters listened to a session, they were asked to record when a client began to talk "on theme" and then when the client stopped talking "on theme" or moved to a different theme. Thus, for each session, raters identified a series of segments that were either "on-theme" or "off-theme." Raters recorded the time length of each "on" or "off" theme segment. Thus, for each session, the rater recorded how many minutes were "on-theme" and the length of each segment. For each "on-theme" segment, a subsequent judgment was made about the "centrality" of the theme for the client. "Centrality" referred to the rater's judgment of how important, meaningful or pivotal the particular

issue seemed for the client as the client talked about it. Ratings were made on a 5-point scale ranging from "very little" to "extremely" of the degree to which the rater thought the particular theme segment was "central" for the client.

After listening to a full session, raters were asked to provide a global rating of the degree to which it was "on-theme". The criteria for this judgment was a) the amount of minutes that clients were "on-theme", and b) the centrality of the material. The degree of theme centrality was to be considered three times as important as the number of minutes the client spent talking "on-theme." Thus, a segment of 4 minutes in length that received a 4 and 5 on degree of centrality was as "on-theme" as a 12-minute segment that was rated as "on-theme" but only received a rating of 1. Raters were asked to then add up the minutes spent "on-theme" (weighting "centrality" 3 times as heavily) and assign a rating between 1 and 5 of how "on-theme" they judged the session to be. This procedure was repeated for each session.

Based on each session's global on-theme rating, the rater was to make a decision about which session of the 2-4 session block was the most "on-theme." This is how one session was chosen from each of the 3 session blocks over the last half of therapy (for a full set of instructions, see Appendix II). In total, three sessions were chosen from each therapy.

Inter-rater reliability

To check this procedure for choosing theme-related sessions, six cases were given to a second rater. The rater rated sessions from the last half of each of the cases. Using the

same "instructions for theme-identification"(Appendix II), the rater was asked to identify which session from within 2-4 session blocks, were most theme-related. The chosen sessions were compared with those chosen by the actual theme session raters. The percentage agreement was 75%.

Sampling Procedure

Early Session Segments

Twenty minutes from the middle portion of the second session for each therapist-client dyad was extracted for the purpose of measuring client depth of experiencing at the beginning of therapy. The rationale employed for extracting random segments from the second session was that, at this point, core themes would not have been established. This was confirmed by the consistent observation that it was difficult to identify theme-related material in this session. Each 20-minute segment was broken into five 4-minute segments. These five segments were randomized for rating. For the purposes of contextual rating, each segment was accompanied by a two-minute segment preceding the four minutes of material.

Late Session Segments

To obtain the most "theme-related" 20 minutes from the three chosen "on-theme" sessions, an independent rater examined the segment ratings of the three theme-related sessions selected for each client. Thus, the second rater went through the theme-related session ratings, choosing portions of dialogue that a) had been assigned the highest degree of centrality in theme-related material and b) were multiples of four minutes in length

(.ie, 4, 8, 12, 16 or 20). The rater thereby accumulated twenty minutes of theme-related material that could be broken down into five four-minute segments. To complete this procedure, the rater was instructed to choose portions of dialogue that were both a minimum of and multiples of four minutes and had received "degree of centrality" ratings above 4 and 5. If this procedure did not yield a consecutive series of segment lengths of four minutes that added up to a total of twenty minutes at a high degree of centrality, raters were then instructed to choose other portions of dialogue that were rated as "on-theme" but given a rating of a lower degree of centrality, (provided they were a minimum of four minutes in length). This is how the rater accumulated 20 minutes, or 5, 4-minute theme-related segments of theme-related material per session. If a selected session did not contain 20 minutes of theme-related material, (at any level of centrality), other portions of non-theme related material were extracted and included in the 20 minutes of material. Again these portions were required to be a minimum of four minutes and/or multiples of four minutes. The accumulated twenty minutes from each session, was then divided into five, four-minute segment units for rating. Again, two preceding minutes of transcript were added to the beginning of each rating unit to enable contextual ratings. This was repeated for each of the selected three sessions. Thus, in total three twenty-minute segments were chosen from across the last half of therapy.

Reliability for theme segment sampling procedure

To check the procedure for locating the 20-minute theme related segments within the chosen late sessions, two raters used the immediately above mentioned theme-session

identification procedure to identify the most theme-related twenty minutes from the last half of one-third of all the therapies studied in this data set. The proportion of minutes on which the two raters agreed was then calculated. The percentage agreement was 78.1%.

Rating Procedure

All four-minute segments from early and late sessions were randomly mixed and rated on the Experiencing Scale (EXP). For each segment, raters assigned a modal and peak experiencing rating; a modal rating described the overall, most frequent or average level of experiencing attained at any point. Two independent, clinically-trained graduate students performed the ratings from transcripts. Each rater completed two-thirds of the rating, and overlapped on one-third (230/ 690) of the ratings to obtain reliability estimates.

Results

Themes

Themes were collected and validated using the theme identification method. Once thematic segments had been identified, EXP was rated in relation to them. Figure 1 displays a summary list of the most frequently occurring intrapersonal and interpersonal themes of the clients in the data set. For a full list of themes, see Appendix III.
of experiencing in the segment, and a peak rating described the highest momentary level

Analyses

Outcome Variables: Change Scores

To examine the relationship between depth of experiencing and change in therapy outcome, it was necessary to compute change scores for outcome variables.

The issue of how to measure change in both psychology and psychotherapy research has been a subject of much debate (Burr & Nesselroade, 1980; Cronbach & Furby, 1970). An obvious measure of change is the raw difference score. However, many statisticians and methodologists have pointed out possible errors in the use of change scores as a measure of treatment outcome (Burr & Nesselroade, 1990; Cohen & Cohen, 1983; Cronbach & Furby, 1970). According to Burr & Nesselroade (1990) the most commonly identified problem with difference scores relates to their unreliability. In addition, scores measured at Time 2 reflect a regression toward the mean, or in other words, the common trend for all extreme scores. This becomes more problematic when clients score extremely low or extremely high. On average, low scores increase and high

scores decrease. Hence, the difference between Time 1 and Time 2 scores is not merely a reflection of the contribution of treatment effects.

An alternative to raw gain scores is the residualized gain score (Linn, 1981). This statistic has gathered support in psychotherapy research as it is believed to offer a more accurate and statistically sound method of taking into account the problem of regression toward the mean. This method accounts for change between Time 1 and Time 2 by adjusting for the initial score. Residualized gain scores are computed by regressing initial scores onto final status ratings and then using standardized residuals as a measure of change.

In this study, change was thus assessed by computing residualized gain scores. Residualized scores were computed on the BDI, the SCL-90R, the IIP, and the RSE to assess change between pre- and post-treatment.

Process Variables

Two types of process variables were used in the analysis: depth of experiencing (EXP) and working alliance inventory (WAI). Experiencing variables were computed for both early and late sessions. To compute the experiencing for the second session, both modal and peak ratings from all 4-minute units were averaged across each twenty-minute segment. To compute the experiencing levels for late sessions, both modal and peak experiencing for all 4-minute segments were averaged across the 3 segments within each sampled session. Then, an average was calculated for modal and peak ratings across the twenty-minute segments taken from the three sessions. In addition, the frequency of both

modal and peak ratings at 4 and 6 and above on EXP was averaged across the late sessions. Two WAI scores were computed for analysis: a) the long form of the WAI after session 4, and b) an average of post-session WAI scores across all sessions from the last half of therapy.

Relating Process Variables to Outcome Variables

Exploratory Correlational Analyses

Correlational analyses were first conducted to assess the nature and strength of the relationship between EXP and the alliance and residualized change scores on four outcome measures: the BDI, the SCL-90R, the IIP and the RSE. Pearson r correlations were computed to examine the following relationships: a) Pre-treatment scores on all 4 change measures and early EXP, b) alliance scores at both the fourth session and averaged across the last half of therapy, and early and late EXP and c) residualized change scores on all four outcome measures with the following variables: average early session modal and peak EXP scores, session 4 Working Alliance Inventory scores, average late modal and peak EXP, average frequency of late modal and peak EXP scores at 4 and above, average frequency of late modal and peak EXP scores at 6 and above, average alliance scores in the last half of therapy sessions and residual change scores.

Hierarchical Regression Analyses

The investigator was interested in understanding the relationship between EXP scores, alliance scores and change in outcome variables. Different statistical analyses were examined in order to ascertain which would most accurately portray the relationship

between independent and dependent variables. While structural equation modelling and path analysis (Klem, 1995) were statistical procedures seen as potentially illustrating the relationships between the variables under study, the sample size of 35 subjects would not provide the statistical power necessary to yield findings representative of the data. Hierarchical regression analyses were then performed to evaluate the proportion of the variance in each of the outcome variables (BDI, RSE, IIP, and SCL-90R) that could be accounted for by the different process variables (EXP and WAI). Hypotheses investigated were a) does late session EXP account for a significant proportion of the outcome variance (as indicated by residual gain scores) when early session EXP is taken into account? b) Given that research has indicated that the alliance early in therapy is predictive of outcome, does the session 4 alliance account for a significant proportion of the outcome variance over and above that predicted by early session EXP? c) does later session EXP make a significant contribution to the outcome variance when the early alliance and early EXP has been taken into account? and d) given that the overall alliance has been shown to account for a significant proportion of the variance, does EXP in the last half of therapy account for a significant proportion of the variance once the alliance has been taken into account? Separate regression analyses were completed for both modal and peak EXP variables.

Independent Variables

Independent variables included all process variables including average early session EXP, average late session EXP, the alliance score after session 4, and the average

alliance score across all sessions from the last half of therapy.

Dependent Variables

In aid of reducing the number of analyses, the BDI and the SCL-90R were combined. The correlation between these two measures (Pearson r= .78) was deemed to be sufficiently high to suggest they were measuring a similar factor. In addition, they are both measures of symptom change. The other two dependent variables were the RSE and the IIP variables and they were analysed independently.

EXP inter-rater reliability

Both experiencing raters had a minimum of two years of clinical training. Both had completed the standard training for the Experiencing Scale, which requires approximately 40 hours of training. Raters completed the equivalent of 90 segments ranging averaging 7 minutes each in training. Raters also received additional training on how to apply the Experiencing Scale to the affective-cognitive tasks undertaken in Process-experiential therapy (see modification of Experiencing scale, Appendix IX). Raters trained on non-study transcripts until adequate reliability was attained (ICC on modal ratings =.69 and peak ratings =.7). The Experiencing Scale was applied to the data set with good reliabilities. Raters independently coded transcripts. The agreement between the two judges was examined by using the intraclass correlation coefficient (ICC) on both modal and peak ratings. Results revealed acceptable levels with ICC =.78 on modal ratings and ICC= .75 on peak ratings, based on 235 4-minute segments per rater from 47 sessions.

Table 1

Means and standard deviations of all process and outcome variables

Variable	N	Mean (and standard deviation)
Independent variables		
Early average modal Exp	35	2.75(.57)
Early average peak Exp	35	3.47(.46)
Late average modal Exp	35	3.43(.55)
Late average peak Exp	35	4.13(.59)
Session 4 alliance	35	4.93(1.02)
Late session alliance	35	5.56(.94)
Dependent variables		
BDI difference score	35	-14.8(8.01)
SCL-90 (GSI mean) difference score	35	-.84(.44)
RSE difference score	34	6.55(4.34)
IIP (mean) difference score	34	-.67(.37)

Findings

Table 1 lists the means and standard deviations for all process and outcome variables studied, including all EXP and alliance variables. Means of difference scores on all outcome variables are displayed in order to indicate the direction of change.

Correlational Analyses

Tests of Abnormality

Before the analyses began, tests were conducted to check the normalcy of all process and outcome variables. The Shapiro-Wilks test was used to establish that all variables were normally distributed.

Relating EXP, the Alliance, and Outcome Variables

Correlational analyses were performed to explore relationships between EXP, the alliance, and all outcome variables. First, correlations between raw pre-treatment scores on all outcome measures and session 2 modal and peak EXP were performed. Table 2 shows the results of these analyses. The correlation between the IIP pre-treatment mean score and the session 2 modal experiencing was significant ($r=.34$, $p \leq .05$), while no other correlations between early session modal and peak EXP and pre-treatment scores were significant. EXP at the beginning of therapy therefore was not significantly correlated with depressive symptoms, or self-esteem, but was somewhat associated with the severity of interpersonal problems. Further correlational analyses were undertaken to understand the relationship between EXP and the IIP (see Additional Analyses). In general, findings suggest that the degree of clients' symptomatology was unrelated to initial capacity for

Table 2

Pearson r correlations between pre-treatment scores and early session modal and peak EXP

	BDI	SCL-90-R	RSE	IIP
Session 2				
Exp (Modes)	.05 (N=35)	.10 (N=35)	-.17 (N=34)	.34* (N=34)
Exp (Peaks)	.01 (N=35)	.02 (N=35)	-.25 (N=34)	.26 (N=34)

Note: *p<.05. BDI =Beck Depression Inventory; IIP= Inventory of Interpersonal Problems; SCL-90-R=Symptom Checklist 90-R; RSE= Rosenberg Self-esteem; EXP=Experiencing Scores.

Table 3

Pearson r correlations between early session average modal and peak EXP and outcome indices

	BDI	SCL-90-R	RSE	IIP
Session 2				
Exp (Modes)	-.21 (N=35)	-.17 (N=35)	.08 (N=34)	-.05 (N=34)
Exp(Peaks)	-.33* (N=35)	-.32 (N=35)	.16 (N=34)	-.15 (N=34)

Note: *p≤ .05. Outcome is represented by residual gain scores. BDI =Beck Depression Inventory; IIP= Inventory of Interpersonal Problems; SCL-90-R=Symptom Checklist 90-R; RSE= Rosenberg Self-esteem; EXP=Experiencing Scores.

EXP. In other words, EXP was not a function of one's level of depression.

Table 3 shows exploratory correlational analyses, looking at the relationship between session 2 modal and peak EXP and residual gain outcome scores. The correlation between early peak EXP and the BDI residual gain score was significant ($r = -.33$, $p < .05$), and the correlation between early peak EXP and the residual gain on the SCL-90-R was fairly high, although not significant ($r = -.32$, $p < .063$). Correlations were not significant between early EXP and other outcome indices. Early session EXP was not associated with changes in interpersonal functioning, or an increase in self-esteem, but was somewhat associated with the reduction in depressive symptoms at the end of therapy.

Table 4 shows the the results of analyses examining the relationship between early EXP (session 2) and late EXP (in the last half of therapy). Average modal and peak EXP variables both early and late in therapy are displayed along with analyses exploring the relationship between them. T-tests between early and late modal EXP and early and late peak EXP yielded statistically significant differences. In addition, correlational analyses revealed that, for both modal and peak EXP, there is a positive and statistically significant relationship between early and late EXP. In particular modal EXP shows a correlation of .47, while peak EXP shows a correlation of .41. These findings do suggest that while there is clearly a relationship between early and late experiencing, it is not a trait variable that remains constant over time. Clients whose EXP is high in the beginning do not necessarily remain high and vice versa. Together, both Table 3 and 4 reveal that clients'

Table 4

Pearson r correlations between average early and late session modal and peak EXP

Early Exp	Mode	Peak
Late Exp		
Mode	.469** (p=.004)	.468** (p=.005)
Peak	.404* (p=.016)	.407* (p=.015)

Note: *p≤ .05;**p < .01; EXP=Experiencing; N=35.

EXP early in therapy is a prognostic indicator for late EXP and to a lesser degree, for positive outcome at the end of treatment. While early EXP is indicative of later EXP and outcome, EXP is clearly influenced by what occurs throughout therapy.

Average EXP and outcome

The next correlational analysis was performed to explore the relationship between depth of experiencing in the last half of therapy and treatment gains. A series of correlations were performed between EXP and residual gain scores on outcome indices.

Table 5 shows the results of correlational analyses in which average modal and peak EXP in the last half of therapy is correlated with outcome. Both modal and peak EXP correlated significantly with change on three of the outcome measures: the BDI, the SCL-90R and the RSE. While results reveal modest correlations between average EXP and interpersonal problems, the effect of EXP was not significant. Clearly, average EXP scores in the last half of therapy was associated with the reduction of both global and depressive symptoms, and an increase in self-esteem, and only modestly associated with changes in interpersonal relatedness.

Frequency of high-level EXP and outcome

Table 6 shows the results of analyses in which EXP ratings at both 4 and 6 and above were correlated with outcome. The frequency of modal and peak EXP at 4 and above correlated significantly with the BDI and the SCL-90R and were modestly associated, although not significantly, with the RSE and the IIP. Thus, the frequency with which clients moved inside to explore and elaborate internal referents was associated with

Table 5

Pearson r correlations between late session average modal and peak EXP and outcome indices

	BDI	SCL-90-R	RSE	IIP
Late Exp				
Modes	-.40* (N=35)	-.44** (N=35)	.43** (N=34)	-.20 (N=32)
Peaks	-.50** (N=35)	-.54*** (N=35)	.49** (N=34)	-.28 (N=34)

Note:*p≤.05. **p≤.01.***p ≤.001. Outcome is represented by residualized gain scores. BDI =Beck Depression Inventory; IIP= Inventory of Interpersonal Problems; SCL-90-R=Symptom Checklist 90-R; RSE= Rosenberg Self-esteem; EXP=Experiencing Scores.

Table 6

Pearson r correlations between late session frequency of high-level modal and peak EXP and outcome indices

	BDI	SCL-90-R	RSE	IIP
Exp				
Frequency of Modal Scores ≥ 4	-.38* (N=35)	-.47** (N=35)	.27 (N=34)	- .20 (N=34)
Frequency of Peak Scores ≥ 4	-.35* (N=35)	-.38* (N=35)	.33 (N=34)	-.28 (N=34)
Frequency of Mode Scores ≥ 6	-.37* (N=35)	-.41* (N=35)	.52** (N=34)	-.01 (N=34)
Frequency of Peak Scores ≥ 6	-.46* (N=35)	-.61** (N=35)	.57** (N=34)	-.36* (N=34)

Note: * $p < .05$, ** $p \leq .01$. Outcome is represented by residualized gain scores. BDI =Beck Depression Inventory; IIP= Inventory of Interpersonal Problems; SCL-90-R=Symptom Checklist 90-R; RSE= Rosenberg Self-esteem; EXP=Experiencing Scores.

the reduction of global and depressive symptoms. The frequency with which clients reached a modal level of 6 and above was significantly associated with the BDI, the SCL-90R, and the RSE. The frequency with which clients reached a peak of 6 and above was significantly associated with all outcome indices. Thus, the frequency with which clients synthesized newly realized feelings to form a new view of self, was associated with changes in global and depressive symptoms, and increases in self-esteem. If clients attained this, even briefly, it was associated with all dimensions of change measured in this study, including a reduction in interpersonal distress.

EXP and the WAI

Table 7 shows the results of correlational analysis looking at the relationships between both modal and peak EXP and the alliance early as well as in the last half of therapy. Results suggest that EXP and the alliance are related, but two separate constructs in the beginning of therapy. The alliance early in therapy is predictive of peak EXP later in therapy. In the second half of therapy, there is a significant positive relationship between EXP and the alliance. Results are suggesting that the alliance and EXP are initially two separate processes in therapy. However, the establishment of a strong initial alliance may relate to deeper (peak EXP) later in therapy. In the second half of therapy, the alliance and depth EXP do affect one another, however from this analysis one cannot determine the direction of the causality.

In summary, correlational analyses suggest the following: there is very little relationship between pre-treatment variables and early EXP, with the exception of a

Table 7

Pearson r correlations between both early modal and peak EXP and the alliance both early and late in therapy

EXP	Early modal	Early Peak	Late Modal	Late Peak
WAI				
Early	.21 (N=35)	.15 (N=35)	.28 (N=35)	.43** (N=35)
Late	.27 (N=35)	.09 (N=35)	.36** (N=34)	.45** (N=34)

Note: *p≤ .05;**p < .01; EXP=Experiencing; WAI=Working Alliance Inventory

modest correlation between modal EXP and the IIP, suggesting that EXP early in therapy is not a function of initial levels of pathology. EXP early in therapy modestly predicts EXP in the last half of therapy and marginally predicts EXP at the end of treatment, suggesting that early EXP is somewhat predictive of later EXP and outcome; however, what occurs over the course of therapy definitely influences EXP. Clearly, however, there is a strong relationship between EXP in the last half of therapy (both average and frequency of high EXP) and treatment gains. In particular, the frequency of EXP at 6 and above predicts treatment gains. Finally, early in therapy the alliance and EXP are independent processes. However, the strength of the alliance early in therapy does predict EXP in the last half of therapy. Over the course of therapy, the relationship between the alliance and EXP is strengthened.

Hierarchical regression analyses

Correlational analyses satisfied the assumption of linearity between process and outcomevariables that was necessary to conduct the regression analyses. Outcome factors used in the regression analyses consisted of a) the SCL-90R/BDI, a composite of scores on the BDI and the SCL- 90R, b) the RSE, and c) the IIP. Initial tests showed that the linear regression model provided the "best fit" between the process and outcome variables.

The first regression model tested whether residual change in modal EXP from the beginning to late in therapy was predictive of outcome. Table 8 presents the summary statistics of an analysis in which the first independent variable entered into the equation

Table 8

Hierarchical regression analyses of modal experiencing factors on outcome indices

Criterion &Variable	Total R^2	R^2 Change	F Change	Dfs	Beta
SCL-90R/BDI					
Early Exp	.04	.04	1.47	1,33	-.21
Late Exp	.20	.15	6.15*	2,32	-.46
RSE					
Early Exp	.007	.007	.23	1,32	.08
Late Exp	.20	.193	7.49**	2,31	.50
IIP					
Early Exp	.002	.002	.10	1,32	-.05
Late Exp	.04	.04	1.24	2,31	-.22

Note: * p≤.05.p≤.01. Outcome is represented by residualized gain scores. BDI =Beck Depression Inventory; IIP= Inventory of Interpersonal Problems; SCL-90-R=Symptom Checklist 90-R; RSE= Rosenberg Self-esteem; EXP=Experiencing Scores.**

was average modal EXP in the second session; the second independent variable entered into the equation was average modal EXP in the last half of therapy. Analyses indicate that the addition of the late EXP factor makes a significant independent incremental contribution to change on the SCL- 90R/BDI factor ($p \leq .05$). Specifically, late EXP accounts for an additional 15% of variance of change on this factor. The addition of late EXP also makes a significant independent incremental contribution to change on the RSE ($p \leq .01$). Specifically, the addition of late EXP accounts for 19.3% of the variance of change on the RSE factor. Neither early nor late EXP variables account for a significant proportion of the variance of change on the IIP.

The significant R_2 change that is contributed by the addition of late modal EXP into the regression equations can also be interpreted as a predictor of changes in the outcome variables. For both of the analyses that correlate EXP with residual changes on the BDI/SCL factor, and the RSE, EXP adds a significant *positive* contribution to the variance of change (as indicated by both the positive R and the beta weights); thus, the addition of the late EXP variable can be interpreted as a residual change score. The addition of late EXP can be conceptualized as a significant increase in EXP over and above early EXP that is significantly contributing to the variance of change in both measures of depressive symptomatology and increases in self-esteem. Thus, change in modal depth of experiencing between early and late in therapy contributes to changes in depressive symptoms and increases in self-esteem.

Table 9 presents the summary statistics for the hierarchical regression analyses of

Table 9

Hierarchical regression analyses of peak experiencing factors on outcome indices

Criterion &Variable	Total R^2	R^2 Change	F Change	Dfs	Beta
SCL-90R/BDI					
Early Exp	.12	.12	4.47*	1,33	-.35
Late Exp	.33	.21	9.75**	2,32	-.50
RSE					
Early Exp	.02	.02	.79	1,32	.16
Late Exp	.25	.23	9.10**	2,31	.51
IIP					
Early Exp	.02	.02	.72	1,32	-.15
Late Exp	.08	.04	1.94	2,31	-.26

Note: * $p \leq .05$. $p \leq .01$. Outcome is represented by residualized gain scores. BDI =Beck Depression Inventory; IIP= Inventory of Interpersonal Problems; SCL-90-R=Symptom Checklist 90-R; RSE= Rosenberg Self-esteem; EXP=Experiencing Scores.**

peak EXP. In these analyses, early peak EXP is the first variable and late peak EXP is the second independent variable regressed onto outcome factors. Analyses indicate that early peak EXP makes a significant contribution to change on the SCL/BDI factor ($p \leq .05$). The addition of the late peak EXP factor, however, makes a significant independent incremental contribution ($p \leq .01$). Specifically, late EXP accounts for an additional 21% of variance. Early session peak EXP, on the other hand, does not make a significant independent contribution to change on the RSE but the addition of late EXP accounts for 23% of the variance, a significant incremental contribution ($p \leq .005$). Neither early nor late EXP variables significantly account for the variance of change on the IIP.

Again, the significant R_2 change that is contributed by the addition of late peak EXP into the regression equations can also be interpreted as a predictor of change in the respective outcome variables. In both the analyses in which peak EXP is correlated with residual change on the BDI/SCL factor, and the RSE, the addition of peak EXP adds a positive contribution to the variance of change (as indicated by both the positive R and the beta weights); thus, the addition of the late EXP variable can be seen as a residual change score. The addition of late EXP can be interpreted as an increase in EXP over and above early EXP that is significantly contributing the variance of change in both measures of depressive symptomatology and increases in self-esteem. Thus, change in modal and peak depth of experiencing between early and late in therapy contributes to changes in depressive symptoms and increases in self-esteem, but not in interpersonal problems. It is important to note that given the smaller, and non-significant correlations between changes

in EXP level and changes on the IIP, hierarachical regression analyses were conducted that correlated changes in EXP with changes on each of the six IIP subscales. However, none of these correlations were significant.

Further hierarchical regression analyses were conducted to test whether a) the alliance early in therapy predicts outcome over and above early EXP and b) EXP later in therapy significantly predicts treatment gains after both early alliance and early EXP have been taken into account. In analyses with both modal and peak EXP variables, the alliance at session 4 was the first independent variable entered into the equation; early session EXP is the second variable and later session EXP was the final variable entered into the equation.

Table 10 presents a summary of results. The alliance at session 4 was found to make a significant contribution to change on the SCL-90R/BDI correlate ($p \leq .005$). Session 4 alliance accounted for 22% of the variance. The addition of early modal EXP did not make a significant incremental contribution to the variance of change over and above the early alliance, but the addition of the late modal EXP factor did make a significant incremental contribution ($p \leq .05$) once these two factors were accounted for. This variable accounted for an additional 10% of the variance of change on the SCL-90R-R/BDI outcome factor.

Session 4 alliance did not contribute significantly to change on the RSE, accounting for only 4% of the variance. Early modal EXP did not add a significant contribution. The addition of late modal EXP once these two factors are accounted for,

Table 10

Hierarchical regression analyses predicting changes on outcome factors from alliance and modal experiencing variables

Criterion &Variable	Total R^2	R^2 Change	F Change	Dfs	Beta
BDI/SCL90R					
Alliance4	.22	.22	9.18***	1,33	-.47
Early Exp	.23	.01	.53	2,32	-.16
Late Exp	.33	.10	4.41*	3,31	-.36
RSE					
Alliance4	.04	.04	1.29	1,32	.19
Early Exp	.04	.01	.08	2,31	.19
Late Exp	.20	.17	6.36*	3,30	.47
IIP					
Alliance4	.03	.03	1.08	1,32	-.18
Early Exp	.03	.00	.02	2,31	-.02
Late Exp	.06	.03	.83	3,30	-.19

Note: * $p \leq .05$.* $p \leq .001$. Outcome is represented by residualized gain scores. BDI =Beck Depression Inventory; IIP= Inventory of Interpersonal Problems; SCL-90-R=Symptom Checklist 90-R; RSE= Rosenberg Self-esteem; EXP=Experiencing Scores.**

however, made a significant incremental contribution ($p \leq .01$), accounting for an additional 17% of the variance of change on this factor. None of the independent variables contributed significantly to changes in interpersonal problems.

Thus, late modal experiencing predicted a reduction in depressive symptoms, and an increase in self-esteem above and beyond the alliance measured at session 4.Both the alliance variable and the addition of late modal EXP can be interpreted as significant predictors of change on the SCL/BDI factor. Also, as in the previous analyses, the addition of late modal EXP to the regression equations, once the alliance and early modal EXP has been accounted for can be seen as residualized change score. This suggests that when the alliance is taken into account, an increase in EXP significantly predicts change on both the SCL/BDI factor and the RSE. An increase in EXP from early to late in therapy is predicting a reduction in depressive symptomatology and increases in self-esteem, over and above the alliance early in therapy.

Table 11 presents a summary of results exploring the contribution of peak EXP variables, and the alliance to outcome variables. The alliance at session 4 was found to make a significant contribution to change on the SCL-90R/BDI correlate ($p \leq .001$). Session 4 alliance accounted for 22% of the variance. The addition of early peak EXP did not make a significant incremental contribution to the variance of change over and above the early alliance, but the addition of the late modal EXP factor did make a significant incremental contribution ($p \leq .05$) once these two factors were accounted for. This variable accounted for an additional 10% of the variance of change on the

Table 11

Hierarchical regression analyses predicting changes on outcome factors from alliance and peak experiencing variables

Criterion &Variable	Total R^2	R^2 Change	F Change	Dfs	Beta
BDI/SCL90R					
Alliance4	.22	.22	9.18***	1,33	-.47
Early Exp	.29	.07	3.49	2,32	-.28
Late Exp	.39	.10	4.87*	3,31	-.37
RSE					
Alliance4	.04	.04	1.29	1,32	.20
Early Exp	.05	.02	.53	2,31	.13
Late Exp	.21	.16	7.60**	3,30	.52
IIP					
Alliance4	.03	.03	1.08	1,32	-.18
Early Exp	.05	.02	.49	2,31	-.12
Late Exp	.08	.04	1.20	3,30	-.23

Note

* p≤.05.**p≤ .01.***p≤.001. BDI =Beck Depression Inventory; IIP= Inventory of Interpersonal Problems . Outcome is represented by residualized gain scores; SCL-90-R=Symptom Checklist 90-R; RSE= Rosenberg Self-esteem; EXP=Experiencing Scores.

SCL-90R-R/BDI outcome factor.

Session 4 alliance did not contribute significantly to change on the RSE, accounting for only 4% of the variance. Early peak EXP did not add a significant contribution. The addition of late peak EXP once these two factors are accounted for, however, made a significant incremental contribution ($p \leq .01$), accounting for an additional 16% of the variance of change on this factor. Thus, an increase in late peak experiencing predicted a reduction in depressive symptoms and an increase in self-esteem above and beyond the alliance measured at session 4. None of the independent variables contributed significantly to changes in interpersonal problems.

Summarizing, it appears that even when the alliance early in therapy is taken into account, change in modal and peak EXP from beginning to late in therapy is still predictive of a reduction in depressive symptoms and an increase in self-esteem.

To test whether EXP late in therapy accounted for changes in therapy in addition to that accounted for by the alliance over the last half of therapy, hierarchical regression analyses were completed. Table 12 presents the summary of results when the average alliance score from the last half of therapy was entered first and late modal EXP was entered second and regressed onto outcome factors. The alliance contributes significantly to the variance (23%, $p \leq .05$) and in addition, late EXP makes a significant incremental contribution ($p \leq .05$) to changes on the SCL- 90R/BDI factor. The addition of late EXP contributed an additional 9% of the variance. The alliance in the last half of therapy does not contribute significantly to changes on the RSE, but the addition of late modal EXP

Table 12

Hierarchical regression analyses of late alliance and late modal experiencing factors on outcome indices

Criterion &Variable	Total R^2	R^2 Change	F Change	Dfs	Beta
SCL-90R/BDI					
Late WAI	.23	.23	9.89*	1,31	-.48
Late Exp	.32	.09	3.98*	2,32	-.31
RSE					
Late WAI	.06	.06	1.99	1,32	.24
Late Exp	.19	.13	5.14*	2,31	.39
IIP					
Late WAI	.001	.001	.06	1,32	-.04
Late Exp	04	.04	1.23	2,31	-.21

Note: * p≤.05.p≤.01. Outcome scores are residualized. Residual gain means corrected for initial level.**

contributes significantly ($p \leq .05$), accounting for an additional 13% of the variance of change. Again, the independent variables failed to produce significant change in interpersonal problems.Overall, late modal EXP was found to contribute significantly to outcome (depression and self-esteem) over and above the alliance measured in the second half of therapy.

Table 13 presents a summary of results in which hierarchical regression analyses were conducted with the alliance later in therapy and late peak EXP as predictors of outcome. The addition of peak EXP made a significant incremental contribution to the variance of change ($p \leq .01$) on the SCL-90R/BDI factor. It accounted for an additional 14% of the variance. Late peak EXP also made significant incremental contribution to the RSE factor ($p \leq .01$), accounting for an additional 19% of the variance of change. It appears that EXP in the last half of therapy in relation to core themes contributes to changes in depressive symptomatology and increases in self-esteem over and above the alliance in the last half of therapy. Overall, late peak EXP was found to contribute significantly to outcome (depression and self-esteem) over and above the alliance measured in the second half of therapy.

In summary, hierarchical regression analyses suggest that an increase in EXP from early to late in therapy predicts a decrease in depressive symptoms and an increase in self-esteem, even when the alliance early in therapy is taken into account. In addition, late EXP significantly predicted change on depressive symptomatology and self-esteem measures over and above the alliance in the second half of therapy.

Table 13

Hierarchical regression analyses of late alliance and late peak experiencing factors on outcome indices

Criterion &Variable	Total R^2	R^2 Change	F Change	Dfs	Beta
SCL-90R/BDI					
Late WAI	.23	.23	9.89*	1,31	-.48
Late Exp	.37	.14	7.37**	2,32	-.42
RSE					
Late WAI	.06	.06	1.99	1,32	.24
Late Exp	.24	.19	7.59**	2,31	.48
IIP					
Late WAI	.001	.001	.06	1,32	-.04
Late Exp	.09	.08	2.85	2,31	-.32

Note: * $p \leq .05$. $p \leq .01$. Outcome scores are residualized. Residual gain means corrected for initial level.**

Additional Analyses

Given the finding that early EXP correlated significantly with the IIP, but not other outcome measures, further analyses were conducted to see which of the six subscales of the IIP correlated with EXP. Table 14 shows the results of analyses in which average modal and peak EXP was correlated with the six subscales. These results indicate that the two subscales of the IIP that are initially associated with capacity for experiencing are the sociality and intimacy problems scales of the measure.

Differences Between Groups on EXP

Given that the sample used in this study consisted of two groups each of whom received different forms of Experiential therapy (Client-centered and Process-experiential), it was important to explore differences in EXP level that existed between the two groups. While this question did not address any of the major hypotheses of this particular study, any differences that may have resulted from treatment approach was of interest. A t-test did not reveal any significant differences in modal or peak ratings between the Process-experiential and Client-centered group in the second session (Modal Exp: t=-26, p= .80; Peak Exp: t=.06, p=.96). A comparison between the two groups on mean modal EXP in the last half of therapy also did not reveal significant differences (t=1.73, p=.092). A comparison of means did reveal a significant difference in peak EXP between therapy groups in the second half of therapy (t=2.30, p=.028). It appears that average peak EXP in the Process-experiential group (M=4.13) was significantly higher than the Client-centered group (M=3.71). Note that the N of the two groups was relatively

Table 14

Pearson r correlations between early session average modal and peak EXP and IIP subscales

	Ass	Soc	Sub	Int	Res	Con
ses2m	-.01	.40*	.25	.39*	.06	.25
ses2p	-.15	.43*	.28	.50**	.06	.18

Note: *p<.05. **p<.01. Ass=assertive; Soc=sociable; Sub=submissive; Int=intimacy; Res=responsible; Con=controlling; ses2m=session 2 modal EXP; ses2p=session 2 peak EXP.

small (P/E: N= 18, C/C: N=17) suggesting the possibility of a Type II error. Differences that may exist may not be reflected in the results, given the reduced power of the t-test. One must be circumspect in drawing any conclusions from these findings.

Discussion

Study Summary

This study explored the relationship between in-therapy client processes and change over two types of Experiential therapy with a depressed population. Change over the course of therapy was inferred by change on four outcome measures: reduced symptom distress, measured by the Global Severity Index (GSI) of the Symptom Checklist 90-R (SCL-90-R; Derogatis, 1983); reduced interpersonal distress, measured by the Inventory of Interpersonal Problems (IIP) (Horowitz, Rosenberg, Baer, Ureno, & Villasneno, 1988), mean score; reduced depressive symptoms, measured by the Beck Depression Inventory (BDI) (Beck et al., 1961), and increased self-esteem, measured by the Rosenberg Self-Esteem (RSE) (Rosenberg, 1965). The study sample consisted of 35 clients, 18 who participated in Process-Experiential therapy and 17 who participated in Client-Centered therapy. All clients participated in 16-20 week sessions of psychotherapy. Depth of experiencing was measured by the Experiencing Scale (EXP) (Klein et al., 1969). All rated segments received both a modal and peak rating on the scale. Investigators were interested in whether overall theme-related EXP as well as change in theme-related EXP over the course of therapy was related to positive outcome. A method was developed for isolating core therapeutic themes. EXP was sampled early in therapy and in three highly theme-related sessions from across the last half of therapy. In order to investigate whether or not EXP was a stronger predictor than the alliance, the alliance was measured early as well as late in therapy.

The following predictions were proposed regarding the relationship between theme-related EXP and outcome: a) overall, theme-related EXP in the last half of therapy would predict positive outcome, b) theme-related EXP later in therapy would predict positive outcome over and above early EXP c) both early EXP and the early session alliance would predict positive outcome, d) EXP in the last half of therapy would predict outcome over and above either early session alliance and early session EXP and e) late session EXP would predict outcome over and above late session alliance.

Initially, correlational analyses were performed to study the relationships between EXP and the alliance both early and late in therapy, and the pre- and post-therapy outcome measures. Correlations with pre-treatment scores on the four change measures were not significant, with the exception of the correlation between modal EXP and the IIP. These findings suggested that degree of depressive symptomatology does not affect one's capacity for EXP. EXP was not a function of depression in this sample.

EXP early in therapy showed a small but significant correlation with a change in depressive symptoms at post-treatment, but did not correlate with other measures of change (an increase in self-esteem and a change in interpersonal problems). Early EXP and EXP in the last half of therapy were significantly correlated; correlations hovered around .45. These analyses suggest that EXP early in therapy may be a prognostic indicator for later EXP. They also suggest that the therapeutic interaction that occurs between these points determines whether high EXP will in fact occur. In other words, EXP is not simply an individual trait that remains constant over therapy ultimately

determining whether change occurs. Clients may have a propensity toward high or low depth of EXP, but therapeutic interventions affect whether or not higher depth of EXP occurs later in therapy.

Further correlational analyses did reveal a strong relationship between both theme-related average modal and peak EXP as well as frequency of EXP at both 4 and 6 and above in the last half of therapy, and change in symptom reduction (as measured by the BDI, and the SCL-90R), as well as increases in self-esteem (as measured by the RSE). These analyses suggest that EXP in the last half of therapy is strongly associated with positive change in therapy.

In summary, correlational analyses relating EXP early in therapy to EXP in the last half of therapy, and post-treatment outcome, reveal that early level of EXP is somewhat indicative of depth of EXP in the second half of therapy, and marginally indicative of a reduction in symptoms at the end of treatment; the strongest relationship exists, however, between theme-related EXP in the last half of therapy and post-treatment outcome. Average theme-related EXP and particularly frequency of EXP at 6 and above in the second half of therapy is the strongest predictor for a reduction in depressive symptoms, and an increase in self-esteem. Thus, while early EXP is a prognostic indicator for high EXP later in therapy, high EXP later in therapy is a stronger indicator for success at the end of therapy.

Correlational analyses between the alliance and EXP scores early in therapy showed non-significant correlations suggesting that initially, they are two separate

therapeutic processes. The alliance early in therapy did correlate significantly with peak EXP later in therapy, suggesting that the alliance early in therapy is predictive of EXP later in therapy. Finally, correlational analyses showed a positive significant relationship between the alliance and EXP later in therapy. Thus, over the course of therapy, the alliance and depth of EXP do become inter-related, although results have not determined the direction of the causality.

Hierarchical regression analyses were employed to study the relative strengths of both EXP and the alliance at different points across therapy in predicting outcome. Overall, late session theme-related EXP predicted positive outcome over and above early EXP, early session alliance, the combination of these two factors, and late session alliance. Hierarchical regression analyses showed that both average modal and peak EXP in the last half of therapy was a significantly stronger predictor of changes in symptom distress (as measured by a composition of scores on the BDI and SCL-90R) and increases in self-esteem than early EXP. These analyses suggested that an increase in EXP over the course of therapy predicted changes in symptom distress and increases in self-esteem. These changes in EXP were not associated with changes in interpersonal distress (as measured by the IIP).

The alliance at session 4 was predictive of a reduction in symptom distress, but was not significantly associated with increases in self-esteem or a reduction in interpersonal distress. Nevertheless, late session theme-related modal and peak EXP was a significant predictor of changes in symptom distress and increases in self-esteem, over

and above the alliance at session 4, as well as the combination of the early alliance and early session EXP. These changes in EXP from early to late sessions were not associated with changes in interpersonal distress. Finally, the alliance in the last half of therapy was significantly associated with a reduction in symptom distress, however, late session theme-related modal and peak EXP were significant predictors of these treatment gains even when controlling for late alliance. The alliance in the second half of therapy was not significantly correlated with increases in self-esteem; however, late theme-related modal and peak EXP was a significantly stronger predictor of increases in self-esteem. Again, neither the alliance in the second half of therapy nor late modal and peak EXP were significant predictors of a reduction in interpersonal distress.

In summary, analyses suggested that an increase in theme-related EXP over the course of therapy predicts a reduction in depressive symptoms and an increase in self-esteem. While the alliance early in therapy does predict a reduction in depressive symptoms (although not an increase in self-esteem), the increase in EXP over therapy predicted changes in both depressive symptoms and self-esteem, over and above the early alliance, early EXP or the two combined. Analyses also suggest that the alliance and EXP are separate factors early in therapy. Over the course of therapy, however, they do become inter-related. EXP, however, predicts changes in depressive symptoms and increases in self-esteem over and above the alliance in the last half of therapy. While EXP at the end of therapy was marginally related to changes in interpersonal problems, none of the other variables measured were significantly predictive of changes in interpersonal problems.

Conclusions and General Discussion

A number of the important hypotheses were confirmed in this study. As in earlier studies (Rogers et al., 1967; Kiesler, 1971), EXP was strongly correlated with changes in outcome. Thus, empirical support for Rogers' (1958; 1959; Rogers & Dymond, 1954; Walker et al., 1960) and Gendlin's (1962; 1964; 1967; 1969; 1974) early articulation of and subsequent measurement of the experiencing process as an important process of change in therapy has once again been established.

This study differs from previous studies reporting associations between EXP and outcome in a few fundamental respects. It specifically establishes that change in theme-related depth of experiencing predicts outcome in the Experiential psychotherapeutic treatment of depression. It is important to emphasize that this does not establish that positive findings were obtained *because* EXP was measured in the context of thematic material. It is possible that if EXP was measured in relation to random segments of therapeutic dialogue, such a study would have yielded positive results. In order to claim the superiority of the sampling technique used in this study, a comparative study using the same data set would need to show that EXP in randomly sampled segments does not positively correlate with outcome, nor does a change in EXP in relation to randomly sampled segments predict positive outcome.

Research studies investigating the experiencing process in relation to change in psychotherapy have commonly utilized personality change measures as opposed to psychotherapy outcome measures (Kiesler, 1971; Klein et al., 1986). The current study

specifically employed outcome measures that have been established as reliable measures of change in depressive symptomatology (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961; Beck, 1972). In addition, previous studies have investigated EXP selected from sessions in a random manner, while the current study explores EXP in the context of important thematic client material. Besides recent studies looking at the micro-processes of change in relation to EXP (Hardtke & Angus, 1995; Warwar & Greenberg, 1995), the relationship between in-therapy EXP and outcome has been little studied with depressed clients. What these findings suggest about the relationship between EXP and outcome is that in Experiential therapy with depressed clients, when themes are a focus of therapy and clients are able to move through a sequence of increasing depth of experiencing in relation to them, their depressive symptoms tend to decrease and their self-esteem tends to increase.

This study also addressed the question of whether EXP is a trait variable that remains constant throughout therapy, or in fact changes depending on what transpires during the therapeutic process. Findings suggest that initial EXP is unrelated to initial levels of pathology. Thus, EXP is not influenced by depression or self-esteem. Some clients do appear to enter therapy with a propensity toward EXP. This is shown by the finding that early EXP modestly predicts EXP later in therapy and marginally predicts outcome at the end of therapy. Early EXP level, however, by no means *determines* later levels of EXP. Furthermore, an increase in EXP from early to late in therapy, over and above the alliance is the strongest predictor of changes at the end of therapy. Thus,

findings refute the claim that EXP is a trait variable that remains constant over therapy. EXP is clearly affected by what occurs over the course of therapy.

In addition to the overall relationship between EXP and outcome, investigators were interested in the pattern of EXP across therapy and its relationship with treatment outcome. Early research of this question suggested a positive correlation between EXP measured at various points across therapy (early, middle, and late) (Custers, 1973; Fishman, 1971; Brodley, 1988), but did not establish a pattern of a positive linear increase in EXP across therapy that was associated with positive outcome (Kiesler, 1971). The current study approached this question somewhat differently; by looking at theme-related EXP early and late in therapy, an increase in EXP from the beginning to the last half of therapy was shown to be associated with outcome.

Previous studies that explored the pattern of EXP over the course of therapy adopted the working hypothesis that was generated by Rogers' early conceptualization of the fully functioning person. Rogers believed that therapy was a process of moving from fixed to open, or rigid to fluid functioning. The end goal of therapy was optimal personality change towards a fully-functioning person. If therapy was a process of moving from fixed to open functioning, than this would be reflected through continual upward movement through the stages of the Experiencing Scale. The "fully functioning person" then was one who was open to ever-changing experience and constantly at level 7 experiencing. It thus followed that dipping in randomly through a series of therapy sessions (in a successful treatment) would reveal a picture of linearly increasing EXP.

This study worked with a different assumption about how clients move through the stages of the EXP scale. It looks at the pattern of EXP in relation to thematic material. An assumption of Experiential therapy is that clients bring problems into therapy that are causing them to suffer, and making their lives painful or difficult. The task of therapy is to identify and explore the underlying dysfunctional emotion schemes that are seen as the source of their difficulties (Greenberg et al., 1993; Goldman & Greenberg, 1996; 1997). The working through of underlying emotion schemes is the medium through which change in therapy occurs. Various tasks are proposed to aid in working through dysfunctional emotion schemes for the purpose of creating and adopting more "functional" emotion schemes. Thus, the therapeutic change process is viewed as a series of affective-cognitive problem resolution tasks.

It stands to reason, however, that clients will not, at every moment focus on underlying dysfunctional emotion schemes or be engaged in affective-cognitive problem resolution tasks. Thus, a certain portion of therapy sessions will be consumed by other important, albeit less profound, aspects of the therapeutic process such as building a relationship, negotiating the tasks and goals of therapy, reprocessing events that transpired earlier in therapy, and just generally "searching around" for meaningful material. The experienced clinician can attest that therapy is not a continuous ongoing process of working through deep emotional material.

The method developed for isolating thematic material, then, was seen as a means to identify those portions of therapeutic dialogue that did center upon affective-cognitive

problem solving work, and to measure the pattern of client EXP in relation to it. This methodological approach to investigating theme-related EXP revealed an interesting "pattern" of EXP across therapy. Evidence suggests that while modal EXP in an early session of therapy (2) does not predict changes in depressive symptoms, peak EXP does. However, when early session modal and peak EXP is taken into account, an increase in the last half of therapy in theme-related depth of experiencing does predict treatment gain. In other words, an increase in depth of experiencing from the beginning to the last half of therapy, when clients are working through thematic affective-cognitive processing problems, did significantly predict a reduction of depressive symptoms and increases in self-esteem. What is most important and most predictive of change in therapy is an increase in depth of experiencing from early to late in relation to thematic material. Specifically, experiencing must deepen over the course of therapy in relation to affective-cognitive processing of important material. Furthermore, findings suggest that the resolution of affective-cognitive troubles, indicated by attainment of level 6 EXP at some point in the second half of therapy is most predictive of change.

Themes, Depressive Subtypes, and Emotional Schematic Change

The major finding that change in EXP in relation to depressive themes that were either intra and interpersonal in nature was strongly associated with change over the course of therapy lends support for two important theories regarding change in psychotherapy with depressed clients. First, evidence supports Blatt's hypothesis that depressive schemas tend to be either intra- or interpersonally based (Blatt, et al., 1976;

1982); second, evidence confirms that emotional schematic change in relation to such themes is an important dimension of overall change in psychotherapy (Greenberg & Safran, 1986; 1987; Greenberg et al., 1993; Korman & Greenberg, 1995). The following sections will further explicate how these theories were supported in the current data.

Themes and Depressive Subtypes

It was interesting to the investigator that once themes had been identified for each client, it became clear that the major concern that lay behind all of the themes were either interpersonal or intrapersonal in nature. This very much cohered with Blatt's (Blatt, D'Affiliti, & Quinlan,1976; Blatt, 1982) theory that depression is related to either inter or intra-personal problems.

Blatt, an object relations theorist posits two different types of depression, both seen as responses to trauma occurring at different developmental stages. According to his theory, different types of conflict exist in adult life *depending* on when in the child's life the major trauma occurred and was subsequently internalized. These two types of conflict are seen as major sources of depression and are conceptualized as either anaclitic or introjective. Anaclitic depression is related to fears of loss of love and abandonment arising from early disruptions in the child's basic relationship with the primary object. It is associated with the improper development of ego functioning and excessive dependency. By contrast, introjective depression is related to a harsh, punitive, critical superego that creates feelings of inferiority, worthlessness and guilt. Need gratification is seen as less important than approval and acceptance. As such it is related to

developmental problems associated with superego functioning. In this type of depression, an assumption is made that basic ego functioning is intact and that problems arose later in the child's development when feelings about self-worth and self-strivings were being formed. It is associated with the internalization of a harsh, critical parent. While Blatt states that these two types of conflicts may overlap in the same person, depression is usually associated with one type of conflict.

Anaclitic depression usually represents itself in problematic interpersonal conflict. The person is usually has intense needs to be cared for and soothed. As such, the person is extremely vulnerable to rejection and abandonment. Often s/he will have difficulty expressing rage for fear of destroying the object, the person's source of satisfaction. Introjective depression usually represents itself in problematic intrapersonal relations revolving around self-esteem and self-definition. This person is extremely vulnerable to failure. In reaction to lack of recognition, this person can become intensely harsh and self-critical (Blatt, et al., 1976; 1982). In the following section, I will interpret how emotion schemes might be either interpersonally or intrapersonally-based, and how change in these schemes might occur over therapy. Theorizing will be illustrated with two case examples drawn from the current data set.

Depressive Themes, Emotion Schemes, and Change in Experiencing

An explication of current emotion theory (Fridja, 1986; Leventhal, 1984; Greenberg & Safran, 1987; Korman & Greenberg, 1997) can be invoked to explain how change in theme-related experiencing occurred. It is the fundamental belief of

Experiential theorists that change in therapy occurs through a emotional schematic change. Emotion schemes consist of a complex integration of appraisals, affects, needs, cognitions, and action tendencies that have developed from innate tendencies and responses to past experiences. In early formative years, syntheses of many schemes based on biologically adaptive primary emotions develop and continue to be currently adaptive. Some however, that may have been adaptive in the person's early environment are now currently maladaptive (Greenberg & Safran, 1987; Greenberg & Korman, 1993) and are a source of emotional pain. Maladaptive schemes and the avoidance of pain associated with them is a primary source of dysfunction (Greenberg & Paivio, in press; Goldman & Greenberg, 1996). A closer observation of the data revealed that core emotion schemes were associated with the various inter- and intrapersonal themes that were identified for each client. Thus, a focus on themes signaled that particular sets of maladaptive schemes were being evoked that either centered around intra or interpersonal conflicts.

In light of this observation, it is interesting to explore in depth the correlations between the frequency of various stages of EXP and treatment gains. Modal and peak scores at stage 4 and above were associated with a reduction in depressive symptoms; stage 6 and above was also associated with change in depressive symptoms and increases in self-esteem, and changes in interpersonal problems. This suggests that client processing at the different stages of the Experiencing scale are associated with different aspects of change in clients' emotional schematic processing. In the following section, theme-related client experiencing examples will be used to illustrate the different aspects

of emotional schematic exploration that are associated with stages 4, 5, and 6 of the EXP scale. Examples of both "interpersonal" and "intrapersonal" theme-related EXP in two therapy cases drawn from the current data set will be used.

The two cases will exemplify how EXP change is conceptualized in emotion scheme terms within the context of the thematic problems that these two clients worked through across the sessions. Within these two cases, in addition to thematic material from segments rated for this study, segments were extracted from intervening sessions in aid of illustrating the narrative picture of how thematic problems emerged, changed and were resolved over the course of therapy.

EXP on Intrapersonal Themes

Jill (103): Intrapersonal Theme

The first example is drawn from a Process-Experiential therapy with a 44-year old woman, Jill, who reported that her second and current marriage was "on the rocks." In her first marriage she had been emotionally and physically abused. After six years she had left the marriage, leaving behind her two sons. At the time, she feared that taking them would put all of them into danger. She carried a great deal of grief over her decision to leave her sons with their father, in spite of presently being on good terms with them. One of Jill's themes that fell into the *intra*personal category is:

> **A need to be perfect.** Jill felt that she had to be perfect in every respect in order to be lovable. Being perfect meant being independent and strong in her capacity as daughter, wife, sister and friend. She felt bad about herself if she did not live up to these standards.

The following excerpt from session 01 illustrates the client's representation of this theme in the dialogue. An Experiencing scale rating will follow each client talk-turn:

C: Well, part of me wants to ignore it all and pretend it is not happening, you see, I've always been the strong one you know who's in control of everything and I don't like these feelings (EXP level: 4)

T: So it kind of feels like you shouldn't be like this (Exploratory reflection)

...later in the session....

T: ---sounds like there's a lot of feelings in there, why don't we explore some of that cause I understand that there's a part of you that wants to curl up and kind of ignore it, but uh, since you are here I imagine there's a part of you that doesn't, that's aware that you're hurting and you need to talk.

C: I guess over the years, I have this image of myself as superwoman, to be able to do everything, hold down a full time job, do the cleaning, cook gourmet meals, do all the housework, drive my family around, be there for them when they need me, and do a lot of volunteer work in our church at the same time so (EXP level: 4)

T: so you feel you should be able to do all that and do it well

C: Well, I've been doing this and lately I've been cutting back on some of it and I feel guilty (EXP level: 4)

T: So it's been kind of tough to be perfect lately and its been a struggle and you feel guilty

C: yeah I do

T: you feel like you should be, doing more and getting everything done the way you have been

C: Well, I realize that what I was doing was just not humanly possible because I was pushing myself and I never allowed myself any free time, and its more natural and healthy, but then I ask myself why do I feel guilty about it? (EXP level: 5)

The above excerpt, contains dialogue at stage 4 and 5 EXP. According to Klein et al (1986), stage 4 EXP means that the client's attention has shifted to the "subjective flow of experience as referent, rather than to events or abstractions. The content is a clear presentation of the speaker's feelings, giving a personal, internal perspective or account of feeling about the self"(p.23). In emotion theory terms, stage 4 EXP usually means that an emotion scheme has been evoked an is being currently explored. Schemes consist of appraisals, needs, affects, cognitions and action tendencies. This particular emotion scheme contains such cognitions as "I have to be super competent" which, for this client, is associated with being available to meet others' needs when necessary, and fulfilling all her duties with ease. It also consists of both an appraisal of herself as in control, and likely a fear of losing control. Underlying this may be a need for love and recognition, as this is how she has learned to feel valued.

Stage 5 on the EXP scale indicates that the client content is "a purposeful elaboration or exploration of the speaker's feelings and experiencing. There are two necessary components: First, the speaker most pose or define a problem, proposition or question about the self...second, the speaker must explore or work with the problem in a

personal way. The exploration must ...have the potential to expand the speaker's awareness of experiencing" (Klein et al., 1986, p.23). In emotion theory terms, stage 5 EXP indicates that a client is experiencing and exploring the current emotion schema while stepping outside of it and evaluating emotional experiencing. There is some recognition that the current manner of processing is not functional or satisfying and may be causing the client to suffer. There is implicit intentionality to expand, change or alter one's current mode of emotional processing in relation to the current problem as there is a recognition that current modes are not working. This must emerge from within current emotional processing (stage 4); the emotion scheme must be "up and running" or in current awareness. From within an affectively-laden environment, the client is reflexively questioning the emotion scheme. This might mean an exploration of cognitions, perceptions, needs and associated action tendencies.

In the above example, the client expresses a desire to relax, take care of herself, and meet her own needs. She interrupts this desire, however, with a self-injunction that prohibits her from "taking it easy." This is likely represented (although it is not explicitly stated) by the part of her that says she has to be "superwoman" and be "in control." In the above excerpt she is beginning to question why she makes herself feel guilty, and how she stops herself from taking care of herself, implying a desire to change her current ways. When she begins to question her current emotion scheme, ratings start to jump to a 5 on the EXP scale.

This theme surfaces again in session 10 at which time the client has more of an

opportunity to explore it. Jill reports a current conflict with her husband in which she feels afraid to reveal her fears and wishes in relation to their financial situation. She does not want to confront him because she is afraid she will lose emotional control, break down and cry. She feels that she should be strong and independent, and resolve the problem within herself. The therapist recognizes this as a marker for a two-chair dialogue (Greenberg et al, 1993) and suggests putting the different aspects of herself into two separate chairs. During the dialogue, two aspects of herself emerge: a "strong" part feels the other part is weak for needing people and another more essential part of herself that is not often represented in the client. This is the part that feels needy, vulnerable and sometimes weak.

T: Tell her what you feel towards her

C: You should be less needy, you are weak (EXP level: 3).

The other part of herself feels afraid, and does not want to hurt her husband. She feels she needs his approval. A shift in the dialogue occurs after the client expresses sadness about how alone she feels in the marriage and when the therapist encourages the client to express her needs:

T: What do you want from her (therapist is referring to critic)?

C: I want to be more like her, to feel more confident (EXP level: 4)

T: What are you feeling like?

C: I feel that the two sides have suddenly merged, it is as if the stronger person came over here and sat with me and said you're ok (beginning of EXP level: 6)

Later in the session she says to her critic in the other chair:

C: I'm not so scared anymore to confront the issues, I feel stronger and like you are going to protect me (EXP level: 6).

Later in the session, when she talks about crying and being weak, she says:

C:....I guess I feel secure....and that it's ok, you know to cry and ah that's part of the process I have to go through to deal with some of the problems...and I don't think I want to lose that part of me that feels sad...I don't want to become somebody who's hard and callous..

In the above excerpt, the client begins to hit level 6 EXP. A more elaborate explication of how level 6 is conceptualized in emotion scheme terms will follow in later case examples. First, intrapersonal themes in the case of "Lisa" will be illustrated.

Lisa (306): Intrapersonal Theme

Further illustration of the relationship between themes, EXP, and emotional schematic clients can be seen in the case of Lisa. This client was a 29-year old woman. She received 16 weeks of Process-experiential therapy. She had been married for 6 years, and had two children. Her husband was a compulsive gambler. Her father was also a gambler, and her mother had endured this over the years. If Lisa complained or expressed unhappiness to her family over her husband's gambling, she received the message that she should also put up with it (like her mother had). One of Lisa's themes that fell into the *intra*personal category was:

Lack of self-worth. She felt unheard, diminished and invalidated. She felt to blame for husband's gambling. She felt that if she asserted feelings and needs, she would be betraying her husband, and consequently, was not being a "good wife."

Even though this theme was often manifested in conflict with her husband, it was seen as intrapersonal as the conflict was ultimately between different aspects of herself. In the following excerpts from session 1, the client is discussing her inability to stand up to her husband for fear of losing him.

C: Exactly, because of- whether it's giving up on him, or just let it be, I can't change him, what's the point, but then inside it-it still hurts me um, which doesn't make sense (EXP level: 4)

...later in the session....

C: No, that's what I fear, once the voice gets raised (referring to husband), I kind of simmer down and just take it, I won't go and say to myself oh I'm not going to put up with this (EXP level: 4)

T: It's what you think you should say, but it's not what you feel

C: Yeah but that's not what I feel or do (EXP level: 4)

T: Mm hm, because you do feel like, what's that feeling that you feel in that situation? Like oh no I better not push him, or..

C: Yeah, because he he'll come out with `oh then I'm going to go out, I'm just going to go' (gamble) (EXP level: 4)

T: So you don't want him to leave

C: I guess not, (surprised and puzzled voice) yeah, that's why I stop yeah...(voice trails

off)(EXP level: 4)

T: Are you puzzled about that, like why don't I want him to leave?

C: That's what I say to myself, why don't I stand up for myself--again, he's controlling me, I want to but I don't (beginning of EXP level: 5)

T: Kind of asking yourself, why don't I stand up for myself

C: Yeah, it stops there, I guess I haven't gone that step yet (beginning to be EXP level 5 although not fully elaborated)

In the fourth session, Lisa expresses anger at her husband for abandoning her and her children when he goes out and gambles. She feels rejected and hopeless. She blames herself for his gambling, and relates this back to her experience with her father:

C: I can't really tell him what I really feel or that he's let me down and that I don't like to say these things cause I think oh I'm gonna hurt him, and it's going to get worse (EXP level: 4).

T: There are all these ways in which you stop yourself

C: I fear him, I look at him as my father and I have fear (EXP level: 4)

The therapist makes a process diagnosis that an unfinished business dialogue with her husband in the empty chair would enable her to express feelings towards him. She expresses resentment and hurt towards him for leaving her with the burden of the family. What quickly emerges is a feeling of being trapped and an inability to fully express her feelings. The therapist, observing that she is having difficulty expressing feelings, suggests a self-interruptive dialogue (Greenberg et al, 1993) to help her become aware of

how she holds back anger:

C: I feel like there's these iron bars or something; even though my heart tells me that I should get out and, and do what I feel is right, when he's in front of me I feel I cannot go anywhere (EXP level: 5).

T: That's what you say to yourself, `stop don't go anywhere'?

C: yeah, because he's going to get angry or make me change my mind, like my mind goes the opposite way (EXP level: 5);

T: Come over here [Initiates self-interruptive dialogue] you're telling me; let's take a look; switch this around a bit; be Lisa, and stop her from getting angry at Jerome (husband), somehow or other you are saying you go to get angry and then somehow -something happens- you get scared; How do you scare her? Can you do that now?

Note that this portion is rated as stage 5 EXP because the client is reporting an awareness of an emotional state while acknowledging that it is problematic in nature. When she begins to feel angry, she stops herself. Presumably there is an aspect of her experience that she is not consciously processing in this moment. In the above example, she is implicitly expressing a desire to understand how she stops herself from expressing feelings.

In this segment of session 5, the therapist encourages Lisa to express feelings and needs, and stand up to her self-critic that is finding its expression through the image of her husband in the other chair:

C: (to self-critic in other chair) No, I'm an adult and I want to be treated like one...

T: What do you feel when you say that?

C: I feel strong when I say that and I - I believe that (EXP level: 4)

T: feels good to be heard...what do you feel towards him now?

C: I feel bigger and taller -- like I can stand up for myself (EXP level: 6).

In the following sessions, Lisa begins to distance herself from her husband's gambling problem. By session 8, she asserts herself in relation to her husband and lets go of the blame and responsibility for her husband's problem. She sees it as a pattern learned from her mother that she no longer wants to perpetuate:

C: Yeah, I'm tired of feeling trapped and isolated and believing that this is the way marriage is, but no! This is not the way and I don't want it, I'm tired of it, I'm tired of being phony...that makes me angry now when I try to pretend that it's okay when it's not, I can't stand it anymore. (EXP level : 6) I guess that's what the pain is (crying) and why have I allowed it (now moved to EXP level: 5)

T: Asking why did I allow him to hurt me [empathic understanding]

C: I know it's probably a pattern coming from my mother because she allowed it, and I believed that was the only way but I decided that I don't want to put this into my children either, making them believe...no, it's harmful (EXP level: 5)

According to Klein et al (1986), at stage 6 EXP, the client "senses the inner referent is different....the felt sense is more than recognizable feelings such as anger, joy, fear, sadness...If familiar or known feelings are present, there is also a sense of "more" that comes along with the identified feelings"(p.23). In emotion theory terms, the client

has now become aware of previously unidentified, disowned, or unacknowledged aspects of experience and incorporates them into the current emotion scheme. It may be that in early experiences, the person learned to ignore or not to symbolize these feelings. This would have been functional when the schemes were originally being formed. It is no longer functional to ignore such feelings; it is in fact, dysfunctional. She discovers that believing that denying the importance of those needs is a pattern of behavior she has learned from her mother. She watched her mother put aside her own needs in relation to Lisa's father. This came to form part of Lisa's scheme of what a "good wife" does. In therapy though, she realizes that she no longer has to follow this script. She no longer sees her needs as selfish. She learns how to be kind towards herself and comes to feel that her needs for care and concern are indeed legitimate. She comes to feel that she deserves more respect. Lisa also realizes that she no longer wants to pretend (to either herself or others) that it is okay when her husband gambles, and generally neglects her and the family. This allows her to see that things can be different and that she no longer has to "play along." She is able to then incorporate this into her current scheme, which gives her firmer ground on which to stand up to her husband.

When clients are in the middle of a task, they will often come to a new realization, such as Lisa did, and quickly integrate this into a new view of self. From this new perspective, they will start to form new self-related propositions. This describes how a client might attain stage 6 EXP and then quickly move to stage 5 EXP. In a sense, this self-questioning can only occur once the new view of self is formed. Thus, in this case,

once Lisa realizes that she does not have to put up with things as they are, she begins to question how she has "put up with it" until now.

In Session 9, Lisa gathers strength to stand up to her internal critic, and the critic begins to soften in response:

T: So what do you feel when she says these things..you're being selfish, you don't deserve that

C: I disagree, (crying) I'm going to feel my feelings, (EXP level: 4)

T: What do you want from her?

C: Just back off and.. let me run my life the way I feel is right for me..I know the difference between right and wrong, and I'm not going to let you talk to me that way (EXP level: 4)

T: Okay, switch--she says she wants understanding from you um - what do you say?

C: Okay, yes that's fair (beginning of EXP level: 6)

T: You're saying I understand your need, or how would you put it?

C: I'm sorry (crying)...I feel sad, you deserve to be loved ... I'm sorry for saying those things...I'm sorry for being demanding...I was just protecting you (EXP level: 6)

In a dialogue with her internal critic in session 13, the critic softens more fully, expressing more vulnerability and giving up control:

T: You were protecting her but you've changed, do you want anything from her

C: To be happy - to be free (EXP level: 6)

T: Can you tell her that?

C: I want you to feel happy and free, to be-be yourself (crying) (EXP level: 6)

T: You feel sad?

C: I um, feel lost (as critic) (EXP level: 6)

T: you feel lost, what is it you feel like you are losing

C: Authority, being in charge

T: You don't feel so sure anymore, tell her

C: I don't feel so sure any more, maybe I (critic) don't always know what's good for you (EXP level: 6)

Resolution in a two-chair dialogue often receives a stage 6 rating on EXP (Whelton & Greenberg, 1995). As illustrated in the above example, resolution of a conflict split is preceded by a softening (Greenberg, 1979; Greenberg, 1984) of the critic. At this point, clients are experiencing feelings of which they have previously been unaware, have been disowned, or have never been symbolized. In this example, Lisa stands up to her critic, stating that she wants a chance to "feel her feelings." After continuous assertion on the part of the "essential" self, the critic eventually backs down. The critic moves from a position of "you are being selfish," to "you deserve love". This is a new experience that is being incorporated into the current emotion scheme. The next step in the resolution of the self-evaluative conflict involves the expression of underlying vulnerability on the part of the critic. The critic has lost some of its power and is now more aware of sadness, loss, and uncertainty. This is all representative of shifts in emotion schemes and receives a "6" on EXP. This process involves a reworking of

current emotion schemes that will eventually lead to the formation of a new, more fully integrated self-scheme. The exploration and expression of new material promotes shifts in the architecture of the client's emotional schematic processing. Therapy is thus seen as a restructuring of emotional experiencing.

EXP on Interpersonal Themes

Jill (103): Interpersonal Theme

What follows is the explication of how both EXP and the emotional schematic change process occurred in relation to one of Jill's interpersonal themes. The theme that is being explored in the following passages is:

> **Need for approval from mother**. Jill still longed to be the "good little girl" who always did right by her parents.

In session 9, Jill talks about her guilt about leaving her two sons with her ex-husband, worrying that she "messed up their lives." Despite feeling that her son has forgiven her, she feels unable to forgive herself. In session 11, she works through the conflict in an empty-chair dialogue in which she confronts her mother's extreme disapproval of her decision.

C: Mom, I don't think we're ever going to see eye to eye-because you see it in a different light (EXP level: 4)

T: Can you tell her how you feel?

C: I feel that I've lived my life to please everybody else, and it's been very hard and I don't want to do it anymore, and maybe we should agree that your life has been hard and you

will never understand how difficult it has been for me (EXP level: 6)

T: Is there anything you want from her?

C: Don't expect so much from me anymore, cause I don't think I'm going to be able to deliver it (EXP level: 6)

T: How do you feel saying that?

C: I don't feel so guilty anymore, that I can't jump every time they want something...it's been a real burden trying to live up to what everybody else thought of me and it's made me very sad (EXP level: 6).

In session 13, Jill reports feeling more self-confident, in charge of her life, and able to make changes. She continues to report positive feelings for the duration of therapy. In session 14, she reports standing up to her mother, not letting her push her around, and feeling more self-confidence in asserting her needs.

Lisa (306): Interpersonal theme

What follows is the explication of how the both EXP and the emotional schematic change process occurred in relation to one of Lisa's *inter*personal themes. The theme that is being explored in the following passages is:

> **Unresolved feelings toward father.** She was angry with her father for being restrictive and authoritarian. She felt that she was not allowed to express her real feelings, that she was "locked in a closet."She felt responsible for his gambling problem and felt resentful of his denial of it, as well as his abandonment of her mother and the family.

In the third session, Lisa reported a family crisis in which her schizophrenic brother

had been violently threatening her mother. Her father was attempting to ignore the problem, telling her not to do anything about it. Lisa harbored strong feelings of anger towards her father who she saw not protecting her mother. She also expressed confusion about not being able to fully feel her anger towards him.

C: Why should she be living that way---it makes me really angry towards my dad (EXP level: 4).

T: Really angry, like you'd just like to tell him off, or;

C: Well, yes, why doesn't he just wake up and see it,...I suppose he's an emotionally sick man himself (EXP level: 4).

T: So when you get angry, you slide into understanding his predicaments.

C: Yeah, I don't know if it's right or wrong, but I'm excusing him, or um -- I, I'm also protecting him, I'm not blaming him (EXP level: 4)

Identifying a marker of an affective problem state of painful feelings toward her father, the therapist suggests that it would be best to put him in the empty chair so that she may express feelings towards him:

T: Maybe we should try something with your Dad, what you're describing is a very strong feeling of anger towards him, if you bring him in here in your imagination, it would give you a chance to express it toward him, would you be willing?

C: yeah

T: Ok, can you actually imagine him being here; in a sense, in your mind, bring him in here, get a sense of him. What do you feel when you see him?

C: (Crying) it just feels that way, I always feel scared (EXP level: 4)

T: You feel scared?

C: Yes scared (crying). scared--I feel that I always had to be a good girl in front of him (EXP level: 4).

This results in an initial acknowledgment of fear and the later expression of anger and a recognition of her need for acceptance.

In the dialogue with her father in session 3, Lisa expresses anger toward him for denying the family (and herself) the right to be angry at him for gambling and abandoning them. She stands up to her father and places the responsibility for his gambling back onto him:

C: It's not my fault! It's not my fault! (EXP level: 4)

T: Again, it's not my fault that you gambled

C: it's not my fault that you gambled!(EXP level: 4)

T: And then what do you feel inside?

C: Separate, away from him, like I'm my own self.(EXP level: 6)

In another dialogue in session 7, Lisa reasserts her sense of individuality, and expresses a feeling of strength. She later expresses sadness at having missed a close relationship with him:

C: I feel strong, and a bit sad...I guess I feel sad because I missed out on having a good relationship (EXP level: 4)

T: How would you have wanted it?

C: For us to be together, to trust me (sniff), to let me go....(EXP level: 4)

Initially, the interpersonal scheme associated with expression of feelings toward her father consisted of fear, a sense of guilt and responsibility for her father's weaknesses, and a (cognitive) belief that she should "be a good girl". Through therapy, Lisa came to express an aspect of this scheme that had was newly felt, integrated and expressed. This was a feeling that she was not to blame for his problems and that she had not *caused* his troubles. This shift allowed her to feel more separate from her father and to access a sadness of which she had not been aware. When she expresses a feeling of separateness, this receives an EXP rating of 6 because it is a new experience she had not previously felt. While this shift allows her to access and further explore her sadness, the expression of sadness receives a rating of 4; while she is exploring new feelings, they are not yet fully integrated into her self-schema, and thus do not yet warrant an EXP rating of 6.

The emotional scheme that was related to this interpersonal theme consists of such beliefs as "my mother has to approve of my actions before I feel okay about myself," and "she sacrificed herself for her children. I did not. I am a bad mother and a bad person." Lisa felt associated feelings of guilt, inadequacy, and sadness. When she was able to access a primary need to care for herself and stand on her own two feet, she found the strength to differentiate herself, and to let go of her need for her mother's approval. The shift occured when she decided that she could no longer live for her mother's approval. She was then able to access her own willingness to forgive herself for her

actions, and no longer criticized herself through her mother's eyes. She let go of the enormous burden of trying to please her mother, and was now able to live by her own standards.

Thus, two case examples have shown how both intra and interpersonally-based emotion schemes might change in Experiential therapy. Such changes were also evidenced on outcome measures. Both clients showed significant reductions in depressive symptoms (as measured by the BDI and SCL-90R), increases in self-esteem (as measured by the RSE), and a reduction in interpersonal conflicts (as measured by changes on the IIP) (Goldman & Greenberg, 1996; 1997).

Given this explication of the relationship between themes, emotion schemes and change in EXP, it is worth reconsidering the correlations between frequency of EXP at 4 and above and 6 and above and treatment gains. These data suggest that the evocation of emotion schemes that are related to core interpersonal and intrapersonal concerns is an important element in therapy. Stage 4 is associated with the exploring and working through of emotion schemas. This is, in itself, predictive of changes over the course of therapy. What is even more predictive, however, is a shift in core emotion schemes. Resolution of a core conflict, or a shift in or restructuring of an emotion scheme (which receives an EXP rating of 6), is most predictive of a reduction in depressive symptoms and increases in self-esteem, and a resolution of interpersonal problems.

Depth of Experiencing Redefined

What is being suggested in spelling out the relationship between change in

emotion schemes and EXP is an elaboration of the definition of the upper stages of the EXP scale. This redefinition takes into account the previous conceptualization of a change in inner referents but further articulates the processes by which emotion schemes change. The following is a proposal of how the stages would be redefined:

Stage 4

Core emotion schemes are evoked and explored in relation to material that is thematic or central to the person. The speaker is working through and elaborating emotion schemes consisting of appraisals, cognitions, affect, needs and associated action tendencies. There is a clear indication that emotional material is presently felt.

Stage 5

While exploring and elaborating current emotion scheme(s), the speaker stands back from his/her experience and evaluates that some aspect of current experience is unsatisfying or unworkable. The person, explicitly or implicitly indicates a desire for current emotional processing to change. This must occur within an emotionally-felt context.

Stage 6

The speaker becomes aware of disowned or unsymbolized experiences and synthesizes and integrates material into current emotion scheme(s). This produces a shift or restructuring of currently felt emotion scheme(s) and contributes to a new view of self.

The therapeutic interaction affects level of EXP and change in therapy

Previous research that investigated the relationship between EXP and outcome has

not explored the relationship between the alliance, EXP and outcome. Thus, while EXP has been shown to be significantly associated with outcome, it has been difficult for researchers (i.e. Brodley, 1988) to ascertain whether this effect is a function of a strong alliance or whether EXP and the alliance are in fact separate processes that both predict outcome. Findings from the analyses undertaken suggest that EXP predicts a reduction in depressive symptomatology even when the alliance is taken into account. After session 4, the alliance was a significant predictor of a reduction in symptoms at the end of therapy. Once the effect of both early EXP and the alliance at session 4 was accounted for, however, both modal and peak theme-related EXP in the last half of therapy were significantly stronger predictors of a reduction in depressive symptomatology. In fact, late modal and peak theme-related EXP was even a stronger predictor than the alliance in the last half of therapy. While in this sample, the strength of the alliance at both session 4 and in the last half of therapy did not predict an increase in self-esteem, theme-related EXP in the last half of therapy was a stronger predictor than both of these factors. Thus, evidence suggests that the level of experiencing measures more than the strength of the alliance between the therapist and client, and does in fact predict change in therapy.

Findings also showed that while both early and late in therapy, the alliance and EXP are significant predictors of change in therapy, they are in fact separate processes. It is of interest, however, that early in therapy, they are two independent processes, but that over the course of therapy, they come to influence each other.

Further research is necessary to determine the way in which the alliance and EXP

affect each other later in therapy, although it is possible to conjecture about the relationship. Initially clients may enter therapy conceptualizing problems at a level of EXP that is "usual" for them, while simultaneously establishing an alliance with the therapist. As therapy progresses, however, both the bond and the agreement between the therapist and client on the goals and tasks of therapy may **affect** client EXP. That is, for example, a client might come to believe through the therapeutic process that s/he is harshly self-critical and that this contributes to her depression (agreement on goals and tasks). The client may then believe that the therapist can help her with this problem (strength of bond) by facilitating her through a two-chair dialogue to resolve her self-critical "split." Through the working through of this affective-cognitive task, s/he may attain high levels of EXP. In this way, the strength of the alliance might affect EXP. Alternately, if a self-critical split is worked through to resolution, which would likely mean high depth of EXP, the client may then feel good about the therapeutic process and as a result feel closer to her therapist. The client may judge the process as worthwhile. Thus, EXP may in turn, affect the strength of the therapeutic alliance. This is an example of how therapeutic alliance and client experiencing may be two related but separate factors that influence each other and predict outcome.

EXP and the Inventory for Interpersonal Problems

One surprising finding in the study was the lack of a significant correlation between EXP and change on the IIP. Changes in EXP were <u>related</u> to initial interpersonal distress but not predictive of decreases in interpersonal distress. When interpreting such

findings, one needs to keep in mind that although statistical power was adequate to obtain significant results, the n of 35 does yield less than a 50% chance of obtaining medium-sized effects. However, these null results are in contrast to the fact that changes in EXP predicted reductions in depressive symptoms and increases in self-esteem. It is also worth noting that while the correlations between EXP and changes on the IIP were not significant, some of the variance of change on the IIP *is* accounted for by modal and peak EXP (modal r = -.20 , peak r = -.28). In addition, peak EXP at 6 and above does predict change on the IIP, suggesting that at times, a synthesis of feelings and meanings to form a new view of self (level 6 EXP) does predict changes in interpersonal functioning.

These findings warranted a closer look at the data. Upon examination, the investigator observed a trend that may explain the lower-order correlations between change on the IIP and change in treatment. In a number of cases in which change on the IIP was particularly high, EXP changed very little. What was striking to the investigator was the counter-intuitive nature of the findings; one might have expected the opposite to be true. In other words, it was not the case that when EXP changed a great deal, interpersonal problems did not change. Rather, this data suggests that in some people, a significant change in EXP is not necessary for change to occur in therapy. It may be that these people need a strong supportive relationship with their therapist. For these clients, therapy may indeed be the "talking cure." Having another empathically attuned individual help them to explore, articulate, and symbolize experience in awareness may in itself be helpful and indeed improve their interpersonal relationships. Being validated by another

may help them to be more secure and open in their interpersonal relationships. In therapy, such clients would not necessarily attain levels of EXP over 4 in order to improve. In fact, this sort of processing would likely only receive a rating of 4 on the EXP scale. These clients may not need to reflexively pose problems to the self, explore and work through these problems, and integrate new experience in order to resolve problems (level 5 and 6 EXP). For these clients, talking alone may be enough.

Methodological Limitations

While process-outcome psychotherapy studies such as this one are labor-intensive, the researcher often finishes with the feeling that more intensive analysis would have yielded more comprehensive findings. In this study theme-related EXP was measured in 4 segments, each 20-minutes in length. The first point of measurement was in the second session, while three points were chosen from across the last half of therapy. The design was constructed such that the "most" theme-related sessions from 2-4 session blocks from across the second half of therapy were gathered in an attempt to measure EXP in relation to the most contextual material. One might assert, however, that the results would have been different had all theme-related segments from across the entire therapy been measured. In particular, an even clearer picture of the pattern of EXP across therapy may have been revealed. By looking at patterns across the entire therapy, one might obtain an even better sense of how clients explore and work through thematic issues.

One might argue, however, that the measurement of <u>all</u> theme-related EXP from the last half of therapy would not reveal a different pattern of EXP; that what was

revealed was in fact *representative* of the last half of therapy. Findings from the current study suggest that two aspects of change in theme-related EXP throughout therapy are important. First, an increase from the beginning through the second half of therapy seems predictive of change. Second, achieving a resolution of affective-cognitive problems that exist in relation to thematic issues is highly predictive of change. Thus tracking all the sessions in the second half of therapy might reveal similar, albeit stronger findings. In this scenario, two educated predictions would be that a) greater depth of experiencing would continue to predict outcome, and b) the degree of resolution of affective-cognitive problematic processing in relation to **all** theme-related material would be predictive of outcome.

Another limitation of the study is that while a representative sample of theme-related material was taken from across the last half of therapy, EXP was only sampled from one twenty-minute segment from the beginning of therapy. One might assert therefore, that this one unit is not representative of early EXP. Had other samples been extracted, average EXP might have been different. The major interest of the investigators in this study was the nature of theme-related EXP that only emerged in the last half of therapy. EXP was measured early in therapy in order to track change in EXP by the second half of therapy. Theme-related EXP in the final half of therapy, was compared with a sample of EXP from the beginning of therapy for the purposes of measuring differences from the beginning through the last half of therapy. EXP was thought to be more stable and representative in the early stages of therapy. It was thought that only as

therapy progressed, and clear problems emerged, EXP would vary in relation to them. In short, a twenty minute segment was thought to be representative enough of EXP early in therapy.

Another limitation of the study may have been that selected themes were based on therapist's reports of their view of client themes, and supported by statements made in clients' post-session and post-therapy report. While there was an attempt to corroborate the themes from different angles, one might argue that the client verbal articulation of therapeutic themes would have altered the selection of the themes. In response to a direct question, their conceptualization of themes might have been different, and thus changed the results. Different themes would have affected which moments and sessions were extracted for measurement on EXP. On the other hand, as therapy is a co-constructive process, it is entirely possible that client and therapist might have reported similar themes at the end of therapy. That is, therapy is a process of client and therapist coming together to conceptualize and work through a client's problems. Furthermore, even if themes had been somewhat different, EXP in relation to thematic material may still have yielded significant correlations with outcome.

A final caution must be stated with regard to the somewhat small 'N' in this study. While this is an adequate sample size upon which to perform and draw conclusions from correlational analyses, and a minimally adequate size upon which to perform and draw conclusions from hierarchical regression analyses with up to four predictor variables, one must be careful not to generalize widely based on this sample. Replication is necessary in

order for firmer conclusions to be drawn.

Recommendations for further research

Further study of the relationship between theme-related EXP and change in therapy might investigate questions generated from findings in this study. First, it would be interesting to further investigate the reliability of the interpersonal and intrapersonal categories. One could then ascertain what proportion of material was interpersonal versus intrapersonal in nature. With this knowledge one could conduct further studies such as the one conducted by Hardtke and Angus (1996) comparing EXP in relation to the two types of themes. One might also explore whether a focus on one type of theme or the other relates to overall change in therapy? Does change in EXP in relation to one theme or another relate to change in therapy? Future research might also involve the study of the relationship between Process-experiential tasks and the two different types of themes. Does work on specific tasks relate to change in particular types of themes? For example, does a focus on intrapersonal themes lead to work on two-chair dialogues, while a focus on interpersonal themes is associated with work on Unfinished business dialogues?

Clearly, another study that needs to be undertaken is a comparative study that asks whether a random sampling of segments reveals significant findings. Using this current data set, would a random sampling across sessions reveal that higher EXP is associate with positive outcome, and in particular does an increase in EXP over therapy predict positive outcome. In order to claim the superiority of contextual sampling of themes on which to measure EXP, such a study must be conducted.

Given the finding in this study that EXP did not uniformly predict change in interpersonal distress, further study of a longer treatment (more than 20 weeks) might ask whether longer term treatment involves an initial focus on intrapersonal issues and an increasing focus on interpersonal problems as therapy progresses. If this does prove to be the case, does a focus on intrapersonal problems initially lead to a reduction in depressive symptoms, and does a stronger focus on interpersonal problems later in therapy lead to a specific reduction in interpersonal distress?

With a larger sample size, investigators could answer questions with regard to differences between C/C and P/E therapy. Current data suggests that the Process-experiential group has significantly greater peak EXP than the Client-centered sample. With a larger sample, one could ascertain with confidence whether a difference in levels of EXP does exist between the two groups. Does a more direct focus on specific problematic affective-cognitive problems in the P/E approach lead to a greater depth of experiencing overall, and does this difference account for more significant change in P/E therapy? Do such changes last over time? With a sample of at least 30 in each group, research might reveal a differential emphasis on either intra- or interpersonal themes, depending on therapeutic approach.

Finally, another interesting study might ask the same research question with a different population. Does theme-related EXP predict outcome in therapy with post-traumatic stress survivors? Do different types of themes emerge with different populations? Is change in EXP in relation to different types of themes more predictive of

change with a different population?

Implications and Conclusions

This study suggests that in Process-Experiential and Client-Centered therapy with depressed clients, change in experiencing from beginning to late in therapy in relation to thematic issues of either an intrapersonal or interpersonal nature is associated with an alleviation of depressive symptoms and an increase in self-esteem. Furthermore, the data suggest that in relation to core thematic issues, a shift or resolution in affective-cognitive processing problems is predictive of a reduction in depressive symptoms, an improvement of self-esteem, and even improvement in interpersonal distress levels.

In recent years, in the field of psychotherapy process-outcome research, researchers have asserted that common therapeutic factors such as the alliance are the most predictive of change in psychotherapy. While it has been for the most part established as fact that a strong alliance is a necessary component of a successful therapy and is highly predictive of outcome (Horvath, 1994), researchers have continued to ask what accounts for the specific effects of therapy. What are the specific processes that lead to client's improvement? These findings are suggesting that, on the bedrock of a strong alliance, the establishment of a particular type of focus on problems is an important element in the change process. The exploration and working through to resolution of affective-cognitive problems that are important or thematic for the client is highly predictive of change in therapy. This lends support to the notion that in any therapy with depressed clients, an important piece of helping people get better is guiding them through

the working and re-working of emotion schemes. The resolution of and ultimate restructuring of emotion schemes affects how people view their problems as well as how they view themselves. When clients enter therapy, given the often brief nature of treatment, it is highly advisable for therapists to move toward an immediate focus on these thematic emotion schemes that are the source of the problems that clients identify as problematic and painful; the problems that initially lead them to seek the help of the therapist.

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Appendix I

Experiencing Scale Supplement with Two-Chair and Empty-Chair Examples

Stage 3

When in the chairs, a client expresses a need, wish , desire, or goal to the other and it is simply stated without further elaboration from the client's own internal, subjective world, the appropriate rating is 3.

Example 1:

C1: I wish you were able to express your feelings. Not just come so close and, and go, run away. Sort of shut out those feelings.

T: Say it again.

C2: I wish you could get closer to expressing your feelings and share, and share what you're thinking, what you're feeling.

This is an example of a statement of a need which remains at a 3. It is outer directed and is not internally elaborated. It is not about the person's internal experience or feelings.

Example 2:

T: What do you say to her when she tries to push you? Tell her.

C: I want to grow and experience what I have to offer.

Stage 4

Clients reach stage 4 if they are clearly experiencing feelings, needs, wants, and sustain this processing in a constant way, internally elaborating the material on which they are focused, this is a 4. Note: This may be in direct or indirect expression to the other chair.

Example:

C1: Okay, okay. Let's not ever forget that little sixteen year old girl (a chuckle)_ 'cause she was...me (Pause. Sobs). And she (crying) she was so young...._

T: That's good. That's good, stay with it. Describe her some more.

C2: ...so young and afraid...

T: She was pregnant...

C3: ...and on the street. She was a freak because her face was so you and she was pregnant. (Pause, still crying) Go on the bus to the doctor and...people on the bus would look at my stomach and look at my face and look back and forth, they couldn't beiieve it. I'm such a freak.

T: So I feel terrible or I feel...I feel so different, I feel so ashamed.

C4: Yeah (Crying). Everybody knows what I was doing. Oh, so exposed.

T: So everyone know that I must have been a terrible girl.

C5: Yeah. No privacy, just the mark of it. (Sigh) And then to the world, so hard giving my nothing (Sob) There was nothing for me.

T: So I really got nothing from anyone or...

C6: No one.

T: Say that. I was lonely.

C7: I was so lonely, no friends, no family. Just (sigh)...big and sad, oh (sob).

T: Stay with being the young girl who's just so desperately wanting, tell her how, tell her about mother not being there.

C8: And mom was not there and she was not coming. (Sniff) And she hated me because I embarrassed her in front of her family and she just wanted me out of sight, like garbage...So what could I do?

This is a good example of continued processing at Level 4. C1 is not a 4, but the emotional cues (sobbing) can be used to rate it at 4.

Example 2

T: Be the little girl

C1: I feel small and scared

T: Tell her about it (other aspect in self in other chair) like speak from it, it's almost like saying, I'm small and I feel...

C2: I'm small and I feel helpless um, just giving out of myself. I feel lost, insecure. I want to be accepted the way I am

T: So who are you asking for acceptance? The other part of you?

C3: Just accept me the way I am, this is me. Don't make me feel ah, little or scared.

T: So what do you want from her?

C4: Support my feelings

T: Tell her.

C5: I want you to support me, what I think, what I believe is right for myself. I want you to be my friend.

T: Okay, come over here--she's asking for support. What do you say?

C6: (client switches and is now talking from the "critic" chair) I am just trying to protect you

T: Tell her, I just need to protect you

C7: (crying) I am, I need to protect you

T: What's happening?

C8: I guess I am just wanting to protect her, I feel a little like I am losing her.

T: Uh huh. Yes, tell her.

C9: I'm afraid to let you go and experience life by yourself. I am afraid you'll get hurt.

In this example, C1-C5 is clearly at Level 4. When the client switches to the "critic" chair, C6 and C7 move to Level 3, as the client is speaking from a more external place, but by C8 the critic is moving inward and is expressing vulnerability. Thus, at this point, the rating would again move to Level 4.

Stage 5

C1: I feel your loneliness. I know how sad you are. Um, but it's almost like, (sigh) it's hard for me to just, well in a way I need to just let him go and forgive him, forgive, forgive him.

T: Tell him.

C2: Um, something inside me just doesn't let me, let you off the hook, so easily. It's like there's a..there's this unforgiveness within me, that I can't just bury it, it's a wall and I won't allow you to go across that wall, unless something happens...I think I need more than just words, empty words. I think I need the actions, the reactions, the time, the reassurance that this isn't just a, a one-time anomaly or a skip in the cycle that just happened to happen.

T: It's like I want to know that you're really there.

C3: Or genuine. You know I wanna make sure this is all genuine before I actually do forgive. And I want to forgive, I want to forgive you, but I'm just waiting. Believe me, I don't want to wait unitl you die! That's the sad part, that I might have to wait til you die, to let go of my anger, but I don't want that.

C2 and C3 are a 5, especially if C1 is included. The implication in C1 is "I need to forgive him, BUT SOMETHING INSIDE ME DOESN'T LET ME.

Example 2

T: Yeah, so there's still a lot of feelings there that's what you are saying

C: yeah, there are, um, feelings of sadness (crying) um of still I guess resentment towards him?

T: Yeah, mmhmm

C: and that is where I am at right now.

T: You are feeling resentful

C: as much as I don't want to and, you know, we're all supposed to forgive....I still find it hard

T: Uh huh, so there's also a part that does say forgive him, you should just let it go, forgive him.

C: Yeah, but then there's just this stubbornness --it's not that I want him to feel pain himself, it's just that I don't want to just let it go either. I mean I know that he is hiding stuff from me and somehow if I just forgive then I am kind of saying it is ok, but then I feel I should not let it out, it's enough and I don't even want to tell him how I feel anymore.

This is an example of a marker for a two-chair dialogue for a conflict split. The entire excerpt should be rated as 5 because the client is posing a problem to herself and begins to internally elaborate the felt referent. On the one hand, she feels resentment and on the other hand she feels that she should just let go of it, that it is not worth it, and things would be better if just left alone. Yet try as she might, she comes back to the resentful feelings.

Stage 6

(Client is talking to significant other in the empty chair)

T: I'm not going to cover things up for you anymore

C1: No, I'm not going to pretend anymore, I'm tired of pretending...um...I know I deserve better

T: Say it again, I deserve better.

C2: Yeah, I deserve a lot better than what you've given me just putting me aside, it's like leaving a dog at home all the time and never letting him out.

T: Uh huh, you feel very trapped.

C3: Yeah, I'm tired of feeling trapped and isolated and believing that this is the way marriage is, but no! this isn't the way, this is not the way and I don't want it, I'm tired of

it,

T: I'm tired of it,

C4: Really tired of it - I'm tired of covering and being phony and just pretending everything's okay but it's not

In this example the client is at Level 6 because she is stating a change in her feelings about herself, her attitude towards her marriage, and a resolution to make a change. She is expressing a shift.

Example 2

C1: Well, you taught me not to be a fighter, and in trouble all the time. You gave me some values that, that I value personal property and, and privacy of other individuals, and all those things things that make you a good functioning human being. I seemed to have learned from you. And ah, tolerance of others. And ah, accepting their needs. I have no idea when you did it but you did it somehow. And ah, that's good, I mean it's, it made life from that point of view very easy. And then I wasn't always in conflict and trying to hide, with those issues, with those things. And ah, so that's good. Thanks, that was good, thank you. The other stuff, well I guess you did the best you could. It wasn't all that great but, you know, I understand, ah, and I accept it. And ah...it feels better accepting it than being angry about it. (T: Say it again) And ah, I've been really pissed off with you for the last couple of months. And ah, just, poof, after last week it just popped in my mind one day as I was going along. And ah....

T: There's no point hanging on to this....

C2: Yeah, really, it, it's useless to hang onto it. Um, it doesn't do anybody any good. Um. I end up ignoring you and being angry with you when I am talking to you and certainly you can feel that coming through. And that's not right. I don't feel comfortable with that. Makes me uneasy and it makes me anxious. I just don't feel good about it. So it's time to let go of that ah, I guess the anger, that I had. That I realized that I had. And ah, just let that disappear. And for the things that you didn't do that I should have got that I didn't get, you did the best you could. And for screwing that up and not even trying to figure out what was going on, um, ah...it's the, I guess it's the best way I can put it...(Laugh) You are forgiven. And now I want to get on with my life and enjoy the rest of yours as much as I can. Given the time schedule and everything. At least I don't have to go to_____. That was a problem when we were out there. Um, so, thanks for the good things! Messed up some of the bad things or some of the other stuff. But ah, you did the best you could. And I accept that, and ah, I have a responsibility myself, to move myself through life. It's

not like I expect you to do everything for me. You got me to a point and set me free and I hung on to some of the things that I shouldn't have hung on to, I guess. And now, I'm letting them go. And saying "overall you did, not a bad job."

T: Can you just go inside for a moment and check out what you're feeling. What you're experiencing. (Deep breath) What's it like for you?

C3: It's almost like...taking a weight, or something that was, that kind of guiding in the background. Um, getting rid of that. It's ah...and I felt it a couple of times in the last number of weeks. I'm in control. Feels good. I mean it feels good to say "I'm in control." I look after what's going on. And it's my life and I don't need to drag this other crap around.

C1 starts as a 4 and moves to 6. The rest is 6. This is a good example of 6.The client has shifted in relation to the other. The client is no longer holding his parent responsible for the injustice that he committed against the client as a child. He appreciates what he did get from his parent, and most importantly, he has decided to let go of his resentment and anger towards his parent. He describes a shift in his feelings about himself. He feels more free and in control of his own life.

Appendix II

Instructions for theme-related session identification

Please read the set of themes assigned to your client. As you listen to each tape, please record exactly when, in your judgment the client begins to talk "on theme" and clearly indicate which theme. Also indicate when the client stops talking on theme or moves to a different theme. Thus each session will be made up by a series of segments that are either "on-theme" or "off-theme." As you are doing this, record the time length of each "on" or "off" theme segment. Thus, for each session, you will record how many minutes were "on-theme" and the length of each segment. Next, for each "on-theme" segment, judge how "central" the content that is being discussed is to the particular theme. Please rate the centrality of the material to the theme on a 5-point scale ranging from "very little" to "extremely." See below.

---

1 2 3 4 5

Next you need to make an overall judgement of how "on-theme", the session was by the folllowing criteria: a) the amount of minutes that clients were "on-theme", and b) the centrality of the material. The rule to be followed in making this judgment is that the degree of theme centrality is three times as important as the number of minutes the client

spent talking "on-theme." Thus, a segment of 4 minutes in length that received a 4 and 5 on degree of centrality was as "on-theme" as a 12-minute segment that was rated as "on-theme" but only received a rating of 1.

Based on this judgment, please rate how "on-theme" the particular session was. Please rate on a scale as follows:

---

1 2 3 4 5

When you have rated all sessions, please determine which session of the three 2-4 session blocks contains, the most "on-theme" material. Thus, by the end you will have chosen the three most on-theme sessions from consecutive 2-4 session blocks over the last half of therapy.

Appendix III

Themes for the data set

#001

View of self

1. Difficulty assuming responsibility for her life

Rather than taking a proactive role with her husband, she was more comfortable with a submissive, passive position in relation to him. She projected her demanding, taskmaster self outside, thereby silencing herself.

View of self in relation to other

2. Problematic relationship with husband

She remained passive in relation to her husband, often letting him take over without questioning his judgment. She found it hard to express her true feelings toward him.

3. Unresolved grief over loss of grandfather

Until the age of ten, she was raised by her grandfather. When he died, she was unable to grieve. She saw how closing herself off to that pain was similar to how she dealt with pain in her current life.

#002

View of self

1. Feelings of insignificance

She felt unheard, unrecognized, and insignificant. She felt she had lost control of her life. She had difficulty attending to her own needs, often devaluing them in favor of the needs of others. She had trouble standing up for herself.

View of self in relation to other

2. Feeling helpless and ineffective in relation to her kids.

She felt she had lost control of her children. She dif not feel valued and respected by her children, especially in comparison with her husband.

3. Unresolved anger in relation husband.

She felt angry and blaming of her husband who had left her for another woman. She felt she had nothing, and that he had caused all of her problems.

#003

View of self

1. Fragile sense of self

She had an unclear, fragile sense of self. She described a big empty space; a void inside of her. She had a sense of a painful emotional well of feelings deep down inside. At times, she felt she had failed. She was unclear of what she wanted.

View of self in relation to other

2. Unresolved anger towards father.

She hated him and wanted to be free of him. He had been emotionally and verbally abusive, and then abandoned the family when she was an adolescent. He had made her feel like something was flawed inside of her. She had internalized this sense of herself.

3. Difficulties in intimate relationships.

She found intimate relationships difficult to sustain because she was always afraid that someone would leave (either her or the other). She was dependent on the approval of others, in particular that of her family. She often projected and externalized criticism from her family. In spite of this, she wanted to maintain a connection with and get support from her family.

#004

View of self

1. Negative view of self

She had felt unacceptable for most of her life. She felt physically unattractive. She had regrets about not vigorously pursuing her dreams and the things she really wanted in life.

View of self in relation to other

2. Problematic relationship with husband

She experienced her husband as a burden. She was anxious about his retirement because she was afraid she would have to take care of him around the house. She felt emotionally distant from her husband and had difficulty asserting boundaries with him.

3. Difficult relationship with daughter

She felt both resentment and jealousy toward daughter for her freeness and lack of responsibility in her own life. She had trouble setting limits with her daughter, and found it difficult to separate from her.

#005

View of Self

1. Lacking in self-confidence

She was sensitive to others' criticism. Minor criticisms would result in profound feelings of shame and inadequacy.

2. Difficulty legitizing needs and wants

Her desires were filtered through a screen of what she perceived other people thought.

View of Self in Relation to Other

3. Unresolved relations with sister

She felt a great deal of resentment toward sister. She felt her sister did not consult her regarding family matters and she consequently felt excluded and angry.

#009

View of self

1. Flat feelings/ absence of feelings

She experienced emotional flatness and apathy, feeling at times that she was unable to appreciate her own life. She also "stopped" her feelings.

2. Difficulty asserting needs

She exercised tight control over her experience and expression of her needs. She had trouble being assertive. She worked on loosening her control and allowing herself to be assertive.

View of self in relation to other

3. Unresolved feelings toward mother

Her mother was an alcoholic. She felt resentful and angry towards her mother for neglecting her and not making her a priority. She did not want to let go of her anger and resentment, yet felt petty for having these feelings.

#010

View of self

1. Self-critical

He had high expectations and harsh standards for himself. He was highly critical in relation to himself.

View of self in relation to other

2. Unresolved feelings toward parents

He felt humiliated by his father's verbal attacks and mockery when he was younger. He wanted to stand up to his father but also sought his father's approval and found it difficult to assert himself in relation to his father. He felt sorry for his father because of his father's response to his mother's death. These feelings were related to unresolved grief with relation to this.

3. Conflicts with his wife

He felt overpowered by his wife and experienced himself as overly-solicitous in relation to her.

#011

View of self

1. Lack of self-acceptance

She had difficulty being vulnerable. She found it hard to be weak, and in need of help. She suffered from feelings of worthlessness and hopelessness. She felt she was "just unlucky". She felt vulnerable to threats that she projected onto the outside world, as if there was only a thin sheen protecting her from the harsh world around her.

View of self in relation to other

2. Unresolved feelings towards mother

She felt emotionally neglected by her mother. She describes her mother as falsely happy. She felt inadequate and unable to criticize, or be angry with her mother.

3. Unresolved feelings toward father

She felt both love and affection as well as resentment toward her father. He had been verbally abusive, and sometimes physically abusive when she was younger. She remembered feeling afraid of him. On the other hand, he had been somewhat brain damaged when she was younger, and she felt compassionate towards him. He had recently died; she had not seen him for 5 years previous to his death and had unfinished business with him.

#014

View of Self

1. Difficulty accessing emotion

She had difficulty experiencing her feelings. She faced obstacles such as extreme tension when she attempted to access emotions. She found intensely painful, upsetting feelings when she made contact with her internal experience.

View of Self in Relation to Other

2. Felt trapped in an unhappy marriage

She felt unappreciated, controlled, and "put down" by her husband. She felt he only wanted her around for his own selfish reasons. She found it difficult to stand up to him.

3. Unresolved feelings toward mother

Her mother was controlling and alcoholic. She felt great pain that her mother would rather cripple her than see her happy. She felt oppressed by her.

#015

View of self

1. Lacking self-confidence

She felt inadequate, insignificant, and ineffective. She doubted that she had any special talent.

2. Difficulty legitimizing feelings

She felt that her feelings and needs were unimportant and thus had difficulty allowing or expressing them.

View of self in relation to other

3. Felt judged and criticized by others

She worried that others had negative judgements of her that they did not always disclose. Specifically, she wondered whether others were bored by her. She worried that she was wasting the therapist's time.

#016

View of self

1. Lack of self-acceptance

He lacked confidence, sometimes feeling like a failure. He was highly self-critical and sometimes felt small, like a child.

2. Difficulty attending to feelings

He frequently experienced a sense of numbness. He felt life was passing him by and that he was ineffective in initiating his plans and dreams.

View of self in relation to others

3. Difficulty asserting himself

He had difficulty expressing anger or being aggressive. He often felt guilty when he was assertive and felt that his anger was energy he could not use.

#017

View of self

1. Negative view of self

He became aware of his self-critical tendencies and how his self criticism and high self-expectations suppressed his more emotional side. He was also increasingly aware of how his "business" or more rational side dominated his personality. He became more self-accepting and compassionate toward himself.

View of self in relation to other

2. Emotional distance from his family

He did not feel "connected to" his wife and children. He wanted to be emotionally closer. He wanted to be more expressive and emotionally closer to them. Throughout therapy, he began to acknowledge his feelings.

3. Unresolved relationship with father

He felt very ashamed and critical of his father' shortcomings. In therapy, he expressed feelings towards his father, be more accepting of his father, and take more responsibility for himself.

#018

View of self

1. Sense of failure

He was critical of himself. His self-criticism frequently revolved around the feeling of being an inadequate provider. He felt he had never lived up to the family standard or "made it."

View of self in relation to other

2. Marital tension

He experienced his wife as critical of him which lead to relational stress and tension.

3. Unresolved feelings with parents

He felt that his father did not care for him and shown little interest in him. He tended to avoid his mother.

#019

View of self

1. Lack of self-acceptance

She lacked strong feelings of self-worth and could be devastated by others' criticism. Her struggle for self-acceptance expressed itself in a conflict between her ideal (rigid, rational) self and her expressive, emotional side. She had difficulty accepting painful feelings. She was afraid to explore them as she felt that she might "destroy her personality." The more rigid part of herself thus exerted a certain degree of control.

View of self in relation to other

2. Inability to assert self needs with others

It was hard to her to feel that her own feelings and needs were legitimate. This belief existed both in relation to her career in art and with her boyfriend. She had difficulty asserting her own needs for space.

3. Unresolved grief from first marriage

She had leftover grief from her first marriage. She found it difficult to trust both herself and others.

#020

View of self

1. Vulnerable sense of self

She found it difficult to be vulnerable. She felt ashamed of her core self and often disavowed basic emotions. Overall, she experienced a very bleak landscape of a life. She had very little sense of history, and felt like a lost waif. She sometimes felt quite ineffectual. She felt a need to put up a front of strength and invincibility (a survival tactic she had learned) so as to hide her fear and confusion. She felt "too brittle and delicate." Over the course of therapy, she learned more to be herself, to allow herself to feel hurt and fears, and respect those aspects of herself. She also came to feel more in control.

View of self in relation to other

2. Uneasiness with others.

She did not feel at ease with people. It was easy for her to feel betrayed in relationships. She found it difficult to figure out what she needed. She felt awkward and wanted to escape. She had trouble discerning the difference between what felt she should say and what she did feel. Instead of putting up prickles, she learned to be more expressive. This allowed her to feel more in control.

3. Unresolved relations with family members.

Even though she had a very different understanding of her childhood than her mother did, she did not want confront her mother with her own reality of feeling emotionally neglected. She did not wish to re-evoke a bad period in her mother's life when her father died, and her mother had a nervous breakdown, languishing in bed. She came to realize that she was protecting her mother, at the price of her own sense of acknowledgment. This was somewhat related to unresolved grief toward her brother dying, which was related to her feeling that he was the only light at the end of the tunnel when she was growing up.

#021

View of Self

1. Self-critical

He lacked self-confidence. He was sensitive to criticism from others. He had strong perfectionistic tendencies and a self-critic by whom he felt sabotaged. He was afraid to be average and felt dissatisfied with his academic achievement, intelligence, physical attractiveness, and perceived level of importance.

View of self in relation

2. Unresolved relationship with mother

He experienced abuse from his mother. He had unresolved grief at the inadequacy and worthlessness she engendered within him. He was afraid to feel hurt, however, as it would be used against him.

3. Difficulties with commitment in relationships

He linked his perfectionistic attitudes toward work and his lack of vision for his future to his inability to make long-term commitments in intimate relationships. This may also have been related to unresolved feelings with his mother.

#023

View of Self

1. Self-critical/ Lacking self-confidence

She was critical of herself and felt that she did not "measure up". She had difficulty validating her emotions and acknowledging the legitimacy of her needs. She had trouble trusting herself, particularly trusting her ability to be the best she could be.

View of self in relation

2. Conflict in intimate relationships

She readily experienced herself as put down, misunderstood, and denigrated by men. Her experience stemmed in part from her expectations of men and in part from her limited ability to trust herself to be the best she could be. Over the course of therapy, she improved in her ability to trust herself and began to feel newly appreciated.

3. Unresolved feelings towards parents

She experienced her father as an embarrassment to her, an "odd duck" or a "backwoods boy." She felt resentment towards her mother for undermining her father's support of her.

#024

View of self

1. Conflict between critical aspect and emotional, vulnerable part of personality

She had high standards for herself and was critical and controlling in her treatment of herself when she did not meet those standards. She would make herself feel small, worthless, and useless when she felt she had failed.

2. Difficulty acknowledging feelings

She had difficulty "staying with" her feelings and tended to rapidly "shut off" or avoid troublesome feelings.

View of self in relation to other

3. Unresolved feelings toward mother

She had many unresolved feelings towards her mother. She felt her mother expected a great deal of her and provided little acceptance. She experienced her mother as expecting support and companionship but also having difficulty letting go of her "favorite daughter" (the client). She had trouble asserting boundaries with her mother. In addition, she felt her parents, particularly her mother, had not, in the context of abuse, protected her and her sisters to make them feel safe. From a young age, she felt she had to look after herself.

#025

View of Self

1. Conflict between task-oriented and compassionate, maternal self.

She felt driven to achieve, and often pushed and "panicked" herself over her career. She was torn between finding an occupation that would satisfy her and allow her to financially support her daughter, while at the same time attend to her daughter's emotional needs. She came to feel more at ease with her situation and accepting of her more "down to earth" side.

View of self in relation to other

2. Unresolved feelings toward mother.

She did not feel loved as a child, except by her grandfather who died when she was three. She felt that her mother was more of a provider for her, and not affectionate towards her. She did not feel love towards her mother. She felt more detached and remote, which became a more troublesome feeling when her mother was dying. She was afraid to express anger to her mother for fear of hurting her. She felt that her mother had not protected her from others, by not validating her feelings and teaching her to stand up for herself. While she often missed her home country of Brazil, she realized that she left because she felt that no one had anything to offer her, and that she had felt stifled.

3. Unresolved feeling toward ex-husband and his family.

She had felt oppressed in her first marriage. She felt she had not been aware of what she needed. She had felt very unsupported by her mother-in law. She was able to express some of her anger towards her ex-husband and his family, and assert her boundaries. She found this relieving.

#101

View of self

1. Felt unlovable

He lacked self-confidence. He experienced his worth as based on working for others and he felt an overwhelming sense of shame at being unemployed. He was afraid of failure and had a strong perfectionist streak, which lead to reluctance concerning risks and made it difficult for him to motivate himself to achieve his goals.

View of self in relation

2. Difficulty trusting others

He had difficulty trusting others enough to let them know what he was feeling and thinking. This was true both in relation to his family and therapist. He feared being rejected by others socially, which caused him to act in socially "off-putting" ways which in turn caused people to reject him.

3. Unfinished business with parents

His parents were not married when they conceived him. He believed they would not have married except for him. He felt emotionally abandoned, hurt, disappointed and resentful. He grappled with what he could forgive and forget.

#102

View of self

1. Difficulty trusting self to be vulnerable

He was conflicted between being vulnerable and getting hurt.

2. Strong feelings of loneliness and related fear

He had a profound sense of aloneness, and feared losing everything including his job, social service network, and finding himself totally alone.

View of self in relation to other

3. Difficulty trusting others.

He had difficulty trusting those around him.

#103

View of Self

1. Need to be perfect.

She felt that she had to be perfect in every respect in order to be lovable. Being perfect meant being strong in her capacity as daughter, wife, sister and friend. She felt bad about herself if she did not live up to these standards.

2. Difficulty legitimizing feelings.

She did not value her own feelings and needs, and suppressed them, putting others before her own. Disclosing feelings showed weakness and vulnerability that she need to keep under control.

View of self in relation

3. Need for approval from mother.

She felt very guilty about having to abandon her sons in order to escape an abusive marriage. She felt she had been a bad mother by not protecting them, and felt weighed down by her guilt. She sought the approval of her mother. She still longed to be the "good little girl" who always did right by her parents

#104

View of self

1. Difficulties motivating self in relation to work

She felt driven by external pressures, but had very little internal motivation. She found it difficult to relax, and was critical of herself for taking time off.

2. Difficulty asserting needs

With both her clients and her husband, she found it difficult to assert her needs. She avoided situations in which she anticipated conflict.

View of self in relation to other

3. Unresolved feelings in relation to current marriage

She had a disastrous first marriage. Memories of her marriage and leaving her children brought back strong feelings. She did not feel "at peace" with her decision to leave.

#107

View of self

1. Lacking in self-acceptance

She had difficulties accepting her feelings, often deeming herself mean-spirited. She would criticize herself for a myriad of things including intellectual inferiority, lack of self-assertion, and her role in causing her sons' conflicts.

2. Eating problems

She was very troubled by her tendency to binge eat. She saw it as related to her need to feel more in control in contrast to other aspects of her life.

View of self in relation to other

3. Inability to assert self with others

She had difficulty asserting boundaries and revealing her true feelings. When she was more able to assert boundaries, she found herself more able to step into other's shoes, and consequently felt less mean-spirited.

#109

View of self

1. Lacking in self-confidence

She felt unlovable. She was very self-critical. She felt unable to trust herself to make the right moves.

2. Fear of future.

She felt she was to blame for past relationships not working out and responsible for not finding a partner. She felt hopeless about ever finding anyone and felt her life was going nowhere.

View of self in relation

3. She felt disappointed by others.

She felt that people were constantly letting her down and betraying her.

#110

View of self

1. Feelings of inadequacy

She felt unsure of herself. These feelings made it difficult for her to make her own decisions, take charge of her life, and make her own decisions. She did not take credit for her accomplishments. She was critical of herself when she did not live up to her own high standards.

View of self in relation to other

2. Difficulty with self-assertion

She had trouble asserting her needs with her husband and children. She did not feel comfortable expressing her own opinions.

3. Need for approval

Her sense of self-worth was strongly linked with her need to please others. She became anxious and panicky in relation to other's disapproval. This was particularly acute in relation to her mother's death. She felt guilty about not taking control of her mother's treatment in the hospital as she was very worried about other's approval. She often sought the reassurance of the therapist.

#111

View of self

1. Lacked self-confidence

He made negative judgements of himself. He felt blaming, self-critical, and even self-destructive at times. He felt he had been a failure through university, jobs.

2. Difficulty attending to feelings

He had difficulty attending to his feelings. At times he wondered whether he wanted to allow suppressed feelings.

View of self in relation to other

3. Blaming of others

He had high expectations of others which often lead to him being excessively critical as well as withdrawing when expectations went unmet.

#201

View of Self

1. Negative view of self

She thought she was not good enough. She felt she was not perfect enough. She felt that she did not measure up.

2. Fears of aloneness

She was afraid of being alone and concerned about her future. She thought she might be alone for a long time.

View of self in relation to other

3. Resentment toward mother

She felt angry toward her mother. Her contact with her mother was frustrating and controlling. She felt humiliated, criticized and that she had never measured up her mother's eyes.

#303

View of self

1. Conflict between rational, practical self and free, pleasure-seeking self

She had commitments that she felt obligated to fulfill. She felt responsible for many people. She felt she was no in enough control. In contrast, she also felt a need to feel more carefree. She came to realize that a great deal of her need for control was related to fear.

View of self in relation to other

2. Anticipatory grief

She felt a strong need for nurturance and became very panicky without it. She feared her parents death, and most of all, her husband's death.

3. Unfinished feelings toward mother.

She felt disappointment and resentment in relation to her mother, who she felt had not provided her with enough love, support and nurturance. This was also related to her difficulty caring for herself as it was not a way of being with which she was familiar. This was also related to her strong emphasis on "doing" (practical side), rather than "being" (carefree side).

#304

View of self

1. Conflict between free, passionate self and more condemning, critical self.

She had difficulty feeling free to enjoy herself and let herself live. She would control and restrain her softer side. She could be cruel, condemning and judgmental of herself. She had difficulty recognizing the validity of her needs as well as asserting or relating her needs to others.

View of self in relation to other

2. Unresolved feelings toward husband

She resented her husband for mistreating her in the past. She had difficulty expressing those feelings as well as being honest about other feelings towards him.

3. Unresolved grief in relation to father

She had a great deal of sadness in relation to her father dying when she was a young girl. She found it difficult to express her grief. This may have been related to sadness in relation to a lover from whom she had been separated in the recent past.

#305

View of Self

1. Lacking self-confidence/ strong sense of self

She had difficulty accepting herself. She had trouble allowing herself to have the right to do things. It was difficult for her to accept weakness. She had trouble feeling that her needs were legitimate.

View of Self in Relation to Other

2. Problematic relationship with husband

She resented her husband for what she perceived as his lack of care and concern for their relationship. She felt hurt and unable to invest in the relationship. She felt she could not trust him and would do things to push him away. Over the course of therapy, she gained insight into his perspective. Understanding her husband's perspective lead her to take responsibility for her pushing him away with anger and her lack of trust. She began to trust him and invest in the relationship.

3. Sad feelings about children leaving home

Her daughter was getting married and leaving home. She felt sad that both of her children had now left, and was contemplating how she would fill her time.

#306

View of self

1. Lacking in self-worth

She felt unheard, diminished and invalidated. She felt to blame for her husband's gambling. She felt that is she asserted feelings and needs, she would be betraying her husband, and consequently, was not being a "good wife."

View of self in relation to others

2. Unresolved feelings towards father.

She was angry with her father for being restrictive and authoritarian. She felt she was not allowed to express her real feelings, that she was "locked in the closet." She felt responsible for his gambling problem and felt resentful of his denial of it, as well as his abandonment of her mother and the family.

3. Problematic relationship with husband

Her husband gambled away the family money, and neglected his fatherly duties. While she had strong feelings of resentment over this, she had trouble expressing them. She came to feel stronger in her convictions, and was able to stand up to him. She came to feel more separate from him; that he was responsible for his actions, and that there was nothing she could do to control it.

#307

View of self

1. Feelings of inadequacy

He found it difficult to feel proud of his accomplishments and good about his work. When he was younger, he remembered feeling "different" than others.

2. Difficulty legitimizing expression of feelings.

He found it hard to both allow and express feelings that he had (i.e., anger, desires, needs). He felt he should be more in control of feelings. He had trouble knowing what he wanted.

View of self in relation to others

3. Difficult relationship with wife

He felt hurt by the lack of affection and desire coming from his wife. He found it difficult to feel legitimate about his needs in relation to her. He felt responsible both for her feelings and responsible to his family to maintain normal family functioning.

#309

View of self

1. Negative view of self

He was very self-critical and self-doubting, particularly in relation to his career as an artist. He felt undervalued by both himself and society. He had many unrealistic expectations of himself. He would fluctuate between feeling bad and feeling resigned and a sense of futility in relation to his doubts. He identified a "spirit of condemnation" that he had inherited from his family.

View of self in relation to other

2. Feelings of responsibility for other's problems

He felt responsible for the problems of those with whom he was close, such as his wife and mother. He related this to the burden and responsibility he felt for his mother's unhappiness when his family had immigrated to Canada.

3. Unresolved relationship with father

He sought his father's approval with relation to his career and identity. He felt that his father never really quite understood or validated who he was and what he did.

#312

View of Self

1. Lack of self-worth.

She doubted her inner voice. She felt she was imperfect. At times, she felt she was stupid and that she had nothing to contribute. Through therapy she came to value her inner self, and to feel more self-accepting.

View of self-in-relation to other

2. Needing approval from others

She was afraid to assert herself for fear that others would not like her and abandon her. She met her own needs for attention through trying to please others. This stemmed from not getting what she needed as a child. She worked on accepting and legitimizing her own needs and feelings and asserting her own personal boundaries without being afraid of others abandoning her.

3. Unresolved feelings with father.

She felt invalidated by both parents: she felt that her father was controlling and manipulative, and that her mother was weak. She harbored a great deal of her major resentment towards her father, feeling that he had expected her to conform to his expectations, be calm, rational and productive, and did not allow her to express her own feelings and desires.