Emotional Processing in Experiential Therapy: Why “the Only Way Out Is Through”

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The purpose of this study was to examine observable moment-by-moment steps in emotional processing as they occurred within productive sessions of experiential therapy. Global distress was identified as an unprocessed emotion with high arousal and low meaningfulness. The investigation consisted of 2 studies as part of a task analysis that examined clients processing distress in live video-recorded therapy sessions. Clients in both studies were adults in experiential therapy for depression and ongoing interpersonal problems. Study 1 was the discovery-oriented phase of task analysis, which intensively examined 6 examples of global distress. The qualitative findings produced a model showing: global distress, fear, shame, and aggressive anger as undifferentiated and insufficiently processed emotions; the articulation of needs and negative self-evaluations as a pivotal step in change; and assertive anger, self-soothing, hurt, and grief as states of advanced processing. Study 2 tested the model using a sample of 34 clients in global distress. A multivariate analysis of variance showed that the model of emotional processing predicted positive in-session effects, and bootstrapping analyses were used to demonstrate that distinct emotions emerged moment by moment in predicted sequential patterns.

Keywords: emotional processing, emotion-focused therapy, distress, task analysis, change mechanisms

Within the field of psychotherapy research a growing number of investigators have suggested that the most essential questions to be addressed refer to the process of psychotherapy. In other words, “how” does change happen (Orlinsky, Grawe, & Parks, 1994)? Experimental research by Hunt (1998) has concluded that when it comes to recovering from dysphoria, “the only way out is through.” The purpose of the current article, which borrows from her title, is to show why that conclusion may be true in the context of psychotherapy. This article looks at how distress is changed in psychotherapy.

Emotional processing is described as a central process in exposure-based therapies (i.e., Foa & Kozak, 1998) as well as in integrative approaches to short-term psychodynamic psychotherapies (i.e., Fosha, 2000; McCullough et al., 2003). The role of processing underlying emotion has recently emerged as important to cognitive behavioral formulations of problems like generalized anxiety (see Borkovec, Alcaine, & Behar, 2004) and in cognitive therapy in general (Samoilov & Goldfried, 2000). Moreover, Elliott, Watson, Goldman, and Greenberg (2004) provided a broad framework for how emotional change occurs through the intrapersonal tasks described in emotion-focused therapy (EFT). However, although emotion has been championed in recent years as playing a crucial role in the process of client change in several major approaches to therapy, the claim still needs elaboration from both phenomenological and developmental perspectives. Furthermore, it will be important to elaborate the role of emotional processing in different treatment approaches, because facets of emotional processing likely apply differently across treatment models (Greenberg & Pascual-Leone, 2006). To formulate some specific model of how experiencing emotion actually changes people—or how “emotion changes emotion” to use Greenberg’s (2002) phrasing—researchers must examine the mechanisms underlying this process directly.

In their study on psychodynamic processes, Jones, Pare, and Pulos (1992) highlighted the need for more “in motion” descriptors of the evolution of change processes that permit an understanding of process as a sequence of patterns that extend over time” (p. 14). Again, in an article that applied dynamic systems to cognitive-behavioral therapy (CBT) processes, Hayes and Strauss (1998) argued that treatment research should study growth curve process in an effort to generate trajectories of change (see also Hayes et al., 2007). The current study follows this call to describe and examine patterns of client change, this time with respect to emotional processing in experiential therapy.

How clients might process highly aroused states of negative feeling is a question already considered by Greenberg and Paivio (1997). Based on both clinical theory and practice, they proposed a model for the restructuring of what they referred to as “bad feelings.” Greenberg and Paivio’s model of client processes reflected the treatment steps for evoking, exploring, and restructuring unhealthy emotion. As such, it stands as the null hypothesis for the current study. According to their model, restructuring bad feelings begins with attending to the aroused feelings followed by exploring the cognitive–affective sequences that generate those bad feelings. Eventually this leads to the experience of the output of some core maladaptive emotion scheme. Often, this is a form of fear,
shame, guilt, or sadness that represents an unhealthy and painful way of perceiving and experiencing oneself; one that is regrettably familiar to the client, like an age-old emotional wound. Greenberg and Paivio described the source for changing maladaptive emotion as being the introduction of something new, a new adaptive emotion that leads to a new perspective. In short, the essence of emotional reorganization is the creation of some healthy emotional alternative (i.e., assertiveness or appropriate grieving) in the face of a dysfunctional feeling and belief. The key transformational process in accelerated experiential dynamic psychotherapy, according to Fosha (2000), bears a lot of similarity in that it involves moving from distress through state transformation into an embodied (visceral, somatic) experience of core affect without defense, anxiety, or shame.

The proposed models of emotional transformation would benefit from a more detailed moment-by-moment description of how emotions actually interact and produce change. These ideas also need to be tested empirically. For a model of emotional processing to be applied and used by researchers and/or clinicians it must be concretized by observable phenomena and accompanied by some form of measurement. Finally, as indicated by Hayes et al. (2007), to show its broader clinical relevance, researchers must elaborate a moment-by-moment model of emotional processing in how it relates to the development of therapeutic changes sustained across treatment. In other words, the role of emotional processing must be considered across treatment as well as in the moment and in the session. This project addressed these issues in two separate studies by developing a model, testing it, and studying its process of change over the whole treatment.

Aside from work in EFT (Greenberg, 2002; Greenberg & Paivio, 1997; Greenberg & Safran, 1987), psychotherapies have not clearly articulated how people actually deal with their feelings of distress. On one hand, ideas of exposure and habituation do not adequately account for the emergence of categorically new experiences. On the other hand, explanations that simply appeal to a growth tendency still beg for some type of refinement and elaboration. Furthering researchers’ understanding of precisely how individuals shift their experience from emotional distress (i.e., the problem state) to some more meaningful and adaptive resolution state will open the way to advancement in both clinical theory and methods of intervention for any approach to therapy that targets emotion.

The task-analytic approach temporarily puts the therapist in the conceptual background so as to focus on optimal client process (Greenberg, 1999, 2007). So, this study is not about the role of the therapist in facilitating client emotional change but rather about how clients actually change. Productive client processes are not always self-evident, especially when it comes to negotiating painful emotion. Thus, the issue investigated here was whether emotional sequences exist during the in-session resolution of global distress. In this study, both discovery-oriented and validation phases of a task analysis were used to examine this change process (Greenberg, 2007).

STUDY 1: DISCOVERY-ORIENTED PHASE

Method

Participants

In the first round of discovery-oriented analyses, the sample consisted of six single sessions, each from a different client. Clients were selected from clinical trials of the resolution of interpersonal emotional problems (Greenberg & Malcolm, 2002; Paivio & Greenberg, 1995). The treatment protocol was EFT (also known as process experiential therapy) to help individuals resolve long-standing interpersonal grievance. Clients had given informed consent to have their sessions studied for psychotherapy research. The sessions selected ranged between Sessions 2 and 9 ($M = 5.2$, $SD = 2.9$). Each client’s session was selected on the basis of expert consensus by two assessors that it was a good representation of the treatment protocol, demonstrated substantial emotional distress, and would therefore be fruitful for a discovery-oriented examination. In the second round of discovery-oriented analyses, three of the original six cases were then examined across the course of their treatments (12–14 sessions).

Procedure

The discovery-oriented phase of task analysis involves a systematic program for constructing a specific model of client change process. This phase of task/process analysis was done in three steps, by developing (a) a rational model; (b) an empirical model; and, finally, (c) a synthesized model (for a detailed description of this method, see Greenberg, 2007).

Step 1: Rational Model

Drawing on the literature, investigators specified a model of how they thought the process of change occurred. Both investigators hold doctorates and are clinical psychologists, practicing and teaching experiential therapy. The model was developed within a framework of emotion research.

Specifying the task. The rational analysis began by delineating the emotional processing task, circumscribed by a problem state and an eventual end marker for when the task is achieved. Global distress marker refers to the problem state. This category of feeling (a) is an aversive state of suffering, (b) is high in expressive arousal, (c) is nonagentic and without a clear sense of direction, and (d) does not entail a clear and specific internal referent of experience. This emotion state is best characterized as an emotionally expressed distress reaction, with little or no substantive meaning elaboration. Commonly expressed examples of this type of emotion include undifferentiated hurt, hopelessness, helplessness, resignation, self-pity, unelaborated loneliness, vague self-blame, confusion, and undifferentiated complaint. Note that an expression of sadness may or may not be global distress, depending on the manner in which it is expressed.

This sort of emotional state can be described as being of high expressive arousal and low meaningfulness in regard to some personally sensitive theme and/or life event. Ratings of this state reach a minimum of 4 out of 7 on the Emotional Arousal Scale (Warwar & Greenberg, 1999); or the client must verbally report that his or her arousal is high, indicating that the emotion is activated. Moreover, the person experiences himself or herself as a passive recipient of this state. This state is nonagentic; it has no adaptive action tendency associated with it, and it usually lacks a sense of direction. The object of distress is never well elaborated; it is either unknown, minimally elaborated, or not addressed beyond a subjective sense of victimhood. Global distress has been referred to as secondary emotion in EFT and is often referred to as
defensive emotion or unformulated experience by psychodynamic–experiential theorists (i.e., Fosha, 2000; Stern, 1997). Thus, both of these approaches discuss global distress as an emotional reaction to some other, unarticulated, perhaps unformulated, affective-meaning processes. The reliability of identifying the marker state, global distress, was high, with reliability coefficients ranging from .76 to .91 (see Study 2).

Advanced processing indicators serve as end markers for the task. Because emotional processing is an open-ended problem with no specific end state, the advanced processing marker or end state cannot be defined in the same structured manner as the start marker, global distress. The “solution” for the transformation of global distress through a task that is referred to as emotional processing lies in meeting certain performance criteria that characterize skillful affective-meaning making.

Advanced emotional processing is indicated by any of the following: (a) new feelings being freshly experienced in the moment, expressed clearly in an integrative and affirmative fashion; (b) productive meaning making associated with the ongoing experience; (c) positive self-evaluation (either implicit or explicit); (d) agentic stance with an adaptive action tendency; (e) the identification of clear and specific object(s) of emotional concern. As with global distress, the reliability of identifying states that met criteria as advanced processing markers was high, ranging from .76 to .91 (see Study 2).

Specifying the task environment. The environment in which participants attempt this emotional processing task (a) is a validating, empathic interpersonal environment, supportive of emotional processes; (b) has minimal content directiveness; (c) has minimal interruption of emotional continuity; and (d) focuses attention on the client’s bodily felt experience.

Steps 2 and 3: Empirical and Synthesized Models

Empirical analysis required the creation of models for transforming distress by discerning the steps of advanced processing as observed in actual client performances. This was paralleled with developing criteria for the measurement of those steps. Thus, video recordings of the six psychotherapy cases were systematically observed to discover the essential steps in the advanced processing of distress. Then, based on the full cycle of rational and empirical analyses, a final synthesized model was developed.

Results

Task analysis of the emotional processing of global distress produced a synthesized rational/empirical model that represented the final results of the discovery-oriented phase of research. The diagram in Figure 1 shows key findings regarding clients who start with an expression of nonspecific emotional distress and progress to the productive emotional processing of that distress. A measure was also developed for identifying model components called the Classification of Affective-Meaning States (CAMS; see A. Pascual-Leone & Greenberg, 2005).

At the starting point of this model, the client in global distress is already emotionally aroused and engaged. From then on the path toward emotional processing is nonlinear and reveals that there is more than one way in which clients therapeutically transform states of global distress. However, according to these empirically grounded findings, each of the components in Figure 1 is a necessary stepping-stone in a nonlinear ladder toward emotional processing. Nevertheless, getting “stuck” in any of these states is what makes for disordered regulation and inadequate processing. Detailed descriptions and case transcripts elaborating the phenomenology of this differentiation process can be found in A. Pascual-Leone and Greenberg (2006).

Affective-Meaning States in Processing Distress

Global Distress

At the top of the model is global distress; this client marker state is one of feeling pain, hopelessness, helplessness, complaints, self-pity, confusion, despair, and so on. As described previously, this is a state of high expressive arousal (i.e., tears, emotional voice, etc.) and low specificity in meaning (i.e., the object of distress is often unknown, the client has no sense of direction). Characteristically the marker of global distress emerges suddenly, the person becomes dysregulated, and the specific concern at hand is often very vague and global. Sometimes, when therapists initially explore this, clients explicitly state that they do not know why they are feeling so inundated with distress.

For example, in a prototypical statement of global distress, Client 407 described, “I feel hurt, miserable, and angry and I’m tired of it. It’s so overwhelming,” followed by, “I don’t know what that pain is” (9 min into Session 12). Client 076 said in an emotional voice, “I feel terrible today . . . I burst into tears 10 times a day,” but when the therapist inquired as to what was going on, the client replied, “I’m not sure . . . I feel all alone and stuff like that” (2 min into Session 7). When clients in a state of global distress begin to elaborate and differentiate their thoughts and feelings, they subsequently move in one of two directions. The path on the right side of the model (toward fear or shame) is described first (see Figure 1).
Fear/Shame

This component state is both maladaptive and specific (compared to the global nature of the distress state). Although they are distinct emotions, fear and shame are functionally equivalent in their role here and moreover are often complementary aspects of the same specific and maladaptive emotional experience. In other words, as experiential states they embody similar pieces of information (i.e., affectively laden meaning) about the self vis-à-vis the environment. Clients in fear and shame experience themselves as feeling inadequate, empty, lonely, unable, and so on. This state represents a familiar source of deep and enduring pain and often carries some implicit meaning of “I am defective/bad” or “I am weak/insecure.” The meaning in this state refers to the self, and the action tendency associated with it is universally one of “closing down” or withdrawing. Part of what makes this “deep and enduring” is that the affective meaning is formulated by the client as a generic autobiographical memory—a collation of repeated occurrences within a specified type of interpersonal situation/context (Angus, Lewin, Bouffard, & Rotondi-Trarisan, 2004). As such, meaning entailed in this state is much more specific and differentiated than that in the examples of global distress cited earlier (for which there is very little autobiographical context).

For example, in describing his chronic sense of personal inadequacy and shame, Client 505 covered his face and said, “I have to monitor everything I say, even while I’m saying it because I’m . . . I know, or feel that everything I say is a bit off . . . People will do a double take when I speak and disregard me as a nutcase” (33 min into Session 5). In a session of fear, Client 516 shuddered and said of her mother, with whom she had a pernicious and emotionally abusive relationship, “I just have this sinking feeling, that—She’ll get me” (52 min into Session 8). In an example of feeling shame, guilt, and fear, Client 500 talked about being neglected as a child and stated “but then I still feel it’s my fault. I must deserve this . . . to be punished” (at the end of Session 9). Then she broke into sobbing tears.

Dialectical Construction 1: “I Am Lovable/Worthy”

The next stage in processing that occurs is a dynamic dialectical construction, represented by the first set of three arrows that are marked by a positive evaluation (see Figure 1). This is produced by first a progressive unfolding or differentiation of the presenting fear/shame state into both an existential need and a core negative evaluation about the self, and then a dynamic synthesis of these. The three arrows are used to indicate that the subsequent step is the product of an interactive process (rather than a simple state-to-state transformation). Thus, when a client begins to move beyond the experience of shame and fear, a critical moment of constructive abstraction takes place. Constructive abstraction has been described in the cognitive developmental literature as reading or collating invariances across different types of situations or contents to create higher order truths (Greenberg & Pascual-Leone, 1995; A. Pascual-Leone & Greenberg, 2006; J. Pascual-Leone, 1990).

The essence of statements that a client might make at this point based on feeling ashamed and/or scared might be as follows: “On the one hand, I have the sense that I am a really unlovable/ unworthy person [negative evaluation]—and on the other hand and at the same time, I feel like I desperately need that love/validation [need].” This statement captures several aspects of a client’s dynamic construction of meaning in the processing of emotional experience. Notice that both the need and negative evaluation are partly evoked by the same releasing cues (i.e., the preceding state of fear and shame), and yet these two parts are contradictory. These conditions of both simultaneous emergence and inherent opposition make the negative evaluation and the need a dialectical pair. The client will subjectively experience this internal state of contradiction as an impossible situation, finding it both very distressing and disorienting.

Eventually, the contradiction is overcome by the creation of new meaning through a dialectical construction that extracts invariances across the two positions. Within the context of a supportive relationship in which the need is attended to and activated, a new more positive evaluation of the self emerges as a synthesized outcome (i.e., the conclusion that “I am entitled to be loved/valued”). This evaluation regards the self in a new and positive way. By contrast, it also makes an appraisal of the circumstances as being unfortunate or unsatisfactory. When the client experiences the self and the need positively, this awareness also entails an implicit acknowledgement of loss or injury (i.e., “I still don’t have what I need, and I miss what I deserved”). Bridging two categories of meaning in this way to create a third, higher order meaning (through a dialectical construction) involves two important shifts. First, there is a shift in perspective from the other to the self as the judge of self-worth. Second, the new meaning entails a shift from the possible present (i.e., “I need/want/hope to be lovable/valued”) to the actual present (i.e., “I now experience myself as being lovable/valued”).

Rejecting Anger

Rejecting anger is a generic type of emotion (not yet specific in its meaning). It is characterized by feelings of protest, repulsion, hate, disgust, and so forth. This is usually expressed with relatively high arousal (i.e., angry tears, shaking head, fists, etc.) Moreover, the action tendency is one of either distancing or sometimes even destroying. For example, in a prototypic statement of rejecting anger, Client 505 said of his father, “I’m disgusted, I want to get rid of him” (40 min into Session 7); and on a different occasion, “He’s repulsive, I’d like to punch him out” (21 min into Session 3). What initially makes this emotion adaptive is that it is an agentic rejection of some noxious experience, as opposed to shrinking away or closing down, which as we have seen is characteristic of maladaptive fear and shame.

Although more differentiated than global distress (in that this emotion has a clearer action tendency, meaning, etc.), the state of rejecting anger is still not very specific or well differentiated in its meaning. A client who expresses rejecting anger essentially protests the noxiousness of a given situation but does not go on to elaborate the subjective experience of that situation. This, of course, is a step in the right direction toward adaptive self-organization and self-protection, but as an emotion it remains generic and unanchored in personal and idiosyncratic information.

In the left-hand path of Figure 1, further differentiating rejecting anger can transform the affective-meaning state of a client into a new type of emotion: assertive anger. In the right-hand path, clients who seem not to have a strong enough positive self-
evaluation or are unable to access existing emotional resources are faced with the difficult task of literally constructing a positive self-evaluation from aspects of their present emotional experience, which is a more difficult, laborious, and painful process.

**Assertive Anger**

Assertive anger has been grouped with self-soothing as a single component in the model in Figure 1. This is because although they are very distinct states that can be easily differentiated by an outside observer, these two affective-meaning states are functionally equivalent for processing emotional distress (just as fear and shame are also functionally equivalent). Assertive anger is essentially anger that has enough differentiation to embody a positive self-evaluation and the clear assertion of that evaluation or of some personal need. This means that assertive anger is not just about pushing away something noxious. More than that, it is about setting boundaries and engaging in a fight for one’s rights and/or existential needs. Some prototypical statements that represent assertive anger could be “I won’t accept this, I have value! I have been mistreated” or “I am different from you. I exist, I deserve.” Expressions of this state are both very specific and clearly adaptive.

As a case in point, after the expression of rejecting anger cited earlier, Client 505 went on to differentiate the meaning of his anger in an imaginary dialogue with his father: “It’s not right. I should have had a father who loved me . . . I didn’t deserve the way you treated me, it wasn’t a way to treat a child” (Session 7). In another instance of assertive anger Client 516 stated, “I can love, I am loveable. I have been mistreated and abused by you . . . It’s my right and I’m walking away, I want you to leave [me] alone!” (Session 8).

**Self-Soothing**

On some other occasions, after experiencing fear and shame and creating a positive evaluation through the dialectical synthesis of a negative evaluation and an existential need, some clients do not assert their need but rather directly address it. (Thus, some clients may not express anger over the course of processing their emotional distress.) Self-soothing or self-nurturing is the affective-meaning state that is characterized by fulfilling certain expressed needs oneself. This serves the same function as assertion, but instead of directing the emotion outward (i.e., in anger) it expresses the emotion as tenderness or caring turned inward toward the self.

This state can appear in several forms, including explicit self-soothing, attributed self-nurturing (as when the client roleplays a caring significant other), or acknowledgment of and reflection on existing resources (such as available social support, past personal successes, etc.). Some prototypical examples include when Client 521 spoke to herself reassuringly from the role of her parents, saying, “I love you. It’s going to be alright” (26 min into Session 7); or when Client 509 expressed grief over a serious falling out he had had with his siblings and with one sister, in particular: “Tremendous sadness . . . It means we won’t ever get together again, to have a swim, to have a BBQ, to . . . talk . . . I’m very sad about losing [her]. Oh! . . . She more than anybody” (Session 3, starting at 45 min). Client 505 reflected on something missing from his childhood relationships: “In many ways I never had a family. If it weren’t for extended family it wouldn’t have been much . . . I’m missing that particular type of love . . . the love that only a parent could give” (45 min into Session 7).

One should note that although assertive anger/self-soothing and hurt/grief can elicit one another, both of these model components exist and emerge as a result of some positive evaluation. In other words, they are two parts elaborated from the same ongoing experience. Assertive anger and self-soothing are states that represent the experience of, or lead to, need fulfillment, whereas hurt and grief are states that represent the very opposite—the lack of need fulfillment. As before, the conditions of both simultaneous emergence and inherent opposition make the components of assertive anger/self-soothing versus hurt/grief a dialectical pair (represented by the second positive evaluation in Figure 1).

**Dialectical Construction 2: “I Will Survive and Can Cope”**

It follows, then, that the final stage toward resolution is a second dialectical construction, this time between the experiences of assertive anger/self-soothing and the experiences of hurt/grief. On one hand, the client has the experience of “I feel wounded, I have lost the love” (hurt/grief), whereas on the other hand the client is at the same time aware that “I am strong and deserve to be loved/validated or I am currently being loved/validated” (assertive anger/self-soothing). The dialectical synthesis of these two states creates the new experience of acceptance and agency: “I will survive and can cope. I accept the past wounds/losses. I can let go and move on with the rest of my life.” This is a second positive evaluation of the self as confident and future oriented. If in the first
positive evaluation (discussed earlier) one of the shifts was from
the possible to the actual present, then at this point there is a shift
from the present to the future. At this point the client is in a
position for acceptance and agency of the distressing issues, which
meets all of the criteria of performances characterized as advanced
emotional processing (see the bottom of Figure 1).

Successful Emotional Processing

Acceptance and agency is not an end state but a momentary crystallization of “skillful” performance in emotional processing, aspects of which are also present in some other states. To resolve this type of open-ended problem (i.e., emotional processing), the client must maintain engagement among affective-meaning states near the bottom of the model. Every successfully performing client who begins in global distress is likely to go through each of the different states described previously, to reach other states that meet performance criteria for advanced emotional processing. In this sense, all of the states are “components” of a model for emotional processing. Of course, a given client will not usually accomplish emotional processing in a single session, or in one fell swoop, but rather in a “two steps forward, one step backward” fashion. This saw-tooth pattern of improvement has been observed both in single sessions and across sessions.

STUDY 2: VALIDATION PHASE

Hypotheses About the Structure of the Model

The validation phase is the second part of a task/process analysis. In this phase the model already developed in the discovery phase (Study 1) was reexamined using empirical criteria to test a larger sample of cases. This phase of research established predictive and external validity of the synthesized model using single sessions that were not part of the original model building. The microprocess research in this study did not attempt to predict final treatment outcome. Rather, the purpose of this study was to predict good in-session process. Most would agree that good in-session events are incrementally important to producing a good treatment outcome. The contribution of this research, then, is a prior step: to determine what emotional processes predict good events in therapy. The assumption, of course, is that good in-session events are the building blocks of good treatment and, as such, are highly relevant to clinical work.

Advanced Processing Hypothesis (Hypothesis 1)

The first test of predictive validity addresses the following question: Can good within-session effects (i.e., events that end in reduced distress and increased meaning making) be discriminated from poor within-session effects (such as events in which clients do not make new meaning) on the basis of model components? This hypothesis tests whether cases with positive within-session effects enter advanced model states more often than cases with poor within-session outcomes. In other words, it is predicted that clients who show good within-session effects are more likely to enter the states of hurt/grief, assertive anger, and self-soothing than those clients with poor within-session outcome.

Sequential Processing Hypothesis (Hypothesis 2)

This research hypothesis addresses the following question: Are components of the model sequentially ordered? In other words, are the model’s components really structured in a stepwise and sequentially ordered fashion, or is the ordering of the model’s components more reflective of chance? This hypothesis states that the first emergence of either hurt/grief or assertive anger or self-soothing (i.e., a Level 4 state) is always preceded by either negative evaluation or need (i.e., a Level 3 state), which in turn is always preceded by either fear/shame or rejecting anger (i.e., a Level 2 state), which in turn is always preceded by global distress (Level 1).

Method

Participants

Sample

The sample in this study of single sessions comprised 34 clients. This sample came from several larger participant pools originally recruited for four clinical trials completed at a large urban university psychotherapy research clinic between 1991 and 2002. All clients had given informed consent to have their sessions studied for psychotherapy research.

Sample Demographics

The research sample of 34 clients included 28 women and 6 men between the ages of 27 and 59 (M = 42, SD = 10.4). In all, 9 clients were single, 20 were married or common law, and 5 were separated or divorced. The education level of the selected sample included 12 graduates of college or university, 3 clients with some postgraduate education, and 9 clients who had postgraduate or professional school educations. Information on ethnicity was not systematically collected in each of the original participant pools, but the diversity of client ethnicities in the current sample is believed to be representative of a large multicultural urban area.

According to pretreatment assessments, the mean Global Assessment of Functioning score for the sample was 69.2 (SD = 10.7, range = 53–90). This mean score indicates mild to moderate symptoms of impairments in psychological, social, and occupational functioning. In the sample, 20 clients (58.9%) suffered primarily from mood disorders; another 6 clients (17.6%) suffered primarily from anxiety disorders. Five clients (14.7%) out of the total sample suffered from a secondary, comorbid Axis I disorder. There were 8 clients (23.5%) who did not receive any Axis I diagnosis at all, based on the Diagnostic and Statistical Manual of Mental Disorders (3rd ed., rev.; American Psychiatric Association, 1987). Based on the Structured Clinical Interview for DSM–IV, assessment for personality disorders indicated that 13 clients (38.2%) in this sample had Axis II disorders (American Psychiatric Association, 1994).

Therapists and Final Treatment Outcome

The relevance of providing final treatment outcome at this point, even if it is not pertinent to the design of this study, is to provide context. When describing a sample of selected sessions, the suc-
cessfulness of the treatment from which cases were taken is as relevant as the type of treatment or sample demographics. The psychotherapy in each of the four clinical trials differed slightly according to the nature of the original study. The therapeutic modalities included 32 clients in EFT (Greenberg, Rice, & Elliott, 1993) and another 2 clients in client-centered therapy (Rogers, 1957), both treatments that embody highly humanistic and experiential therapies. In the sample of 34 cases, treatment was conducted by 19 therapists (17 women and 2 men). Of these, 17 therapists were advanced doctoral students of clinical psychology and 2 were registered clinical psychologists. All therapists had a minimum of 3 years of clinical experience. Twenty clients in the sample had enjoyed good final treatment outcomes, and 14 had had poor final treatment outcomes (details on final outcome measures can be found in the articles cited earlier as sources for the sample).

Process Measure

The Classification of Affective-Meaning States (CAMS; A. Pascual-Leone & Greenberg, 2005) is an instrument for the systematic observation of emotion and affective-meaning states and was designed in the discovery-oriented phase of the task analysis. It measures discrete and specific emotional states that are unique to the model and that are central to the hypotheses of this study. Reliability coefficients for different facets of this measure are high and are reported in detail for the first time here (see the Results section of Study 2).

Measure for Within-Session Event Effects

Client Experiencing Scale. The Experiencing Scale (Klein, Mathieu-Coughlan, & Kiesler, 1986) is a 7-point scale that measures the degree to which clients orient to and symbolize their internal experience and use this felt experience as information to resolve their problems. It makes no reference to discrete emotions or affective states. The 7-point scale was reduced to a binary scale of low (Levels 1–4) versus high (Levels 5–7). Higher experiencing ratings at or near the end of a given emotion event were used as indicators of good event outcome with respect to the immediately preceding client processes. The Experiencing Scale is widely considered to be the gold standard of good experiential process and remains one of the most extensively studied and validated measures of productive in-session process in psychotherapy research. High ratings on this measure have been shown to be predictive of good treatment outcome across most major schools of psychotherapy, including client-centered, cognitive behavioral, psychodynamic, and emotion-focused psychotherapy (see Greenberg & Pascual-Leone, 2006). Interrater reliability coefficients for the measure have been reported to range from .76 to .91 (Klein et al., 1986).

Expert clinical judges. The second measure for determining good versus poor effects of within-session events was the binary evaluation of expert clinical judges, which provided clinical validity from a separate set of criteria. Note that client self-report measures of mood or functioning completed outside the session were not appropriate for this study because good versus poor effects were with respect to moment-by-moment events that were nested within a given session. Moreover, positive in-session effects are similar in kind to an insight or productive cognitive shift, and although they are theoretically and empirically regarded as productive, such microprocesses do not necessarily translate immediately into postsession mood or functioning.

Procedure

Event Selection

The first step in the procedure of data collection was selecting events relevant to the topic of inquiry. The unit of analysis in this study was a within-session emotional event of a naturalistic length that varied from client to client. This unit was not necessarily the whole session and was never more than one session. The model describes the affective-meaning state of global distress as the initial marker of the event. Accordingly, the criteria defining global distress served as identifying markers for the events to be studied. (See the coding criteria for global distress in the CAMS measure in A. Pascual-Leone & Greenberg, 2005.) The selection of global distress events was done in a series of convergent appraisals through the combined efforts of therapists, two independent raters, and the principal investigator. A total of 102 session videos from approximately 60 cases were initially reviewed for the presence of the marker. Markers were found in 34 cases, and only one session was taken per client.

Emotion Process Ratings

Ratings began with a confirmation of the preselected global distress marker, which served as the rater’s first code. Using the CAMS, the rater then coded emotion event continuously for the presence of any one of the given possible emotion codes. Raters were instructed to make codes as they saw them unfold sequentially and indicated the time at which they initiated a change in code. This procedure is well documented in ethology and is technically referred to as continuous cross-classification (Bakeman & Gottman, 1986; Martin & Bateson, 1986).

Identifying the Effects of In-Session Events

Raters using the Experiencing Scale were operationally independent from raters using the CAMS. High experiencing in the last 15% of each event was used as an indicator of good within-session outcome. An additional, confirmatory criterion for discriminating between good versus poor event outcome was the clinical judgment of an outside expert. The expert appraisal of event outcomes confirmed the identification of each good event outcome case. In only 1 case out of 34 clinical judgments was there disagreement between the judge and the Experiencing Scale ratings in discriminating between in-session event outcomes. In that case, the distress event had high experiencing in the last 15%, but the expert clinical judgment evaluated the event as having a poor within-session event outcome. However, the high experiencing that occurred was very brief in that event, and a second expert clinical judge independently confirmed the appraisal that it was indeed a poor-outcome event case. Because it so happened that if and when high experiencing occurred it only occurred in the last 15% of the event, sorting criteria did not produce any intermediate event outcome cases. In this way, the procedures resulted in the full sample (N = 34) being
subdivided post hoc into two equal groups. Thus, 17 cases were identified as good and 17 as poor within-session effects.

**Analyses**

**Advanced processing hypothesis (Hypothesis 1).** A total of 17 cases with good within-session effects were compared with 17 poor within-session effects on the number of times each group initiated different affective-meaning states in the model. This was done for all model components except the global distress marker, with which all cases began on account of the event selection. A $7 \times 2$ multivariate analysis of variance used seven predictor variables to test for differences on a single outcome variable. Thus, one rating for each predictor variable per selected event was used to predict event outcomes. Using this analysis allowed for both an omnibus measure of the model as well as $F$ tests for each model component.

The seven predictor variables were dichotomous; each indicated the presence or absence of either (a) fear/shame, (b) rejecting anger, (c) negative evaluation, (d) need, (e) hurt/grief, (f) self-soothing, or (g) assertive anger. A client entering a given affective-meaning state at least once in the duration of the sampled emotion event determined the “presence” of a state. If a client never entered a given state, then that affective-meaning state was considered “absent” from the emotion event. The event outcome variable was also dichotomous: good versus poor within-session outcome. As indicated, good and poor outcomes of selected in-session events were determined by high and low ratings on the Experiencing Scale at the end of the distress event (last 15%) and by expert clinical judgments.

**Sequential processing hypothesis (Hypothesis 2).** Data were recoded into a 4-point scale: (1) global distress, (2) fear/shame or rejecting anger, (3) negative evaluation or need, (4) assertive anger or self-soothing or hurt/grief. Following this procedure, if a given affective-meaning state in the data (a) emerged for the first time and (b) was preceded by affective-meaning state(s) from each and every one of the lower level(s) as specified by the 4-point scale, then it was considered to be in sequential concordance with the model. If, in contrast, a state (a) emerged for the first time but (b) was not preceded by hypothesized state(s) from each of the previous level(s) in the prescribed order, then this was considered to be a disagreement and not in concordance with the model. If state(s) from a particular affective-meaning level did not occur at all, it was considered neither a concordance nor discordance with the model.

Given that according to the research hypothesis the base rates for each level of component are predicted to be different (meaning not all combinations have equal probability), one cannot assume there is a normal distribution. In essence, there is no simple traditional inference method for this data set. For this reason the significance of observed findings compared to chance was determined using a bootstrapping technique (for an overview of this, see Hesterberg, Moore, Monaghan, Clipson, & Epstein, 2006).

To do this, we randomized the sequential ordering of the four levels of emotion states within each of the 34 cases, thereby producing a new “simulated” data set. Next, the number of times the hypothesis was fulfilled by chance was counted. This resampling procedure was repeated with replacement 100,000 times, thereby producing a probability curve known as a bootstrapping distribution. The likelihood of the observed data having occurred by chance was subsequently measured using an empirical $p$ value. In this way, it was possible to calculate the probability of the observed findings having occurred by chance (out of 100,000 simulations) without making assumptions of normality.

**Results**

**Reliability**

**Reliability of CAMS Process Measure**

Of the total sample of 34 cases used in this study, 27 cases (79.4%) were randomly selected and independently rated in their entirety by a second rater for the purpose of establishing reliability. With respect to the number of actual codes made during data collection, 352 out of 395 individual codes (89.1%) were rerated. Ratings produced by continuous cross-classification require different forms of reliability depending on how data are being used. First, the continuous nature of ratings required that independent rater agreement on what constitutes a discrete change in state be demonstrated; this is referred to as the initiation of observations and reached an agreement of 85.9%. Second, the classification of 11 different codes in the measure required that the sequential ordering of those classes also be reliable in the ratings (which they were; Cohen’s $\kappa = .91$). Third, the continuous nature of ratings required that an agreement be demonstrated between independent raters on the duration of any given unit of coding, and this was also shown to be high ($r = .76$). According to Fleiss (1981), levels of agreement above .75 can be considered excellent agreement above chance. Thus, the measure demonstrated high overall reliability.

**Reliability of Experiencing Scale Ratings (Measure of Within-Session Effects)**

One half of the data set (17 out of 34 cases) was randomly chosen to be coded by two independent raters to establish the reliability of high versus low experiencing ratings (i.e., on a binary scale). The interrater reliability was high (Cohen’s $\kappa = .88$), which was consistent with the measures of reliability from psychotherapy cases reported by Klein et al. (1986).

**Description of Groups: Good Versus Poor In-Session Effects**

Clients with good within-session effects had longer emotional events ($M = 32.0$ min, $SD = 12.8$) as compared to clients with poor event effects ($M = 21.5$ min, $SD = 12.7$), and that difference was significant, $t(32) = 2.40$, $p < .025$. There was no evidence that shorter and less effective events were truncated by running into the end of the therapy hour. There was no difference between groups ($n = 17$ vs. $17$) on demographic variables of age, marital status, or education (using $t$ test and chi-square analyses; all $p > .45$). This indicated that the two subgroups were representative of a homogeneous client population with respect to basic demographics.

The final treatment outcome and therapy from which events were selected served as a descriptive variable for the research sample. Although raters were blind to the final treatment outcomes of the 34 cases, 13 out of 17 with good within-session effects, as
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contrasted with 4 cases out of 17 with poor within-session effects, went on to eventually end in good overall treatment outcomes. This was a significant positive relationship between in-session effects (i.e., task resolution measured by high experiencing) and good overall treatment outcome, $\chi^2(1) = 4.37, p > .05$. Thus, outcome of single within-session events had some predictive power over treatment outcomes (explaining nearly 13% of the final outcome variance, $\eta^2 = 0.129$). Note that the predictive power of these selected sessions, in the context of 12 to 14 session treatments, was not the focus of this study. However, it does provide descriptive information about the sample of sessions and their relative importance to the clinical process.

**Advanced Processing Hypothesis (Hypothesis 1) Findings**

Presence of specific affective-meaning states coded by the CAMS was compared across both groups using a $7 \times 2$ multivariate analysis of variance (see Table 1). Clients with good as opposed to poor within-session effects used the model components to significantly different degrees (Wilks’s $\Lambda = .325$), $F(7, 26) = 7.723, p < .001$. Seven univariate $F$ statistics (one for each model component) determined the nature of group differences (see Table 1).

The emotional performance of all clients was statistically equivalent with respect to fear/shame ($p > .70$). Contrary to the hypothesis, rejecting anger occurred more often in good as compared to poor event outcomes ($p < .05$). Clients who had good within-session event outcomes expressed an existential need significantly more often than clients who had poor in-session events (good = 14/17 vs. poor = 6/17; $p < .005$). There was no significant difference in negative evaluations between groups (good = 10/17 vs. poor = 9/17; $p > .70$). As predicted by the hypothesis, clients with good within-session event outcomes more frequently initiated the three advanced model components of hurt/grief, self-soothing, and assertive anger (see Table 1). Clients with good event outcomes were almost 5 times more likely to engage the experience of hurt/grief ($p < .001$) and 6 times more likely to self-soothe ($p < .001$) than those clients who had poor within-session event outcomes. In addition, 9 out of 17 clients with good within-session event outcomes entered the affective-meaning state of assertive anger, as opposed to 0 out of 17 clients with poor event outcomes ($p < .001$). Overall, the aforementioned findings supported the advanced processing hypothesis (Hypothesis 1).

**Sequential Processing Hypothesis (Hypothesis 2) Findings**

Affective-meaning states coded by the CAMS were grouped into four levels in the model and then examined for their emergence in the correct or incorrect sequence according to the stated hypothesis. This was done for the distress event experienced by each of the 34 clients. If the first instance of a newly emerging state was preceded by a prerequisite state from each of the earlier levels as indicated by the hypothesis, this was counted as a concordance. Table 2 indicates the number of clients who experienced a given state in the hypothesized sequence over the number of clients who experienced that state (irrespective of sequence). Although the preceding analyses showed that advanced states occurred more often in the experiences of clients with good event outcomes, if and when they occurred in either event outcome, they generally occurred with the correct prerequisites (and this at a comparable rate for both good and poor in-session effects). Note that all clients experienced Level 1, global distress, before any other state entirely as an artifact of the process by which events were selected (see column marked Level 1). Because that particular model component was the “marker,” it was excluded from any calculations of sequential concordance. Although the second level in the model (fear/shame and/or rejecting anger) did not necessarily occur for every client, when it did occur it was always preceded by the previous level in the hypothesized sequence (i.e., global distress). If it occurred, the concordance of a Level 2 occurrence in the correct sequence was 100% because there were no degrees of freedom (34/34 cases started with Level 1). Table 2 only shows the number of clients who did experience a given state. However, Level 2 was not experienced at all by 4 of 34 cases (all of which eventually resulted in poor within-session effects). Level 3 was not experienced by 8 of 34 cases (2 resulted in good within-session effects, 6 in poor effects). Level 4 was not experienced by 14 of 34 cases (all of which were poor event

### Table 1

| Presence of Model States as Summed Across Clients and Their Between-Event Differences |
|---------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| State                           | In-session effects | 7 × 2 MANOVA: | Univariate | $F$ | $p$ | Partial $\eta^2$ |
|                                 | Good ($n = 17$) | Poor ($n = 17$) | $F$s ($df = 1$) | $p$ | $F$ | $p$ | $\eta^2$ |
| Fear/shame                      | 13 | 12 | 0.14 | .708 | 0.004 |
| Rejecting anger                 | 12 | 5  | 6.53 | .016* | 0.170 |
| Negative evaluation             | 10 | 9  | 0.11 | .738 | 0.004 |
| Need                            | 14 | 6  | 9.48 | .004*** | 0.229 |
| Hurt/grief                      | 14 | 3  | 23.05 | .000*** | 0.419 |
| Self-soothing                   | 12 | 2  | 17.78 | .000*** | 0.357 |
| Assertive anger                 | 9  | 0  | 18.00 | .000*** | 0.360 |

*Note. Global distress was the event marker and as such was present at the beginning of all 34 events. MANOVA = multivariate analysis of variance. *$p < .05$. **$p < .01$. ***$p < .001$. 
outcomes). Thus, model components in Levels 2, 3, and 4 did not necessarily occur.

The sequential processing hypothesis was tested using nested arguments. In this very stringent test of concordance, a Level 4 affective-meaning state was considered to have occurred in the correct sequence if and only if it was preceded by a Level 3 state, and that Level 3 state was in turn preceded by a Level 2 state. Thus, this approach to testing the hypothesis required that three qualitatively different kinds of emotion represented in the model emerge in a specified series, like links in a chain. Based on 100,000 randomized bootstrapping simulations, the findings in all 34 cases (irrespective of within-session outcome) were compared against chance. The hypothesized pattern was found to occur in 9 out of 18 cases (50%). Based on simulations of the sample, the randomized probability of this particular pattern in emotional experience taking place 50% of the time was shown to be less than 1 in every 250 samples, thereby indicating the statistical significance of this finding (empirical $p < .004$). This finding supported the sequential processing hypothesis (Hypothesis 2).

**DISCUSSION**

Prior to this investigation, the most thorough emotion-based model of how clients’ experiences of bad feelings actually change in therapy was that of Greenberg and Paivio (1997). Consequently, many of the steps in that method served as null hypotheses for the discovery phase regarding components for processing emotional distress. The new model both confirms this model and develops an original model of how bad feelings are restructured through emotional processing. Overall, progression through the model describes a differentiation of emotion states from global to more specific feelings/meanings (see vertical axis in Figure 1). This supports work by Stern (1997), who argued within contemporary psychoanalytic theory that working through distress begins by helping clients interpret raw, unformulated, “global” experiences.

**Table 2**

<table>
<thead>
<tr>
<th>Client in-session outcome</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Global</td>
<td>Fear/shame</td>
<td>Rejection</td>
<td>Assertive anxiety</td>
</tr>
<tr>
<td>Good ($n = 17$)</td>
<td>17/17</td>
<td>13/13</td>
<td>12/12</td>
<td>5/10</td>
</tr>
<tr>
<td>Poor ($n = 17$)</td>
<td>17/17</td>
<td>12/12</td>
<td>4/4</td>
<td>7/9</td>
</tr>
<tr>
<td>All ($N = 34$)</td>
<td>34/34</td>
<td>25/25</td>
<td>16/16</td>
<td>12/19</td>
</tr>
</tbody>
</table>

Note. The denominator indicates the number of clients who experienced a given state; the numerator indicates the number of clients who experienced that state in the predicted order. Some clients experienced more than one state at the same level (i.e., fear/shame and rejecting anger, both of which are at Level 2). This table does not contain information on the number of clients who did not experience a given level at all (i.e., neither fear/shame nor rejecting anger for Level 2). That information is in the text.

Not All Emotions Are Created Equal

Discerning the key affective-meaning qualities of emotions has demonstrated that not all forms of “sadness,” or not all forms of “anger,” are equally useful emotional experiences. A fine grain of refinement in the identification of emotion qualities, tone, and context is important when working with emotions, on both clinical and research fronts. The question to be answered is the following: “What type of anger?” or “What type of sadness?” Several authors have called for a more elaborate differentiation of anger types and anger-related problems (see Linden et al., 2003). This study identified observable, reliable criteria for rejecting anger and assertive anger and described their respective roles in the healing process of therapy. Differentiating these two types of anger is one important contribution of this work.

The model also discriminates between three types of sadness: one global and undifferentiated, one specific and maladaptive (i.e., blended with fear/shame), and one specific and adaptive (i.e., authentic grief/hurt). Work by Greenberg (2002; Greenberg & Paivio, 1997) has made the powerful distinction between primary versus secondary sadness in the therapeutic process. Secondary sadness, which is an emotional reaction to some more primary and underlying feeling, would be included here as global distress. The model suggests that global distress, on account of its ill-defined quality, is a prevalent form of maladaptive sadness. Moreover, when global distress as a form of sadness is differentiated in terms of feelings and meanings, it consistently leads to emotional states that are at least tinged with either fear (i.e., as in fear–sadness, such as feeling lonely) or with shame (i.e., as in shame–sadness, such as feeling worthless or empty). In short, the core facet of a maladaptive emotional experience seems to be fear and/or shame based rather than being the simple experience of sadness and loss.

**Emotional Experience as a Mechanism of Change**

The advanced processing hypothesis (Hypothesis 1) examined the model as a whole in terms of its relevance for the outcome of in-session events. A good in-session effect was defined as high experiencing at the end of a selected emotion event and was verified by expert clinical judges as being “therapeutically productive.” When examining the probability of entering any given emotional state, it was especially clear that although clients who enjoyed good in-session effects were having longer emotional experiences, they were also having qualitatively different emotional experiences than clients with poor event outcomes. In general, good in-session effects were preceded by a more diverse array of qualitatively distinct emotional processes.

As predicted by the model, most early model components were shown to be present in both good and poor within-session events. For the most part this means that clients experience both global distress and fear/shame regardless of the outcome of the event.
Rejecting anger, in contrast, was unexpectedly significantly more related to good event outcomes, albeit with the smallest effect size. However the case may be, sequential findings were significant in the final analyses, lending support to the description of rejecting anger as an early model component.

Intermediate model components that represented the level of personal evaluation and reevaluation proved to be a point of critical distinction between good and poor in-session effects. Statements of negative evaluation about the self were shown to be present in virtually the same number of cases across event outcome. Thus, painful and heartfelt statements about feeling worthless, frail, or unlovable could not be predicted by in-session outcome—just as the experience of fear/shame could not distinguish between event outcomes. However, a heartfelt statement expressing an existential need to feel valuable, lovable, safe, or alive was predictive of good in-session event outcomes (i.e., high experiencing levels).

This finding is consistent with Greenberg and Paivio’s (1997) model and supports the view held in EFT that the expression of a need—a wish for attachment, personal agency, or survival—is the “gateway” to deeper emotional experiencing (Greenberg, 2002; Greenberg & Paivio, 1997; Greenberg et al., 1993). Of course, even though the expression of a need may herald more adaptive emotion, it is not synonymous with adaptive emotion and does not ensure deeper levels of experiencing. This is indicated by the fact that approximately one third (6/17) of the clients who had poor in-session events expressed a core need. The key differentiating factor between event outcome groups is likely to be whether the expression of a need is embodied and followed by the emotional impetus of advanced model components (as discussed below). Even so, this finding offers an empirically supported clarification for CBT: Identification of a core negative belief (i.e., a negative evaluation) is indicative of therapeutic progress (Beck, 1995), but more so in experiential therapy if it is followed by the explicit articulation of an existential need.

The overwhelming majority of clients with good within-session events were characterized by the presence of advanced model components. Thus, engaging in the affective-meaning experiences of hurt/grief, self-soothing, and/or assertive anger was predictive of good in-session outcome. These findings support the advanced processing hypothesis (Hypothesis 1) and validate both the models of Greenberg and Paivio (1997) and the current model that was derived through task/process analysis. The model is empirically related to good in-session effects, and clients who have good versus poor effects experience components of the model in systematically distinct ways.

Sequences of Productive Emotion

This part of the study begins to address the call made by a number of psychotherapy researchers (i.e., Hayes et al., 2007; Jones et al., 1992) for the description of growth curves and the analysis of sequential patterns in client change. Findings supported the sequential processing hypothesis (Hypothesis 2), validating that the first time a given model component occurred it followed at least one component from each of the preceding model levels (irrespective of lag or other interjected states). In concrete terms, the first emergence of advanced states (either hurt/grief or assertive anger or self-soothing) was preceded by an intermediate state (either negative evaluation or need), which in turn was preceded by an early state (either fear/shame or rejecting anger), which in turn was preceded by global distress. Thus, when the emotional experience of clients included all four levels in the model, that experience unfolded in a step-by-step sequence that was predicted by the model and occurred significantly more often than chance. This sequential processing hypothesis was supported by the sample as a whole, irrespective of good or poor in-session outcome.

Overall, these findings suggest that when certain prerequisite affective-meaning states occur it increases the likelihood that emotional processing of global distress will reach the final stage. One explanation why these canonical moment-by-moment patterns may exist is that emotional experiences develop in predictable patterns due to the psychological proximity between affective-meaning states involved. These findings support the hypothesis that model components are organized in a sequential structure that is empirically grounded.

In recent works in EFT, Greenberg (2002) introduced the conceptualization of two- and three-step emotional change processes. Clients undergoing a three-step change process, according to Greenberg (2002), find themselves confronted with more deeply rooted emotional obstacles than simply secondary/defensive emotion. The three-step process is perhaps the single most important contribution of emotion-focused interventions and theory to understanding emotional processing. In this series of emotional shifts, successful clients move in their moment-by-moment experiences from (a) a secondary emotion to (b) a primary maladaptive emotion and eventually to (c) a primary adaptive emotion that is activated through the articulation of an existential need.

As discussed in the results of Study 1, global distress represents a secondary emotion; fear/shame represents primary maladaptive emotions; and assertive anger, self-soothing, and hurt/grief each represent primary adaptive emotions. Thus, the three-step process of change conceptualized by Greenberg (2002), that is, how emotion changes emotion, can be described concretely using affective-meaning states from the current model. Note that “emotion” is understood here as the complex synthesis of both affective feelings and the meaning embodied by those experiences (hence “affective-meaning” states). More important, for the first time, the three-step model of emotional transformation in EFT is empirically supported by these findings as a general change process. The ordering of states and dialectical syntheses (i.e., transformations) in this empirically supported model also bear some resemblance to the clinical and theoretical observations made in accelerated experiential dynamic psychotherapy, in which core affects are accessed and transformed (Fosha, 2000).

The sequential processing hypothesis (Hypothesis 2) findings are critical in demonstrating that this model of emotional processing is actually a process model rather than a model of “attainment” or “missing ingredient.” Clients with poor in-session effects are missing the experience of the advanced model components, and, for clients with good event effects, those components are attained by following a particular sequential process. This study speaks to productive client processes without addressing its causal determinants. Whether sequential patterns are primarily explained by spontaneous self-organizing processes (within a described therapeutic context) or by participation in some specific task is a separate question that is beyond the scope of this inquiry. Therefore, one could also interpret the current findings as characteristic
of intervention approaches generally employed by experiential therapists, which might imply that more directive approaches, such as CBT, could generate different sequences.

**Productive Emotion or Unproductive Emotion?**

As the model shows, some emotions, such as hurt/grief or assertive anger, will be painful and unpleasant but will promote healing. This makes it impossible to separate positive and negative emotions as if they were healthy and unhealthy, respectively. Assuming that unpleasant or negative emotion is unhealthy overlooks the primary function of emotions as being adaptive (Frijda, 1986; Greenberg & Safran, 1987; LeDoux, 1996). In addition, one must also be careful not to consider more superficial states of affective meaning, such as rejecting anger, as categorically dysfunctional in therapy. Rejecting anger is often a useful approximation toward assertive anger, and it represents a step in the right direction toward self-assertion and eventual resolution. As the process model suggests, none of the affective-meaning states are inherently pathogenic. However, getting stuck or persistently “repeating” any one of these components will cause emotional disorder, whether that component is global distress, fear/shame, rejecting anger, hurt/grief, or even a sense of need. In this way, the client’s moment-by-moment experiential history is what most clearly tells which model components are main sources of difficulty and which others will usher in new experiential meaning for the client.

Some emotional experiences propel the client on a healthy self-organizing trajectory that reaches its completion as a meaningful, emotionally differentiated, and integrative experience. However, before such an experience is carried forward it may begin as a sense of intense, poorly regulated, and ill-defined global malaise. Thus, potentially injurious affective-meaning states such as global distress, fear/shame, or negative emotions could be painful and stagnant or could be rendered into important affective meaning to be developed forward into an emotional experience that eventually results in healing. In the sequential order of change, working with painful emotion is accepted as contributing to emotional processing and resolution.

**A Guide for Therapists**

In conclusion, these findings show that certain emotional patterns predicted well processed emotion during in-session events. Moreover, the nature of these events was positively related to treatment outcome. The implication is that good in-session events (measured by high experiencing) are eventually important and relevant to good overall outcomes in therapy, something that is well supported by the literature on the relationship between client experiencing and outcome (Greenberg & Pascual-Leone, 2006). Thus, the major contribution of this study is to show that a processing sequence of emotions posited by the theory of a specific approach (EFT) can empirically predict a peak in productive emotional processing according to the unrelated measure depth of experiencing, which itself has repeatedly been demonstrated to predict good treatment outcomes across types of treatment.

The findings of this project are formulated in terms of clients’ concrete emotional experiences (i.e., states and transitions), and, as such, they offer a model for guiding therapeutic work with global distress. First, therapists familiar with this model may recognize their client’s unfolding states of feeling and meaning by using the criteria of model components described here. Second, familiarity with the sequences of productive emotional processing will help therapists identify those facets of complex client experience that are viable alternative states of self-organization and that, therefore, would be most helpful to explore. Thus, this model could be used within different approaches to inform which type of interventions will be most fruitful according to the client’s presenting state and proximal zone of emotional development at any given time.

**Limitations**

The client population in this study was restricted to those who suffered primarily from depression and/or long-standing interpersonal grievances and who had been screened for suitability for brief treatment. Moreover, all clients were treated with experiential therapies, and the investigation was done within an a priori framework of emotion research. Therefore, these findings are not generalizable to the population at large or to other therapeutic contexts. It will be important for future research to show that the same sequences can be observed in globally distressed clients receiving psychodynamic or cognitive behavioral therapies. Even so, the speculation that these findings represent aspects of emotional development is provocative and suggests that the model might reflect characteristics of how humans process emotional distress.

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